HSCRC Transformation Grant

FY 2020 Report

The Health Services Cost Review Commission (HSCRC) requires the following information for FY 2020 Regional Partnership Transformation Grant Program participants: this Report, the Budget Report, and the Budget Narrative. Whereas the Budget Report distinguishes efforts between each hospital, this Summary Report should consolidate information and describe all hospitals, if more than one, that are in the Regional Partnership.

Regional Partnership Information

Regional Partnership (RP) Name	TidalHealth (formally Peninsula Regional Medical Center)
RP Hospital(s)	● Tidal Health- Peninsula Regional ● Atlantic General ● McCready Health (until 2/29/2020)
RP Point of Contact	Kathryn Fiddler 100 East Carroll Street Salisbury MD 21801 410-219-4923 Kathryn.fiddler@peninsula.org
RP Interventions in FY 2020	1. Wagner Wellness Van Mobile Outreach & SWIFT (Mobile Integrated Health) 2. Smith Island Telemedicine 3. Care Management and Disease Management Program for Chronic Conditions
Total Budget in FY 2020 *This should equate to total FY 2017 award*	FY 2020 Award: **$ 1,099,679**
Total FTEs in FY 2020	Employed: **30.5** FTEs Peninsula Regional **2.06** FTEs Atlantic General
	Contracted: 0
Program Partners in FY 2020 *Please list any community-based organizations or provider groups, contractors, and/or public partners*	● Wicomico, Somerset and Worcester County Health Departments ● Wicomico, Somerset and Worcester County Boards of Education

	• Wicomico, Somerset and Worcester Community Health Providers • City of Salisbury • Salisbury Fire Department • Salisbury Police Department • United Way of the Lower Eastern Shore • HOPE • HALO • Chesapeake Housing Mission • Salisbury Urban Ministries • St. James AME • St. Peter's Lutheran • Resource and Recovery Center • Atlantic Club • Marion Pharmacy • MAC, Inc • National Kidney Foundation • Maryland Food Bank • YMCA

Overall Summary of Regional Partnership Activities in FY 2020

(Freeform Narrative Response: 1-3 Paragraphs):

The Regional Partnership is comprised of TidalHealth(formerly PRMC), Atlantic General Hospital, and McCready Health. The Partnership focused on the three priority program areas that continued to evolve and expand over the course of fiscal 2020. The Community Wellness team (formerly the Wagner Wellness Van team) continued to build on partnerships throughout the community to identify and outreach vulnerable and at-risk populations in Wicomico, Worcester, and Somerset counties. It has become one tool of broader community health and wellness initiatives. In FY20, screening fairs were conducted by the Community Wellness team in all three counties several days each week including; local migrant camps, Haitian community centers, schools, Smith Island, shelters, and churches. Their commitment to and trust from our community, proved to be significant in their COVID-19 response.

The Community Wellness team also supports the Salisbury Wicomico Integrated FirstCare Team (SWIFT) program, a mobile integrated health initiative in partnership with the City of Salisbury, and the Wicomico County Health Department. The program continues to reduce unnecessary use of the 911 EMS system and Emergency Department by addressing the physical and social needs of those who are identified as high utilizers of EMS and/or ED. The program currently serves clients in Wicomico County only, but is aggressively working towards expanding its reach to other areas of the county and beyond.

Both Atlantic General and TidalHealth continue to have dedicated care coordination teams that function both in the ambulatory care and community settings. Over the course of FY20, community-based coordination has evolved as new Medicare and other HSCRC initiatives have been introduced. Care coordination staff embedded within the primary care offices and those working within Transitional

Care Services predominantly support care management functions associated with the Maryland Primary Care Program and Episode Care Improvement programs, which focus on the evolving and high-risk Medicare beneficiaries. These functions include transitional care management following an emergency department visit or acute care hospitalization, as well as, longitudinal care management that incorporates chronic disease self-management education, nurse led-advance care planning, and social determinant of health interventions.

