Transforming Health and Health Care: Focus on Maryland

An AcademyHealth Symposium Exploring the Role of Health Services Research in State and Local Policy and Practice

by Bruce Steinwald, Margo Edmunds, and Gerry Fairbrother

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Introduction
Transforming health care delivery into a system that improves population health, enhances the patient experience, and constrains cost increases is a priority for clinicians, health services researchers, and policymakers. These aims were also the focus of the day-long symposium, “Transforming Health and Health Care: Focus on Maryland,” hosted by AcademyHealth. Meetings that set out to tackle these difficult issues are important for a variety of reasons. Substantive health care reform requires building communication channels and trust between entities that have not often worked together in the traditional health care delivery system. By bringing together people from disparate organizations to share information, discuss common goals, and showcase innovations across settings, this meeting began to lay the foundation for a “learning system” essential to achieving meaningful transformation.

Convened by AcademyHealth on the campus of the University of Maryland, Baltimore County (UMBC) on June 21, 2013, this was the second of what is expected to be a series of meetings sponsored by AcademyHealth preceding, and in the location of, its annual research meeting. The first meeting was held at the University of Central Florida in Orlando on June 22, 2012, and the third meeting will be held in San Diego in June 2014. AcademyHealth, as a national organization of health services and policy researchers, is uniquely positioned to convene meetings of this nature. With a focus on delivery system transformation, health care cost and value, and public and population health, AcademyHealth is engaging partners at local, regional, and national levels to foster the type of shared learning that is necessary to transform the health care delivery system.

“Transforming Health and Health Care: Focus on Maryland” was opened with welcoming remarks by Lisa Simpson, president and CEO of AcademyHealth. Joshua Sharfstein, secretary of the Maryland Department of Health and Mental Hygiene, then offered the opening keynote address on the important topic of aligning health and health care. Margo Edmunds, vice president for evidence generation and translation, and Gerry Fairbrother, senior scholar, AcademyHealth, followed by providing an overview of the Maryland demographic and delivery system landscape.

The following panel discussions made up the bulk of the remaining presentations. (biographical sketches of the panelists and their presentation titles may be found in the appendix).

- The Promise and Potential of HIT/HIE: Quality Analysis and Assessment
- Lowering Health Care Costs and Improving Health Care
- Population Health Focus: The Evolving Relationship Between Health Care and Public Health Systems
- Focus on Disparities Reduction: Maryland’s Health Enterprise Zones and Local Health Improvement Programs
- Reflections on the Day: Industry Perspectives

The final panel identified several themes that emerged during the day’s conversation. For purposes of this summary, they are reduced to the following four:

- The role of partnerships in achieving system reform goals collaboratively
- Research and data as the emerging drivers of determining which directions to take
- Patient centeredness and empowerment as key factors in improving health care delivery and health
- Challenges that must be met to achieve meaningful health care reform

Closing remarks were delivered by Freeman Hrabowski, III, President of UMBC. He observed that the purpose of universities is to address the “sticky issues of the day,” which is why he founded the Hilltop Institute at UMBC (one of the meeting co-sponsors) to conduct critical analysis and provide decision support to advance the health of vulnerable populations. Dr. Hrabowski also connected this purpose to training UMBC’s students for careers of the future, particularly in science and technology, so they can also be prepared to tackle the challenges of tomorrow. From the day’s discussions, participants clearly agreed that transforming health care delivery is, indeed, one of the sticky issues of the day.

The remainder of this summary will provide a review of the Maryland landscape and an overview of the key themes that emerged from the day’s discussions. While most of the attendees were from the Baltimore-Washington area, the key themes that emerged and are described in this summary are useful for readers from across the country in considering their own states’ reform efforts. The summary also includes an appendix where, in addition to speaker bios, the meeting agenda, list of participants, and slides covering the Maryland landscape may be found.

Additional presentation slides may be accessed at http://www.academyhealth.org/Events/events.cfm?ItemNumber=10996&navItemNumber=1995
Maryland Overview
Despite its relatively small size, Maryland is a remarkably diverse state. With a population of 5.9 million, it is the 19th most populous state. However, 90 percent of Maryland’s population is concentrated in the Baltimore-Washington corridor, leaving large rural areas in both Western Maryland and on the Eastern Shore. Further, Maryland is diverse racially, with substantial proportions of African-American residents and rapidly growing Hispanic and Asian populations. While Maryland’s poverty rate (10.2% in 2011) is lower than the national poverty rate (15.1% in 2011) and among the lowest in the nation, there are areas of significant poverty, including portions of Somerset and Allegany counties and the city of Baltimore.

Maryland had the 8th lowest uninsured rate in 2010, 11.7%, at the time when the national uninsured rate was 16.4%. Again, just as with the poverty rate, there are areas of Maryland with higher uninsured rates, including Prince George’s county (17.0%). Looking at county health rankings, similar disparities can be seen. For example, the city of Baltimore has the worst health outcomes, based on key indicators such as tobacco use, education, and access to care. However, just 20 miles outside of Baltimore, Howard County has the best county health ranking in the state.

There are a total of 60 hospitals in Maryland, 15 of which are located in Baltimore City, and 18 systems with Federally Qualified Health Centers in the state. Rural areas of the state are faced with limited access to places of care and safety net providers. Maryland also has five Health Enterprise Zones (HEZs) that were established by legislation in 2012 that provides $16 million over four years to improve health (see Box 1 and Figure 1). The Maryland Health Benefit Exchange, which has selected six regional connectors, is charged with enrolling consumers into the appropriate health insurance product.
Partnerships
In his keynote address, Secretary Sharfstein made it clear that Maryland’s health care transformation strategy relies heavily on the formation of partnerships involving both public and private entities. Examples include the efforts of the Health Enterprise Zones (HEZs) and State Health Improvement Process (SHIP—see Box 2) to reduce disparities in population health outcomes. Organizational responses range from urban coalitions, such as the West Baltimore Community Asset & Resource Exchange (CARE), to largely rural entities, such as the MedStar St. Mary’s Hospital-based HEZ involving St. Mary’s County government agencies.

