MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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HEALTH ENTERPRISE ZONES SUMMIT:

SUSTAINING SOCIAL DETERMINANTS OF HEALTH PROGRAMS

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November 3, 2016
8:30 a.m.

Doordan Institute Conference Center
Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, MD 21401

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1 M E E T I N G

2 (8:50 a.m.)

3 DR. DWYER: Good morning. Welcome. Good
4 morning. We're going to go ahead and get started
5 even though we have some folks stuck in traffic. My
6 name is Maura Dwyer, and I am serving as the Program
7 Director for the Maryland Health Enterprise Zones
8 Initiative. So I want to welcome you today and thank
9 you for your interest and your time today. We're
10 very happy that you're here.

11 Just a few housekeeping items: There's no
12 Wi-Fi password, so you can just go to public access
13 on their webpage. Bathrooms are past the elevators
14 to the right. There's breakfast, continental
15 breakfast in the back, and then we'll be serving
16 snacks and lunch. And there's an all-day drink
17 fountain with tea, water, ice tea, coffee, I believe,
18 so help yourselves.

19 And I'd like to thank Anne Arundel Medical
20 Center and Annapolis HEZ for hosting us today and for
21 all of their hard work to help pull this day
22 together. They've really been a tremendous support.

1 In your package, you'll notice the agenda.
2 And we have a tight agenda today, so we'll be keeping
3 things moving along. We have a lot of great speakers
4 to hear from. The speaker bios are included,
5 information about the awards and the awardees that
6 we'll be presenting after lunch, and evaluation
7 forms. So please be sure to complete your evaluation
8 forms.
9 Dr. Ed Ehlinger, who is the current
10 Minnesota Secretary of Health and former ASTHO
11 president, said when we were meeting with him in a
12 series of meetings focused -- of the Big Ten Academic
13 Alliance focused on health equity issues, said that
14 we cannot achieve health equity by tinkering on the
15 edges of social justice issues. So I'd just like to
16 thank DHMH and our leadership and the HEZs for making
17 Maryland a place where we take these issues head on
18 instead of tinkering around the edges.
19 So I'd like to now introduce our Secretary,
20 Van Mitchell. Secretary Mitchell has been a champion
21 on public health programming and a leader of the
22 State's Department of Health and Mental Hygiene, and

1 he's been a supporter of the ongoing efforts and
2 commends the zones in their focus to enhance
3 community-based care through innovation and
4 partnerships.
5 Prior to serving as Secretary, Secretary
6 Mitchell served as Principal Deputy Secretary from
7 2004 to 2007 and served in the Maryland House of
8 Delegates from 1995 to 2004.
9 Secretary Mitchell?
10 (Applause.)
11 SECRETARY MITCHELL: So good morning.
12 AUDIENCE: Good morning.
13 SECRETARY MITCHELL: All right, for those
14 of you who have Waze on your phone app, don't put in
15 2601 because you'll end up in Parking Lot A, which is
16 where I was this morning. So I thought I was going
17 to be late for Michelle, and I thought she'd be upset
18 at me. I told Tori I've already toured all of the
19 parking garages this morning at Anne Arundel Medical
20 Center. And all of the garages are working great, by
21 the way.
22 (Laughter.)

1 SECRETARY MITCHELL: All right, before we
2 get started, how about those Cubbies?
3 (Cheers and applause.)
4 SECRETARY MITCHELL: Dr. Hussein's a Cubs
5 fan. Great night last night. I actually went to bed
6 in the bottom of the ninth; I can't believe it. But
7 the Cubs did win, 108 years. Great for the city of
8 Chicago and a lot of folks around the country.
9 I do have talking points, but I'm not going
10 to use them, as always, thanks to Michelle and her
11 team.
12 Sincerely, I do want to thank you for
13 coming out this morning. I saw Dr. Reece last night
14 at the Center Club. I was speaking to a group, and
15 he was with a group, so I'm sure he's on his way. I
16 do want to thank Tori and her staff here at Anne
17 Arundel for hosting this event. I'm glad
18 Dr. Hussein's here to join us. And I know Dr. Thomas
19 is going to be here as well later.
20 I just want to tell a little story about
21 coming back to the Department. So, you know, I've
22 been back about 20 months, and I've had the

1 opportunity to meet a lot of people. And that's
2 always something that I really enjoy doing. And one
3 of the reasons I wanted to come back to the
4 Department was because I thought it was one of the
5 best groups I'd ever worked with in my life. And I
6 sincerely mean that.
7 So Dr. Hussein, unfortunately, didn't stick
8 around to see me come back. She had already retired.
9 And we had a vacancy there, and I said to my chief of
10 staff, you know, I really want to change the dynamics
11 for minority health. I wanted to go to the next
12 level. Dr. Hussein and her staff had done a
13 tremendous job, as many of you know, for 10 or 12
14 years, putting us on the map, but where do we go from
15 here? We know all the data. We have all the data.
16 And so I get introduced to Michelle
17 Spencer. And so I'm having some conversations, and I
18 said, you know, Sean, I want to -- when we go to hire
19 this replacement, I want Michelle on my panel. So
20 Michelle and myself and Dr. Thomas made up the panel
21 to hire Dr. Hussein's replacement, which is not an
22 easy task to do. It's a hard situation.

1 Hello, Senator Eckardt. How are you?
2 Good. Welcome. Come on in.
3 So we took the task of going to do that,
4 and I got to work closely with Michelle Spencer. And
5 we came to an agreement with a young lady who I hope
6 a lot of you have met, Shalewa, who I think is doing
7 an outstanding job for us in that and will take us to
8 the next level. But in going through that process, I
9 really found out how much Michelle Spencer meant to
10 our Department.
11 And, you know, public health is one of
12 those things where, in the budget side of it, it
13 doesn't get a lot of attention. Over the last 10 or
14 15 years, core funding in local health departments,
15 as many of you know, unfortunately has gone from 68
16 million to 42 million. We're back up to 56 this
17 year. My goal is to get it back to 70 before I
18 leave. And that's something that we need to be
19 doing.
20 But, you know, when I was there before and
21 when I came back, MRSA, Zika, Ebola, all of these
22 infectious diseases that are now front and center

1 weren't there. So not only do they do their day-to-
2 day job, but, oh, by the way, we have this 24/7
3 scenario and, as they like to call it down in their
4 offices, like crazy Fridays at 5. Everything happens
5 after 5:00 on Friday.
6 But I wanted to take this time to recognize
7 Michelle because Michelle unfortunately is leaving us
8 but going on to bigger and better things. She's
9 going to the --
10 Are you actually at the Bloomberg School?
11 Right, with the new grant with
12 Dr. Sharfstein and will be the Deputy Director. And
13 so I would like all of us just to recognize and thank
14 Michelle --
15 (Applause.)
16 SECRETARY MITCHELL: And wish you the best.
17 You'll be sorely missed.
18 With that, I'm going to like -- who am I
19 turning it over to?
20 And again, thank you all. Have a great
21 conference. And thank you for everything that you do
22 for us. Thanks.

1 (Applause.)
2 MS. SPENCER: Oh, okay. Well, hi. Good
3 morning.
4 AUDIENCE: Good morning.
5 MS. SPENCER: Thank you, Secretary
6 Mitchell. Woo. I'm a crier, so just so you know,
7 the emotions of working with such wonderful people
8 such as Secretary Mitchell and the team at the
9 Department of Health and Mental Hygiene, particularly
10 those who are within the Prevention and Health
11 Promotion Administration and certainly individuals
12 like Dr. Dwyer and Donna Gugel and Valerie and Kyle
13 and so many more, and certainly the Health Enterprise
14 Zone leadership, there's so much that can be said.
15 And so it's so funny, I try really hard not
16 to talk about this, and I've asked my team not to say
17 anything about it because it's been super emotional.
18 So as individuals are coming in -- I think -- from
19 Anne Arundel County came this morning, and I said
20 don't say a word, don't say a word, and so she said,
21 okay, what can I talk about that's not about that?
22 And I'm like let's talk about family.

1 So anyway, thank you again, Secretary
2 Mitchell. And again, good morning to each of you.
3 And thank you, Anne Arundel County, for hosting us.
4 Certainly, Anne Arundel County is one of
5 our Health Enterprise Zones, and I've been asked this
6 morning to talk a little bit about the history and
7 the background of the HEZs. And I will do so as --
8 oops. Perfect. And so I'll do so in some rapid
9 succession. I'm particularly excited to talk about
10 the zones in the context of the social determinants
11 of health programs and how do we sustain those.
12 So, Maura, can you just -- oh, perfect.
13 Okay.
14 So I find this particular quote to be
15 particularly applicable to the zones because they
16 ultimately had to address these issues while
17 implementing their individual place/space
18 initiatives. And so the World Health Organization
19 Commission report back in 2008 on the social
20 determinants of health indicated that "Social justice
21 is a matter of life and death...avoidable health
22 inequities, arise because of the circumstances in

1 which people grow, live, work, and age, and the
2 systems put in place to deal with illness. The
3 conditions in which people live and die are, in turn,
4 shaped by political, social, and economic forces."
5 And you'll see why that's so important, not just
6 because of what it says but because of the work that
7 the individual zones had to do to get to this place,
8 to get to where they are today.
9 So a little bit about the state of
10 Maryland. Maryland has a total population of about
11 5.8 million individuals. Our state is racially and
12 ethnically diverse. About 45 percent of our state
13 are minorities. Four jurisdictions have greater than
14 50 percent minority populations, and nine
15 jurisdictions have greater than 33 percent minority
16 populations, and we have 24 total jurisdictions in
17 our state.
18 We are a state much like other states that
19 have rising healthcare costs. Prior to the
20 implementation of the Affordable Care Act and
21 certainly the expansion of Medicaid, we had about
22 720,000 individuals in our state who were uninsured.

1 We have an aging population, and we know that health
2 disparities do exist across our state. We also know
3 that for every dollar spent on healthcare in the
4 U.S., approximately 84 cents are spent on persons
5 with chronic conditions.
6 Although chronic conditions are
7 preventable, chronic diseases are among the most
8 common and costly health problems in our country.
9 Throughout Maryland, in every county in our state
10 where rates have been reported, there are enormous
11 disparities. Certainly asthma, by race, emergency
12 department visits being one such of those particular
13 factors. We know that chronic diseases such as heart
14 disease, cancer, and diabetes are the leading causes
15 of death, disability, and healthcare costs,
16 accounting for about 70 percent of all deaths each
17 year and 75 percent of all medical costs.
18 So the burden of heart disease in Maryland,
19 this represents about 25 percent of all deaths, and
20 this is from 2010. That's about 11,000 people in the
21 state of Maryland. Heart disease is the number one
22 cause of death in Maryland. And nationally it's

1 about 600,000. This map shows disparities by region,
2 where pockets of high mortality sits next to areas
3 with significantly better mortality rates.
4 So how do we begin to address costs,
5 chronic diseases, and disparities in health? This is
6 where we all come in.
7 So some critical dates: Back in October of
8 2010, the Office of Minority Health and Health
9 Disparities, led by Dr. Hussein, presented to the
10 Health Care Reform Coordinating Council on Maryland's
11 Health Disparities. In January of 2011, the HCRCC's
12 report noted Recommendation No. 14: "Achieve
13 reduction and elimination of health disparities
14 through exploration of financial, performance-based
15 incentives and incorporation of other strategies."
16 In March of that year, the Maryland Health
17 Quality and Cost Council was established. The Health
18 Disparities Workgroup, chaired by Dean Reece of the
19 University of Maryland, included as well other
20 diverse experts in minority health from across the
21 state. The previous governor gave the charge of the
22 workgroup to think about improving the quality of

1 care, improving health outcomes, and reducing costs.
2 And so then Senate Bill 234, the Maryland
3 Health Improvement and Disparities Reduction Act, was
4 passed of 2012. The Act was signed into law, and
5 that act established the Health Enterprise Zones,
6 with the goal, again, of reducing health disparities,
7 expanding access in underserved areas and improving
8 health outcomes, reducing healthcare costs and
9 hospital admissions and readmissions. And Dean Reece
10 and Dr. Gaskin and Dr. Hussein were pivotal in the
11 execution and development of that legislation that
12 then passed, and certainly Senator Addie Eckardt as
13 well as Senator Nathan-Pulliam.
14 So then January 2013 the Health Enterprise
15 Zones were designated. There were 19 applications
16 that were received by the Department of Health and
17 Mental Hygiene. There was a multi-disciplinary
18 review team, and five zones were selected: one in an
19 urban area, that's West Baltimore; two in suburban
20 zones, Anne Arundel County and Prince George's Health
21 Department; and two in rural areas, Dorchester-
22 Caroline Health Department and St. Mary's Hospital.

1 There were $4 million over four years that were
2 allotted. The eligibility criteria included
3 continuous clusters of zip codes of communities with
4 at least 5,000 residents with demonstrated economic
5 disadvantage and poor health outcomes, and this was
6 all based on data.
7 Included in the legislation were tax
8 credits for practitioners as well as hiring tax
9 credits. There were also the Maryland Loan
10 Assistance Repayment Program and the Janet L. Hoffman
11 Loan Assistance Repayment Program, and the goal here
12 was to incentivize individuals to come into the zones
13 to address health and access in these disadvantaged,
14 socially disadvantaged communities.
15 So the need for focused attention: We know
16 that minority health disparities cost Maryland
17 between $1 and $2 billion per year of direct medical
18 costs. And so these excess charges, and how do we
19 begin to address these given the social, economic,
20 and health challenges?
21 When we think a little bit about the
22 largest health impact, and socioeconomic factors are

1 at that very last level, how do we begin to address
2 that level when we think about the Health Enterprise
3 Zones? How do we begin to do that from a perspective
4 beyond health but certainly addressing issues such as
5 housing and unemployment and structural issues?
6 Those structural historic issues of racism and
7 unemployment and education and those things that have
8 been in communities for hundreds of years, and yet,
9 here we are telling the zones that we're giving you
10 these dollars, and we're giving you an aggressive
11 agenda in terms of reducing health disparities and
12 reducing hospital admission and readmission rates and
13 reducing costs. How do you begin to do that when
14 there's so many other underlying socioeconomic
15 concerns that needs to be addressed?
16 And so we looked at the integration of
17 community-based health with a focus on primary care
18 support at the center of community-integrated medical
19 whole model, of this medical whole model, a model
20 that better addresses the full range of health needs
21 for the most vulnerable residents while reducing
22 overall health costs and improving individual and

1 community health.
2 And I know Dr. Gaskins is going to go into
3 details in terms of some of the successes. This was
4 early data that revealed, based on all-cause
5 unplanned readmission rates, we were going down. The
6 zones had seen the benefits of their actions in
7 implementations of their strategies within the first
8 two years. But we know that more still needs to be
9 done. And I just want to note this again, the root
10 causes of health inequities: institutional racism,
11 social inequities, including housing and education
12 and access to quality healthcare, conscious and
13 unconscious biases that we each carry, economics,
14 limited resources, access, trust, and political
15 structures all play a part in the execution of these
16 Health Enterprise Zones and their ability to do their
17 work.
18 I want to end on this one quote: "One
19 should be able to see that things are hopeless and
20 yet be determined to make them otherwise."
21 You know, I want to tell you about Wilt
22 Chamberlain, right? So I'm not a -- I'm a basketball

1 fan, but I'm not that intimately knowledgeable. But
2 Wilt Chamberlain had, I think it was, one game where
3 he shot over 100 points doing this underhanded free
4 throw, right? And then he stopped doing it, and they
5 said why did you stop? And he said because I looked
6 silly, I looked foolish, even though he scored 100
7 points at the free throw line.
8 So I want to say that the Health Enterprise
9 Zone leaders are not the Wilt Chamberlains. These
10 are the individuals who address all of those social
11 determinants of health issues. They faced it, and
12 they did it courageously. They did it when the
13 funding wasn't available. They did it when questions
14 about why they existed remained. They did it in the
15 face of so much.
16 And even though we have strong leadership
17 in our secretary, Van Mitchell, we have strong
18 leadership at DHMH in our Prevention and Health
19 Promotion Administration, there have been challenges.
20 And each of you face them with us. When we asked for
21 data that you could not produce because we didn't
22 quite know exactly what we were doing, you stood with

1 us. Dr. Gaskins, he was there in your face and in
2 your area for two years trying to figure this out
3 with you, and you guys just continue to press
4 forward.
5 So I want to tell you that you are my
6 greatest champions. You are the individuals that
7 look at social determinants and say yes, we can make
8 a difference because we're able to see things that
9 are hopeless and determine that we are going to make
10 them otherwise.
11 So thank you all.
12 (Applause.)
13 DR. DWYER: Thank you very much, Michelle.
14 Well, next we have Dr. Darrell Gaskin,
15 who's a professor at the Johns Hopkins Bloomberg
16 School of Public Health and Director of their Center
17 for Health Disparity Solutions. Dr. Gaskin has spent
18 the last two years working closely with the zones,
19 and he served on the Disparities Workgroup that
20 birthed the vision for the Health Enterprise Zones.
21 Dr. Gaskin is a health services researcher and health
22 economist who is internationally known for his

1 expertise in health disparities, access to care for
2 vulnerable populations, and safety net hospitals.
3 Dr. Gaskin?
4 (Applause.)
5 DR. GASKIN: Thank you very much, Maura,
6 for that kind introduction.
7 And it's good to see you all. And we're
8 certainly always pleased to see the Secretary, Van
9 Mitchell, here with us. And I think his presence
10 here demonstrates how important this initiative is to
11 the state and to the persons who you all serve. And
12 we're very excited that Michelle is coming over to
13 Hopkins. And so I hate to be the one that says,
14 well, you all's loss is our gain, but I'm sure that
15 you all will find someone equally, who can continue
16 this work.
17 So what I want to do --
18 DR. DWYER: If you could just speak a
19 little bit louder. We are recording.
20 DR. GASKIN: Okay. Great. So what I want
21 to do is I want to share with you some of the
22 thoughts and findings of the work of the external

1 evaluation team. And I just want to acknowledge both
2 my colleague Roland Thorpe and then the main persons
3 on the team, Yolanda Klemmer, Rachael McCleary, and
4 Roza Vazin.
5 So the Health Enterprise Zone is really,
6 it's a good idea, and so I've got two pictures of two
7 individuals here, which one is Jack Kemp, and the
8 other is Donna Christensen. One is a former
9 congressman from New York; the other is a
10 congresswoman from the Virgin Islands.
11 And so what do these two people have in
12 common? Well, Jack Kemp came up with an idea that he
13 promoted, these health -- I mean, economic
14 empowerment, economic enterprise zones, and this
15 notion of trying to provide resources to the
16 distressed communities in such a way that you can
17 then leverage those resources to bring in other
18 resources to try to improve employment opportunities,
19 business opportunities in places that were
20 distressed. And the literature on how effective
21 those zones are, it's pretty mixed. There are some
22 places where they've been very successful and other

1 places where they haven't done as well.
2 So as I was on the workgroup and we were
3 thinking about what we could do and trying to think
4 out the box, we came across this idea that Donna
5 Christensen was promoting, which is a notion of
6 trying to apply a similar type of approach to
7 distressed areas, places where there were challenging
8 health problems, to try to create these zones,
9 essentially, where we would put resources there so
10 that the people in those communities, the
11 stakeholders in those communities can attack the
12 problems that they're facing.
13 And so the Health Enterprise Zones, the
14 HEZs is really sort of an evolution of this notion of
15 trying to do some interesting things. So in that
16 sense, it's in the spirit of the kinds of things that
17 Jack Kemp was promoting, and it's this notion of
18 instead of trying to develop a one-size-fits-all
19 approach to addressing disparities, addressing poor
20 health outcomes, what we instead do is we provide
21 some sort of incentives in targeted areas so that the
22 people in those areas can then address the problems

1 that they're facing. And then what you do is you sit
2 back and you try to measure the things in which, in
3 this case, the State of Maryland would be concerned
4 about and measure those things. But in terms of
5 trying to prescribe individually what each individual
6 zone should look like, we sort of let the stakeholder
7 groups try to figure out how to do that because every
8 situation is different.
9 So the Health Enterprise Zones initiative
10 has an overall goal of trying to reduce disparities
11 and improve access to care and reduce the costs of
12 healthcare and hospital readmissions in distressed
13 areas. And that's the overall goal, but in some
14 sense, what it does is it allows stakeholders in
15 those various communities to come together, create
16 coalitions of both public partners and private
17 partners to address the unmet healthcare needs. And
18 so when you're looking at what a HEZ is, in the real
19 sense it's this coalition of people who are working
20 together, in different organizations, trying to
21 address these pressing healthcare needs.
22 So these are our five HEZs. And as

1 Michelle indicated, there's one real urban one, which
2 is in Baltimore City, and then we have two that are
3 in suburban areas and then two that are in rural
4 areas. And so it's a real good mix of what sort of
5 the unmet healthcare needs in the state are.
6 So the scope of our evaluation is to do
7 five things. One is to think about what the overall
8 impact of the HEZ initiative has been and evaluate
9 the individual performance of each or the performance
10 of each HEZ, to think about what the economic impact
11 of the HEZs are, and then to chronicle the residents'
12 experiences and the clinicians' or providers'
13 experience because some of the providers are not
14 clinicians.
15 So we have five strategies that we're
16 employing, and I'm going to talk about two of them
17 today that we're in the midst of. One is to do these
18 individual site visits. And each of you all have
19 seen me and my team during this past year, and we had
20 a wonderful time coming and seeing your various
21 projects, if you will. And then telephone interviews
22 with providers, both clinical and non-clinical,

1 telephone interviews with residents about their
2 experience, their level of satisfaction, and economic
3 impact analysis, which is based on the BEA's regional
4 input-output model, and then an analysis of some
5 hospital data to sort of think about what the impact
6 may be on hospital admissions, emergency room use and
7 readmissions.
8 Now, the one thing that I would say, if you
9 have seen a HEZ, you have seen one HEZ.
10 (Laughter.)
11 DR. GASKIN: And that is really the -- I
12 mean, if you sort of lay down these HEZs and look at
13 them individually, you have -- while they all have
14 pretty much similar health outcomes, healthcare
15 goals, the way in which they have to go about
16 achieving those goals are different. And so you
17 can't just sort of put them all in the same -- you
18 know, the HEZs are anchored by either a health
19 department or a hospital, but even in that case,
20 because of just the heterogeneity, the diversity of
21 both problems and needs and the way in which -- and
22 the resources that HEZs have at their disposals, they

1 have to look different. They can't look the same.
2 And so one of the things in which -- in
3 thinking about the site visits, the thing that we've
4 concluded is that while each of the HEZ are in some
5 ways addressing common healthcare problems, each of
6 them have to be -- you have to be creative in order
7 to develop solutions because the underlying causes of
8 the problems are not necessarily the same in
9 Baltimore City as they are in St. Mary's County. And
10 so that requires, they required different means in
11 order to get people to the area that they need and
12 also promote the kinds of healthy behaviors that you
13 want to promote.
14 So even though all the HEZs, for the most
15 part, do care coordination, community health workers,
16 they're deployed in different ways because the
17 underlying causes, the needs of the community, the
18 people who live there are quite different. And then
19 on top of that, you're laying heterogeneity of
20 underlying causes, but then you think about each of
21 these communities in which they're located are
22 different.