MAC, Inc. is a partner providing evidence-based classes in chronic disease management, depression, and fall reduction. The care coordination staff routinely refer patients to MAC, Inc. Hundreds of community members have attended community-based classes in all three counties. TidalHealth Peninsula Regional Clinically Integrated Network has added these classes to their clinical pathways, and the partnership is the first in the State to pilot work with CRISP to build a referral pathway with patient information and class participation added into Care Alerts. These alerts then highlight any social determinants of health needs. Focused effort on IT and data sharing has been a priority with these programs.

Smith Island telehealth is continually evolving- A health fair was held on the island during the summer of 2019. New PCP appointments were offered to community members with no PCP. Telehealth acute visits continue with an NP at PRMC. Staff continues to screen Island residents and offer support for chronic disease management. There is a full time community health worker on Smith Island who works with community members on chronic disease education, medication management, referrals and follow up post discharge and ED visits.

Intervention Program

Please copy/paste this section for each Intervention/Program that your Partnership maintains, if more than one.

Intervention or Program Name	1. Wagner Wellness Van Mobile Outreach & SWIFT (Mobile Integrated Health)
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	All three (3): ● Peninsula Regional Medical Center ● Atlantic General ● McCready Health
Brief description of the Intervention *2-3 sentences*	The Wagner Wellness Van, SWIFT and Community Care Coordination works to provide in-home and telephonic care coordination and clinical assessment and treatment for high utilizers of the 911 system or Emergency Departments. Multidisciplinary teams led by a nurse practitioner provide telehealth, and linkage to linkage to outreach services, community programs, primary care services, chronic disease and preventative care to address the physical and psycho-social needs of our communities.

Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	● Wicomico, Somerset and Worcester County Health Departments ● Wicomico, Somerset and Worcester County Boards of Education ● Wicomico, Somerset and Worcester Community Health Providers ● City of Salisbury ● Salisbury Fire Department ● Salisbury Police Department ● United Way of the Lower Eastern Shore ● HOPE ● HALO ● Chesapeake Housing Mission ● Salisbury Urban Ministries ● St. James AME ● St. Peter's Lutheran ● Resource and Recovery Center ● Atlantic Club ● Marion Pharmacy ● MAC, Inc ● National Kidney Foundation ● Maryland Food Bank ● YMCA
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2020: **112** SWIFT Patients **1,097** Community Wellness Patients **3,353** COVID Tests administered
	Denominator of Eligible Patients: **38, 795** Eligible Patients Source: RP Analytic Files FY 2020 : Population
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	SWIFT Pre-Post Analysis attached.

Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	In FY20, the Community Wellness outreach team performed outreach services throughout Worcester and Wicomico Counties reaching over 1,000 community members during approximately 40 outreach events. During these events and daily community outreach missions, the team provided flu vaccines, connected patients to primary care providers and provided referrals to various community partners and agencies for housing, faith, utilities, healthcare and many other social determinants of health. SWIFT utilized CRISP to identify vulnerable patient populations and patients that are considered high risk and rising risk. SWIFT is also utilizing the CRISP care alerts for when patients have an ED encounter.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The community wellness team from the Wagner Wellness Van and SWIFT programs were able to work with individuals throughout the region to address social determinants of health that were preventing them from gaining control of their health conditions and causing crisis situations and high utilization of the Emergency Department. The team connected residents to various assistance programs ranging from housing, dental, substance abuse treatment and recovery support, food, shelter, utility bill assistance, health care coverage, social services. The team serves as an extension of an integrated and coordinated health care team that works to address all of the needs and issues impacting an individual's health. Once the coronavirus pandemic took hold of the community, the needs of residents changed and the SWIFT and Wagner Wellness Van mobile teams adapted to meet the changing needs of vulnerable and disadvantaged residents most impacted by the pandemic. The staff were critical for mass community-based COVID-19 testing throughout the region. The teams were recruited to participate in a regional, grassroots task force organized to bring together agencies, organizations and services to better meet the needs of vulnerable populations at a time when so many lost their employment, income and access to brick-and-mortar programs. Again, the programs adapted to the needs of the community and provided health services, education and outreach to pop-up resource fairs in the hardest hit communities. This work continues as the pandemic continues to affect communities.