Box 2: State Health Improvement Process (SHIP)
The Maryland State Health Improvement Process (SHIP) was launched by the Department of Health and Mental Hygiene (DHMH) in October 2012 to establish a framework for accountability, local action, and public engagement to improve the health of Marylanders. SHIP is implemented through the work of 18 Local Health Improvement Coalitions (LHICs) and uses 39 separate measures to evaluate health-improvement progress. The measures are linked to the following DHMH vision areas:
- Healthy Babies
- Healthy Social Environments
- Safe Physical Environments
- Infectious Disease
- Chronic Disease
- Healthcare Access

Source: Maryland Department of Health and Mental Hygiene

Public-private partnerships are also developing to expand the availability and use of data to both understand and respond to population health needs. An example is Adventist HealthCare’s creation of the Ambulatory Care EMR Support (ACES) Program to encourage electronic health record (EHR) adoption in ambulatory clinics serving low-income residents in Montgomery County, Md. This program is building a health information exchange (HIE) system that is integrated with the state’s Chesapeake Regional Information System for Our Patients (CRISP) to reduce disparities in population health outcomes. Organizational responses range from urban coalitions, such as the West Baltimore Community Asset & Resource Exchange (CARE), to largely rural entities, such as the MedStar St. Mary’s Hospital-based HEZ involving St. Mary’s County government agencies.

Box 3: Chesapeake Regional Information System for our Patients (CRISP)
The Chesapeake Regional Information System for our Patients (CRISP) was incorporated in 2009 as a not-for-profit membership organization, with the intention of building a statewide Health Information Exchange (HIE), chartered to serve all Maryland providers and patients. CRISP operates under the direction of the Maryland Health Care Commission (MHCC) whose Center for Health Information Technology helps to facilitate development of the statewide HIE, crafts policy around privacy and security, and develops initiatives to expand health information technology adoption, including electronic health record adoption and meaningful use. Policy direction is provided by the MHCC consumer-oriented Board, including the determination that Maryland will be an opt out state for patient participation in the HIE. The following types of data are available to providers from CRISP:
- Patient demographics
- Lab results
- Radiology reports
- Medication fill history
- Consults
- Discharge summaries
- History and physicals
- Operative notes

Source: Chesapeake Regional Information System for our Patients (CRISP)

Another example, shared by Matthew Levy, is Medstar Health’s partnership with the US Department of Health and Human Services and the Maryland Department of Health and Mental Hygiene, as well as the American Heart Association and the American College of Cardiology, to prevent 1 million heart attacks and strokes over 5 years. Among other things, the Million Hearts Campaign is developing EHR features that make it easier for clinicians and their patients to “do the right thing” to reduce risk of heart attack and stroke. For example, as indicated in Figure 2, the EHR prompts providers and patients to “remember your ABCS” – appropriate Aspirin therapy, Blood pressure control, Cholesterol management, and Smoking cessation.

Figure 2: Premise of Million Hearts – Improve the ‘ABCS’ of Modifiable Cardiovascular Risk

<table>
<thead>
<tr>
<th>Modifiable Risk</th>
<th>2012 National Baseline</th>
<th>2017 Clinical Target</th>
</tr>
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<tbody>
<tr>
<td>Aspirin use for Primary Prevention of MI/Stroke</td>
<td>47%</td>
<td>70%</td>
</tr>
<tr>
<td>BP – screen and control</td>
<td>46%</td>
<td>70%</td>
</tr>
<tr>
<td>Cholesterol – screen and control</td>
<td>33%</td>
<td>70%</td>
</tr>
<tr>
<td>Smoking – cessation</td>
<td>19% current smokers</td>
<td>↓ by 10% (17%)</td>
</tr>
</tbody>
</table>

Source: Million Hearts Initiative
A community-integrated medical home model is being implemented in Maryland through a partnership between community health and primary care. This is being implemented through collaboration and data sharing between the community health worker and the care manager in the provider organization (See Figure 3). Ultimately, it will be impossible to reform the delivery system to value health over service volume without effective collaboration between governmental entities and mostly private providers of care.

**Research and Data**

A crucial part of the public-private collaboration model described above is the creation and sharing of data that enable each participating entity to understand and enhance its role in improving population health. According to Jonathan Weiner, Director of the Johns Hopkins Center for Population Health Information Technology, “Health IT alone will not lead our health care system to becoming population-health-focused, but we cannot have a population-health-focused system without health IT.” As explained by Scott Afzal, Maryland has made a substantial investment through its CRISP program to create an extensive patient (or identity)-based data set that includes, among other things, GIS mapping by patient zip code or address (See Figure 4). As mentioned previously, the CRISP system can notify practices when any of their patients are seen in a Maryland hospital or ED. This allows the practice to follow up and enroll the patient in case management or develop another appropriate intervention. “Has the patient been CRISPed yet?” has become a common inquiry among the various entities that are using the data for care management and other purposes.

The power of effective use of data to drive behavioral change is exemplified by Kaiser Permanente’s (KP) efforts to control hypertension within its insured population, including some Maryland residents. As shown in Figure 5, KP’s tracking, outreach, and measurement of performance in adhering to guidelines in this area have achieved remarkable success.

According to Amy Compton-Phillips, KP’s integrated delivery system facilitates managing change at the group rather than individual provider level. However, most of Maryland’s population is not enrolled in Kaiser-like managed care, and efforts to create population-based reimbursement systems are still in an early stage. Nevertheless, coalitions are forming to implement data-driven actions to improve population health. The 18 local health improvement coalitions that comprise the State Health Improvement Process have adopted 39 measures of health outcomes and determinants and have established baselines for these measures and 2014 targets.

According to Laura Herrera, the state’s actions on this front embody the philosophy that effective use of data will both enhance population health and reduce health care costs. At the same time, many private organizations representing the interests of employers and other purchasers are developing data and methods to implement value-based purchasing systems for privately insured populations. As John Miller said in his presentation, reducing costs without rationing is also a form of quality improvement.