1 Some communities have real strong not-for-
2 profit, community-based organizations. Others of
3 them don't have the same sets of nonprofit
4 organizations on which to draw from. And so you sort
5 of -- the persons who put together each of these
6 programs really had to sort of look out and see who
7 are the potential partners in my community, what are
8 their capabilities, and what is it that they can do
9 in order to contribute to improving health. And that
10 mix of people are different in each community.
11 In my office, if you ever get to come and
12 visit my office, I have these pictures of these
13 wonderful jazz greats on my wall. And one of the
14 things I like to do is, when the students come in, I
15 like to get them to sort of name the people because
16 they're not of this era. And sometimes they figure
17 out who Duke Ellington is and who Billie Holiday is,
18 and they sort trip up on Dizzy Gillespie. But the
19 reason that I have those greats on the wall is
20 because the thing about jazz is that while it's
21 structured, you have to be innovative within the
22 structure, right? And if you're not innovative

1 within the structure, then you really can't be
2 successful with regard to playing good jazz music.
3 And I tell my students that we have structure here,
4 but you have to bring your creativity and your
5 innovation.
6 And that's what I see when I see the HEZs
7 throughout the state, because while the State has
8 provided some structure, the individual HEZs have to
9 be creative and innovative in order to deal with the
10 fact that you have different underlying causes
11 sometimes, as well as different community-based
12 resources. And then as we think about going forward,
13 even the way in which the long-term sustainability of
14 these HEZs, there's not one solution for all of them
15 because of the way in which these -- the problems
16 which they're trying to address and the manner in
17 which they have to address them.
18 So one of the things that we did not
19 anticipate, I think, in the workgroup is just how
20 hard it is to bring primary care physicians to
21 underserved areas and that a loan repayment alone is
22 not the strongest incentive because providers have

1 other opportunities. And so sometime you get the
2 person who you'd like to have, and then another
3 opportunity will open up for them, and they're out
4 the door and you have to then recruit someone else.
5 The other thing is that just trying to find
6 a location for them sometimes is very challenging,
7 and getting through the permitting process in order
8 to locate your person in a practice in a setting in
9 which they then can have access to the patients is
10 challenging. And as I was sort of reflecting on
11 this, one of the things that we probably did not
12 think about as well is the legislative or the
13 regulatory environment, because one of the things
14 about the economic HEZs is that they try to create
15 the regulatory environment so that people could do
16 things fairly quickly in order to get things done.
17 So the HEZs have to be creative. And so
18 it's more than just primary care. It's more than
19 just bringing a physician. Because we know that
20 while having access to a physician is important,
21 there's much more to delivering healthcare than just
22 making sure that there's a physician-patient

1 encounter.

2 So we have community health workers working

3 with high utilizers; providing transportation

4 services to try to get people not only to their

5 physicians but also to their medicines; providing

6 behavior healthcare so that when people are having

7 episodes in the community they don't find their way

8 to the emergency room, that there are people in the

9 community; providing care in schools so that we're

10 impacting the number of children who potentially

11 would have problems with asthma.

12 One of the things that I really found

13 interesting was this notion of care teams, where all

14 the people who are touching the high utilizer are

15 brought together in a room to try to help solve their

16 problem, help them get through their -- to address

17 their healthcare issue. And so it's these kinds of

18 things which I think are noteworthy about the HEZs.

19 So we looked at some hospital utilization

20 data to try to at least get a sense as to what's

21 happening in terms of utilization. Now, there's two

22 main messages here. On the inpatient side, it looks

1 like things are going down. On the emergency
2 hospital side, it looks like things are going up.
3 And we're not quite sure, you know, exactly what's
4 going on, so what we did was we divided the state
5 into three different groups. One is the zip codes
6 for which there are HEZs located, zip codes which
7 were eligible to apply for HEZs but did not get them,
8 and then zip codes that were not eligible for HEZs.
9 And then we looked at the trend in hospital
10 utilization and also compared hospital utilization in
11 the HEZs compared to those zip codes that were
12 eligible for HEZs but did not get them.
13 So this is the emergency room use data and,
14 as I said, it looks like, I mean, we -- if you look
15 over the nine-year period, the HEZs --
16 Do you have a pointer? Does it have a
17 pointer? Oh, okay, good.
18 So the blue line here are the HEZs, the red
19 line are the HEZ-eligible. And if you look at it, it
20 doesn't look like we're getting any really
21 appreciation in terms of changes in emergency room
22 visits. And it doesn't matter whether we're looking

1 at conditions for which -- visits for conditions in
2 which the HEZs are focusing on or -- whoops -- or
3 visits that are associated with sort of these
4 preventable quality indicators that AHRQ developed.
5 We still see this trend.
6 And when we look on the hospital side, this
7 is what excites us. In the blue line are the HEZs.
8 The red lines are the HEZ-eligible. And we see this
9 narrowing of downward trend in inpatient
10 hospitalization, which is good, and then a narrowing
11 between where the HEZs are and where the HEZ-eligible
12 are. And just a little bit -- when we compare the
13 HEZs to the HEZ-eligible zip codes, the HEZ-eligible
14 zip codes tend have lower rates of poverty and near
15 poor. I mean, they're still needy, but they're not
16 as needy as the HEZs. So the State really picked the
17 zip codes where there were problems.
18 And then likewise, for HEZ-related
19 conditions, we see this narrowing and then for these
20 PQEs. So we did this, and then this is data on
21 hospital readmissions and downward trend, somewhat
22 looks like it's narrowing. So we did a regression

1 analysis of difference and difference analysis.
2 I won't bore you with the details of how we
3 did this, but what it looks like is that from the
4 enactment of the HEZ program, that there is a 10
5 discharge per 1,000 reduction in hospital use in HEZs
6 inpatient use, 1 discharge per 1,000 for HEZ-related
7 conditions, and then almost 2 discharges for these
8 preventable hospitalizations. So it looks like there
9 may be some impact that's happening.
10 And then on the -- when we look at
11 readmissions and we just sort of look at the trend in
12 readmissions, it looks like in 2013 the HEZs had 1.2
13 per 1,000 less readmissions than HEZ-eligible places,
14 and then that trend continues. And I'm sorry, that
15 should be a point not a dash. It increases to 2. So
16 it looks like there's something that's happening on
17 the inpatient side.
18 So our preliminary conclusion from the
19 hospital side is that it looks like lower inpatient
20 utilization. We're not quite sure what's happening
21 on the outpatient side.
22 So we still have a lot of work to do.

1 We're in the midst of doing our interviews with our
2 physicians, actually just finished the physician and
3 other provider interviews. We're still completing
4 the resident telephone interviews. We're updating
5 the economic analysis. Some of you have seen that
6 work, and the BEA has updated their RIMS model, so
7 we're in the process of revising that analysis. And
8 then we're -- because we're revising this hospital
9 utilization analysis because we just received the
10 2015 data, have three-quarters of the data in for the
11 year, then there's just a little problem with ICD-9s
12 versus ICD-10s, and they're not exactly the same.
13 So next year, what we hope to do, in the
14 spring, is to bring residents in and actually have
15 some focus groups with them to talk about their
16 levels of satisfaction and so forth like that, do
17 another round of conversations with the physicians on
18 the telephones to talk about their level of
19 satisfaction and sustainability.
20 I think I have overstayed my welcome
21 because she had the red sign up that says please
22 stop.

1 (Laughter.)

2 DR. GASKIN: And so I'm going to be -- I

3 didn't look over at her because she's had that sign

4 up for a while.

5 (Laughter.)

6 DR. GASKIN: But I really appreciate this

7 opportunity. I think this is an exciting project and

8 a real sort of model as to how we can address

9 place/space problems that create disparities in

10 health and healthcare utilization. Thank you very

11 much.

12 (Applause.)

13 DR. DWYER: We have time for a couple

14 questions for Dr. Gaskin. So if you have any

15 questions, please raise your hand, introduce yourself

16 and your organization that you're with, and we'll

17 have him answer them.

18 No questions? That means that he did a

19 very good job, then. All right, thank you.

20 (Applause.)

21 DR. DWYER: Thank you, Dr. Gaskin.

22 So now I'm going to introduce our master of

1 ceremonies for the day, Dr. Stephen Thomas, who's one
2 of the nation's leading scholars on community-based
3 interventions designed to eliminate racial and ethnic
4 health disparities. He's a tenured professor in the
5 Department of Health Services Administration in the
6 School of Public Health and founding director of the
7 Maryland Center for Health Equity at the University
8 of Maryland in College Park.
9 He applies his expertise to address a
10 variety of conditions from which minorities generally
11 face poor outcomes, including cardiovascular disease,
12 diabetes, obesity, and HIV/AIDS. Currently, he's
13 principal investigator of the Center of Excellence on
14 Race, Ethnicity and Health Disparities Research
15 funded by the National Institute on Minority Health
16 and Health Disparities.
17 Dr. Thomas is also, unfortunately, a
18 devoted fan of the North Carolina Tar Heels, who lost
19 to my alma mater, the Villanova Wildcats, in the 2016
20 NCAA men's basketball championship. And we happened
21 to be at a conference at the time, and we had great
22 fun. So despite that, we would like to thank

1 Dr. Thomas to his commitment to and support of the
2 HEZs and for being here to lead us through our day
3 today.
4 Dr. Thomas?
5 (Applause.)
6 DR. THOMAS: So you want to start a fight
7 just when I walk in.
8 (Laughter.)
9 DR. THOMAS: That's what I get for being
10 tied up. I am telling you, I cannot tell you how
11 exciting it is to see the Health Enterprise Zones.
12 Are you guys fired up?
13 (Cheering.)
14 DR. THOMAS: I've just returned from
15 Denver, where the American Public Health Association
16 had its annual meeting, and you all would be so
17 excited because the pendulum is moving to right where
18 you are. You're at the center of attention, center
19 of action. And around the country they're looking at
20 Maryland, and they're looking at the HEZ model as a
21 way of moving forward. So I was very excited this
22 morning to read in the *Washington Post* that Medicare

1 has decided to pay for prevention. Put your hands
2 together for that.
3 (Applause.)
4 DR. THOMAS: All right? They have figured
5 out that it's actually cheaper to keep people
6 healthy.
7 (Laughter.)
8 DR. THOMAS: Finally. And they're going to
9 figure out how to pay for it. But like anything
10 else, it's a big ship. Are all the infrastructure
11 components in place? Are the troops on the ground
12 ready to go once we put the policies in place? And
13 that's why it's so important -- our next speaker is
14 so important because these reports that we do
15 sometimes just gather dust. I will submit to you
16 that there are a lot of solutions that we actually
17 have that could save lives that are living in
18 journals that few read, reports sitting on desks and
19 in libraries gathering dust. And the whole effort
20 here is to take what we know and to put it into
21 action.
22 And I was just blessed, I'll call it

1 blessed, to have been at the table where such a
2 report was being developed. And I think at the time,
3 I'm looking at Dr. Carlessia Hussein here, we had no
4 idea that that report would actually come alive. And
5 that's because leadership matters.
6 And so I'm very, very pleased to introduce
7 our next speaker, Dr. Albert Reece, who's the Vice
8 President of Medical Affairs at the University of
9 Maryland and the John and Akiko Bowers Distinguished
10 Professor and Dean of the School of Medicine.
11 Dean Reece chaired the committee that
12 produced the health disparity report that went to the
13 office of the Lieutenant Governor and was later
14 translated and turned into the legislation that
15 created the Maryland Health Improvement and
16 Disparities Reduction Act of 2012.
17 He's probably going to speak on this, but I
18 just wanted to say that at that time, we had no idea
19 that it would actually come alive. And you're all
20 the evidence of that. And that meant that after the
21 report was done, someone had to be a champion and
22 keep moving it forward and getting over all the other

1 barriers and getting the resources to launch this
2 initiative. And so Dean Reece was pivotal as a
3 thought leader in both the development and passage of
4 the Maryland Health Improvement and Disparities
5 Reduction Act of 2012.
6 Focused on innovative options to address
7 the state's persistent health disparities, Dean Reece
8 led the workgroup, the Maryland Health Quality and
9 Cost Council's Health Disparity Workgroup that
10 articulated the concept of applying principles of
11 economic development and revitalization to public
12 health and healthcare delivery, creating an
13 innovative approach we now know to be the Maryland
14 Health Enterprise Zone.
15 Now, you know, we fought in that room. You
16 know, sometimes people say we're speaking to the
17 choir, but every great choir I know has practice.
18 And so we need to practice here our song. We fought
19 in that room about what this would be called, Health
20 Enterprise, Health Empowerment. There were a lot of
21 little nuances, and Health Enterprise won the day.
22 And I think that's very important because it gets at

1 the heart of the economic issues and the community
2 capacity building that we want to leave behind and
3 create sustainable infrastructure.
4 So help me bring your choir director to
5 this microphone, Dr. Dean Reece. Give him a hand,
6 will you?
7 (Applause.)
8 DR. REECE: Well, I thought Dr. Thomas was
9 just going to deliver my comments.
10 (Laughter.)
11 DR. REECE: I thought he did a great job
12 and just about summarized how I felt then and how I
13 feel now. But it's a real delight to be here. I
14 wish this morning a two-hour travel would have been
15 the 45 minutes that it should have been.
16 (Laughter.)
17 DR. REECE: But traffic is totally
18 unpredictable. So, again, I know you got a chance to
19 hear Dr. Gaskin's remarks, and it was very exciting.
20 So let me say, first of all, it is
21 exciting, and I was privileged, as Dr. Thomas
22 mentioned, to serve as the chair of that workgroup.

1 And I made it very clear that I was simply the chair
2 leader, because the folks in the room, there could
3 have been, I don't know, 25 people, 30 people. It
4 was a number of people who were real experts. They
5 were the content experts. And my role was going to
6 be the chair leader. The only requirement was they
7 had to meet on my turf so it was more convenient. So
8 they did come to my office, and we met for a few
9 hours for maybe 10 times.
10 And as Dr. Thomas said, we started from a
11 blank slate of knowing how to proceed, a tabula rasa,
12 if you will, and was able to craft together what we
13 eventually called the HEZ, or the Health Enterprise
14 Zones. But nevertheless, we had a very strong
15 conviction that it was based on sound principles.
16 It was based on principles and practices
17 that have worked before, such as the economic zones
18 that have been used before and the concept of
19 basically identifying areas of great need, areas of
20 great disparities, or greatest disparities and
21 greatest need, and try to make efforts to replete or
22 replace those deficiencies that were identified

1 within those specific regions. So that was the
2 principle of which it was based off. And if indeed
3 these deficiencies were either the cause or certainly
4 the associated factors with these health disparities,
5 then repleting those neighborhoods with deficient
6 areas should in fact have a positive impact.
7 So that was the principle. But as you
8 know, not every scientific hypothesis or principle
9 necessarily works in practice. So I was eager to see
10 the initial results and will continue to follow the
11 progress as we proceed. But most importantly, I'm
12 delighted to be here with you to really celebrate a
13 milestone in what has been an innovative and an
14 aggressive initiative that was long overdue, one that
15 was focused on the right things: reducing costs,
16 improving quality of healthcare, improving health
17 outcomes for most vulnerable population or citizens.
18 Who can argue with that? This, to me, is an
19 apolitical position.
20 The last four years has helped us to
21 leverage the passage of a number of initiatives, the
22 Affordable Care Act, the expansion of Medicaid in our

1 state, the coverage of more people, hospital global
2 budgets, all of which are aimed at trying to be
3 helpful in one way or another to advance health and
4 equity within our state. But today we're hearing, we
5 just heard a moment ago and we'll continue to hear
6 for the remainder of the morning and afternoon,
7 lessons learned and certainly progress that we've
8 made. We may also see progress that have not been
9 made just yet, and we'll explore those. But most
10 importantly, we'll begin to applaud early successes
11 and identify ways that can be tangible in themselves
12 to further improve these Health Enterprise Zones
13 across the state.
14 I recall during our first summit, during
15 our first meeting of this sort, I went back and
16 reviewed my notes, and I said then as follows as a
17 quote: "All organizations advance faster and go
18 further together. The knowledge and expertise of
19 academic medical centers, of hospitals, and of health
20 providers will result in a reduction in health and
21 healthcare disparities in Maryland's most vulnerable
22 populations," unquote.

1 So my comments then were somewhat
2 prophetic. I see elements. I saw Dr. Gaskin's talk,
3 and I saw elements of what I believe will happen,
4 what we believe will happen. Now, we obviously put
5 forth a proposal on principles, but we certainly are
6 eager to watch the results. We believe in the fact
7 that these will occur. But most importantly, I am
8 pleased by the commitments of each group in advancing
9 the health equity agenda of the Health Enterprise
10 Zones.
11 This is, from my perspective, the only way
12 that we can make a difference. The difference that
13 we seek is through our commitments and through our
14 relentless efforts. The success of Maryland Health
15 Enterprise Zones arises from what I believe is deep
16 dedication. People are not doing this because they
17 just want to do things for academic purposes, but
18 there's a really deep dedication of working on the
19 front lines and trying to make a difference in
20 individuals' lives. In communities, hospitals,
21 care-coordinated centers, local health departments,
22 state agencies, federally qualified health centers,

1 academic institutions, and faith organizations, all
2 of these various constituencies in their own way need
3 to be involved and to some extent have been involved.
4 They certainly were present within our working group.
5 So because of all of these efforts, I want
6 to just extend my personal, and I believe
7 appropriately on behalf of the committee that really
8 worked to put this together -- Dr. Hussein was there,
9 Dr. Thomas was there, that group of 30 strong, vocal
10 individuals -- extend on our collective behalf our
11 gratitude to those whose unrelenting efforts have
12 touched and transformed the lives of individuals and
13 families across the Health Enterprise Zones.
14 The creation and the passing of the
15 legislation, as Dr. Thomas mentioned, is further the
16 proof that Maryland continues to be a leader when it
17 comes to addressing issues of health disparities.
18 These Health Enterprise Zones have collectively
19 addressed so many of the causes of health
20 disparities, some of which, not inclusive, include
21 transportation, food deserts, housing, unemployment,
22 access to healthcare, to quality healthcare, safe

1 places for physical activity, education, et cetera,
2 et cetera. This is, in fact, just some of the
3 determinants that we believe that the Health
4 Enterprise Zone collaboratives are actually working
5 to address.
6 But overall, these are not easy tasks, and
7 therefore, I applaud the leadership of the state, the
8 hands-on leaders, leaders within each of these Health
9 Enterprise Zones, and those who are working on the
10 front line to make the difference. You have indeed
11 risen to the challenge. And let me conclude by once
12 again commending you for your commitment and your
13 dedication to addressing the health disparities in
14 our state and really taking a very bold agenda and
15 moving it forward. We have been the leaders in this
16 area.
17 I should just mention before I close that
18 shortly after we completed our work, I got a few
19 calls from leaders across the United States asking me
20 how we came up with the idea and how we got around to
21 it. And, you know, they thought it was a secret
22 sauce that I had to share. I was a little

1 embarrassed to say that we got together and just
2 argued and talked and argued and talked and discussed
3 what seemed to have worked elsewhere, what should
4 work, and through the collective brains, I would say,
5 of everyone, we came up with what seems to be a very
6 plausible approach.
7 And I shared with them those -- not in
8 great detail of how the sausage was made, but shared
9 with them that basically we believe that it's based
10 on principles that have worked before, and we have
11 strong belief that, therefore, when applied in our
12 setting here, should have similar effect. These were
13 state officials who were planning to take it to their
14 state legislature as well. I have no idea how it
15 fared.
16 But let me conclude once again by
17 applauding those who are taking this effort so
18 seriously. It is a matter of individuals' lives, and
19 the fact that we're taking it seriously and making a
20 difference for this, I greatly appreciate and applaud
21 you on behalf of our entire workgroup. Thanks very
22 much.