Additional Freeform Narrative Response (Optional)	The community wellness and SWIFT programs temporarily halted their traditional in-home services out of an abundance of caution and the need to focus on COVID-19 response in our community. The community wellness team became the primary staff to work community-based testing sites. However, as tests became more available through local labs, immediate/urgent care facilities, the health department and pharmacies, the team was able to resume in-home visits for referred patients and modify the mobile clinic/outreach model and schedule to better respond to the changing needs in the community. This team has now been part of multiple "One Stop Shop" events providing food, sign up for school, insurance sign up, translation services, disease management and screening, sign up for the 2020 Census, legal air, housing and many other events to improve health equity and access to services.

Intervention or Program Name	2. Smith Island Telemedicine
RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	● Peninsula Regional Medical Center ● McCready Health
Brief description of the Intervention *2-3 sentences*	The community members of Smith Island have no direct access to health care. The program provides the residents access, by way of a medical assistant who lives on the island and Telehealth services from a TidalHealth Nurse Practitioner and Physician.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	● Wicomico, Somerset and Worcester County Health Departments ● Wicomico, Somerset and Worcester County Boards of Education ● Wicomico, Somerset and Worcester Community Health Providers ● City of Salisbury ● Salisbury Fire Department ● Salisbury Police Department ● United Way of the Lower Eastern Shore ● HOPE ● HALO

	● Chesapeake Housing Mission ● Salisbury Urban Ministries ● St. James AME ● St. Peter's Lutheran ● Resource and Recovery Center ● Atlantic Club ● Marion Pharmacy ● MAC, Inc ● National Kidney Foundation ● Maryland Food Bank ● YMCA
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may overstate the population, or may not entirely represent this intervention's targeted population.* *Feel free to **also** include your partnership's denominator.*	# of Patients Served as of June 30, 2020: **184**
	Denominator of Eligible Patients: **38, 795** Eligible Patients Source: RP Analytic Files FY 2020 : Population
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	None
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	In FY20, the Smith Island Community Wellness team was successful in transmitting 46 telehealth visits, providing 18 medication refill prescriptions to patients that could not leave the island due to their declining health, lack of transportation or access, or inclement weather. In addition, the team provided "office visit" access to 32 residents. During these visits, 27 blood pressure screenings were completed and 14 lab draws.
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	Telemedicine accessibility improved through the Smith Island initiative as the program installed DSL internet in the Health Clinic, providing a more reliable connection to PRMC's Electronic Medical Record and ability to facilitate the

	telemedicine visit. In addition to technology improvements, relationships and trust continued to be built among the residents of the island because of the medical assistant residing on the island and making herself available to patients in between scheduled appointments/visits with the nurse practitioner. Many patients have not physically seen a medical provider in years, and this program brought access and improved the health of residents. For example, one patient in her 30s had not left the island for two or three years and had untreated, severe depression. She was also suffering from chronic conditions - obesity and diabetes. Access to telemedicine connected her to psychiatric care and primary care. The local medical assistant was able to build trust with the patient and connect her to mental health and physical health care. Another patient attended the annual health fair and because of the education and screenings, she took the advice of the staff and had a follow-up dermatology appointment in which she discovered that she had melanoma on her back. She would not have known that she needed to see the specialist had she not attended the health fair and spoke with health care practitioners. Other residents participated in additional screenings offered which also led to follow-up visits with specialists.
Additional Freeform Narrative Response (Optional)	Due to COVID19, the partnership was not able to conduct its Annual Health Fair on the island in fiscal 2020. Looking forward, the Smith Island Telehealth program will continue to grow in volume and services offered. As of fall (fiscal 2021) the community health team hosts biweekly clinic days to promote health and nutrition, as well as other services offered by the health system, and to build trust and relationships within the community in addition to holding telemedicine appointments. The community health team plans to purchase a lightweight telemedicine kit with secure video conferencing and diagnostic equipment to provide real time clinical data to utilize on Smith Island.