**Patient Centeredness and Empowerment**

A population-health-based delivery system requires greater patient involvement than the current delivery system. After all, patients, even those with chronic illnesses, only spend a small fraction of their time receiving health care services.

The evolving health policy scene in Maryland is designed to give patients access to information that helps them manage their health and their health care. For example, as part of the Million Hearts Initiative, Kaiser Permanente and MedStar Health provide after-visit report cards that describe reasonable steps patients can take to reduce their risk of heart disease and stroke, such as changing their health habits by improving their diets and becoming more physically active. This personalized and actionable information not only becomes part of their medical records, but also helps them to set achievable goals to improve their health.

Most, if not all, of the innovative new programs that are expanding HIT capabilities are enabling Maryland residents to expand their access to their own data through “portals,” mobile apps on smartphones, and other means, allowing them to access their “numbers” at any time, and to use this information to better manage and make decisions about their care.
As stated by Newell McElwee, “data is the new currency.” Not only is this true for providers and insurance entities, but also for patients, as access to data empowers them to become true partners in their own care. In speaking about common ground between medical care and public health, Jonathan Weiner described this new environment as a “digital milieu” with the provider-patient relationship at the center of a large integrated delivery system that interfaces with the community and the larger population.

Much has been written about the promise of patients having more “skin in the game” in their health care and behavioral choices and giving them access to actionable information to enable them to make more effective decisions. Instead, patient empowerment is accomplished through giving patients and families data and latitude for collaborative decision-making with their practitioners and care teams, health coaches, and other community-based resources such as YMCAs and support groups. For example, the Horizon Foundation supports local obesity prevention efforts in Howard County, which has Healthy Schools, Healthy Restaurant, and Healthy Workplace programs to help promote healthy lifestyles and improve population health.

**Challenges**

In Maryland, as in other states, several challenges must be met in order to encourage the delivery system to value population health. Doing this requires creating financial incentives that replace the tendency of fee-for-service reimbursement to drive volume and costs upward.

Maryland is the only state to have an all-payer payment system for hospitals and a waiver from CMS that provides Maryland authority to set payment rates for Medicare, through the Maryland Health Services Cost Review Commission. As indicated in Figure 6, Maryland is developing reimbursement structures that alter hospital financial incentives.

However, the test that permits the state to maintain its waiver focuses on per-case costs of inpatient hospital services. This makes it difficult, according to Mary Beth Pohl, for the state to provide incentives aligned to population health and comprehensive coordinated care across different settings. The per-case orientation of the waiver implicitly perpetuates the fee-for-service mentality that the state is trying to overcome.
Despite this impediment, the state is determined to reform its delivery system. For example, 10 rural hospitals have been converted to Total Patient Revenue systems that utilize population-based rather than service-based reimbursement. Other innovations spring from the state’s community centered activities, such as the Health Enterprise Zones and private sector reforms. An example of the latter is the program adopted at Anne Arundel Hospital to make extensive use of order sets to reduce errors and unnecessary utilization of services. The program, as described by Barry Meisenberg, is designed to encourage physician leadership to improve communication on all types of patient handoffs and to make effective use of electronic health records.

**Conclusion**

Although the purpose of the meeting was not to explicitly contrast Maryland with other states, the ways in which Maryland’s health care delivery and financing systems are different from, or similar to, the rest of the country entered into the conversation many times during the day.

Maryland, as the only state to have an all-payer (including Medicare) rate setting system for hospitals, is different from other states. Nevertheless, Maryland’s attempt to modernize its health care delivery system by emphasizing total costs of care rather than the prices of individual services and hospital discharges may provide lessons for other states. As is the case with all states, the incentives of fee-for-service payment to drive cost increases and perpetuate uncoordinated care must be attenuated to achieve meaningful delivery system reform.

Maryland is fully participating in the provisions of the Patient Protection and Affordable Care Act (ACA), including the Medicaid expansion and creation of state-based exchanges under the Maryland Health Connection to provide subsidized health insurance for its low-income population and small employers. Maryland research entities also are taking advantage of funding from the Medicare and Medicaid Innovation Center to promote and evaluate community integrated medical homes and Accountable Care Organizations.

Finally, Maryland is attempting to coordinate its efforts to make health data universally available to providers, payers, and patients with its parallel efforts to make health care delivery and public health entities work together. As noted by John Colmers, there is much work that remains to be done, but it is an exciting time to be involved in health policy and reform. If Maryland is able to accomplish the goal, as one presenter asserted, of becoming the first state to move to a population-based health care delivery system, then the cutting-edge steps the state has taken will be of interest to other states that want to reform their delivery systems to value population health over volume of services.

**About the Authors**

Bruce Steinwald is an independent, Washington, DC-based consultant who focuses on health policy, economics, and financing. Margo Edmunds is Vice President, Evidence Generation and Translation, at AcademyHealth, and Gerry Fairbrother is Senior Scholar at AcademyHealth.
Appendix A: Agenda for “Transforming Health and Health Care: Focus on Maryland”

8:30 – 9:00 am
Registration and Continental Breakfast
Lecture Hall Foyer

9:00 – 10:00 am
Opening Plenary
Lecture Hall Room 104

Welcome and Goals for the Day
Lisa Simpson, President and CEO, AcademyHealth

Opening Keynote
Joshua Sharfstein, Secretary of Health and Mental Hygiene, State of Maryland
Topic: Aligning Health Care & Health in Maryland

Highlights of the Maryland Landscape
Margo Edmunds, Vice President for Evidence Generation and Translation, AcademyHealth and Gerry Fairbrother, Senior Scholar, AcademyHealth

10:00 – 11:15 am
The Promise and Potential of HIT/HIE: Quality Analysis and Assessment
Chair: Robin Newhouse, Professor and Chair of the Department of Organizational Systems and Adult Health, University of Maryland School of Nursing

Panelists: Amy Compton-Phillips, Associate Executive Director for Quality, The Permanente Foundation, LLC
Topic: Leveraging HIT for Healthcare Transformation