1 (Applause.)
2 DR. THOMAS: So Dean Reece, we have time
3 just for a few questions, if anyone wants to just
4 line up there to the microphone. I'll take the
5 prerogative and take the first question to set the
6 stage because Dean Reece has been very modest as he's
7 describing the fights and the fussing that we did in
8 that room.
9 One of the things that I think that you did
10 as a leader was we had to set aside our competition.
11 Leave your sabers outdoors, and put the people first,
12 and stay focused on the deadline. We had a crushing
13 deadline. Can you say something about the importance
14 of that kind of accountability that we had in that
15 room?
16 DR. REECE: Well, I think one of the
17 benefits, I think, is that we had a number of
18 stakeholders from different areas, from academia,
19 from hospitals, from public health. And this is
20 great. So we had a diversity of views. And so it
21 was very easy, as Dr. Thomas says, for there to be
22 competition and almost rivalry, just human nature.

1 But I think to the extent that, one, from a research
2 standpoint, this not my area of research but
3 obviously an interest, I was able to adjudicate much
4 better when there were conflicting voices. I said
5 no, no, let's not talk about that now; let's focus on
6 trying to identify this aspect or that aspect.
7 So I do believe that it's important to have
8 a, if you will, a semi-neutral voice, but you're also
9 trying to adjudicate between various conflicting
10 thoughts, and in the end, as you can see, that's what
11 we got.
12 DR. THOMAS: So, Dr. Reece, you had
13 hospital systems at the table, you had the competing
14 universities at the table, local county health
15 departments, and this whole notion of Health
16 Empowerment versus Health Enterprise, we really
17 struggled with that, and I'm hoping somebody might go
18 to the mic and see what they think about the
19 difference. But now we see that this whole economic
20 piece matters. But what you do at the local level,
21 rolling up your sleeves, what motivates you to go
22 forward, it may not simply be about return on

1 investment, how we balance that motivation to get the
2 work done and these economic imperatives to lower
3 costs and reduce hospital readmissions.
4 DR. REECE: Well, first of all, what we
5 probably hadn't said earlier, and that is one of the
6 mandates of the larger committee, was really to
7 achieve increased quality and decreased costs. And
8 that committee, actually, the larger committee
9 started working on initiatives that would do that,
10 the first of which was a hand-washing campaign across
11 all the 52 hospitals through the state of Maryland,
12 which we did.
13 A second project we took on was to use the
14 blood products. Many of you may not realize that
15 once you -- a doctor calls for two or three units of
16 packed red cells or fresh frozen plasma and it comes
17 to the floor, it's been thawed out. You can't really
18 refreeze it, so essentially, if you don't use it, you
19 actually waste it. So we came up with an approach
20 where, in fact, we would be able to communicate with
21 all hospitals across the state so when you need a
22 unit of two or three of fresh frozen plasma or packed

1 red cells, you can actually identify them in any
2 other hospital that was already thawed and you didn't
3 have to throw them away. So that was another cost
4 savings. So that was kind of low-hanging fruit. We
5 then decided to go way in the top of the tree with
6 these health disparities.
7 So the point I'm trying to make, it was
8 both an economic imperative as well as a health
9 imperative. So we had to always balance those. The
10 first two were a little less difficult, but it was
11 always looking at cost while looking at health
12 improvement. So we're balancing this out. The
13 Health Enterprise Zones phraseology, we think,
14 addressed that because it's really an enterprise that
15 we're taking on with costs as well as health. So
16 those two principles were constantly in our sights
17 and have been our operative terms that we've used.
18 DR. THOMAS: One question? Yeah. And
19 please, stand up and introduce yourself.
20 MS. JOHNSON: Hi, my name is Susan Johnson.
21 I'm Vice President of Quality and Population Health
22 at Choptank Community Health, the FQHC on the mid-

1 shore over on the Eastern Shore. And my organization
2 came sort of late to the HEZ. We joined in 2014.
3 But one of the things that I want to make
4 sure, as we're sort of wrapping up this version of
5 the HEZ, that you realize, when we're talking about
6 people and changes in culture, it takes more than
7 four years. And, you know, I think that in some of
8 the graphs we saw earlier, there is a downward trend,
9 but it's too early to see whether we've actually made
10 a difference because it takes a good two or three
11 years for a community to gel around whatever the
12 topic is we're working on. And that has just
13 happened, and now the funding is going away.
14 So I wanted, I just wanted to push that
15 forward, that when we're talking about these huge
16 culture paradigm shifts with people, it's different
17 than adding, you know, having economic -- even an
18 economic -- having a new business plan and putting in
19 a plant. We're talking about changing people's
20 approach to their lives and how they care for
21 themselves, and that takes a long time.
22 And I don't want us to give up. We've

1 scratched the surface, and we've awoken the beast.
2 We can't leave it. So we've got to make sure that
3 we're continuing to push forward. We have a rural
4 health workgroup that's been commissioned, and we're
5 looking at those same kind of issues. How do we
6 deliver care in a way that gets to the things that we
7 need to take care of?
8 DR. REECE: Two quick points. First of
9 all, I totally agree with you. It took us more than
10 four years to get there. This is going to take us at
11 least the same time to get out of where we are. I
12 just noticed that we have changed the term from
13 Health Enterprise Zones to HEZ. That's a new one
14 now.
15 (Laughter.)
16 DR. THOMAS: Let's give Dean Reece a hand,
17 will you?
18 (Applause.)
19 DR. THOMAS: Well, I can assure you that
20 Dean Reece has not taken his hand off the wheel. He
21 has been describing this work and his various venues,
22 and you should know, also, that it's gotten the

1 attention of the Big Ten Academic Alliance. Have you
2 talked about the Big Ten yet, Dr. Spencer?
3 MS. SPENCER: No, we have not.
4 DR. THOMAS: And you should know that the
5 Big Ten -- where's my ACC person over here?
6 (Laughter.)
7 DR. THOMAS: But the Big Ten Alliance has
8 embraced community capacity building, and at the
9 center of their concept of community capacity
10 building is the Maryland model of the Health
11 Enterprise Zone.
12 So I want you to have hope, ma'am, and stay
13 the course and recognize that the needle is moving to
14 you. Wayne Gretzky, they asked him how he got so
15 many goals. He said some people skate -- some people
16 wait for the puck to them, and others go to where the
17 puck's going to be. You are where the puck is going
18 to be, and you just need to hang in there and use
19 this meeting to document where you are and where you
20 want to get to.
21 So now I think it's kind of time to roll up
22 your sleeves and get down to what's happening on the

1 ground. What are those lessons learned about
2 sustainability challenges and strategies? And here's
3 where we have to have some truth-telling here.
4 Michelle, are we recording this?
5 MS. SPENCER: Yes.
6 DR. THOMAS: All right, this is good.
7 Okay, you've got to set the workers straight. You've
8 got to let people know what page they're supposed to
9 be singing on and in what key. And that means
10 lessons from the front lines. You've got to give
11 voice to those people that you know have no voice and
12 how the HEZ has made a difference and how we can
13 improve it.
14 So this next panel called Leadership from
15 Each of Maryland's Five HEZs will now share some of
16 their lessons, their successes, their sustainability
17 challenges, the good, the bad, the ugly. Extremely
18 important. So let's have our speakers head to the
19 front table. And as they come up, I'll begin to
20 introduce them. And you can take your seats.
21 So what we're going to do is I'm going to
22 introduce all the speakers, and we're going to

1 welcome them. And we'll let them speak in the order
2 in which they are listed here. And what we're going
3 to do is we'll hold our questions for the end. So I
4 want you to be jotting down your questions, because
5 the most important part of this, I think, is that
6 kind of discussion that's going to come when we open
7 up the floor.
8 Our first panel member comes from the
9 Caroline-Dorchester Competent Care Connection.
10 Angela Mercier, raise your hand, please. There's
11 Angela.
12 And we also have the Prince George's County
13 HEZ represented by Dr. Ernest Carter. And the Anne
14 Arundel Medical Center's Annapolis Community Health
15 Partnership, Ms. Sharon Cameron, a manager. And we
16 have the MedStar St. Mary's HealthAccess, Lori
17 Werrell. And the West Baltimore Primary Access
18 Collaborative, Maha Sampath. Boy, I did -- give them
19 a hand. Give everybody a hand.
20 (Applause.)
21 DR. DWYER: We also have Dr. Pat Czapp from
22 Anne Arundel Medical Center.

1 DR. THOMAS: And Dr. Pat Czapp.
2 (Applause.)
3 DR. THOMAS: Okay. Sorry, my apologies if
4 I messed up on your names. So we'll go in that order
5 and I will -- where's my timekeeper?
6 We'll have a time -- so I'm going to be the
7 bad guy if I have to stand up and move close. We'll
8 get through them, and then we'll open this whole
9 conversation up. So Angela Mercier, would you like
10 to begin?
11 MS. MERCIER: Yes, I would.
12 DR. THOMAS: Just pull that mic right
13 there. Bring it really, really close to you.
14 MS. MERCIER: How about now?
15 DR. THOMAS: There you go.
16 MS. MERCIER: All right. Good morning. I
17 thought maybe it was because I had two cups of
18 coffee, but really I think it's the enthusiasm and
19 the pride about the HEZs for why I'm so excited about
20 being here and to kick it off with our Caroline-
21 Dorchester HEZ Competent Care Connections, which was
22 developed by 15 organizations in Caroline and

1 Dorchester Counties and designed to improve
2 healthcare access and the health status for
3 individuals living in our underserved community. And
4 the primary mission, of course, can be summed up in
5 two words: health equity. I think we all know that
6 and that's why we're here.
7 DR. THOMAS: How do we advance the slides?
8 DR. DWYER: Sorry.
9 MS. MERCIER: Thanks. That's okay. There
10 we go. All right, so this is our region. It covers
11 seven zip codes from Federalsburg to Cambridge, with
12 a total population of a little over 36,000. And our
13 area is unique because we have a lot of geographic
14 features that are barriers for accessing healthcare,
15 transportation being a huge barrier. And beyond
16 geographical characteristics, economics, education,
17 everything you've been hearing about this morning, a
18 history of racial prejudice, they've all had a
19 substantial impact on the health status and
20 healthcare access. I mean, we were identified as a
21 Health Enterprise Zone for a reason.
22 Being a medically underserved area,

1 Dorchester County has been declared as having the
2 largest population designated as medically
3 underserved in Maryland. And all of Caroline County
4 has been designated that as well. So what do we do
5 about this? It's absolutely been a collaborative
6 effort. That's been an essential part of the
7 solution.
8 I don't think any single type of
9 organization can effectively address the health of
10 individuals and communities. There are such complex
11 coordinates that requires coordination, especially
12 with multiple chronic conditions, and our coalition
13 made up of 23 leaders, community members, advisory
14 partners, et cetera, have different levels of
15 capacities and resources and skill sets that they
16 bring to the table and really just strategize,
17 understanding health issues, how to engage the
18 community and identify gaps and build bridges across
19 groups to create shared values and goals.
20 So this kind of recaps our goals, which
21 we've already kind of covered this morning, but I
22 just wanted to point out that the coalition was built

1 into a model with four key values of cultural
2 competence, citizen leadership, behavioral healthcare
3 integration, and recruitment and training. And these
4 values correspond with strengthening healthcare
5 access. So -- oops. Sorry. Okay. Correspond with
6 strengthening healthcare access, so health status is
7 addressed through the availability of four healthcare
8 service teams: primary care, peer recovery, community
9 health, and behavioral health.
10 So I'm not going to cover all the services
11 provided, but I wanted to put this slide on here just
12 so you can see how many partners -- and these are
13 just the funded partners -- that we have for our HEZ,
14 and just a brief snippet of the services provided.
15 And really they do so much more, but I can only fit
16 so much on one slide. And I wanted to highlight more
17 as I talk about some of our major accomplishments
18 anyway.
19 So this picture here is from the opening of
20 our Federalsburg Mental Health Clinic. So Caroline
21 County Health Department opened that in November of
22 2015, with licensed clinical social workers and a

1 psychiatrist to provide adult outpatient mental
2 health services. And really, this helps overcome
3 that serious transportation barrier by having a
4 clinic closer for the Federalsburg participants as
5 well as the Hurlock area.
6 We contracted Choptank Community Health,
7 which is our FQHC, and they have two clinics in our
8 zone for care coordination. So we have a full-time
9 care coordinator that ensures patients are referred
10 appropriately and assists patients with navigating
11 the healthcare system.
12 Dorchester School-Based Wellness, they help
13 to expand access to pediatric care. So they have a
14 nurse practitioner in one of our middle schools to
15 provide on-site care, primarily somatic but also
16 primary mental health. And one of the great
17 accomplishments was developing and implementing an
18 asthma management program, and that was in
19 collaboration with our local pediatrician, and also
20 involves families even though it's an on-site
21 program. Until recently, Dorchester County only had
22 one pediatrician for the whole county. So expanding

1 access to pediatric care was a really huge
2 accomplishment.
3 Eastern Shore Area Health Education Center,
4 they assisted with two-mini residency rotations in
5 one of our high schools to kind of grow our own and
6 give a taste of practicing in a rural school setting.
7 And they've done so much work developing our CHW
8 workforce, community health workers. And 50
9 community health workers have been trained to date.
10 Beyond that, they've provided testimony and just done
11 a lot of advocacy work, working with legislators,
12 which resulted in the passing of a bill to provide
13 tax credits to preceptors who work with medical
14 students, again to increase capacity in our region.
15 MedChi, again, promotes incentives to open
16 or expand services in our zone. They helped to
17 recruit a satellite office for Chesapeake Women's
18 Health. Previously, we had no prenatal healthcare
19 providers in Dorchester County. And then, also,
20 three additional physicians were recruited.
21 We are proud to say we have a culturally
22 competent workforce who can also address health

1 literacy challenges through training and increase
2 access to peer recovery support through several
3 partnerships and leveraging resources. Chesapeake
4 Voyager and DRI-Dock, which is our recovery drop-in
5 center, have peer support specialists who use their
6 own life experiences and training to support those
7 with substance abuse or mental health conditions or
8 co-occurring.
9 Associated Black Charities established our
10 community health worker team, and they really
11 solidified the reach of our HEZ into homes and
12 communities through various direct services like
13 blood pressure screenings, chronic disease and
14 diabetes self-management trainings, connecting to
15 resources and education.
16 And this data listed here is just for the
17 span of April to September 2016. So really, it's
18 just a six-month snippet: 70 percent of currently
19 enrolled participants are actively advocating for
20 their health; 59 percent of participants with
21 diabetes showed reduced medications prescribed by the
22 primary care providers, so there can certainly be

1 some cost savings in that; 97 percent of participants
2 report they trust their CHW and have modified their
3 behavior to improve health outcomes.
4 Maryland Healthy Weighs offers medical
5 weight loss services. And they did a yearlong study
6 from July 2015 to June 2016 with 55 HEZ patients.
7 They lost an average of 15 percent of their initial
8 BMI over an average of 25 weeks in the Phase 1, which
9 is the weight-loss program. The average starting BMI
10 for these patients was 44, and using results from a
11 2015 study published in *PharmacoEconomics*, the
12 estimated savings in annual medical care costs for
13 one HEZ patient is over $13,000.
14 Eastern Shore Mobile Crisis Response, they
15 actually receive funding from Behavioral Health
16 Administration, but they've been such a crucial
17 partner, and really, the collaboration is what made
18 all of this happen, so I did want to highlight them
19 as well.
20 They are crisis response. They help people
21 in crisis with mental health issues, substance abuse,
22 and developmental disabilities, however the person

1 defines crisis. They started a Dorchester-Caroline
2 team to be a closer resource because of, again, that
3 transportation barrier and added 4.4 FTE behavioral
4 health professional positions, increasing capacity.
5 And the initial goal was to reduce response time to
6 less than 60 minutes, but for the length at HEZ, they
7 have a reduced median response time of 21 minutes,
8 which if you know our area is a huge accomplishment.
9 And they facilitated 545 ER diversions and over 1,500
10 dispatches, for a potential savings of nearly 1.2
11 million based off of the Healthcare Bluebook value,
12 which rates ER visits or average psychiatric
13 emergency room calls.
14 I wanted to just show a slide of our reach
15 for how many participants have received services, and
16 this is for up to June 30th, 2016. A little over
17 4,200 unduplicated patients and over 21,000 patient
18 visits. But I also wanted to add we have been
19 keeping count of passive contacts because a lot is
20 done with making phone calls, leaving messages,
21 sending letters, e-mails, et cetera, for providing
22 services, which was over 8,500 passive contacts.

1 And I also wanted to highlight how many new
2 and retained jobs the funding has brought, just
3 almost 26 FTE, and that includes, you know, school-
4 based wellness nurse practitioner, physicians,
5 community health workers, social workers, addictions
6 counselors, and other support staff.
7 Of course, when we're talking about
8 sustainability, I wanted to highlight our
9 expenditures. For the four-year period, it's a
10 little under 2.8 million. And these are the services
11 vulnerable without HEZ funding. And I kind of
12 already covered that, but I did want to have a slide
13 so you can see some of the things that we're trying
14 to sustain.
15 But I really wanted to get to the meat with
16 the lessons learned and sustainability challenges.
17 And I lumped this together because I really think
18 they kind of go hand-in-hand. To start off with,
19 because we have so many partners providing such
20 different services, collecting and compiling data is
21 really challenging. And it wasn't until fall of 2015
22 that we began using Cyfluent EHR, which has, you

1 know, limitations as well.
2 And like was said earlier, ROI is not
3 always tangible, and it's just too soon to
4 effectively demonstrate. An example we've often
5 referred to is, you know, how do you measure ROI for
6 the trust that's built between a community health
7 worker and a patient? But there's significant value
8 in that, especially just being in a rural area with
9 limited resources and cultural challenges. So
10 continuation of funding would help us better be able
11 to determine ROI.
12 We've made so much progress expanding the
13 community health workforce, but we still had to
14 continue advocating for reimbursement or policy
15 change and buying from others such as, you know,
16 healthcare providers and payers and insurers. We
17 have committed partners who know our community and
18 the people living in it and the integration and
19 coordination among these partners to identify needs
20 and develop solutions is really one of the main
21 important pieces of our program.
22 And I just wanted to say, too, we need a

1 multifaceted approach because of the complexity of
2 issues, from provider shortages and transportation.
3 There isn't just one solution. We can't just look to
4 the hospitals. We can't look at just grant funding
5 or just insurance companies. And, of course, all of
6 this takes time and is not easily resolved.
7 So, you know, if HEZ no longer exists, we'd
8 be competing for the same funds, and we wouldn't be
9 able to communicate and collaborate to identify gaps
10 in serving the same population.
11 So I know I am out of time. So please, I
12 strongly encourage you to read our participant
13 testimonials. One of them is one of our ABC CHW
14 participants, and then another highlights the asthma
15 management program in Dorchester School-Based
16 Wellness.
17 And I know you had mentioned you had never
18 heard HEZ before, but with a project this intense, we
19 live and breathe HEZ, and we, you know, have to
20 lighten it up, and we like to do a play on words like
21 what the HEZ is going on in here.
22 (Laughter.)