Intervention or Program Name	3. Care Management and Disease Management Program for Chronic Conditions

RP Hospitals Participating in Intervention *Please indicate if All; otherwise, please indicate which of the RP Hospitals are participating.*	● Peninsula Regional Medical Center ● Atlantic General Hospital ● McCready Health
Brief description of the Intervention *2-3 sentences*	Deploy and embed care managers in Primary Care Practices, the ED, and Transitional Care to provide evidence-based care management services for evolving and high-risk Medicare beneficiaries. Enroll beneficiaries in chronic disease management programs available through partner programs. Implement disease management protocols and develop patient-centered care plans.
Participating Program Partners *Please list the relevant community-based organizations or provider groups, contractors, and/or public partners*	● Wicomico, Somerset and Worcester County Health Departments ● Wicomico, Somerset and Worcester County Boards of Education ● Wicomico, Somerset and Worcester Community Health Providers ● City of Salisbury ● Salisbury Fire Department ● Salisbury Police Department ● United Way of the Lower Eastern Shore ● HOPE ● HALO ● Salisbury Urban Ministries ● Tri-County Mediation ● St. James AME ● St. Peter's Lutheran ● Resource and Recovery Center ● Atlantic Club ● MAC, Inc ● Maryland Food Bank ● YMCA
Patients Served *Please estimate using the Population category that best applies to the Intervention, from the CY 2018 RP Analytic Files.* *HSCRC acknowledges that the High Utilizer/Rising Risk or Payer designations may over-state the population, or may*	# of Patients Served as of June 30, 2020: **4,678** Community Members have had Care Coordination in the last 12 months. **35** Community Members Care Managed in partnership with MAC, Inc. and Atlantic General.

not entirely represent this intervention's targeted population. *Feel free to **also** include your partnership's denominator.*	**348** Community Members Care Managed in partnership with MAC, Inc and Peninsula Regional (See attached data from MAC, Inc. Evidence Based Classes in FY20). **316** Community Members have had a Community Health Worker
	Denominator of Eligible Patients: **38, 795** Eligible Patients Source: RP Analytic Files FY 2020 : Population
Pre-Post Analysis for Intervention (optional) *If available, RPs may submit a screenshot or other file format of the Intervention's Pre-Post Analysis.*	
Intervention-Specific Outcome or Process Measures (optional) *These are measures that may not have generic definitions across Partnerships or Interventions and that your Partnership maintains and uses to analyze performance.* *Examples may include: Patient satisfaction; % of referred patients who received Intervention; operationalized care teams; etc.*	Case Managers and Social Workers work in the Emergency Department, 24/7/365, where their primary role is determining admission criteria for hospitalization. They prevent many admissions by providing other levels of care, they work with all populations. Social Workers provide resources to many of our patients whether medication assistance, transportation, referring to financial counselors if no insurance, referring to home health, rehab, hospice, assisted living or nursing homes. ED Case Managers also assist with outpatient appointments, arranging DME, provide education and have end of life discussions with patients/families. The Case Managers utilize CRISP Care Alerts to identify current Care Management resources within the Regional Partnership and the Community. ER Case Managers: ● Have the responsibility to maximize the resources of the hospital – help prevent readmissions/PAU ● Oversee implementation of established clinical protocols to ensure quality care ● Help determine medical necessity for admission to the hospital ● Here to help, the patient, the families, the nurses, the providers, the hospitalists