Scott Afzal, HIE Program Director, Chesapeake Regional Information System for our Patients
Topic: Leveraging Maryland’s HIE Infrastructure to Support Health Care Payment and Delivery Reform

Matthew Levy, Associate Medical Director of Ambulatory EHR and HIT Policy, MedStar Georgetown University Hospital
Topic: Million Hearts Initiative

11:15 – 11:30 am
Break

11:30 – 12:45 pm
Lowering Health Care Costs and Improving Health Care
Moderator/Chair: Harold Miller, Center for Healthcare Quality and Payment Reform

Panelists: Mary Beth Pohl, Deputy Director for Research and Methodology, Health Services Cost Review Commission
Topic: Hospital Rate-Setting in Maryland

Barry Meisenberg, Chair of Quality and Director, Anne Arundel DeCesars Cancer Institute
Topic: Improving Clinical Quality and Services in an Era of Constrained Resources

Meg Murray, CEO, Association for Community Affiliated Health Plans
Topic: Innovations in Safety Net Health Plans

12:45 – 1:45 pm
Networking Lunch
University Center Ballroom

1:45 – 3:00 pm
Population Health Focus: The Evolving Relationship Between Health Care and Public Health Systems
Lecture Hall Room 104

Chair: Renee Fox, Executive Director, Institute for a Healthiest Maryland

Panelists: Laura Herrera, Deputy Commissioner, Maryland Department of Health and Mental Hygiene
Topic: State Health Improvement Program (SHIP)

John Miller, CEO, Mid-Atlantic Business Group on Health
Topic: How Public Health and ACOs Work Together for Maryland and the Nation

3:00 – 3:15 pm
Break

3:15 – 4:30 pm
Focus on Disparities Reduction: Maryland’s Health Enterprise Zones and Local Health Improvement Programs
Chair: Nikki Highsmith Vernick, President and CEO, The Horizon Foundation

Panelists: Novella Tascoe, Health Policy, Advocacy, and Project Management Specialist, Bon Secours Baltimore Health System
Topic: West Baltimore Health Enterprise Zone

Joan Gelrud, Vice-President, MedStar St. Mary’s Hospital
Topic: Lexington Park Health Enterprise Zone

Marcos Pesquera, Executive Director, Adventist HealthCare’s Center on Health Disparities
Topic: Creating Evidence for Research and Health Improvement

3:45 – 4:00 pm
Break
4:45 – 5:15 pm
Reflections on the Day: Industry Perspectives
Chair: Margo Edmunds, VP, AcademyHealth

Presenters: John Colmers, Vice President for Health Care Transformation and Strategic Planning, Johns Hopkins Medical Institutions

Newell McElwee, Executive Director of U.S. Outcomes Research, Merck

5:15 – 5:30 pm
Closing Remarks

Freeman Hrabowski, President, University of Maryland, Baltimore County

5:30 – 6:30 pm
Networking Reception
Atrium – Performing Arts & Humanities Building

Host: Freeman Hrabowski, President, University of Maryland, Baltimore County
Appen dix B: Speaker Biographies

Scott Afzal is a principal of Audacious Inquiry (Ai) and directs the firm's Health Information Technology practice. He is also the program director of CRISP, Maryland's state-designated entity for HIE. In this role, Mr. Afzal has overseen the development and deployment of an infrastructure for health data sharing between health care providers throughout Maryland. His responsibilities at Ai include establishing strategies for Ai's growth in the health information technology industry. Prior to joining Audacious Inquiry, Mr. Afzal served as a business and systems integration consultant with Accenture, Inc. He holds a BSBA from Bucknell University.

John Colmers, M.P.H., is vice president, health care transformation and strategic planning for Johns Hopkins Medicine. In this position, Mr. Colmers works with leaders from the Johns Hopkins Health System, the Johns Hopkins School of Medicine, and related organizations to develop and implement a strategic plan consistent with the organization's tripartite mission of research, education, and patient care and responsive to the new challenges of health reform and a more value-demanding health marketplace. Prior to Johns Hopkins, Mr. Colmers served as the Secretary of the Maryland Department of Health and Mental Hygiene from 2007-2011 and was a senior program officer for the Milbank Memorial Fund from 2000-2007. Prior to joining the Fund, he spent 19 years in Maryland State government where he held various positions, including executive director of the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission, the agency overseeing Maryland's all-payer hospital rate setting system. Mr. Colmers has a B.A. from the Johns Hopkins University and an M.P.H. from the University of North Carolina, Chapel Hill.

Amy Compton-Phillips, M.D., is the associate executive director, quality, for The Permanente Federation, the national umbrella organization for the regional Permanente Medical Groups that employ approximately 16,000 physicians who care for approximately 8.8 million Kaiser Permanente members. She is responsible for supporting and developing clinical quality and safety improvements. She also co-chairs the Kaiser Permanente National Quality Committee. Prior to joining The Permanente Federation, Dr. Compton-Phillips served the Mid-Atlantic Permanente Medical Group as the physician director of population care from 2003 to 2009, internal medicine service chief from 1997 to 2001, and physician director for the Columbia Gateway Medical Center from 2002 to 2003. Board certified in internal medicine, Dr. Compton-Phillips received her medical degree from the University of Maryland Medical School, her executive business training from the University of North Carolina Kenan-Flagler School of Business, and her bachelor's degree from the Johns Hopkins University.

Margo Edmunds, Ph.D., is vice president, evidence generation and translation at AcademyHealth, where she leads the organizational portfolio in information infrastructure, research translation, delivery system reform, and population health. Previously, she directed a Congressionally-requested Institute of Medicine study on hospital and physician payment reform under Medicare; was an adjunct associate professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health; and was a vice president of The Lewin Group. She has designed, implemented, and evaluated a variety of policy initiatives for federal and state government, foundations, associations, and other clients. A founding member and former chair of the AcademyHealth interest group on health IT, she chairs the public policy committee of the American Medical Informatics Association and is a member of the editorial board of Applied Clinical Informatics. Dr. Edmunds holds a doctoral degree in community/clinical psychology from The Pennsylvania State University, completed a post-doctoral fellowship in health policy at the Johns Hopkins School of Public Health, and was a research and clinical fellow at the Johns Hopkins School of Medicine. She is a fellow of the Society of Behavioral Medicine.