1 MS. MERCIER: So I'm just going to say I
2 want to let this HEZonate and pass it off.
3 (Laughter and applause.)
4 DR. THOMAS: Yeah, give her a hand, will
5 you?
6 (Applause.)
7 DR. THOMAS: And, you know, throughout
8 these talks, you're going to hear how much we saved
9 this, we saved that, we averted costs here. Does
10 that just go into ether? So think about some of
11 those. As you think about it, that adds up. That's
12 real dollars somewhere to recover.
13 Dr. Ernest Carter is with the Department of
14 Health. He is the Deputy Health Officer, Project
15 Director of Prince George's County Health Department.
16 Dr. Carter, you have the floor.
17 DR. CARTER: Thank you, Dr. Thomas.
18 I would like to say before I start, I'm
19 going to run out of time.
20 (Laughter.)
21 DR. CARTER: Because it's a lot to say, and
22 all of us have a lot to say, and you know, we're

1 going to try to get through most of this. And a lot
2 of stuff we're not going to be able to say, but we're
3 going to try. I can tell you one thing that I want
4 to be able to be sure to impart to you all, that
5 everybody up here is doing God's work. And that's
6 what we're doing.
7 (Applause.)
8 DR. CARTER: And we say that in Prince
9 George's County. We say that in our meeting, we're
10 doing God's work. And so we're going to continue
11 this one way or the other.
12 I just wanted to tell you more about our
13 Health Enterprise Zone, which is in Prince George's
14 County. When we took on this project, our goal was
15 to find a zip code where we actually could make a
16 difference. We looked at all the zip codes that we
17 had in our county, and the one that stood out to us
18 was 20743. It had about 40,000 people in it. It
19 didn't have hardly any physicians whatsoever. It had
20 huge health disparities. All the outcome measures
21 were very low. And we said, well, we've got to go
22 after it. We have to go after this, because if we're

1 going to demonstrate how health disparities can
2 change the dynamic in health costs, et cetera, et
3 cetera, this is where we have to go. So that's
4 where -- so we applied for the grant.
5 And this is what Capitol Heights looks
6 like. That's 20743. And those little dots on there,
7 which you can hardly see, but there was only one
8 really major dot there before we started, and that
9 was Greater Baden. Other than that, it was hardly
10 anything there. And we had -- we put on this little
11 map, we put where pharmacies were, everything else,
12 and we said, oh my God, we don't have a lot of
13 infrastructure here, we've got to do something. That
14 means we have to come up with a system, not just a
15 project. We have to come up with a system that's
16 going to address this.
17 Because what we found in those -- where you
18 see those little circles, there were townships.
19 There were three mayors and three municipalities in
20 20743. And we talked to them, and these are good
21 people doing good work, again, doing God's work in
22 communities that need to be built. And so we knew we

1 had to start with the people. We talked to the fire,
2 police, everybody, anybody in the county so we could
3 figure out -- in that particular zip code so we could
4 figure out what kind of system do we need to create,
5 and then how can we get to the promise land of being
6 able to say we actually improved this zip code.
7 So in this particular overview, we set out
8 to create a system. And to do that, we had to say,
9 well, we start at the patient, we start at the client
10 and say what do we need to do? Where are the points
11 where we can create this system? And we looked at
12 where people transition from hospital to home, then
13 they come from a nursing home to home, or they come
14 from some ER to home. At least we know that because
15 they're going to get sick and use these facilities.
16 Where can we intervene?
17 So we started looking at that, and we
18 realized that we've got services in the Health
19 Department that might be able to help. We realized
20 that there are county services. And there are
21 services all over the place, but they're not
22 necessarily all in 20743. We're going to need a

1 system to coordinate these services. And not only
2 that, we said to ourselves, we're going to have to
3 have some people go out there. And this is one of
4 the fundamental points here is that it's the
5 peer-to-peer interaction. It's people in the
6 community working with people in the community that's
7 absolutely critical. Because that's how you change
8 behavior is peer to peer. It's not all this other
9 stuff; it's peer to peer.
10 And then you've got to create a system that
11 helps peer-to-peer interaction, so we knew we had to
12 use community health workers, and we need to have
13 some health information technology underbelly so we
14 can communicate, so we could pass information, and so
15 that we can have a way to create what you call a
16 longitudinal care record so that we can actually
17 manage that. So we did that.
18 And the other thing, while we were in
19 parallel, we knew people in -- we had a lot of
20 uninsured folks, and we needed people to get onto
21 insurance. So these were the considerations that we
22 had. And more important, we knew that our health

1 system that surrounded this county had to help us
2 with preventing disease. So we knew that we were
3 going to have to create points of access to help
4 people manage their disease.
5 But even more important than that, we knew
6 we had to organize the community. So we created
7 community coalitions. We created literacy
8 coalitions. We worked with the folks in the
9 community, at the community level, and we knew most
10 importantly the bedrock of being able to transform a
11 community was to make sure that the community has
12 health literacy, because that is not -- along with
13 the peer-to-peer interaction, it's the health
14 literacy that starts to transform. Knowing that,
15 that's where we knew our system had to go, and more
16 than anything else, we knew we were going to have to
17 reduce costs. If we didn't do that, then people
18 don't want to sustain us.
19 So one of the things we did in terms of
20 creating the system was to say in order to reduce
21 costs and create a system, it had to be what they
22 called a value-based care system. It had to be a

1 system that relied on how the quality indicators were
2 improved by what you did. But in order to do that,
3 again, I'm going to keep re-emphasizing, you have to
4 engage patients. So to do that, we came up with the
5 criteria. And I didn't come up with this. This is,
6 you know, this is -- you can find this on HHS'
7 website, that we sort of imposed what we had onto
8 those areas that could cause value-based purchasing
9 in this area, which would be to do care coordination
10 using community health workers, build a health
11 information technology infrastructure, leverage CRISP
12 and those types of things.
13 So we did that, and we came up with a
14 system, and we started creating what we needed to
15 make this Enterprise Zone work. First, we knew we
16 had to increase the infrastructure, and that was one
17 of the charges of the grant, so we said we need at
18 least five Health Enterprise -- at least five
19 patients in medical homes. We've got to bring some
20 doctors in here. But we didn't want to bring doctors
21 into a clinic necessarily. We wanted doctors to come
22 in and have a practice there. So we insisted that

1 practices come in, we'll help you set up, and we said
2 we want five of those to help our people in this
3 Health Enterprise Zone.
4 Secondly, we said we're going to create a
5 care coordination team using community health workers
6 that were from the community. Number two, we're
7 going to have to have an organization that oversaw
8 that care coordination team, which we call a CCCT, a
9 Community Care Coordination Team, that helped us with
10 the quality of what we were doing and to oversee us.
11 Are we doing a good job? Are we helping the patients
12 who we were looking at? We had to have a health
13 literacy campaign, and we also needed to integrate
14 behavioral health into what we were doing. And
15 that's what we set out to do, along with social
16 services integration.
17 So here are some of the -- starting with
18 increasing the access, here are some of our results.
19 We've had about 42,000 total number of patient visits
20 in our Health Enterprise Zone after we had set up.
21 We have four. We have a fifth one that's really
22 coming online in December. And we've had about

1 30,000 patients seen that have been unduplicated, and
2 about 40 percent of those, 41 percent of those come
3 from the zone itself. Now, one thing you should know
4 about our numbers, we take everybody. You know,
5 whether somebody comes in to see somebody in one of
6 our facilities -- well, not our facilities, one of
7 their facilities, if they are in the zip code or not,
8 we take them. So that's how we count it, just so you
9 know.
10 And we've increased the workforce, and you
11 can see those numbers there. I think our zone FTE
12 count has gone up to almost 25 now. The other thing
13 we had to do then, that second down that tier, so we
14 created these five, one coming online in December,
15 and we feel like that's coming on, and we've done
16 something there.
17 But secondly, we did care coordination.
18 And so we created the care coordination team, and we
19 needed to know, okay, who are we coordinating? So
20 the idea was to find the people who over-utilized
21 that system the most. And what system were we
22 talking about? Well, the hospitals, primarily. Are

1 they over-utilizing the emergency room and getting
2 readmitted to the hospital too many times? So the
3 best way for us to get that data was to go to CRISP
4 and say, okay, who are the people who are really
5 being readmitted all the time? Who are they, and can
6 we go get them from our zip code, 20743?
7 And they were kind enough to supply us with
8 that data, and we found out that it was about 10
9 percent of the people in our zip code who was really
10 being readmitted the most, about 80 percent of the
11 time. And that's on this graph. And it was really
12 striking to us because that was only about -- in our
13 zip code, it was somewhere around maybe 200 -- well,
14 the 10 percent is about 400 people, but it really was
15 about 270 people who were really causing the --
16 costing the system the most. So we said, well, we
17 don't need to do a lot of risk stratification, we
18 just go get -- let's go ask the hospitals who those
19 people are and let's try to manage those people.
20 And so that's what we did. And so our care
21 coordination team functioned that way, and I listed
22 out here the way we went about creating that care

1 coordination team. And the idea was to make sure we
2 take care of that patient's needs. And you can see
3 all of the delineation there, because I don't have a
4 lot of time. I'm out now, but I'm still going to get
5 through this.
6 (Laughter.)
7 DR. CARTER: So what we did, we did create
8 those teams. We decided that we needed to
9 concentrate a lot on their social determinants, be
10 able to manage them when they come out of the
11 hospital, but not only out of the hospital, also
12 between their doctor visits. And we did that.
13 We created that Community Care Coordination
14 Team, that oversight team, which really has about 45
15 people in it. It has EMS. It has visiting home
16 nursing. It has QIO. It has all the people who
17 touch that patient at some point. It has our case
18 managers from the hospital systems. It has case
19 managers from our patients in medical homes. And
20 it's overseen by Barbara Banks-Wiggins, who makes
21 sure all that stuff happens. And what that does is
22 we take case by case, and we look at their needs, and

1 we try to satisfy their needs. And each one of their
2 needs we delineate into a pathway. It's sort of like
3 a workflow. And if we can say we meet that need,
4 then we've gotten over that workflow, that pathway.
5 So that organization exists. We have a
6 workflow for it, and it works for us really, really
7 well. And this is sort of -- these are just sort of
8 some graphical depictions. I'm going to get through
9 that real quick. And I'm not going to go over a
10 case. We have nice cases that we could tell you
11 about, people who came in that had horrible
12 situations, that when we did each, when we addressed
13 each one of their needs, we were able to help these
14 people. We call those people people who graduated
15 from our program. And it takes about 120 days to
16 graduate. I don't know about you guys, but it took
17 us about an average of 120 days to graduate somebody
18 from our program.
19 But we had -- so we got the data from the
20 hospitals, and I'm going to show you our 2015 data,
21 where we looked at the people who graduated, the
22 people who were noncompliant but we still were

1 working with, but they were not compliant. Then we
2 had people that we're working with but they're still
3 ongoing. After 120 days, they still have need after
4 need. And you all can imagine that. I'm going to
5 show you the data we got from working with these
6 patients.
7 This particular graph right here shows to
8 you each one of our pathways. These are the needs
9 that we concentrated on. When we sent a community
10 health worker out, they had to do initial assessment,
11 and they created a profile of needs. And each one of
12 those needs, you can see in this graph, shows you how
13 needy people were. And they had combinations of
14 these. It's going to be interesting, and at least
15 was interesting to us is that even the people who we
16 touched once and were noncompliant, something
17 happened.
18 And in this graph right here, this is our
19 analysis of our 2015 hospital data. This is from
20 Doctors Hospital and Dimensions. We found that the
21 people who graduated from our program, that they
22 stuck -- six months prior to coming and seeing us,

1 they would have been in the -- they would have been
2 seen -- they would have had 3.5 hospital visits. But
3 then after seeing us, six months after that, that
4 six-month period after seeing us, those visits
5 dropped to about two visits. But that was a
6 tremendous cost savings. That's almost a $10,000
7 cost savings.
8 But the other thing that was interesting to
9 us was the people who were noncompliant, they also --
10 they had about six visits, on average, six months
11 before we saw them. Six months after, it dropped to
12 about five, which also was a cost savings. So
13 there's something about touching that person. It is.
14 And everybody is going to say that. It's something
15 about having that -- even if they're noncompliant
16 helps to save money. I'll just say it that way, and
17 that's as quick as I can say it.
18 So I'm not going to go through all the
19 other stuff. We had a great health literacy
20 campaign. We do things with Sister Circles, which
21 also helps modify people's behavior. And I'm not
22 going -- and I guess I don't have time to go through

1 all our successes and lessons learned, because like
2 Angela, myself, Sharon, Pat, Lori, and Maha, we did a
3 whole lot of work in four years, and we got like 15
4 minutes to talk about it.
5 (Laughter.)
6 DR. CARTER: I can't talk about it in 15
7 minutes.
8 (Applause.)
9 DR. CARTER: I can't do that. I can't do
10 it. It's impossible. So you can look at our slides,
11 I suppose, and look at our lessons learned. We've
12 got a whole lot of lessons to learn. We've got
13 things that we think can be sustainable. But because
14 I'm out of time, I just wanted to make that one
15 point. Our work actually does save money, because
16 we've got the data, everybody here has the data. Our
17 work is God's work. We need to be sustained.
18 (Applause.)
19 DR. THOMAS: I'm so glad to hear that it's
20 possible to talk about the patient as not being the
21 problem. All right? So you built the systems around
22 that were making the problem, not labeling them in

1 ways that were negative or stereotype. I love that
2 graduating, graduating from our program. So even
3 bringing in this new language is extremely important
4 for how we move forward.
5 Now, from Anne Arundel Medical Center, we
6 have Sharon Cameron and Dr. Patricia Czapp. You have
7 the floor.
8 (Applause.)
9 DR. CZAPP: Hi. Hello. Good morning, I'm
10 Pat.
11 MS. CAMERON: Good morning, I'm Sharon.
12 DR. CZAPP: And we're going to do something
13 a little different. We thought about this last night
14 at the last possible moment. We decided we're going
15 to tell you a story, and this is a special story for
16 two reasons: number one, it's brief; number two,
17 this story won an award. It won the 2015 National
18 Total Cost of Care Story Contest. And we feel like
19 -- this is a story about our HEZ. It tells the story
20 well.
21 Sharon, let's do it.
22 MS. CAMERON: "'Doc, I need an MRI for my

1 back.'"

2 DR. CZAPP: "I recognized the voice

3 immediately and turned to greet one of my favorite

4 patients, Mr. P. There he was, smiling, leaning on

5 his walker. Mr. P visits me several times a day in

6 my primary care office that is essentially in his

7 living room.

8 "The practice itself, sized fewer than a

9 thousand square feet, is on the first floor of a

10 high-rise apartment building that houses disabled and

11 low-income adults. My team and I provide primary

12 care to the residents of the building, which is a

13 public housing unit, and the surrounding community, a

14 diverse population that has in common these

15 characteristics: social isolation, poverty, low

16 health literacy and low general literacy, a high

17 prevalence of behavioral health problems, and limited

18 transportation.

19 "We came to practice in the building

20 because our health system, Anne Arundel Medical

21 Center, several years ago noted a high number of ED

22 visits from individuals of one address. We visited

1 the address to meet the residents of the building and
2 their landlord, the local housing authority. We
3 found a population of individuals who were aged
4 beyond their years, suffering from preventable
5 complications of chronic disease and for whom a visit
6 to the hospital met medical as well as non-medical
7 needs, individuals like Mr. P.
8 "Mr. P is a man living a marginalized
9 existence, but he thrives when people take the time
10 to listen to him, to touch him and show him that they
11 care. For many decades he found this comfort in the
12 ED. When his landlord agreed to try an experiment
13 with us, we came to practice in his building. Mr. P
14 was one of our earliest patients. We provide a low-
15 cost alternative to meet his needs and do so with
16 kindness, tolerance and generosity.
17 "'What happened to your back, Mr. P,' I
18 asked. 'Did you fall or hurt yourself?'"
19 MS. CAMERON: "'No, Doctor. I just woke
20 up, got out of bed, and it hurt real bad for a while.
21 I could hardly stand up.'"
22 DR. CZAPP: "Rather than lecture him about

1 the lack of medical necessity for an MRI, I accompany
2 him to his modest apartment where we together review
3 the condition of his bed and mattress and suggest
4 alternative ways to use pillows to support his back.
5 Mr. P beams" --
6 MS. CAMERON: "'Thank you so much.'"
7 DR. CZAPP: -- "and then meanders toward
8 the community room. If we had not been there to
9 intercept Mr. P, he would have dialed 911. It shocks
10 many to learn that many individuals use the ED for
11 non-emergency and non-medical needs, but for some
12 this is their only access to supportive human
13 interaction.
14 "Our practice has been open for three
15 years. In that time, we have experienced a
16 significant decrease in medical 911 calls, ED visits,
17 admissions and readmissions of residents of the
18 apartment building. They have an alternative now to
19 the ED, and we meet their social needs in their
20 living room, one visit at a time, sometimes multiple
21 times a day."
22 MS. CAMERON: "'Doc, I need a CAT scan for

1 my head.'"
2 DR. CZAPP: That's our story.
3 (Applause.)
4 DR. CZAPP: Okay, so we're going to fly
5 through these slides. You already know what we did.
6 We opened a patient center medical home, a very
7 special one, with the aim to not only serve residents
8 of that building but the surrounding environment,
9 which is medically underserved.
10 Our goals were to provide a special type of
11 primary care to them. We accomplished that. Our
12 secondary goal was to reduce that potentially
13 avoidable utilization, and we accomplished that. We
14 have, to date, in that tiny space, served with
15 medical care 1,700 people, more folks through
16 navigational services.
17 Some lessons that we learned. Take it
18 away.
19 MS. CAMERON: All right. On-demand
20 services: It's not about our schedule; it's actually
21 about our patient's schedule. Team-based care: It's
22 not all about the doctor. Let me say that again.

1 It's not all about the doctor.

2 DR. CARTER: Wait a minute now.

3 (Laughter.)

4 MS. CAMERON: It's not, okay?

5 DR. CZAPP: Current company excepted.

6 MS. CAMERON: Fun health education events:
7 It's all about them. Relationship building: a
8 trusted, consistent team, not the free clinic, a
9 parade of volunteers. Psychosocial needs competently
10 identified and addressed. Navigational services,
11 particularly for the newly insured, who really don't
12 know what this means to them. Medication therapy
13 management. Health coaching: tobacco use cessation
14 counseling.

15 Also, we have a ready and willing network
16 of behavioral health, dental, and medical
17 subspecialty providers. Integrated EMR, which helps
18 immensely, especially in capturing all the data that
19 we need in the matrix. Traditional and non-
20 traditional community partnerships: housing, EMS,
21 police, the food bank, whatever it is that we need to
22 meet the needs of that individual at that moment in

1 time, that's what our team is trained to do.
2 My mantra is welcoming, forgiving, tolerant
3 atmosphere, absolutely no judgment to patients,
4 family, and staff. Everyone is welcome where they
5 are at that moment in time and beyond. Ongoing staff
6 training/coaching: annual retreat, daily team
7 huddles, constant humor and goodwill.
8 The really important thing about staff
9 training, and I need to emphasize this, is when
10 you're hiring your staff in these Enterprise Zones,
11 they need to be compassionate, passionate, well
12 trained in their skill; however, trained in
13 additional scenarios like crisis
14 prevention/intervention, where they're able to, you
15 know, learn how to deescalate a situation as opposed
16 to escalate a situation and also how to be able to
17 navigate community resources. That is crucial from
18 all levels, from the time they walk in.
19 Want me to keep on going, or you got it?
20 DR. CZAPP: Do you want me -- okay. So
21 other lessons learned: Just because you build it
22 does not necessarily mean they will come. This is a

1 marginalized society. They're angry. They're hurt.
2 We have a lot of history to get past, so you have to
3 be there past the photo op, if you will.
4 Intercultural conflicts can be overcome.
5 If I had more time, I'd go into those stories.
6 The newly insured individuals don't know
7 what a primary doc is or what that person can do.
8 They don't know how to refill a prescription. They
9 don't know why they should keep a follow-up
10 appointment. So what we do is we are that patient
11 training ground, if you will. Obviously, if you're
12 doing this in somebody's living room, you have to be
13 aware of that.
14 You already talked about the staff. So, in
15 summary, right care is given at the right time and
16 the right place, chronic disease in marginalized
17 populations is identified and treated earlier so we
18 can prevent those costly complications, and a trusted
19 community-based healthcare resource provides a better
20 alternative to the ED. If you can accomplish that,
21 wow.
22 So sustainability, we're just going to keep

1 doing this because it's the right thing to do, right?
2 We've seen results. We've seen reductions in PAU.
3 We've made people happy. So would we stop now? Are
4 you kidding me? How would we ever recover if we
5 pulled out? The door would be slammed shut forever.
6 So we will be continuing this. We operate the clinic
7 at a loss, but we hope that by telling our story we
8 can inspire others to go ahead and do this as well.
9 It can be done. Thank you.
10 (Applause.)
11 MS. CAMERON: Before we totally close,
12 there are some members of the audience we really need
13 to recognize. Dr. Scott Eden, who is our Medical
14 Director of the Community Clinics, please stand up.
15 (Applause.)
16 MS. CAMERON: Dr. Kari Bichell is our
17 anchor physician.
18 (Applause.)
19 MS. CAMERON: We have Joanne Ebner and
20 Tuesday Tynan, our tobacco cessation team. Please
21 stand up. They come on-site.
22 (Applause.)

1 MS. CAMERON: We have our grant team over
2 there, Gretchen Mulvihill and Maureen O'Neill, which
3 is phenomenal.
4 (Applause.)
5 MS. CAMERON: We also have Lenny Nyangwara.
6 Woo. Yeah.
7 (Applause.)
8 MS. CAMERON: He is the director of our
9 respiratory team and really helps us immensely.
10 And I want to do a special thank you to
11 Tori and the executive leadership team for supporting
12 us and really being part of this journey, one step at
13 a time, one patient at a time, one moment at a time.
14 Thank you so very much, everybody.
15 (Applause.)
16 DR. THOMAS: Yeah, I just really love this
17 theme of dignity and respect that's running through
18 these conversations of putting the patient at the
19 center and not blaming them. I really like the self-
20 reflection, that you're saying we as health
21 professionals must look in the mirror, look at
22 ourselves, and address those issues. And at the core

1 is trust. Many of these communities, like you said,
2 are angry. And I love the story. That's the other
3 part of this. Behind every one of those data points
4 is a human being. Give their story life and lift it
5 up. What a wonderful, wonderful -- and you make it
6 sound so fun.
7 DR. CZAPP: It is.
8 DR. THOMAS: To save lives.
9 DR. CZAPP: We love it.
10 DR. THOMAS: You look forward to going to
11 work, right?
12 DR. CZAPP: We do.
13 DR. THOMAS: Now, from MedStar St. Mary's,
14 we have Lori Werrell, who's the Project Director and
15 Director of Population and Community Health at
16 MedStar St. Mary's. You have the floor.
17 MS. WERRELL: Thank you. Can you hear me
18 now? Okay. So, you know, what they said.
19 (Laughter.)
20 MS. WERRELL: All of them. You know, this
21 has been a five-year really journey because those of
22 us that were around when we actually wrote these

1 puppies didn't really know what we were doing, to be
2 perfectly honest, but we knew our communities. And
3 so we set out, just like everybody else, to try to
4 tell a story of a community that doesn't have a
5 voice.
6 In our case, it's Lexington Park, which is
7 an area right outside our naval base. Embedded in a
8 rural county of about 110,000 folks are 35,000 folks
9 that live in the greater Lexington Park area. And,
10 you know, when we -- when I took my job, I took my
11 job about six years ago, you know, I was charged with
12 trying to find ways to improve the health of our
13 community.
14 So when the Health Enterprise Zone grants
15 came up, we looked at it. And we had a hard time in
16 our community getting money because it's hard to tell
17 our story because St. Mary's County is a relatively
18 wealthy county. So when we looked at the zip codes,
19 when we realized that Lexington Park, Great Mills,
20 and Park Hall qualified, I had one of those moments
21 where I went, we qualified! And then I'm like, oh my
22 gosh, we actually qualified.