	● During FY20, the ED Case Managers supported 1,359 patients. During FY2020, Atlantic General Hospital reduced ED visits by 25.5%, decreased PAU by 4.1% and lowered our readmission rate to historic low of 7.5%
Successes of the Intervention in FY 2020 *Freeform Narrative Response, up to 1 Paragraph*	The Care Managers are utilizing CRISP ENS alerts for care management coordination and patient identification within all three hospitals in partnership, as well as community providers.The Regional partnership continued its strong collaboration, developing a referral pathway process with MAC, Inc. in Salisbury, MD and the Living Well Center of Excellence for its evidence based programs. Through the partnership, MAC is able to provide countless resources to patients. For example, a patient was primarily eating processed frozen meals and processed convenience foods. As a result of being coached to read labels and guidance on healthy eating and how to plan her meals and snacks Rhetta was able to exceed her weight loss goals. Rhetta has also purchased a used stationary bike and has also reported that due to the increase in physical activity both her pain levels and shortness of breath have decreased. The Regional Partnership and MAC, Inc. are actively working to develop a Social Determinants of Health tracking system to provide both support and visibility to care managers. In addition, the Community Health Workers provided support to over 300 high utilizers from within the ED and in the Community during FY20. As well as, The Community Health Program Social Worker provided support Services to over 600 patients within the Regional Partnership's community. These patients range in risk scores and need, however they typically seem to need the most help. For example, one patient found himself alone and homeless, living behind a gas station. The Community Health Workers, in collaboration with the SWIFT team were able to get him accepted into the local homeless shelter, HALO. Next, they assisted him in getting a new government ID card that had previously been stolen, as well as a new disability card that provided this gentleman an income of 800 dollars per month, for shelter, clothing, toiletries and shoes. The Community Health Workers then helped him apply for food stamps and actively worked with local housing authorities to get this gentleman safe and

	permanent housing. Without the Community Wellness program, the Regional Partnership would not be able to provide this level of support to our community.
Additional Freeform Narrative Response (Optional)	The onset of the COVID19 pandemic prevented many educational programs and community outreach events in the second half of FY 2020, however MAC has recently been approved for a Telehealth Program to reach patients in isolation.

Core Measures

Please fill in this information with the latest available data from the in the CRS Portal Tools for Regional Partnerships. For each measure, specific data sources are suggested for your use– the Executive Dashboard for Regional Partnerships, or the CY 2019 RP Analytic File (please specify which source you are using for each of the outcome measures).

Utilization Measures

Measure in RFP *(Table 1, Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Total Hospital Cost per capita	**Partnership IP Charges per capita** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Charges per Capita, reported as average 12 months of CY 2019 -or- Analytic File: 'Charges' over 'Population' (Column E / Column C)	**$118** IP Charges per Capita Source: Regional Partnership Executive Dashboard: July 2020
Total Hospital Discharges per capita	**Total Discharges per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Hospital Discharges per 1,000, reported as average 12 months of FY 2020	**3** Total Discharges per 1,000 Source: Regional Partnership Executive Dashboard: July 2020

	-or- Analytic File: 'IPObs24Visits' over 'Population' (Column G / Column C)	
ED Visits per capita	**Ambulatory ED Visits per 1,000** Executive Dashboard: 'Regional Partnership per Capita Utilization' – Ambulatory ED Visits per 1,000, reported as average 12 months of FY 2020 -or- Analytic File 'ED Visits' over 'Population' (Column H / Column C)	**9** Ambulatory ED Visits per 1,000 Source: Regional Partnership Executive Dashboard: July 2020

Quality Indicator Measures

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Readmissions	**Unadjusted Readmission rate by Hospital** (please be sure to filter to include all hospitals in your RP) Executive Dashboard: '[Partnership] Quality Indicators' – Unadjusted Readmission Rate by Hospital, reported as average 12 months of FY 2020 -or- Analytic File:	**9.8 %** Unadjusted Readmission Rate Source Regional Partnership Executive Dashboard: JUNE 2020 , as July's report stated NULL.