Gerry Fairbrother, Ph.D., is a senior scholar at AcademyHealth and an adjunct professor of pediatrics at the University of Cincinnati. Dr. Fairbrother’s research areas include measuring quality of care, impact of churning in Medicaid and CHIP on measurement of quality, and use of technology to improve quality of care. She is currently the evaluator on a Beacon Communities project and for one of the CHIPRA demonstration projects. She is also currently on the technical assistance faculty for the National Association of State Health Policy, and on the Advisory Committee for Evaluation of the CHIPRA demonstration project in Vermont/Maine. Before coming to AcademyHealth, Dr. Fairbrother led investigations on gaps and patterns of enrollment in child health insurance, barriers and cost to enroll in these programs, impact of Medicaid managed care on preventive screening for children, and impact of financial incentives on physician behavior. She also led the planning and implementation of the Citywide Immunization Registry in New York City, and has published on issues around registry development. Dr. Fairbrother holds a Ph.D. from The Johns Hopkins University and is a fellow of the New York Academy of Medicine and a fellow of the Ambulatory Pediatric Association.

Renee Fox, M.D., became the executive director of the Institute for a Healthiest Maryland in September 2012. She is an associate professor in the department of pediatrics at the University of Maryland’s School of Medicine. Prior to work at the Institute, she worked in the Congressional Budget Office as a Robert Wood Johnson Foundation Health Policy Fellow (2007-2010). A gradu-
ate of Cornell University College of Arts and Sciences, she received her M.D. from the University of Rochester School of Medicine and Dentistry. She completed a pediatric residency at Rochester and a neonatology fellowship at the Joint Program for Neonatology at the Harvard Medical School.

Joan Gelrud, R.N., M.S.N., CPHQ, FACHE, is vice president of MedStar St. Mary’s Hospital, where she has been since 1983. Her responsibilities as vice president include assuring compliance with all hospital regulatory agencies and accrediting bodies and working with all hospital departments to ensure continuous implementation of evidence-based best practices. Ms. Gelrud also serves as patient safety officer and as such promotes safe, high quality processes. In 2010, Ms. Gelrud assisted in opening an outpatient pulmonary and cardiac rehabilitation center at the hospital. In addition, she helped coordinate outpatient pediatric endocrinology, cardiology and pulmonary services. Ms. Gelrud received her bachelor’s degree in nursing from the University of Maryland and her master’s degree in nursing from the Catholic University of America. She is also a certified professional in healthcare quality (CPHQ), a fellow in the American College of Healthcare Executives, and a member of the Maryland Hospital Association’s Continuous Quality Improvement Council.

Laura Herrera, M.D., M.P.H. currently serves as the chief medical officer at the Maryland Department of Health and Mental Hygiene (DHMH), where she assists with the implementation of health delivery reform, advises on approaches to monitor and improve care at Medicaid-participating managed care organizations, and leads efforts to develop standards and policies across the Department’s sixteen hospitals. Prior to her work with Maryland DHMH, Dr. Herrera served as a medical officer in the United States Army Reserve and has been deployed domestically to care for active duty soldiers and briefly served overseas in Iraq in 2008. After returning from Iraq, she served as the national director of women’s health and then served as the acting deputy chief officer of patient care services at the VA. She has also served in director positions at the Men’s Health Center in Baltimore and the Baltimore City Health Department, and has treated patients at the Moore Clinic at The Johns Hopkins Hospital. Dr. Herrera, a graduate of CUNY Baruch College, attended the SUNY Health Science Center at Brooklyn for medical school and completed her internship and residency in family practice at the University of Maryland. She completed her masters of public health in infectious diseases at the Johns Hopkins Bloomberg School of Public Health.

Nicolette (Nikki) Highsmith Vernick, M.P.A., is president and chief executive officer of The Horizon Foundation, where she has overseen the approval of a new strategic plan focused on promoting healthy lifestyles and increasing access to health care and the launch of several new initiatives. Before her tenure at the Foundation, she served as senior vice president for program at the Center for Health Care Strategies (CHCS). Ms. Highsmith Vernick has served as project director, deputy project director, and principal investigator for many national philanthropic programs, including the Robert Wood Johnson Foundation’s Medicaid Managed Care and State Action for Oral Health Access programs. Prior to joining CHCS, she was the deputy director of the Medicaid Managed Care Program for the Massachusetts Medicaid Program, worked as a senior Medicaid analyst during the Clinton Administration at the Executive Office of the President, and was a professional staff member for U.S. Congressman Michael A. Andrews of Texas. Ms. Highsmith Vernick holds a master’s degree in public administration from American University, and a bachelor’s degree in history from the University of Texas.