1 (Laughter.)
2 MS. WERRELL: We have more -- we do have a
3 problem. We do have folks that don't have what they
4 need. So, you know, this is not about MedStar St.
5 Mary's Hospital. What this story of the last four
6 years is about is about, you know, again, the
7 patients and clients we serve, and it's about the
8 folks doing the work. So June Castro and Debbie
9 Baker are here from our team.
10 Debbie is community health worker
11 personified. She has grabbed this role, and she's
12 our go-to now. It's like if Debbie doesn't know the
13 people, first of all, there's a problem because I
14 think Debbie knows everybody. And then she's related
15 to the other half of the folk that she maybe doesn't
16 know as well.
17 And June Castro, who is our operations
18 specialist, kind of our jack-of-all-trades, I mean,
19 the woman is running bus routes. I don't think she
20 saw that in her job description when we started this
21 journey. So I want to say that's the story.
22 And so we do -- we also have a patient

1 story, and Debbie's going to help me a little bit
2 with the details. But this just tells you how far
3 we've come, but how far we have to go.
4 So we have a gentleman that we've been
5 working with, and he needed hernia surgery. And it
6 was specialized hernia surgery, so of course, it had
7 to happen at the University of Maryland, which might
8 as well be on the moon if you live in St. Mary's
9 County and you don't have transportation. So through
10 a series of phone calls and coordinations, we got him
11 up there to get his surgery, and then they found
12 bedbugs on him, and so they wouldn't let him come
13 home until the bed bugs were taken care of. So
14 Debbie got on the phone and got an exterminator in
15 there through, you know, working with our partners in
16 the housing authority and a bunch of other people,
17 got the bed bugs remediated. He only had to stay
18 like an extra day at the hospital, which was good.
19 So we saved the University of Maryland some money.
20 Got him home. Home health was supposed to
21 show up on Monday because, of course, he's wearing a
22 big old Foley bag, you know, one of the big ones

1 that's up on his belt, so gravity is not helping him
2 there. And the home health agency from up the road
3 was supposed to come in and take care of all this.
4 They got there, and they refused to go into the home.
5 So we got a call. So, again, the healthcare system
6 has not fixed itself yet.
7 Got a call. Debbie and Stephanie, his care
8 coordinator, went to work, because they're like now
9 what do we do? Because if we leave him there with a
10 full Foley bag, guess where he's going to be? In our
11 emergency room. First call we made was to his PCP;
12 can you please see him and show him how to empty this
13 Foley and make sure he's okay? Primary care doctor
14 said send him to the ED. Stephanie said no, he
15 doesn't need to go to the ED.
16 (Applause.)
17 MS. WERRELL: So I think she was having a
18 mini nervous breakdown at this point because she had
19 said no but she didn't know what she was going to do.
20 (Laughter.)
21 MS. WERRELL: So we put our heads together,
22 kept trying, made some more phone calls. A local

1 walk-in primary care/urgent care associate, we're all
2 related down in St. Mary's County, called them and
3 said we know this is weird, but would you, if we got
4 him to you, would you (A) empty the bag, make sure
5 that it's emptied and that he's okay, and teach him
6 how to empty it himself because he has some cognitive
7 issues. And they said yes, and we said okay. So
8 Debbie jumped in what, the repurposed cop car?
9 MS. BAKER: Yes.
10 MS. WERRELL: Yeah, jumped into our
11 repurposed cop car, which we got from the County
12 because we didn't have enough money to buy another
13 one, vehicle, when we realized we needed one. Went
14 to his house, picked him up, took him over, got him
15 taken care of, took him home. He's not in the
16 emergency room. He doesn't have a UTI. Yeah.
17 (Applause.)
18 MS. WERRELL: So still a lot broken, but a
19 whole lot fixed because that gentleman would probably
20 still not have his hernia surgery if the HEZ did not
21 exist.
22 So having said that, you all that have been

1 around for a while have seen these slides a million
2 times. We're very proud of our community work. We
3 moved them, early on, down into the zone. They were
4 up at the hospital in the very beginning. We
5 realized very quickly that wasn't going to work. And
6 now they have more clients that walk in and ask for
7 help than they probably find when they call, make
8 their calls.
9 So our community down in the Park is about
10 70 percent Caucasian, 30 percent African American.
11 We have a small Hispanic population. But the clients
12 we're serving are disproportionately coming from our
13 minority populations, which we think is really great
14 because it means we are building trust. They're
15 coming in, they're asking for help, they want to be
16 healthier, and we see that as a real win.
17 There's just, you know, the usual picture.
18 Lexington Park is the smaller area. If you don't
19 know where St. Mary's County is, we're the one all
20 the way at the bottom, surrounded by water. And I'm
21 sorry it took some people to get here from Baltimore.
22 It only took me an hour and a half from St. Mary's

1 County this morning.
2 (Laughter.)
3 MS. WERRELL: So here's our major program
4 components. Again, not a whole lot different than
5 anybody else's, although transportation is huge for
6 us because of our rurality. Here's some of our
7 demographics; you've seen them all. We're all doing
8 well. There's no need to really spend a lot of time
9 here.
10 So sustainability, you know, you don't want
11 to -- the worst thing you can do is start something
12 that is working and then pull out, the absolute worst
13 thing you can do because then you've set yourself
14 back. You might as well not have started it because
15 the community is not going to trust you. They're not
16 going to think that you're there for them.
17 So the good news is, you know, between us
18 and our partners, we are sustaining all the things we
19 feel are critical. So, you know, the hospital
20 absorbed the care coordination, CHWs. Between the
21 hospital and our partner, Greater Baden,
22 transportation. Baden's taking dental. We have two

1 behavioral health partners that are committed to
2 sticking with us.
3 We've been in the process for a very long
4 time of building a house center. It's not done yet,
5 but you know what? So what. We're still going to
6 get there, and it will open, and it will do what it
7 was designed to do. And so we in the meantime,
8 opened another primary care office down in the zone
9 so we could get providers down there. As we find
10 them and can recruit them, which is difficult for us,
11 we're bringing them into this other office, and we'll
12 sort them out and staff the health center once we get
13 it up and running.
14 So lessons learned -- I don't think any of
15 us is doing what we originally thought we were going
16 to be doing, because I don't know about anybody else,
17 but we wrote our grant really late at night, under a
18 lot of pressure, and things that sounded good then
19 maybe weren't so smart afterwards.
20 But again, lessons learned, the same as
21 everybody else. You know, we are seeing some
22 reduction in our readmissions in the HEZ versus the

1 county as a whole, and so we're clinging to that.
2 End of story, because that's really what's important
3 is the patient experience. And there's a health
4 center being built. Better late than never.
5 And so thank you.
6 (Applause.)
7 DR. THOMAS: Wonderful. Again, love the
8 stories, and amazing that saying no was the way to
9 get to yes, and the flexibility and the creativity of
10 realizing that what you wrote in the original grant
11 had to now be adjusted by the realities on the
12 ground, and again, showing that man dignity and
13 respect. Those people that refused to go in the
14 house, you need to really document that as well. So
15 all across the whole system, we have to advocate and
16 make change.
17 Our next speaker comes from West Baltimore
18 Primary Care Access, Maha -- I'm going to have you
19 pronounce your name for everyone.
20 MS. SAMPATH: Sure. My name is Maha
21 Sampath.
22 DR. THOMAS: Maha Sampath. Give her a

1 hand, will you?
2 (Applause.)
3 MS. SAMPATH: So good morning, everyone.
4 Just like everyone already shared, so I just want to
5 share a little bit of the West Baltimore, which is
6 the urban HEZ that was mentioned earlier. So I just
7 want to talk a little bit about our call to action.
8 So for West Baltimore Primary Care Access
9 Collaborative, Bon Secours Baltimore is the fiduciary
10 organization. And more than Bon Secours Baltimore
11 being just the community hospital, we were on the
12 population health track before it was known as
13 population health. So we have housing, we have a
14 support center called Community Works, where we
15 primarily address social determinants of health. So
16 HEZ is a perfect grant for us to go through. So
17 thank you for giving us the grant.
18 So our call to action, I just want to talk
19 a little bit about what the West Baltimore community
20 looks like. We have approximately 86,000 residents,
21 mostly African Americans, and the median income is
22 only $27,000. And we have the highest disease burden

1 and the worst indicators of social determinants of
2 health than any other community in the state of
3 Maryland. And then as you can notice, that's where
4 the unrest happened in April, so a community which
5 has a huge need.
6 What does our patient look like? The
7 patients are usually often unemployed or they are
8 part of the working poor. They are living in and out
9 of crisis daily. They are frequently on the edge of
10 homelessness. And they are three times more likely
11 to have cardiovascular disease than any other area in
12 the state of Maryland.
13 As part of the Health Enterprise Zone, we
14 knew that Bon Secours couldn't do it all, so we
15 partnered with a number of partners, as mentioned on
16 the slide. We partnered with FQHCs, we partner with
17 four other hospitals, community-based organizations,
18 schools, as well as the City and the State.
19 I just want to talk a little bit about our
20 goals and strategies for building a health community.
21 So our focus was on the 86,000 residents that reside
22 in West Baltimore, primarily in the four zip codes of

1 16, 17, 23, and 29. But we focus on the 1,200 high
2 utilizers as well. Our core disease and target
3 conditions that we focus on is cardiovascular disease
4 as well as the cardiovascular risk factors, which is
5 diabetes, hypertension, et cetera. And two
6 strategies that we have implemented is the care
7 coordination, which is our biggest piece of what we
8 do, as well as community-based risk factor reduction
9 strategies. And we have a number of strategies
10 underneath it that I'll talk about.
11 This is our structure. We have a steering
12 committee that provides us oversight and guidance,
13 and Bon Secours Baltimore, as I mentioned, is the
14 fiduciary organization that provides program
15 management. We have an advisory board that assists
16 us in terms of daily programmatic initiatives that we
17 work on, that advises on those things, as well as we
18 have the program management team, where we have two
19 coordinators as well as one community health worker
20 as well. And then I would be remiss if I don't thank
21 our State HEZ Team, who has always been super
22 supportive of everything that we've done, even in

1 times where we struggle with data.
2 Our care coordination piece, which is huge,
3 we actually partner with the coordinating center in
4 providing these services, and this is focused on the
5 high utilizer population, which is the 1,200 that I
6 mentioned before. And we follow patients for 30 days
7 and 60 days as needed.
8 And how it actually works is there's a
9 referral made from the hospital, usually by the case
10 management team based on a set of criteria, a high
11 utilizer criteria that's been identified, and then
12 they are referred to the coordinating center as
13 they're enrolled into the care coordination program,
14 and then where a health coach or a community health
15 worker goes into the patient's home, makes a home
16 visit and up to three phone calls. That's our ideal
17 intervention. And they are followed for 30 days and
18 up to 60 days as needed. And then as mentioned
19 before, if they complete the full intervention, then
20 they have officially graduated from the program. And
21 then we keep track of the number of referrals that's
22 been made, how many went through the full program as

1 well as the readmission rate.
2 These are the other factors, because we
3 can't just focus on the medical and the clinical
4 piece and not address the other issues that may be
5 other factors that may be the source of these issues.
6 One is increased identification and screening of
7 residents. So we look at the screening rates for the
8 cardiovascular risk factors that I talked about at
9 our provider practices and see how many visits have
10 we had, and then have we increased it over year to
11 year since the HEZ has been in place.
12 I don't know if you can see this, but
13 second it says recruitment of primary care
14 professionals. The state tax credits has been huge
15 in this piece in terms of recruitment and retaining
16 of providers into the zone. And then we also do
17 community outreach and health awareness education.
18 So one piece is the community health worker that we
19 have. She actually goes into public and senior
20 housing facilities where she provides care
21 coordination as well as brings in other folks from
22 Hopkins or University of Maryland to do vision

1 screenings and, you know, blood pressure screenings
2 and things like that.
3 We also have cooking classes. We have
4 nutrition education.
5 And then we also have community partnership
6 grants. So using the money that we have in order to
7 have a larger reach, we provide mini grants to other
8 community-based organizations such as Paul's Place,
9 schools so they can have a larger impact into the
10 community and serve more residents that we can't
11 serve as an HEZ ourselves.
12 We also have a scholarship program because,
13 if you can imagine, it's really hard to recruit folks
14 to come work in West Baltimore. So for folks who are
15 pursuing careers in healthcare who live within the
16 four zones, and if they're pursuing something in
17 healthcare, we give them a stepping point so that,
18 you know, they can start a career in healthcare and
19 hopefully be employed in the zone, commit to being
20 employed in the zone two years after they've
21 graduated. And then we also do -- we connect them
22 with Bon Secours Community Works where they can get

1 assistance with job readiness and job placement as
2 well.
3 Physical activity. Safe places. Free
4 fitness classes. So it's safe places for folks to
5 come and exercise. And then we also give them
6 incentives in order to keep them coming back.
7 Some of our impacts and outcomes: So we've
8 successfully connected 7,200 high utilizers to a
9 community health worker. We've had about 7,400
10 encounters with the high utilizers in terms of home
11 visits, phone calls, health screenings, and clinic
12 visits. We connect those high utilizers to a primary
13 care provider.
14 We've provided state tax credits and loan
15 repayments in the amount of $116,000 to about 17 HEZ
16 providers, awarded 16 community-based organizations
17 with a total of $130,000 to support community-based
18 cardiovascular programs serving 2500 residents.
19 We've awarded 85 scholarships, about $250,000 to
20 students pursuing careers in healthcare.
21 We offer free fitness classes in
22 partnership with our neighborhood recreation centers

1 because we have to realize that, you know, that's
2 where folks go and that's within the community, and
3 churches. And we've seen an average weight decrease
4 of about 15 pounds, as well as a BMI decrease of
5 about 1.5.
6 We have provided 25 community health
7 workers trainings, as well as one trauma informed
8 care training. That's also been really helpful. I
9 know we got great feedback from that because folks
10 that come into West Baltimore, they have at least
11 five or six traumatic factors that have affected them
12 in their life, so we have to keep that in mind before
13 we can give them any sort of medical care. And then
14 we also, we are planning for a cultural competency
15 training as well.
16 Some of the outcomes that have been shared:
17 West Baltimore, in terms of our decrease in
18 readmission rates, overall improvement in quality of
19 care in terms of our PQIs.
20 So just talking a little bit about data,
21 something that we've been doing is working with CRISP
22 to see what the pre and post impact has been for our

1 care coordination program. So the initial
2 preliminary results only focused on the one hospital
3 out of the five hospitals that we work with, and it
4 has shown some improvements in charges and visits for
5 the residents that we've served in that population.
6 The plan is to do that for all five hospitals, and
7 our next report is due end of November. So we are
8 eagerly waiting to see what those results look like.
9 Some of our lessons learned -- I know I
10 have two minutes until your stretch break. So we
11 have a lot of partners, which is great, but that also
12 comes with we need to be extremely clear on their
13 roles and responsibilities and then continuing to
14 keep them engaged when there's lots of things that
15 are going on in the, you know, healthcare arena. And
16 they also have competing priorities, not just with
17 other things that they're working on, but they also
18 have their own care coordination efforts that they're
19 building within their hospital.
20 And then in terms of the patient
21 population, we talked a lot about trust. There's not
22 a lot of trust there, and you know, these folks are

1 struggling with just the basic resources. It's not
2 the clinical things that they are looking for, but
3 it's, you know, food, utilities, housing. So that's
4 what they're looking for, so you need to affect those
5 before you can move on to anything else. So
6 continuing the dialogue with the community to see
7 what they actually need.
8 And being flexible and agile with our shift
9 of focus. So originally, we tried to focus on all
10 86,000 residents, and we realized that's difficult,
11 so we moved to -- you know, we need a separate
12 approach for the 1,200 high utilizers and then
13 focusing on prevention and community outreach for the
14 other population. We are planning for
15 sustainability, but obviously we're here because we
16 are looking for funding. But we wish we had planned
17 for this well ahead of time, but then it's also hard
18 to plan for it when you don't have much data to show
19 for. But we are working diligently to get the data
20 to prove our business case.
21 Almost done, I promise. Moving to
22 sustainability, some of the things that we worked on

1 is assessing ongoing engagement of these partners.
2 We explored filing a 501(c)(3) and becoming our own
3 entity and filing for grants that way, but then we
4 decided that that would need additional
5 infrastructure. Who's going to pay for it, et
6 cetera, so we ruled that out, and we decided that it
7 nicely aligns with our currently finished CHNA
8 process, so we are working towards building something
9 around that. And then finalizing the CRISP reporting
10 hopefully will help us build a stronger business
11 case.
12 And then we did get a grant from the Kaiser
13 Foundation to help with our scholarship program, so
14 we did assist more folks than we thought we
15 originally could and then connected them with
16 Community Works so people can get jobs and such.
17 And do we have time for a patient story?
18 It will be one minute, I promise.
19 Jennifer, can I invite you up?
20 MS. SULIN-STAIR: Good morning, my name is
21 Jennifer Sulin-Stair, and I'm the program coordinator
22 for what we call our Get Well program at the

1 coordinating center, and I just wanted to share a
2 huge impact that we had particularly -- I know we
3 have a huge impact on everyone, but in particular a
4 very high utilizer who was 37 years old and had
5 actually been to multiple hospitals within our Health
6 Enterprise Zone.
7 We got a referral. She was 37, morbidly
8 obese, diabetes, legally blind from diabetic
9 complications, hypertension, high cholesterol, and a
10 history of mental health issues. She had three
11 children and one with a disability, and she was what
12 we call medically homeless, meaning she did not have
13 a primary care physician.
14 So we were referred, and of course,
15 sometimes when we go to visit, individuals don't
16 really want to see us because they're not really sure
17 what we're offering. And as we were able to get to
18 know her, we found out a lot of different things that
19 we were able to do to help her.
20 One important thing was that she was
21 insulin dependent, and her glucometer did not talk to
22 her. So she was only checking her blood pressure

1 when her boyfriend was home or her oldest child was
2 home because if she checked it, you know, she often
3 couldn't see the reading. So we were able to get
4 her, through our nurse contacting and getting her
5 connected to a primary care physician, we were able
6 to get her a glucometer that spoke to her. And in
7 addition to that, we got her the insulin pen, where
8 she could click and she would know how much insulin
9 she needed through that click. So that made her
10 independent, which also decreased her need to go to
11 the emergency room.
12 In addition, we helped her with
13 transportation. In getting her signed up for
14 long-term MA transportation, we were able to provide
15 transportation for her on an immediate basis to get
16 her to the primary care physician and to get her to
17 the Joslin Diabetes Center that we were able to hook
18 her up with. And in addition to that, we were able
19 to help her sign up for WIC and get her some of those
20 services so she could get food into the house.
21 So Dr. Reece and Dr. Thomas, thank you from
22 her family for helping her and having such a huge

1 impact on her life.

2 (Applause.)

3 DR. THOMAS: Well, it really does take a

4 village, doesn't it? Thank you very much.

5 It really, really does take a village, and

6 I know in the city of Baltimore it's hard to get a

7 good story out, right? And so the one story I did

8 read in the *Sun* was, you know, had to do with people

9 not trusting. But once you open the door and the

10 people start sharing, you're going to be ready to be

11 told off. You might get told off for the first three

12 months, because that's how they build trust. And now

13 this positive story also needs to find legs and have

14 a voice. What a wonderful panel. Give them a hand

15 again, will you?

16 (Applause.)

17 DR. THOMAS: Now, we're doing fine on time.

18 Those microphones, let's have people line up at the

19 mic. Just line up at the mic because I don't want to

20 have to come out there and take a mic away. But just

21 line right up. Stand right up and introduce

22 yourself, please.

1 Oh, you're such a gentleman. Ladies first.
2 I see.
3 MS. SAMMONS HACKETT: Good morning. I'm
4 Doreleena Sammons Hackett, and I'm the Executive
5 Director for the Directors of Health Promotion and
6 Education in Washington, D.C. I am so impressed with
7 the work that these communities have done, and you,
8 the Right Reverend Dr. Ernest Carter.
9 (Laughter.)
10 MS. SAMMONS HACKETT: I'm a P.G. County
11 resident, so I'm quite proud of your efforts. I
12 often wonder and wanted to know, how well were you
13 able to get men into care? I've dealt with 36 years
14 of public health and directed a cancer screening
15 program for women and a prostate cancer screening
16 program for men and always note that men are the ones
17 that are least likely to have a medical home because
18 they don't go unless somebody else pushes them. So
19 my question to the panel is how successful were you
20 in reaching men and getting men to become compliant?
21 DR. THOMAS: Very good question, the
22 demographics cutting along gender lines. Who wants

1 to take that? Just jump right in there.
2 MS. WERRELL: Actually, I want June and
3 Debbie to answer that question for us. What do you
4 think?
5 DR. THOMAS: Since they're recording, just
6 step over there to the mic. Uh-oh. Don't pass that
7 mic around.
8 MS. CASTRO: For our office, it was very
9 easy. Because we're right there in the neighborhood,
10 once everybody heard about what we were doing, we
11 didn't have a problem with the guys coming in. We
12 have veterans who come in who didn't realize they
13 were veterans.
14 DR. THOMAS: Okay.
15 MS. CASTRO: Once we helped them realize
16 that, they -- you build that trust, they start doing
17 what you recommend. Debbie is the mother. She gives
18 them tough love. She will really let them know if
19 you don't do this, this is what's going to be the
20 consequence.
21 DR. THOMAS: You mean she can tell those
22 men off and make them like it, and make them like it?