	'IP Readmit' over 'EligibleforReadmit' (Column J / Column I)	
PAU	**Potentially Avoidable Utilization** Executive Dashboard: '[Partnership] Quality Indicators' – Potentially Avoidable Utilization, reported as **sum** of 12 months of FY 2020 -or- Analytic File: 'TotalPAUCharges' (Column K)	**$3,550,338** PAU Source: Regional Partnership Executive Dashboard: July 2020

CRISP Key Indicators (Optional)

These process measures tracked by the CRISP Key Indicators are new, and HSCRC anticipates that these data will become more meaningful in future years.

Measure in RFP *(Table 1 in Appendix A of the RFP)*	**Measure for FY 2020 Reporting**	**Outcomes(s)**
Portion of Target Population with Contact from Assigned Care Manager	**Potentially Avoidable Utilization** Executive Dashboard: 'High Needs Patients – CRISP Key Indicators' – % of patients with Case Manager (CM) recorded at CRISP, reported as average monthly % for most recent six months of data *May also include Rising Needs Patients, if applicable in Partnership.*	**23.0 %** High Needs **9.7%** Rising Needs Source: Regional Partnership Executive Dashboard: July 2020

Self-Reported Process Measures

Please describe any partnership-level measures that your RP may be tracking but are not currently captured under the Executive Dashboard. Some examples are shared care plans, health risk assessments, patients with care manager who are not recorded in CRISP, etc. By-intervention process measures should be included in 'Intervention Program' section and don't need to be included here.

Return on Investment – (Optional)

Annual Cost per Patient as calculated by

Total Patients Served (all interventions) / Total FY 2020 Expenditures (from FY 2020 budget report)

Impact of COVID-19 on Interventions – (Optional)

Please include information on the impact of COVID-19 on your interventions, if any. Freeform Narrative response, 1-3 paragraphs.

As a result of the COVID19 pandemic, our regional partnership, health systems, and collaborating partners were able to develop unique strategies to meet the ever changing needs of our communities during this healthcare crisis. As a result of legislative changes with the Federal and State systems, we were able to respond to rapid changes in the delivery of healthcare services. Examples include the expansion of healthcare services to alternative treatment settings, expanded telehealth / virtual care services, screenings and call center support. The pandemic dramatically changed our climate and elicited the creation of innovative Care Management programs.

Both TidalHealth and Atlantic General Hospital (AGH) developed alternative care units within our hospital settings as well as externally in preparation for surge capacity. AGH developed a medical-surgical overflow unit in a local skilled nursing facility (SNF) which required a complete build of infrastructure, EMR, supply management, staffing and care navigation from acute care to SNF. Expansion of services required intense resource management, policy development, and the implementation of regional care management efforts to ensure all healthcare agencies received up to date information on regional resources and bed availability. TidalHealth developed and implemented a region wide call center where healthcare agencies across the tri-county region called each day to report their daily statistics and identification of barriers such as staffing and PPE shortages. TidalHealth handled more than 3,80 calls from April to May. This is a hugely successful program and continues to current day.

Intervention Continuation Summary

TidalHealth Peninsula Regional will continue to support all three areas of focus from this grant. Despite direct ROI, the ability to integrate with the community, build trust and rapport as we work to improve health disparities is critical for this region. All current roles have continued to be supported and are key strategies for our future. We are working as a region with a large Vulnerable Population grass roots group, composed of local, regional and state stakeholders to focus on removing health disparities in the region.

Opportunities to Improve – (Optional)

Acquiring data to sufficiently detail the time and effort of care coordination and outreach remains a challenge. CRISP data is often limited to Medicare claims only which limits ability to measure success in other groups, specifically the Medicaid populations. CRISP data is limited in its ability to show impact to broader populations in the community. There is also limited data in CRISP related to health disparities and vulnerable populations which could have helped inform our teams about areas of focus. More local

and census tract data mapped to claims for all payers would be helpful to understand where to focus the community efforts.