Freeman Hrabowski, III, has served as president of UMBC (The University of Maryland, Baltimore County) since 1992. His research and publications focus on science and math education, with special emphasis on minority participation and performance. He chaired the National Academies’ committee that produced the recent report, Expanding Underrepresented Minority Participation: America’s Science and Technology Talent at the Crossroads. He also was recently named by President Obama to chair the newly created President’s Advisory Commission on Educational Excellence for African Americans. Dr. Hrabowski has been recognized by a number of awards, including being named one of America’s Best Leaders by U.S. News & World Report, which ranked UMBC the nation’s #1 “Up and Coming” university the past four years (2009-12). Also in 2011, he was named one of seven Top American Leaders by The Washington Post and the Harvard Kennedy School’s Center for Public Leadership. In 2012, he received the Heinz Award for his contributions to improving the “Human Condition” and was among the inaugural inductees into the U.S. News & World Report STEM Solutions Leadership Hall of Fame. Dr. Hrabowski serves as a consultant to the National Science Foundation, the National Institutes of Health, the National Academies, and universities and school systems nationally. He also serves on several boards, including the Alfred P. Sloan Foundation, Marguerite Casey Foundation (Chair), T. Rowe Price Group, Inc., The Urban Institute, McCormick & Company, and the Baltimore Equitable Society. A child-leader in the Civil Rights Movement, Dr. Hrabowski was prominently featured in Spike Lee’s 1997 documentary, Four Little Girls, on the racially motivated bombing in 1963 of Birmingham’s Sixteenth Street Baptist Church. Dr. Hrabowski graduated at 19 from Hampton Institute with highest honors in mathematics. At the University of Illinois at Urbana-Champaign, he received his M.A. and four years later his Ph.D.
Matthew Levy, M.D., M.P.H., F.A.A.P, is division chief of community pediatrics and an associate professor of clinical pediatrics at the Georgetown University School of Medicine. Since October 2011, he has been the associate medical director of ambulatory EHR and HIT policy for MedStar Health. He currently sits on several MedStar Health and MedStar Georgetown University Hospital EHR committees to improve the systems looking for efficiencies and more effective strategies in using EHR for better health outcomes. Dr. Levy began his career at Georgetown University as a fellow in community pediatrics and child advocacy, and then took over as medical director of community pediatrics and re-built the program. Over the last 13 years he has developed and operated the KIDS Mobile Medical Clinic (a mobile medical home), the Anacostia Wellness Center (a School Based Health Center), and the HOYA Clinic at DC General (the first student driven clinic in Washington, DC) as well as other programs. In 2010, as a Robert Wood Johnson Foundation health policy fellow, Dr. Levy worked with Senator Conrad and the Senate Budget committee on implementation of health reform and other health related issues. Dr. Levy received his B.A. from the University of Michigan, an M.P.H. from Johns Hopkins School of Public Health and is a member of the Delta Omega Honors Society. He is a graduate of New York Medical College.

Newell McElwee, Pharm.D., M.S.P.H., is a pharmacist and epidemiologist who is currently the executive director of the U.S. Outcomes Research group at Merck where he leads a group of scientists who are primarily focused in the areas of quality measurement and improvement, medication adherence, health technology assessment, and health care reform. Prior to joining Merck in April 2009, he was a vice president in the medical division at Pfizer. Dr. McElwee is currently a member of the AHRQ National Advisory Council and is on the steering committee for the AHRQ Centers for Education, Research, and Training. He is on the advisory board for clinical and economic review at Massachusetts General Hospital, the executive committee for the Foundation for Managed Care Pharmacy, and is a member of the Institute of Medicine’s Roundtable on Health Disparities and Inequities. Dr. McElwee received his B.S. in pharmacy from Northeast Louisiana University, his Pharm.D. at Mercer University, and his M.S.P.H. at the University of Utah.

Barry Meisenberg, M.D., is the director of the DeCesaris Cancer Institute at Anne Arundel Medical Center (AAMC). He also serves as chair of quality and health systems research. In the fall of 2012, he was appointed as the founding director of the Center for Health Improvement, a coordinating body for patient safety and quality efforts. Before coming to AAMC, Dr. Meisenberg headed the division of hematology/oncology at the Marlene and Stewart Greenebaum Cancer Center at the University of Maryland School of Medicine and was deputy director for clinical affairs of the Cancer Center. Previously, he held clinical and academic positions at Duke University. Widely published in oncology and research journals, Dr. Meisenberg has also received numerous awards and distinctions. He received his medical degree from Albany Medical College in New York, and completed both his residency in internal medicine and a fellowship in hematology/oncology at the Naval Hospital in San Diego. He is currently a visiting professor of oncology at the Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins Medicine.

Harold Miller is the executive director of the Center for Healthcare Quality and Payment Reform. In this role, he works at the local, state, and national levels on initiatives to improve the quality of health care services and to change the fundamental structure of health care payment systems in order to support improved value. Mr. Miller also serves as adjunct professor of public policy and management at Carnegie Mellon University. Mr. Miller is a nationally-recognized expert on health care payment and delivery reform, and has given invited testimony to Congress on how to reform health care payment. He has authored a number of papers and reports on health care payment and delivery reform. Mr. Miller also served for over four years as the president and CEO of the Network for Regional Healthcare Improvement (NRHI), and he designed and led a multi-year PRHI (the Pittsburgh Regional Health Initiative) initiative that significantly reduced preventable hospital admissions and readmissions through improved care for chronic disease patients. In 2007 and early 2008, he served as the facilitator for the Minnesota Health Care Transformation Task Force. He is currently working in a number of states and regions to help design and implement payment and delivery system reforms. Mr. Miller serves on the board of directors of the National Quality Forum, and he has represented the Network for Regional Healthcare Improvement on the National Priorities Partnership.

John Miller is the executive director of both the Network to Improve Community Health (NICH) and the MidAtlantic Business Group on Health. In 1997, he founded NICH, a non-profit organization that forms partnerships among businesses, hospitals, health insurers, pharmaceutical companies, physicians, public health agencies, and community groups. As executive director, he brings together this large, often competing group to collaborate on the one thing they have in common: a desire for healthier workers, citizens, and community members. In 1999, Mr. Miller also became executive director of the MidAtlantic Business Group on Health, an association of business health benefits professionals. This organization helps benefits managers for these multinational companies
exert their purchasing influence on the health care system, encourage better value in health care, and design health benefits that will maximize employee health while controlling cost. Previously, Mr. Miller was with the Washington, DC metropolitan hospital association, the Healthcare Council of the National Capital Area, and was the executive director of the Wellness Council of the National Capital Area, an association of businesses promoting healthier lifestyles for employees and their families.

Margaret Murray, M.P.A., is the founding CEO of the Association for Community Affiliated Plans (ACAP). As the CEO, she has led the organization to grow from its origins as an Association of 14 community health center-owned plans to 58 Safety Net Health Plans, covering more than 10 million people in total. Ms. Murray is a national expert on health care policy for low-income people and a frequent speaker and author on these issues at national conferences and in the media. Prior to leading ACAP, Ms. Murray was the Medicaid director for the State of New Jersey and she was also a senior budget analyst for the U.S. Office of Management and Budget, with responsibility for negotiating the budget neutrality agreements for Medicaid managed care waivers. She was reappointed to the Maryland Community Health Resources Commission and has served on the board of a Community Health Center in Southern Maryland. Ms. Murray received her M.P.A. from the Woodrow Wilson School of Princeton University and her B.A. cum laude in economics and classical civilization from Wellesley College.