1 MS. CASTRO: Debbie is known in the
2 community, so she can do a lot that others can't.
3 DR. THOMAS: Okay. Others, how are you
4 getting men? Quickly, just take the mic.
5 DR. CZAPP: One thing that worked for us
6 pretty well was having men's health events right
7 there.
8 DR. THOMAS: Okay.
9 DR. CZAPP: And especially if they were run
10 by men. That peer-to-peer interaction really helped
11 a lot.
12 DR. THOMAS: You can keep the mics on.
13 Just keep them live.
14 Go ahead, Ernest.
15 DR. CARTER: What we had, what happened --
16 that happens a lot, and what you said is absolutely
17 true. And what we found -- well, we had 50/50. We
18 found almost 50 percent of our people who get
19 referred to us are men, so we're balanced. But when
20 you look at who graduated, most of the women
21 graduated; most of the men were in that category
22 where we lost them in the follow-up, et cetera, et

1 cetera. So we increased the number of men community
2 health workers. That helped a small bit, but there
3 is a huge problem there, and we're still trying to
4 address that.
5 DR. THOMAS: So we've got to work on issues
6 of masculinity, that masculinity doesn't mean that
7 you simply wait until your arm's ready to fall off
8 before you say you've got a problem. And the ladies
9 in the lives of these men can make a big difference.
10 Yes, sir?
11 DR. JACOBS: Yes, I am Troy Jacobs. I'm a
12 pediatrician. I work in D.C. And this question came
13 to mind as Dr. Carter was talking of the work that's
14 happening in Prince George's County, but I suspect
15 that any of the speakers that are from suburban or
16 urban areas, and this is maybe -- Maha was talking
17 about model complexity. Maybe this is part of that
18 is that as we understand the care coordination that
19 needs to happen, the social networks that exist in
20 these communities in our zones that we're working in,
21 very quickly we reach and we start to cross
22 jurisdictions.

1 In the case of Capitol Heights, you cross
2 state boundaries, and the benefits change and
3 there's -- our patients or clients, in fact, are
4 navigating those cross-jurisdiction boundaries. What
5 experience have you had in terms of -- or best
6 practices or visions in terms of going forward,
7 because I think as we think about how to broaden the
8 net, how to actually improve the resources, we have
9 to think beyond the jurisdictions, beyond the
10 boundaries of the zones as we've defined them. And
11 in some of them, it becomes a very pressing issue,
12 particularly I would say in Prince George's County,
13 Capitol Heights.
14 DR. THOMAS: It's hard to imagine that we
15 have border health issues right here in the state of
16 Maryland?
17 DR. CARTER: Oh, absolutely. And then I
18 can tell you that was one of the first things we
19 understood and had to consider, especially when
20 you're trying to get data about people who are
21 crossing the border all the time. But not only just
22 Prince George's County, but we're surrounded -- we've

1 got Montgomery County, we have Anne Arundel, we have
2 Charles. We're surrounded by ways we need to
3 collaborate.
4 So when we thought about it, we said we
5 need to take a regional approach. We can't take --
6 you can't say that we're in Prince -- you know, we
7 can't just concentrate on that particular zip code.
8 So one of the ways is we just got in the car and
9 drove over to D.C., went over to the D.C. Primary
10 Care Association, who, you know, basically works with
11 Unity clinics and said we need to connect to you.
12 And then, you know, talked to people, just talked to
13 people and said we need to connect to you, we need to
14 be able to try to get your data. We work with CRISP,
15 who, you know, now has connectivity in D.C. about
16 getting data.
17 But also, you know, how do we -- those
18 first steps of how do we coordinate across this
19 boundary. At the time, actually, St. Mary's Center
20 had a care coordination team that we were working
21 with. You know, they had gotten a CMMI grant, and
22 they were doing care coordination, and we were

1 working with them. So we just -- it's about this
2 sort of -- we don't look at the borders really.
3 We're looking at the patients. We look at the
4 client. Where are they going? Now, let's try to
5 help them, you know, wherever they go. I know that's
6 easier said than done, but that's just -- I agree
7 with you, and I appreciate the question.
8 DR. THOMAS: And also the power of the HEZs
9 give you the flexibility, the creativity to say that
10 we're not going to turn people away because of their
11 zip code, and you're going to follow them wherever
12 they go. Wonderful.
13 Yes, ma'am?
14 MS. SHINE: Yes, my name is Tomiko, and I'm
15 a research anthropologist, and I do research. I
16 volunteer at the RAPP Campaign. We work to release
17 elderly people out of prison. My research, I look at
18 African Americans and their lifecycle and identity
19 developments in America and how racism impacts that.
20 One of the reasons why I'm here today is
21 because there are many elderly people that are in
22 prison, and we decided to start a chapter here in

1 Maryland. One of the reasons is because Maryland has
2 one of the highest number of a group called lifers.
3 These are people that spend most of their lives in
4 prison. One of the things that we're encountering is
5 that they are very sick inside because they spent 30,
6 40, 50 years inside, and when they come out, they
7 have like -- they're just like a public health
8 explosion. So we see it as a public health crisis,
9 which is why we're here today.
10 But my question is for the panel. In your
11 programs and in what you're doing, where does the
12 elderly population begin to fit in?
13 Because we have one story where a
14 gentleman, he was in D.C., he did 50 years. He came
15 out, he had OCD, he had diabetes, hypertension, on
16 and on. He was released to a hospital after 50
17 years. He died four months later. But he was not
18 able to get the health and the public health access
19 that he needed. And so we're finding that we're
20 advocating for them to come out, but when they come
21 out, this is -- they're just like -- it's like a
22 black hole. It's like where do I land?

1 And so one of the problems with Maryland is
2 that we had a gentleman, he did 47 years. When he
3 did 47 years -- when he first went in, there was only
4 5 prisons; now there are 20 prisons in Maryland, and
5 Maryland is a very small state.
6 So this is a crisis we see coming up. It's
7 just like it's right on the brink. There's a lot of
8 talk being done, but as far as with the HEZs, and I
9 guess with all the doctors and public health
10 officials, how do we begin to put the brakes on so
11 when these folks come out they have some type of
12 qualify of life left?
13 DR. THOMAS: So when you're defining the
14 elderly, at what age does elderly start? Be careful
15 here.
16 (Laughter.)
17 MS. SHINE: An elderly, in the data, in
18 prison they considered it 50 years old.
19 DR. THOMAS: Okay, 50 years old is elderly.
20 MS. SHINE: But one thing I wanted to say
21 is that in prison, your body physically ages 10 to 15
22 years. So when a person comes out, they're 70, they

1 may be about 80, 85 physically, physiologically
2 because your body isn't made to exist in concrete and
3 metal for about 30, 40, 50 years. So these are
4 people that their body has just been physically and
5 mentally traumatized.
6 DR. THOMAS: So chronological age versus
7 actual biological, this constant stress, and the
8 returning citizen, as I'm hearing the term, the
9 returning citizen, people coming out of prison back
10 in the community, and it's that handoff, it's that
11 passing of the baton, as you're describing, people
12 falling through the cracks.
13 Yes?
14 MS. CAMERON: I'd like to take that. At
15 Morris Blum, we see six years right on through to the
16 geriatrics, and we do have patients that come in that
17 were recently released from jail and/or prison and
18 they're able to establish care. We also know that
19 when they come out of institutionalized settings,
20 there's many challenges that they're dealing with,
21 many, many challenges.
22 And it goes back to the well-trained staff

1 being able to meet that person right there because
2 sometimes, as we know, their behaviors or the way the
3 interaction goes may be a little special. So it's
4 so, so important, but what -- and this is Sharon's
5 personal vision. What I'd love to see is when they
6 get ready to reenter society is that there is a
7 collaboration between the reentry team and then a
8 primary care team and/or a specialist.
9 And I'm going to share a little story with
10 Dr. Eden, our medical director. About four years
11 ago, we noticed a trend with our Forest Drive Clinic.
12 It's a detention center here on Jennifer Road. And,
13 you know, people were getting released, and they
14 needed medication, whether it was for mental health
15 or blood pressure, whatever, and they had a lot of --
16 they either had the test done in jail -- so we
17 actually met with the medical team. And I don't know
18 if Dr. Eden's recovered from the tour of the jail,
19 but we did that. And we went through all levels,
20 because for me it was extremely important that we had
21 that bridge built and to help. So that's me.
22 DR. THOMAS: Please, because we've heard

1 stories about where your HEZ is, and you have more
2 people in that area of where the uprising was in jail
3 and prison per capita than the entire state and
4 sometimes higher than anyone in the country.
5 MS. SAMPATH: I really wanted to answer
6 this question. We are extremely passionate about
7 this. And Bon Secours is an extension of the HEZ.
8 We work with Bon Secours Community Works, where we
9 have a program called the Reentry Program, which is
10 specifically focused towards this reentry population.
11 We have a Tyro program for men returning from prison,
12 and then a Shero program for women returning from
13 prison. And as you mentioned, West Baltimore in our
14 four zip codes is the highest number -- I forget what
15 percentage exactly it is, but the highest percentage
16 of returning citizens as well as the folks that are
17 being incarcerated.
18 And I see my boss, Dr. Ross. He can speak
19 more to it, as well, on his panel. But that is a
20 program that we are focusing on, and they help
21 with -- it's actually a 12-week program. We don't
22 just start from after they've been released, but we

1 actually go into the prison and start beforehand,
2 letting them know that this program is available, and
3 they can enroll as soon as they are released.
4 DR. THOMAS: Dr. Carter?
5 DR. CARTER: Yeah, one thing I wanted to
6 add was is that this is -- that particular question
7 is really important because it points out the fact
8 that you have to have a systems approach, because
9 there are resources. Like in Prince George's County,
10 we have a reentry program. There are reentry
11 programs. There are people who focus on this. But
12 when you're doing care coordination, you need to be
13 coordinated with those programs. So when we get a
14 patient from a hospital, we don't know whether they
15 were incarcerated for a long time or not. When we
16 find out that they are, we know what program to put
17 them in. It's the system, how we communicate and how
18 we can efficiently put the people in the place where
19 they need to be at the right time. That is the
20 critical thing that I think what our HEZs basically
21 concentrate on. That's very important.
22 DR. THOMAS: And notice how they're not

1 stigmatizing the person who's leaving prison. They
2 are now coming back into your community, and you
3 don't have that care coordination, it can overwhelm
4 what little programs that you have set up. So I'm
5 very glad the questioner put that on the table.
6 Yes, ma'am? Oh, oh, oh, grab that
7 microphone.
8 MS. MERCIER: I really just wanted to
9 highlight the work of our peer recovery support
10 specialists, because we absolutely recognize the need
11 for those social supports, and so we have, you know,
12 that drop-in center and a staff to help, you know,
13 learn how to problem solve, improve socialization,
14 and help them get a job, help them get connected to
15 resources, if it's the food bank or transportation or
16 what have you. There definitely needs to be that
17 support.
18 I mean, learning how to apply for jobs and
19 writing a résumé, those are all important parts for
20 reentering society and being productive as much as
21 they can. So I just really wanted to highlight that
22 as well.

1 DR. THOMAS: And who would have imagined
2 that's now part of care coordination. That's what
3 happens when you address the social determinants of
4 health.
5 Yes, ma'am?
6 MS. CHUNG: Yes, good morning, sir. Good
7 morning, my name is Elizabeth Chung, and I'm from
8 Frederick, Maryland, but I'd like to disclose I am
9 also a Commissioner with the Maryland Community
10 Health Resources Commissions as far as the
11 commissions for the APA commissions. Those are very
12 important. APA is from the Governor's Office of
13 Community Initiative. Why is it important? Because
14 again, public health, public good, public services.
15 So as we serve publicly, we look at, you know, every
16 aspect of our community's life.
17 But what I want to -- first of all, I did
18 have the pleasure to listen to some of your
19 presentations during your report and so forth. I'm
20 very glad to come back again and really as a -- I'm a
21 committee member, so just to let you know.
22 So a different -- a different time, but

1 again, as a director of the Asian American Center in
2 Frederick, Maryland, we have 30 languages in our
3 offices, and one of the very, you know, important
4 programs that we're moving forward -- and I want to
5 share with you -- I know, I promise I'll speak in
6 Chinese, and it will be 30 seconds.
7 DR. THOMAS: No, ma'am, my watch was
8 telling me to stand up and breathe.
9 MS. CHUNG: Just very quickly, first and
10 foremost, my training besides 30-some years in public
11 health is really from -- from Dr. Hussein, who really
12 gave the opportunity to the community to learn, to
13 engage, to participate, to build capacity and so
14 forth. But what I wanted you to consider
15 continuously beyond, you know, this project is
16 inclusiveness. I haven't heard anything from you
17 regarding those other communities. Because our state
18 is diverse. Our country is diverse. You must look
19 at your demographic and say my colleague from
20 St. Mary asked me what can we do. You know, do we
21 have Chinese restaurant? If you do, you have four
22 families that you need to reach out to.

1 (Laughter.)

2 MS. CHUNG: So think about that, right? So
3 don't tell me everything you don't have. So
4 commission -- is the one that is really in the
5 community, is a frontrunner, in my opinion. And I
6 thank Susan. You're talking about this is people's
7 life, so it takes time. Maryland is one of the 15
8 states working on community health workers. I'm also
9 very fortunate to work on a workgroup. I think that
10 Dr. Haft is coming maybe.

11 DR. THOMAS: He's here. He's here.

12 MS. CHUNG: So looking into the --
13 competence skills and so forth. We need to continue
14 this process. We can do it. So I ask that the
15 partners look into economic productivity in terms of
16 workforce, diverse workforce. If we are economic
17 productive, then we are healthy. We have jobs. We
18 have health insurance. So that is what health equity
19 is all about. So, again, you can see my passion.
20 Inclusiveness, all people, you know, all walks of
21 life need to be included in your program, in your
22 strategies. So I just continue to make that pledge

1 to you, and congratulations for a job well done. And
2 I'll continue to advocate for you, too.
3 DR. THOMAS: Very, very good. Thank you so
4 much.
5 (Applause.)
6 DR. THOMAS: This will be our last
7 question. Yes?
8 MS. WILLIAMS: Actually, this is a comment,
9 and it should be quick.
10 DR. THOMAS: Please.
11 MS. WILLIAMS: My name is Antoinette
12 Williams. I'm with the West Baltimore HEZ as a
13 consultant. And so I just wanted to give a shout out
14 to Michelle -- at DHMH on this whole issue of
15 reentering citizens, right, and access to care.
16 Because as a part of the support that they provided
17 to the HEZ in the prep forum, they actually brought
18 DH -- I'm sorry, the State Department of Mental
19 Health and Hygiene and the Medicaid space in to have
20 a conversation about insurance and the gaps that
21 exist for those individuals that are reentering and
22 the quality of care that they receive while

1 incarcerated and what happens to them when they come
2 out. And there's incredible opportunity there.
3 But I just wanted to mention we were not
4 aware of this tremendous opportunity, and I think
5 it's going to help Bon Secours in their efforts,
6 right, the Community Works, to help people get
7 insurance. So tuck that away, guys, right, and work
8 closely with DHMH to make that happen because that
9 was good information.
10 DR. THOMAS: Well, I think that what a
11 wonderful demonstration of what's happening on the
12 front line, because at the end of the day, that's the
13 grand experiment that's going on. And I think that
14 this group here is just tremendous in the lessons
15 learned. And look at the power of the State to
16 convene. Because of this program, you're in the same
17 room, and it's not fragmented, and these lessons can
18 be learned and best practices shared. I think that's
19 a very, very important part of sustaining the
20 lessons. And I want this audience to give these guys
21 a round of applause. Get up off your feet.
22 (Applause.)

1 DR. THOMAS: There you go. Wonderful. And
2 congratulations. So we have a housekeeping comment
3 here.
4 DR. DWYER: Thank you so much for your
5 wonderful questions. We have a court reporter here
6 today, and he would like to make sure he gets all of
7 your names and organizations. So if you have made a
8 comment or will make a comment at any point today,
9 please then stop by the table in the back. You'll
10 see Tom here, and give him your name and
11 organization. Thank you.
12 DR. THOMAS: And so, again, the
13 documentation of this meeting is so very important.
14 This is a bipartisan issue because it's about our
15 citizens. Nobody asks questions when you make that
16 phone call about what party you belong to; it's that
17 you need help. And that's the message that you have
18 to get across, and this is the change that we all can
19 sustain.
20 Now we have a break. And our times says
21 we're supposed to be back --
22 Michelle, tell me what time they can come

1 back. It's 11:26. We're not too far off. So we'd
2 like you to be back in this room at 11:40, but this
3 is your stretch break. Thank you, everybody.
4 (Off the record at 11:26 a.m.)
5 (On the record at 11:44 a.m.)
6 DR. THOMAS: Love the conversation, but I'm
7 going to ask if you could have people begin to move
8 back in the main room, have people start to move back
9 in the main room.
10 You know, I always wonder what's in a word
11 and what we call things, and I go back to when we
12 were in the room arguing with one another about this
13 initiative. And be mindful that in the Maryland
14 Health Improvement and Disparities Reduction Act, the
15 Health Enterprise Zone is just one component, one
16 component of major initiatives that were sent in
17 motion that included standardizing how we measure
18 issues of race in all of our data collection across
19 all the different systems. So I think it's
20 noteworthy that it is this initiative, the HEZ
21 initiative that has really come to signify the entire
22 legislation. And I think that's in large part

1 because it's the one element of that legislation that
2 both challenged and gave the freedom for people to
3 break the mold.
4 I think in that room, when we look at all
5 the data, we recognized that there has indeed been
6 progress over time, and some would say that glass is
7 half full. And then we looked deeply at those
8 numbers and saw that everyone wasn't benefiting
9 equally, and then we realized that the glass was half
10 empty.
11 But as we looked closer to the solution,
12 because we all -- we have a lot of data telling us
13 these problems exist. As we looked closer to the
14 solution, we realized like an engineer, the glass was
15 the wrong size, that we really needed to break the
16 glass, break the mold, get out of our silos and come
17 up with a whole new way of working together by
18 putting the patient first. And even before they
19 become a patient, they're citizens, they're
20 neighbors.
21 And that's the way in which they've been
22 talked about in this room, and I've been so pleased

1 to hear people describe the priority population in
2 terms that give them dignity and respect. And also,
3 the acknowledgement that the solutions cannot reside
4 simply in our clinical facilities, that we have to
5 pay attention to the neighborhood environment where
6 the people live and the incorporation of the social
7 determinants of health. You should know, that's a
8 new thing. That's the new frontier, and the idea of
9 inside of our health systems to create this culture
10 of health, that becomes the new social norm.
11 So, again, I mentioned I just returned from
12 Denver at the American Public Health Association
13 meeting, and I will tell you that what's happening
14 here in Maryland and the themes coming out of that
15 meeting would suggest that we're on the cutting edge,
16 we're at the beginning. I know a number of you were
17 saying, oh, our grant has a certain time frame. You
18 need to know you're at the beginning, not the end,
19 and that you didn't get this far to go backwards.
20 And to be mindful that the moral foundation of public
21 health, the moral foundation of public health is
22 social justice. That's not a bad word.

1 There's an entire book titled *Social*
2 *Justice: The Moral Foundation of Public Health*. Read
3 that book. It gives you the philosophical and the
4 moral imperative for why you're doing what you're
5 doing. And so it's very, very important that you
6 embrace that language as well because it comes down
7 to the fact that you cannot simply collect the data,
8 describe the problem, and say the solution is
9 somebody else's job. That is so frustrating.
10 And if you heard anything in these lessons
11 learned is that your colleagues embraced the tough
12 problems, the wicked problems, and they came away
13 from the battlefield smiling, encouraged, and
14 reinvigorated. And it's very, very important that we
15 translate that into the kind of support you need at
16 the top. Leadership does matter.
17 Remember, this report started almost like
18 at the top, out of a, you know, a commission,
19 Governor's Office, Lieutenant Governor, and making
20 sure that it was not a mandate but a spark for your
21 creativity was an unknown. And I think what we've
22 heard here today, this morning, is that it was indeed

1 a spark for your creativity.

2 And so it gives me pleasure to bring our

3 next speaker to the table, Dr. Howard Taft [sic],

4 who's the Deputy Secretary for Public Health Services

5 at the Maryland Department of Health and Mental

6 Hygiene. And I had the opportunity to work closely

7 with Dr. Taft when the Big Ten Academic Alliance came

8 to town and said we want Maryland to be part of this

9 national effort to mobilize the Big Ten universities

10 across the country to focus on a health equity

11 initiative. And so there's been a team from

12 Dr. Taft's office working with the School of Public

13 Health, and we've been working with the Big Ten

14 Academic Alliance around how to disseminate this

15 model program across the country.