Robin Newhouse, Ph.D., M.S., M.G.A., B.S.N., is professor and chair of the department of organizational systems and adult health at the University of Maryland School of Nursing, and is co-director of the Center for Health Outcomes Research. Her most recent studies have focused on improving the adoption of evidence-based practices in health systems. Dr. Newhouse was appointed to the methodology committee of the Patient-Centered Outcomes Research Institute (PCORI) by the comptroller general of the U.S. Government Accountability Office, with an appointment to vice chair of the methodology committee of PCORI in 2012. She was also appointed to the Institute of Medicine Standing Committee on Credentialing Research in Nursing (2012-2014), serves on the American Nurses Credentialing Center’s Research Council, and is the chair of the research and scholarship advisory council for Sigma Theta Tau International (2009-2013). Dr. Newhouse holds a Ph.D. and M.S. from University of Maryland School of Nursing; an M.G.A. from the University of Maryland University College; and a B.S.N. from the University of Maryland Baltimore County.

Mary Beth Pohl serves as the deputy director for research and methodology at State of Maryland’s Health Services Cost Review Commission (HSCRC). The HSCRC has broad responsibility regarding the public disclosure of hospital data and operating performance and establishes hospital rates for all payers (including Medicare and Medicaid) to promote cost containment, access to care, equity, financial stability, and hospital accountability. Ms. Pohl and her team manage the case mix data submissions, oversee data and audit contracts, develop new reimbursement methodologies, monitor existing methodologies, and provide data to the State and to the public. Ms. Pohl has been engaged in all levels of discussion on developing a new CMS model design approach for Maryland. Prior to joining the HSCRC, as a senior consultant at The Lewin Group, Ms. Pohl worked on a number of state and federal health projects, including error rate calculations, analysis of state operations to develop cost savings strategies, and reviews of the impact of proposed federal regulations. Ms. Pohl has also served as a chief advisor to the executive director of Maryland Medicaid and as an analyst for the Urban Institute.

Joshua Sharfstein, M.D., was appointed by Governor Martin O’Malley as Secretary of the Maryland Department of Health and Mental Hygiene in January 2011. The department includes Medicaid, public health, behavioral health, and services for the developmentally disabled, with an annual budget of approximately $10 billion. In 2009, President Obama appointed Dr. Sharfstein to serve as the principal deputy commissioner of the U.S. Food and Drug Administration, the agency’s second highest-ranking position. He served as the acting commissioner from March 2009 through May 2009 and as principal deputy commissioner through January 2011. Previously, Dr. Sharfstein served as the commissioner of health for the City of Baltimore, Maryland and as minority professional staff...
of the government reform committee of the U.S. House of Representatives for Congressman Henry A. Waxman. Dr. Sharfstein is a graduate of Harvard College, Harvard Medical School, a combined residency program in pediatrics at Boston Children’s Hospital and Boston Medical Center, and a graduate of the fellowship in general pediatrics at the Boston University School of Medicine. In 2008, Dr. Sharfstein was named a Public Official of the Year by Governing Magazine. Dr. Sharfstein now serves on the Health Information Technology Policy Committee, an advisory committee of the U.S. Department of Health and Human Services, and is a member of the editorial board of the Journal of the American Medical Association.

Lisa Simpson, M.B., B.Ch., M.P.H., FAAP, is the president and chief executive officer of AcademyHealth. A nationally recognized health policy researcher and pediatrician, Dr. Simpson is a passionate advocate for the translation of research into policy and practice.

Since joining AcademyHealth in 2011, Dr. Simpson has worked to raise the visibility of the field of health services research and its contributions to improving the quality, value and accessibility of care, reducing disparities, and improving health. Before joining AcademyHealth, Dr. Simpson served as the director of the Child Policy Research Center at Cincinnati Children’s Hospital Medical Center and professor of pediatrics in the division of pediatrics, University of Cincinnati. She also served as the deputy director of the Agency for Healthcare Research and Quality from 1996 to 2002. Dr. Simpson earned her undergraduate and medical degrees at Trinity College (Dublin, Ireland), a master’s in public health at the University of Hawaii, and completed a post-doctoral fellowship in health services research and health policy at the University of California, San Francisco.

Novella Tascoe is the health policy, advocacy, and project management specialist at Bon Secours Baltimore Health System. Ms. Tascoe is responsible for working closely with the executive leadership team on the development, implementation and evaluation of various and complex initiatives. She participates in strategic planning and facilitates the development, implementation and evaluation of policies, programs, and services which are consistent with the Bon Secours Baltimore’s mission, strategic plans, legislative agenda, resource allocation, management plan, budget, medical staff relations, and other activities for appropriate coordination of patient care and operational needs. She was an instrumental part of the team that worked to secure the grant for the Health Enterprise Zone and continues to work on the project as the interim project director. Ms. Tascoe began her career in health care in 2002 as a registered respiratory therapist and has worked as a staff therapist in a variety of health care settings. Previously, she developed legislation for advancing health care reform in Georgia and has worked with the U.S. Department of Health and Human Services on consumer advocacy and health care issues. Ms. Tascoe graduated from Armstrong Atlantic State University, and she earned her master’s in health administration and juris doctorate from Georgia State University.