16 Now, Dr. Taft has 27 years of clinical

17 experience in primary care and internal medicine and

18 10 years of hospital-based emergency medical and

19 clinical leadership experience. He also worked early

20 in his career as a consultant in internal medicine

21 for the State of California, Department of Medical

22 Health -- Mental Health, and at that time his

1 academic affiliation was with the University of
2 California, Davis.
3 You know, a lot of great things come out of
4 California, but Dr. Taft, you have to admit that
5 there are some wonderful things coming out of
6 Maryland that maybe we can share across the country.
7 Among his numerous accomplishments include
8 the fact that he co-founded ConMed Health,
9 Incorporated in 1984 and served as its chief medical
10 officer. ConMed is the Maryland-based provider of
11 correctional healthcare services to county and
12 municipal detention facilities in 15 states. Now,
13 here's a man that knows what it's like on the front
14 end of that system and what it means to ensure that
15 when they come back into the community, they're not
16 simply abandoned. He retired from ConMed in 2010.
17 Dr. Haft also has founded and is President
18 and Medical Director of the Maryland Healthcare
19 Associates, where he established a multi-specialty
20 medical practice. He was Founder and President of
21 the Maryland Foundation for Quality Healthcare and
22 provided healthcare education to uninsured and

1 underinsured Marylanders. Most recently, he served
2 as Chief Medical Officer at Health Partners, a
3 Waldorf-based charitable clinic serving Charles
4 County and the surrounding areas.
5 Put your hands together for Dr. Haft, will
6 you?
7 (Applause.)
8 DR. HAFT: Thank you very much for that
9 really generous introduction.
10 So it's really a pleasure to be here today.
11 This is a great group. And it seems to me that
12 there's some really important times in anyone's life,
13 so, you know, among those important times I count
14 certainly my wedding, the birth of all of my
15 children, last night the Cubs after 108 years finally
16 winning a World Series. So I might be a little tired
17 today because I stayed up and watched every last
18 exciting minute of that. It was absolutely
19 worthwhile.
20 But listed among those great days is this
21 right here. To be able to be here today with all of
22 you celebrating what you have done over the last five

1 years, the incredible, innovative, brave, exciting
2 work that you've done, the results that you've
3 produced, and celebrating also the bright, as
4 Dr. Thomas said, the bright future that you have
5 ahead of you.
6 I'm always harkened by the words of Victor
7 Hugo. You recall he wrote *Les Mis*, but in another
8 book that he wrote, he said that there is no army in
9 the world as powerful as an idea whose time has come.
10 And I think that's what you have right now is an idea
11 whose time has come. And I think as was said
12 already, this is just the beginning, and there's no
13 turning this tide back. So it's exciting to be here
14 with you today.
15 What I want to do today, I'm very, very
16 enthusiastic and excited about having our panel of
17 hospital leaders and CEOs here to talk about the
18 interface between hospitals and the HEZs and the
19 changing landscape of healthcare in the state. And
20 I'm not sure whether you all are already aware that
21 the hospitals have gone through a tremendous change
22 in their world in the last several years as they've

1 moved from a fee-for-service system, a volume-based
2 system to all the hospitals in the state moving to
3 global budgets.
4 And what I want to tell you about today is
5 really looking at what you do, what they do, and what
6 the State is already doing to bring all of us into
7 alignment in terms of changing the world from a
8 valueless, fee-for-service, volume-based system to a
9 valuable, globally budgeted, and value-based system.
10 And one of the things that we're going to be doing in
11 the state, we strongly believe, is to be able to
12 align what happens in the communities, not only what
13 you do but leveraging what our provider communities
14 do and get them aligned with all of the same kind of
15 determinants, the social determinants, the disparity,
16 finding where the gaps are in care and meeting those
17 gaps.
18 But that's a tall order. That system, just
19 like the hospital system, was geared very much to a
20 fee-for-service world, and it responded in that way.
21 It clearly went to volume. It was incentivized by
22 volume. Our providers are still incentivized largely

1 by volume, but that's changing a little bit. And
2 what I'd like to do in the next few slides is just
3 tell you about what the State plans to do to help, on
4 a voluntary basis, provide some opportunities for our
5 community providers to also be aligned in the same
6 way in a primary care model.
7 There. Good. So this is, in short, the
8 goals of the primary care model. And I'm not going
9 to spend -- I have a lot that I want to hear from the
10 hospitals, so I'm not going to go through this line
11 by line. It won't be death by PowerPoint, but I can
12 tell you that the goals of the primary care model are
13 to redirect the efforts of all of our primary care
14 providers so that they're really doing very
15 patient-centric care. As you know better than anyone
16 else, that it's really all about the patients at the
17 end of the day.
18 The systems that we build that serve, the
19 systems themselves are really not valuable systems.
20 Things that make sure that our providers' offices
21 have the lights on, but independent of taking care of
22 patients is not really a good system because we're

1 all about really taking care of the patients at the
2 end of the day. And we want to make sure that the
3 incentives in our system are aligned exactly in that
4 way and that we make it easier for our providers to
5 make that transition from pure volume-based care.
6 Volume means that the more you do, the more you get
7 paid, independent of what value you bring to the
8 people you serve.
9 And that's how the system is now. We want
10 to help bring that system around so that it's not how
11 much you do, but it's how much you do it, what the
12 end results are to the patients that you serve.
13 That's the most important thing.
14 So we have kind of a timeline for doing
15 this on the right-hand side here. It says that, you
16 know, we have to submit, and the State will submit to
17 the Center for Medicare and Medicaid Innovation by
18 the end of this year a plan that we've been working
19 on for a long time that will allow the federal
20 government to provide infrastructure, dollar support
21 to allow this State of Maryland to make that change
22 for our primary care providers.

1 So this really has a relationship to the
2 all-payer model. As I said, and you probably already
3 know, a few years ago the hospitals pivoted from
4 being fee-for-service to being global budgeted. And
5 as they pivoted, they really looked at the world to
6 say, and I'm speaking for them and boldly, now what
7 we have to do is ensure that we only take care of
8 those individuals who need to be taken care of. We
9 don't want to continue to push on volume.
10 In fact, it's better under a global budget
11 to have the volume limited to only those who need to
12 be cared for in the hospital. And the only way to do
13 that is to create healthier communities. If you
14 don't have healthier communities and if you keep the
15 front door open because you always have sick people
16 in the communities, you can't really ever reduce your
17 volume. You might be able to reduce length of stay,
18 or you might be able to prevent a readmission in 30
19 days, but the ultimate key to that is having
20 healthier communities. So hospitals are kind of
21 thinking about how to best do that, and you'll hear
22 more about that in a few minutes.

1 Well, at this point, we want to be able to
2 align the providers in the same way, have them
3 thinking about not just the people who they see in
4 their offices each day but the populations they
5 serve, kind of the flocks of sheep that they tend, as
6 it were. And that's really the important thing, and
7 give the provider tools so that they can do that in
8 an effective way.
9 Our providers, by and large now, our
10 primary care providers are burnt out. You know, they
11 used to see 15 or 16 people a day, and that was
12 sufficient to make whatever necessary revenues they
13 needed to keep the lights on and pay for the staff
14 and have comfortable incomes. That over the last
15 decade has changed. It's more like 30 or 35
16 patients. So what gives in that situation is the
17 time you get to spend with each patient and the
18 quality of each of those visits.
19 So we have to purposefully do things and
20 thoughtfully do things to change that payment system
21 and the delivery system so it goes back to focusing
22 on the patients. And that, I submit to you, is full

1 alignment with what's happening in the hospitals.
2 Good. So we got a little wind at our back
3 here. At the federal government, after many years of
4 suffering under a piece of legislature that was
5 called the Sustainable Growth Rate, or SGR, which
6 said to doctors that we're going to pay you less, and
7 which would cause them to do more volume for each
8 individual they saw, we will pay you less depending
9 on the economy of the country. Seventeen years in a
10 row that was threatened to the doctors, and 17 years
11 in a row there was pushback, and Congress reneged and
12 said, okay, we won't do that until the amount in 2015
13 that would have been -- the doctors' reduction in pay
14 was 29 percent, and all the providers said if you
15 take 29 percent out of the Medicare payments, we'll
16 just simply stop seeing Medicare patients, which
17 would have been a catastrophe.
18 So Congress, in a moment of clarity, and
19 these are rare moments, the fog in Washington, D.C.
20 lifted, and they said let's do something different;
21 let's have a new system that's based on value for
22 paying doctors. And that system is called MACRA, the

1 Medicare Access and CHIP Reauthorization Act. And it
2 allowed basically a pivot beginning now in just two
3 months, in 2017, from pure fee-for-service, volume-
4 based provision of payments for doctors to a
5 value-based system with sort of two arms, only two
6 choices, Choice A and Choice B.
7 Choice A is what we call MIPS, or the
8 Merit-Based Incentive Payment System, which is sort
9 of a draconian system that can ultimately reduce the
10 provider's pay by up to 9 percent and requires a
11 fairly high level of data provided to the federal
12 government. Or the alternative, entering into an
13 advanced alternative payment system. So the system
14 that we said we think the doctors and the State will
15 want is an advanced alternative payment system. And
16 I'll tell you what we sort of ginned up to do that,
17 because in the end, what public health wants is to
18 create a healthier state. And we know we can't do
19 that without you. We can't do it without the
20 hospitals. We also can't do it without the providers
21 being perfectly aligned in the same way.
22 So what the two systems, as you can see in

1 this kind of graphic, do is if you're not in an
2 advanced APM, you simply get this MIPS adjustment,
3 which actually could be 9 percent up or it could be 9
4 percent down. You don't know where you are for two
5 years. You submit data; two years later you find out
6 whether you get a loss or a gain. It's kind of a
7 little tough to deal with, tough to budget for.
8 Or you can be in an advanced APM, where the
9 doctors will get a bonus called a MACRA bonus. So
10 they get a 5 percent bonus on top of everything that
11 they do, and they'll get these supports. They'll get
12 money invested by the federal government, a
13 significant amount of money, something in a range
14 coming to the State. It could be as much as 100- or
15 $150 million a year for building a better
16 infrastructure for care management.
17 Have you all done care management out
18 there? You know how expensive it is. Do you know if
19 a doctor wanted to just say I'll build care
20 management, but I have to do it out of my own pocket,
21 how hard that would be? This is the federal
22 government saying we think we can weigh in and help

1 doctors if they're going to be serious about it and
2 providing an investment to help them do that.
3 And this is kind of a one-time opportunity
4 because we have an opportunity to come parallel with
5 the hospitals' Medicare waiver, which says beginning
6 in 2019 how are we going to manage the quality across
7 the board in the state? How are we going to manage
8 the costs across the board in the state? And this is
9 an opportunity for the federal government to look at
10 it and say I think we can get the providers and the
11 hospitals aligned. And you know what? That doesn't
12 happen in any other state in the country because
13 there's no other state in the country that has an
14 all-payer model and a global budget for all the
15 hospitals. So from their perspective, this is a
16 golden opportunity. So we're leveraging now what is
17 a really great window of opportunity.
18 So what does this look like? The big
19 shadow in the middle is grey. It's not white, it's
20 not black, it's not yellow, it's not red, it's grey.
21 That's patients. That's what this is all about.
22 That's the middle piece on this. But the simple

1 structure of this, if I describe it for you, is that
2 the federal government, up on top in the purple box,
3 said we're going to make investment, and we're going
4 to make investments in a model similar to what we
5 call the CPC+ model in 17 other markets around the
6 country, but we're going to do it for your whole
7 state, as many providers as want to be in there, and
8 we are going to allow you to establish organizations
9 within the state, care transformation organizations.
10 And they've said as long as these are
11 really bona fide care transformation organizations,
12 they can be almost anything, but they have to be bona
13 fide. They have to be there to help the provider
14 transform their practices so that they can
15 effectively and in a sustainable way move from this
16 volume-based system to this value-based system. And
17 then we'll have the providers who will take their
18 practices and move them from the old format, and
19 that's hard to do, to change, to pivot 180 degrees
20 and move from volume to value, but we'll be there for
21 five years to help them pivot, if they want to, on a
22 voluntary basis, to do this. And we'll do it with

1 supports, and we'll give them incentives. We'll give
2 them incentives for doing quality, incentives for
3 reducing unnecessary utilization, and we'll give them
4 a bonus every year if they stay in the program. So
5 it's really kind of -- you know, I look at it as it's
6 almost too good to be true. This is the gift horse.
7 So, further, when we looked at it in terms
8 of Medicare patients, because this is initially just
9 Medicare, although we anticipate over the course of
10 five years the commercial plans and Medicaid and the
11 dual eligibles will all fold in, because it's again
12 an idea whose time has come. But we know when we
13 look at Medicare patients -- got my time?
14 Medicare patients are unique in that they
15 get to pick their own providers. So we're going to
16 say that Medicare patients can design their own
17 providers the way that they want to. So if a
18 Medicare patient, for instance, had heart disease and
19 they only ever saw a cardiologist, that could be
20 their primary care doctor. If they only had lung
21 disease and they only saw a pulmonologist, that could
22 be their primary doctor. And so we changed this from

1 what usually is a patient-centered or patient primary
2 care physician to a patient-designated provider,
3 which kind of rolls a lot of other people into the
4 program. But the key is practice transformation.
5 And from a patient's perspective, here are
6 the things, the list of things. What does a patient
7 see? The patient, you know, has a better experience.
8 They're a Medicare patient, they have a better
9 experience. They can get more time with their
10 physicians. They have a care team from the
11 provider's office that surrounds them, that can make
12 those connections to an HEZ if it was necessary, can
13 make it to social supports, can make it to a
14 pharmacist, to a community health worker, and others.
15 And that's all brand new. That's not really
16 happening at a primary care per se right now.
17 Because my time is short, I'll go through
18 this. From the provider's perspective, it's just a
19 better world. You know, I have more supports, I have
20 somebody to help me with transformation, and I have
21 the financial underpinnings to do this, to make this
22 sustainable. So we look at this as really being a

1 great opportunity to align what's happening in the
2 hospitals -- and now, in a moment, I'm going to bring
3 the hospital folks up -- with what's happening in the
4 community. And at the end, if there are questions
5 about that, I'd be happy to do it.
6 But I'd like to now move to what is really
7 the important part of this and have our hospital
8 partners, Victoria Bayless, who is the President and
9 CEO of Anne Arundel Medical Center; Dr. Sam Ross, who
10 is the President of Bon Secours Health System;
11 Dr. Steve Michaels, who's the Chief Operating Officer
12 and Medical Officer of MedStar St. Mary's Hospital;
13 Ken Kozel, President and CEO of University of
14 Maryland Shore Regional Health; and Tiffany Sullivan,
15 Vice President for Community Population Health of
16 Dimensions Healthcare System, to come up to the --
17 for our panel discussion.
18 (Applause.)
19 DR. HAFT: So while this august group is
20 getting seated, I can tell you there's probably more
21 brainpower here than there is in the Watts and IBM
22 system and more managerial experience and

1 accomplishments. It's great to see them all here. I
2 know these are all people who have been deeply
3 involved in the things that you're doing.
4 And the format that we'd like to do now is
5 just go through each of you, starting here with
6 Victoria Bayless, and ask three questions and have
7 you respond to three questions. I know some of you
8 also have some slides, and we'll be happy to tee up
9 the slides at the same time.
10 But the three questions are this: In the
11 context of the global budgets, which we're now into
12 about the third year of, what can you say about how
13 you would be making smart investments in that
14 context, either from hospital rates or from community
15 benefit dollars, and how that might relate to the
16 HEZs or other kind of community support programs?
17 That's question number one.
18 Question number two would be what has been
19 the valued added of the HEZs for your particular
20 hospital. And three, and I think what everyone here
21 in the audience wants to hear is, how can the HEZs
22 best position themselves to partner with you in the

1 future?
2 So if you need, I'll be happy to repeat
3 those questions. Victoria?
4 MS. BAYLESS: Can folks hear me in the
5 back? I'm good? Live? Thank you, Dr. Haft. And
6 just on behalf of the leadership team here at Anne
7 Arundel Medical Center, we're very pleased to host
8 this group and to be part of today's program.
9 Pat, Dr. Pat Czapp and Sharon Cameron told
10 a little bit of the story of the HEZ that we've been
11 most connected to here, so I'll be happy to address
12 each of the questions. In addition to my role here
13 as the CEO of Anne Arundel Medical Center, I actually
14 serve as an HSCRC commissioner, one of seven
15 commissioners, and we are wrangling with a number of
16 different issues, not the least of which are the
17 global budgets that we're working with now, and to
18 Dr. Haft's point, what the next wave of the waiver
19 will look like, Phase 2, if you will.
20 So I think that the HEZ program is an
21 incredibly important success story to point to and to
22 continue to invest in to help us manage what we're

1 calling now the total cost of care. So hospitals,
2 health systems across the state, even though we don't
3 control all the assets, and we certainly don't
4 control the entire delivery system, we're being
5 called upon to be the conveners to bring together
6 community groups, to support community groups with
7 some of the infrastructure dollars that we have in
8 our global budgets to do just that, to manage the
9 total cost of care.
10 And really, for decades historically,
11 hospitals have been so focused on providing care to
12 patients when they're in crisis. It's not the
13 healthcare system; it's the sick care system. And I
14 do think that all of the work here and all of the
15 stories that we've heard are exactly the path that we
16 need to be on, to focus more on the health of the
17 population with much more of an orientation toward
18 public health rather than sick care. And we do
19 address patients when they're in crisis, and we don't
20 always know what led them to that crisis. We're used
21 to dealing with an acute episode. And we're getting
22 better at that. We've been under the global budgets

1 now. We're in our fourth year. And we do have some
2 infrastructure dollars that have been put to that.
3 And to Howard's question about investments,
4 that is how we think about the HEZs. So the HEZ here
5 in Annapolis that Anne Arundel Medical Center is
6 connected to, we lose money, "lose money" I'll say in
7 quotes. We've lost $880,000 on that, and that's if
8 you look at the HEZ and the clinic operations on a
9 discrete P&L basis. We lose money, but we know the
10 better benefits, the greater good that is happening
11 here in terms of the reductions in the visits to the
12 ER. It's not the right place to be getting your
13 primary care. The reduction in hospital admissions
14 and readmissions, the reduction in the 911 calls, so
15 it's a little bit tricky to display that in a pro
16 forma because you're really making investments for
17 the greater good, not just in terms of those improved
18 statistics around utilization, but ultimately in the
19 health of the population.
20 And Pat said it well, Dr. Czapp said it
21 well; we're going to continue to do this because it's
22 the right thing to do. It's not because we've got a

1 money orchard available to us that we can just tap
2 into, but we know the longer-term benefits are
3 certainly there.
4 In terms of the other couple of questions,
5 for us, the value of the HEZ -- I think, Howard, you
6 said the value of the HEZs for these health systems.
7 Really, I would say for me as an individual, as a
8 leader, it has challenged our thinking, and it's
9 breaking the way that we've thought. For the 25
10 years that I've been working in healthcare, we have
11 been driven around volume, volume, and more volume.
12 And it's important for us to break our thinking, so I
13 think we've learned a lot over the course of the past
14 few years with the HEZs. And again, I think it's a
15 model to point to, to continue to invest in and
16 support as we move towards some total cost of care
17 issues.
18 Also, the challenge for all of us as
19 leaders within health systems is to have the courage
20 to do this, because when you show a P&L that's not
21 really attractive from a financial standpoint, how do
22 you rally your medical community, your boards to say

1 this is the right thing to do and to explain that.
2 Another example -- I was talking with Dr. Sue -- at
3 the break. Another example of investments that
4 hospitals and health systems are making are in
5 programs around palliative care and palliative
6 medicine as well. There's no P&L that's going to
7 show a margin on that, but, you know, we know that
8 it's the right thing to do. It's the right thing for
9 patients. It's the right thing for their families.
10 So I think there are more examples like that, and we
11 just have to keep challenging what has been our very
12 traditional thinking as hospital or health system
13 executives.
14 Sam?
15 DR. ROSS: Thank you, Tori. I experienced
16 some of Tori's creativity on my way in from the
17 garage.
18 (Laughter.)
19 DR. ROSS: I loved the sign that said,
20 "Free exercise equipment; take the stairs."
21 (Laughter.)
22 DR. ROSS: And I did. I took advantage of

1 that. I thought that was really neat. I'll remind
2 my staff of that when I get back. We have the unique
3 experience in Bon Secours Baltimore that our garage
4 does not have an elevator, so that's a stress test.
5 (Laughter.)
6 DR. ROSS: Every day. But you heard
7 earlier from the front line, and now you'll hear from
8 the back line, and that's us as administrators. So
9 we have been on this journey. A number of years ago,
10 patient-centered care was kind of the theme that was
11 always talked about, and now I think I saw in your
12 slide and some other slides it really is about
13 person-centered care. And that's key to our
14 strategic quality plan, and one of those goals is
15 about how do we collectively co-create healthy
16 communities. So I think the HEZ in our journey has
17 been a big part of that.
18 And then the other thing, years ago we
19 talked about medical homes and patients in medical
20 homes. When you really think about the HEZ and GBR,
21 we're now in this area where it really is about the
22 medical neighborhood. And so you really have to

1 think in terms of what makes a community healthy.
2 And I've shared before in presentations that years
3 ago we had a slide that said what would make, you
4 know, a business or a market desirable? And none of
5 us would come into a community that had the
6 challenges, the social determinants that we have, for
7 the most part, and try to start a new business. We
8 wouldn't see those elements as really positive for
9 what we're trying to do.
10 So just, you know, sort of take that
11 forward to what we're experiencing on a daily basis
12 as we try to provide care for people who are really
13 in challenging situations, really do have health
14 disparities, health inequities, and helping them to
15 understand that we are really there to help. So I
16 think one of the value-adds of HEZ, and even GBR, is
17 it really helps us to I'll say crystallize and
18 optimize our mission statements. Because all of us
19 have these mission statements that say we do this,
20 and we've had them for years, but have we really gone
21 beyond the walls of our institutions? So HEZ has
22 really been that accelerator around that.