Jonathan Weiner, Dr.P.H., is a professor of health policy and management at the Johns Hopkins University Bloomberg School of Public Health. He is also a professor of health informatics at the Johns Hopkins School of Medicine’s division of health sciences informatics. Dr. Weiner is the director of the newly formed Johns Hopkins Center for Population Health Information Technology (CPHIT), which focuses on R&D related to the application of electronic health records (EHRs), e-health, and other HIT to the health of populations, integrated delivery systems, and public health agencies. Dr. Weiner’s current research focuses on the application of EHRs and HIT for population-based applications such as performance measurement and predictive modeling/analytics. He is the co-developer and executive director of the Johns Hopkins ACG team. The ACG case-mix/predictive modeling methodology is population-based decision-support software tool that is used to finance, manage, and support the care of more than 80 million people in more than 15 nations. Dr. Weiner holds a doctorate of public health in health services research from the Johns Hopkins University School of Public Health. He also holds an M.S. in health administration from the University of Massachusetts and a B.A. in human biology from the University of Pennsylvania.
## Appendix C: Symposium Participants

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<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>City</th>
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<tbody>
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<td>Karen Adams</td>
<td>National Quality Forum</td>
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<tr>
<td>Betsy Carrier</td>
<td>Carrier Consulting</td>
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<tr>
<td>Linda Dunbar</td>
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<td>Glen Burnie, MD</td>
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<tr>
<td>Scott Afzal</td>
<td>Chesapeake Regional Information Systems</td>
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<tr>
<td>Aruna Chandran</td>
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<tr>
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<td>AcademyHealth</td>
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<tr>
<td>Edward Balotsky</td>
<td>Saint Joseph’s University</td>
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<tr>
<td>Tina Cheng</td>
<td>Johns Hopkins University</td>
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<td>Seth Eisen</td>
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<td>Linda Bartynska</td>
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<td>Leigh Cobb</td>
<td>Advocates for Children and Youth</td>
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<td>Gerry Fairbrother</td>
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<td>Eric Bass</td>
<td>Johns Hopkins University</td>
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<td>John Colmers</td>
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<td>Lauren Bates</td>
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<td>Amy Compton-Phillips</td>
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<td>Karen Fennell</td>
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<td>Donna Folkemer</td>
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<td>Joan Gelrud</td>
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<td>Glenn Schneider</td>
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<tr>
<td>Katie Wunderlich</td>
<td>Maryland Hospital Association</td>
<td>Elkridge, MD</td>
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Appendix D: What Maps Tell Us

Maryland Has 23 Counties

![Map of Maryland's 23 counties]

Maryland Has 5.9 Million People

![Map showing population density in Maryland]

Population per square mile, 2010

- **0 – 100**
- **100 – 300**
- **300 – 1,000**
- **1,000 – 2,000**
- **Greater than 2,000**

Source: Maryland Department of Planning Projections and Data Analysis/State Data Center
Maryland is Racially and Ethnically Diverse

- **64.0%** White Alone, 3,391,308
- **27.9%** African American alone, 1,477,411
- **4.0%** Asian alone, 210,929
- **2.1%** Other, 113,251
- **2.0%** Two or more races, 103,587
- **1.8%** Some other race alone, 95,525
- **0.3%** American Indian and Alaska Native alone, 15,423
- **0.3%** Native Hawaiian and other Pacific Islander alone, 2,303

Source: US Census, 2010

Maryland is an Affluent State With Pockets of Poverty

- **Garrett** 12.0%
- **Allegany** 19.1%
- **Washington** 11.8%
- **Frederick** 6.6%
- **Carroll** 5.5%
- **Howard** 6.0%
- **Montgomery** 6.7%
- **Baltimore** 9.6%
- **Hartford** 8.3%
- **Cecil** 9.7%
- **Kent** 13.9%
- **Queen Anne’s** 8.7%
- **Anne Arundel** 6.1%
- **Prince George’s** 9.4%
- **Calvert** 6.1%
- **St. Mary’s** 8.6%
- **Charles** 7.7%
- **Baltimore City** 24.9%
- **Caroline** 13.1%
- **Talbot** 10.8%
- **Dorchester** 17.5%
- **Worcester** 13.0%
- **Wicomico** 17.7%
- **Somerset** 26.2%

Poverty Rate
- **0.0 – 12.1 percent**
- **12.2 – 15.8 percent**
- **15.9 – 17.8 percent**
- **17.9 – 100.0 percent**

Source: US Census, 2010
Most Residents are Insured, But Not All

Uninsured Rate
- 8.6 – 10.3
- 10.4 – 12.1
- 12.2 – 13.9
- 14.0 – 15.7
- 15.8 – 17.0

Source: US Census, 2010

County Health Rankings Correspond to Uninsured Rates

Maryland Has 60 Hospitals

15 Hospitals Are Located in Baltimore City

Sources: GIS data from the Maryland State Data Center, Maryland Department of Planning, and hospital listings from the Maryland Hospital Association.

Source: GIS data from Open Baltimore, Baltimore City government website
Endnotes

1. This is the three-part aim of health reforms underway in Maryland. See, for example, John M. Colmers and Joshua M. Sharfstein, “Maryland’s Proposal to Modernize All-Payer Rate Setting,” Testimony before the Joint Committee on Health Care Delivery and Financing, May 29, 2013.


3. US Census Bureau, 2010

4. US Census Bureau, 2010 and the Maryland Department of Planning, Planning and Data Analysis/State Data Center, February 2011

5. US Census Bureau, Small Area Income and Poverty Estimates

6. US Census Bureau and the Centers for Disease Control and Prevention, SAHIE/State and County by Demographic and Income Characteristics, 2010


8. GIS data from the Maryland State Data Center, Maryland Department of Planning and hospital listings from the Maryland Hospital Association

9. GIS data from OpenBaltimore, Baltimore City government website

10. Office of Health Policy and Planning, Family Health Administration, Maryland Department of Health and Mental Hygiene, March 2, 2011

11. Maryland Department of Health and Mental Hygiene and Health Resources and Services Administration


13. See, for example, Special Issue: New Era of Patient Engagement. Health Affairs, 2013; 32 (2).

14. Although Maryland officials are committed to its approach to all-payer rate setting, the system has many critics. See, for example, Mark Pauley and Robert Town, “Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency,” Journal of Health Policy, Politics, and Law, 37 (4), March 30, 2012, 697-707.