1 I'll speak to GBR in the context of -- and
2 Tori knows this well since she mentioned she's now a
3 commissioner with HSCRC. You know, this is about
4 regulated services versus non-regulated services. So
5 even under the old model before the GBR waiver, it
6 was about things that really were either at the
7 hospital or closely connected to the hospital that
8 was in our rates that we got. So none of the social
9 stuff really was in that number.
10 And so now we go to GBR, and it's even more
11 clear that the regulated versus the non-regulated,
12 which is where HEZ falls. And the number you gave
13 hits our bottom line. And we had a pre-meeting a
14 couple of weeks ago, I guess it was, for this
15 meeting, and I told people about GBR. And those who
16 did TPR before GBR, it really was presented as this
17 wonderful thing. An example I use, some of you are
18 old enough to remember Sinbad the comedian, and
19 Sinbad talked about in one of his jokes about when
20 you're dating and how wonderful things are. So, you
21 know, TPR and our early days of GBR were about
22 dating. And he said, you know, you're with the woman

1 and you go to the movie, and you say would you like
2 me to buy you a popcorn, and she says no, I'll just
3 lick the butter from your fingers.
4 (Laughter.)
5 UNIDENTIFIED SPEAKER: Where are we going
6 with this?
7 (Laughter.)
8 DR. ROSS: I'll bring it back in, in just a
9 second.
10 (Laughter.)
11 DR. ROSS: But the point is everything is
12 rosy. In our first couple of years, we had more
13 flexibility with the corridors and stuff, and we
14 could invest in these kinds of things to a greater
15 extent, and chronic disease management. It was
16 great. But then Sinbad says, which came year three
17 for GBR, you get to the altar, and the preacher says,
18 I now pronounce you man and wife, and the woman looks
19 up at you and says there's got to be some changes
20 around here.
21 (Laughter.)
22 DR. ROSS: So where we are in GBR and HEZ

1 is that there really have got to be some changes
2 around here. But the good news is, just like in
3 marriage, we're all in this together. So I think our
4 opportunities and the pluses really have been that
5 HEZ has helped to align partnerships. It's got
6 people working together and talking together that
7 for, you know, decades never really did that in a way
8 to be successful. I think it has been an accelerator
9 around a focus on quality. Because I think the other
10 thing that really helped with HEZ, you know, when we
11 did kind of some early-phase changes, it aligned, HEZ
12 metrics aligned with GBR metrics around readmission
13 reduction, around the emergency room utilization and
14 potentially avoidable utilization. So I think all
15 those things have been a plus.
16 And I'll just end by saying, you know,
17 often we do think about the losses, but to Tori's
18 point, I think we are beginning to understand it is
19 an investment. And how we utilize that going forward
20 will be key to sustainability.
21 Thank you.
22 DR. MICHAELS: It's a tough act to follow.

1 (Laughter.)

2 DR. MICHAELS: So I will not be anywhere
3 near as amusing. But what I want to say is that
4 St. Mary's County has been a microcosm of a whole
5 bunch of programs that we've tried over the years,
6 and we like to think of it as a test.

7 When I look at the investments in community
8 health way before GBR and TPR and anyone talked about
9 really value for -- value in healthcare, I looked at
10 investments in establishing a hospice house, I look
11 at 25 years of our Health Connections work. I mean,
12 in 2000 we bought a bus and started doing community
13 screenings, and in 2006 we started putting the bus
14 out for primary care, all in an effort to reach the
15 community, and not just the abject poor but anyone
16 who couldn't get to healthcare. So it was a problem
17 of access. And I think we've made great strides in
18 that, and I, you know, point to some of the metrics
19 that, you know, now are very, very important around
20 GBR and about the at-risk dollars that we all face
21 under the new system. And, you know, we're happy to
22 be, you know, high performers on these metrics. And

1 I think it's because of the foundation that was laid
2 many, many years ago.
3 And as far as the HEZ is concerned, I think
4 that this was -- this is a, you know, plank or I
5 would say a new foundation in what we're doing. When
6 we were awarded the grant, you know, we faced issues
7 of physician recruitment, which is a chronic problem
8 in St. Mary's County. We faced issues of meeting the
9 requirements of the grant to provide the services
10 that, you know, are dictated under the grant. But we
11 put our heads down and said we're going to make the
12 financial commitment, and we built an enormous
13 building.
14 And the MedStar board and the local
15 St. Mary's board and the leadership decided that this
16 was something that couldn't be passed up and have
17 committed millions of dollars not only in capital but
18 in at-risk fees to make this happen. And, you know,
19 I'm happy to report that, you know, when we look at
20 the results of the HEZ work, it's not the doctors --
21 and I'm not sure who said that last time -- but it is
22 in the other aspects of sort of trying to relieve the

1 social determinants that are out there. You know,
2 the transportation issue, the community healthcare
3 workers, these are critically important aspects of
4 getting the care out there.
5 I'll tell you, when I look at my
6 readmissions every single week, I look at patients
7 who have had 12 and 15 and 18 and 22 readmissions in
8 a 12 -- or admissions in a 12-month period. And you
9 can have as many clinics as you want, but until you
10 start really getting to individual solutions for some
11 of these patients, it's not going to -- you're not
12 going to get to the next phase.
13 And so as far as the GBR component, we're
14 facing a unique challenge with GBR in St. Mary's, at
15 MedStar St. Mary's in that we have had significant
16 growth over the last several years. So we had
17 13 percent growth in beds in 2016, and 11 percent the
18 year before. And I don't think GBR accounted for
19 that possibility. And so, you know, it's not a
20 perfect system. I endorse the aims of the GBR
21 system. It's a baby that's -- or not a baby, it's
22 really like a Michelangelo statue that's in the

1 middle of being chiseled into perfection.
2 And so with that, I'll pass it on to my
3 friend, Ken.
4 (Laughter.)
5 MR. KOZEL: This is a really tough crowd.
6 Can you hear me okay? Whoop. Thank you.
7 I tell ya, what a crowd. I'm up here with
8 such esteemed colleagues, and they've pretty much
9 encapsulated the perspective that I have as a CEO as
10 well, but I'll add a few thoughts if you'll indulge
11 me because I also know you want to hear more from
12 Tiffany. So I'll pass the mic along quickly.
13 But, you know, I represent Shore Regional
14 Health, and our HEZ grant covered Caroline and
15 Dorchester Counties. And when I talk to the citizens
16 and the elected officials of those two counties, they
17 often remind me that Caroline and Dorchester have a
18 really distinct presence. And what they're proud
19 of -- or least proud of, I should say, is that
20 they're last in the things they want to be first in,
21 and first in the things they want to be last in when
22 it comes to overall health of the citizens of their

1 communities.
2 And that distinction really encapsulates, I
3 think, the first question, which is what about GBR
4 and what about the HEZs that are important to us in
5 the hospital business? And sitting with you here
6 today, I can share with you that they really helped
7 me and our organization better define why we exist.
8 So we've got a new mission statement. It's all about
9 creating healthier communities together. And that
10 has been the shift of our focus now. That's why we
11 exist.
12 And the GBR process allows us to do that.
13 There are some dollars in our rates that allow us to
14 connect technology and information and data with many
15 of you in the room. It also allows us to cover some
16 of the charity care that we experience that patients
17 can't afford. So those rates are very, very helpful
18 because we can use those dollars to reinvest. But I
19 think the value that it's really added for our system
20 is more about the people, the process, and the
21 technology. It helped us focus on people.
22 And I stand here as the CEO, and I've got

1 2,000 people behind me, but the people you know in
2 this room that you've worked with are Kathleen
3 McGrath, Bill Roth, Terri Ross, Dr. Adam Weinstein,
4 those key people in our organization that have
5 shifted their purpose and function on the vulnerable
6 in our communities. So it's helped us put the
7 structure and the people in place.
8 It's also helped us with the process. And
9 process, we could talk about partnerships, we could
10 talk about alignment, we could talk about identifying
11 exactly what we need to be focusing on. We know we
12 can't solve everything, but we could focus on those
13 five key areas that are important in our communities,
14 and let's work together in doing that. And that
15 process includes partnership with key individuals,
16 many of you in this room, Choptank Health, Center for
17 Behavioral Health Services, the Associated Black
18 Charities. A lot of the groups in this room really
19 help us align our strategies, our purpose, and our
20 functions into those vulnerable communities.
21 And then finally, the technology. I think
22 through the grants, through the GBR budgets, we've

1 now recognized, especially in our region where we've
2 got five counties, we're 2,500 square miles, we need
3 to rely on technology to bring information and help
4 to our communities, because we've got transportation
5 problems. We can't necessarily get our communities
6 to our buildings, to our systems, to our process. So
7 we're going to have to invest in technology to make
8 that happen. So the HEZ grant, the GBR rates have
9 all really helped us align. They've helped us form
10 very strong partnerships that have really, really
11 strengthened our relationships in our communities and
12 allowed us to focus on those things that are
13 critical.
14   So I think that's the contribution, that's
15 the benefit of global budgets and HEZ, and that's the
16 value that it's provided to Shore Regional Health.
17   Thank you.
18   MS. SULLIVAN: Good afternoon. I am the
19 new kid on the block, I think, up here, so I feel a
20 little like they've covered everything. I don't
21 think there's anything left for me to say, really. I
22 want to thank Mike Jacobs, who's in the room, who

1 also works at Dimensions with me. We are kind of
2 joined at the hip. So anything I say today, just
3 double-check it with Mike; he'll tell you whether or
4 not I got it right.
5 But, you know, the GBR for me, coming in,
6 in January from South Carolina, was something to
7 learn about in this particular state. And the
8 infrastructure improvements I want to focus on a
9 little bit, because for me, it gives me the
10 opportunity to implement some of my wild and crazy
11 and creative ideas and say this is part of the
12 infrastructure improvement work that we have to do.
13 I think that is a really big piece in the GBR.
14 That's a positive from my perspective. We are really
15 forced to kind of re-shift and really think in terms
16 of the care continuum, and that is a big deal for our
17 patients.
18 And I think I have one slide that I want to
19 show you. It's number 3, but it puts into
20 perspective from -- you know, I'm a public health and
21 a population health person, and I always like to look
22 at this slide, and it is in terms of the human.

1 Sometimes we really want to focus on the hospitals
2 kind of in the middle, and the hospital is not in the
3 middle. When you look at the everyday life of a
4 human being, look at all of the different pieces and
5 the web that touch the patients that we deal with on
6 a regular basis. And if we're not working with all
7 of these organizations, if we're not working
8 together, then we're missing our patients at some
9 point in this web.
10 So can you imagine when we say, well, how
11 come they're missing appointments, or we call them
12 noncompliant? Look at all the different systems that
13 we have to have them working in. Look at all the
14 different ways that we are crossing over but we're
15 not working together. So our patients are really
16 burdened by some of the things that we put on top of
17 them without working together with all of these
18 different kinds of health systems. And so we're data
19 driven in a lot of ways, but we have to be patient
20 focused and human driven, number one priority, for
21 all the work that we do in our hospitals and in the
22 community.

1 For the HEZ, it's been great to work with
2 Dr. Carter and Barbara and the team to learn more
3 about how we as Dimensions partner together in Prince
4 George's County. We are opening up a specialty
5 practice in December. We are very excited about that
6 work. The HEZ practices have been primary care, and
7 now we have the opportunity as Dimensions to also
8 provide specialty care in the HEZ setting. We also
9 work very closely with our P.G. County EMS and our
10 P.G. County community health workers, with Barbara,
11 for our frequent utilizers in the emergency
12 department. And Dr. Carter talked to you a little
13 bit more about that earlier, but we're linking those
14 patients with a community health worker, and we have
15 our teams in the room to really try to figure out
16 exactly what helps our patients stay healthy at home.
17 How do you partner with us, I think that
18 was one of the questions, or how do you access to
19 partner with us. You know, one of the things that we
20 look at from Dimensions is who is doing great work in
21 the community, who's already out there, who's already
22 doing a great job. We don't have enough money to

1 stand up all of these different organizations. So if
2 behavioral health is an issue, we don't have enough
3 money, we don't have enough funding to start a
4 behavioral health agency, but we do have enough
5 resources to partner with an agency that's doing a
6 great job and expand upon the work and the services
7 that you're doing.
8 So that's the type of relationship we're
9 looking to develop throughout Prince George's County.
10 Who's already doing a great job? How can we work
11 together? Who in these agencies, in these bubbles
12 kind of surrounding our patients are really knocking
13 it out of the park, and how can we work together to
14 expand that work and build upon the foundation that
15 we already have?
16 Thank you.
17 (Applause.)
18 DR. HAFT: Let's hear it for the panel. We
19 have some time for questions from the audience. If
20 you have, I think, specific questions for any
21 individual or for the whole panel, please come on up.
22 DR. JACOBS: Troy Jacobs. I'm the

1 pediatrician. And this question may be more
2 appropriate for Dr. Haft rather than the hospitals.
3 It's that, you know, if you think about MACRA, it
4 also includes CHIP. And you made a passing mention
5 at some point later we would -- I mean, this is all
6 sort of focused on Medicare and Medicare reform and
7 how that works with the HEZ.
8 We do need to -- if we are thinking about
9 in our communities pregnant women that may have
10 chronic conditions like gestational diabetes or
11 preeclampsia or children that have asthma, we've got
12 to think about Medicaid. And so if you could talk a
13 little bit about sort of what's the plan to bring
14 that into the fold? I mean, because this is all very
15 exciting what you talk about in terms of primary care
16 model and development of medical home, but medical
17 homes for children and pregnant women is a little bit
18 different than for Medicare populations.
19 And so I'm just very mindful of that
20 particularly as a pediatrician. But if you could
21 talk about sort of what's planned or what's unfolding
22 in Maryland in terms of the Medicaid piece, that

1 would be good.
2 DR. HAFT: Sure. Well, I can say that
3 Medicaid has in place a dual-eligible plan that would
4 speak to the dual eligibles. The remainder of
5 Medicaid, for the most part, is in the managed care
6 organizations, which are managed to the extent that
7 they are. And I think that the door is open for
8 commercial insurers and for Medicaid in general to
9 move progressively toward more value-based programs.
10 And for whatever it's worth, the
11 opportunity we have before us now is specifically for
12 Medicare. And Medicare is the portion of our
13 population that has a defined payer that is totally
14 unmanaged except for Medicare Advantage programs at
15 this point. So it speaks to that; it doesn't speak
16 to everything. But it is an open door that allows
17 other payers to enter also. But I'm very sensitive
18 to your point, and it's very well taken.
19 DR. THOMAS: I have a question that I'll do
20 from here. If anyone else comes up to the mic --
21 this lapel, hopefully, should be working. I'll hold
22 it a little closer. Just to say you've got your CEOs

1 up here, people. You've got the folks in the back
2 room paying the bills, going through the struggle of
3 this transformation from the volume to value. It's
4 not easy. And at the end of the day, they've got to
5 make payroll.
6 So what I'd like you to do, if you could,
7 take us into that boardroom. Take us into that
8 financial meeting when you're facing these kind of
9 legislative changes, some feel like mandate. You
10 know, you may be at the altar. And what are the
11 arguments that ultimately win the day? What are the
12 arguments that ultimately stay the course in this
13 very scary transformation, this inflection point that
14 we're in so that we have an appreciation of what you
15 do in the boardroom to connect and align these values
16 and mission and the financial obligation that comes
17 with it. What wins the day?
18 DR. ROSS: So I'll start. I'm with Bon
19 Secours. So I'm fortunate, I've been at Bon Secours
20 for 10 years. But what attracted me 10 years ago was
21 the fact that the organization and not just the
22 Baltimore -- because we're part of a national

1 organization in six different states. What attracted
2 me is that that organization had already made a
3 commitment to building up the communities, you know,
4 beyond what was going on in the acute care setting.
5 So for Baltimore specifically, you know, in
6 addition to the hospital, we had, you heard it
7 mentioned, Community Works, and we had other outreach
8 that had been subsidized from our operation, you
9 know, long before I actually got there. And the
10 commitment was to social determinants, so workforce
11 development, financial literacy, child development,
12 but all things that grew out of interaction with the
13 community and community prioritization that said this
14 is what's important to them.
15 So housing was important to them because of
16 a lot of boarded-up buildings, vacant buildings. And
17 so our foundation person likes to say we're actually
18 licensed at this point for 72 beds, but we have over
19 700 low-income housing apartments, because that's
20 been the commitment, long before I got there, that
21 housing was a health issue. And so we subsidize
22 Community Works, depending on the year, you know,

1 somewhere to the tune of at least a million dollars a
2 year.
3 So when we get to decision making, you
4 know, our Vice President of Admission, he says we
5 have our why; our why is our mission. And it just so
6 happened that when Health Enterprise Zone and now GBR
7 came along, it really was consistent with our
8 mission, and so we saw the value-add there is, well,
9 if they can help us bring some dollars that further
10 subsidize the work that we're doing, then that's a
11 plus.
12 And so, when we get into the boardroom, the
13 decision starts with is it consistent with our
14 mission and what we accept as our social justice
15 mandate, and then we get into the other data points.
16 Yeah, we still look at bottom line, but the other
17 data points really are driven by the metrics that we
18 have to achieve, whether it's under value-based
19 purchasing in our other states or GBR and its
20 requirements in this state. And if it's aligned with
21 those purposes, then we make the decision as to how
22 much of that we will subsidize.

1 I can tell you, for our program, knowing
2 that this was, at this point in time, limited, we
3 said a year ago put the team together, the transition
4 team together from behavioral health, from ambulatory
5 services, you know, from Community Works, everybody
6 that has components that are consistent with what
7 we're doing with HEZ, and those things will be
8 integrated into our operations as we go into our next
9 budget cycle, even if we don't get the additional
10 dollars. So we have to weigh the value, what's
11 really helping us achieve those goals, what's not
12 helping us achieve those goals, and that's the basis
13 on which we'll make those decisions.
14 MS. BAYLESS: So I would agree with Sam. I
15 think that for every organization and for -- all of
16 the hospitals and health systems in Maryland are
17 nonprofits, and we are accountable to these boards.
18 As CEOS, we're accountable to the boards, but we
19 really do park everything back to mission, vision,
20 values.
21 And back in 2009, even before the
22 Affordable Care Act was signed into law, we put

1 together a vision that was called Living Healthier
2 Together, and the emphasis even then, and I couldn't
3 have envisioned all the specifics of the HEZ or the
4 GBR at the time, but was to create a system of care
5 that went outside the walls of the hospital, that was
6 accomplished through collaboration and partnerships,
7 that was driven by evidence, and that essentially
8 also needed to be financially viable.
9 So I've co-opted a lot of things under that
10 vision over the past few years. And the only thing I
11 would say, in the boardroom in particular, we focus
12 on five areas. So we focus first and foremost on
13 quality and safety; we focus on serving the
14 community. And there is pressure on health systems
15 now because as we look at community benefit dollars,
16 instead of just counting those in the rearview
17 mirror, hey, what did we do over the past year, let's
18 pencil that down on paper, is actually setting
19 budgets more deliberately for community benefit.
20 Particularly as coverage has expanded,
21 because what hospitals and health systems in Maryland
22 and across the country would claim as a large portion

1 of our community benefit are charity dollars, but
2 more and more people are insured now, so what else
3 are you doing for the community? So that's become a
4 new conversation in the boardroom that wasn't there,
5 I would say, in 2009.
6 The other thing in the boardroom is an
7 incredible amount of teaching and learning. You
8 know, we talk about, you know, building a plane while
9 you're flying it. There's a lot of change happening.
10 It's really an unprecedented amount of change coming
11 with all of these new methodologies, new policies,
12 new laws, new regulations, and we don't want to feel
13 like we're victims of that. We want to feel like
14 we're actually steering this activity, that we're not
15 just, you know, reacting to it.
16 But an incredible amount of teaching and
17 learning and cautions for boards and organizations,
18 because hospitals and health systems, we tend to be
19 the 900-pound gorillas in our communities, right?
20 We're large, we're large employers, we're economic
21 engines, all of those things, but we really have to
22 be careful about not being institutionally arrogant

1 and thinking we have the answers. Because working
2 with partners that we don't control, who aren't on
3 our balance sheet is daunting, but it can be very
4 rewarding as well. So those are the conversations
5 we're having now and a really steep learning curve.
6 These boards are incredibly talented, incredibly
7 dedicated. They're volunteers, and there's a lot of
8 education that goes behind it as well.
9 DR. MICHAELS: Well, what I would say is
10 that the board, the community board at MedStar
11 St. Mary's, they're community members. And they want
12 to know that when they come to the hospital, that
13 they're going to be taken care of in a safe way and
14 have high-quality care. And so that is clearly a
15 driving force between -- at board meetings. You
16 know, are we meeting our quality metrics? And that
17 translates, and I think in a very good way.
18 If you think back to when we first started
19 worrying about things like core measure compliance,
20 and a lot of you know what Delmarva Award is, that
21 was a training for hospitals to get ready for
22 quality-based reimbursement. And, you know, if

1 you're asking me what the financial, you know,
2 discussion is going to be, it's going to be how am I
3 as the administrator going to explain a potential
4 8 percent or 9 percent penalty, which would severely
5 impact our ability to deliver on our mission and
6 vision because we're not meeting our quality
7 measures.
8 So those are hard discussions, and we have
9 four- and five-hour quality and safety professional
10 affair board committee meetings where every detail of
11 the quality of care that we deliver is analyzed and
12 discussed. And that's the data that we're using.
13 We're managing to the metrics that have been put out
14 by GBR, or value-based purchasing out in the PPS
15 system, to make sure that we meet that primary goal.
16 As far as the community, I mean, as I said
17 before, they're community members. They know what's
18 going on in the community. They don't like to be
19 accosted in the grocery store about issues that are
20 going on in the community or at the hospital. And if
21 they do, I get a very quick phone call about that.
22 And so our community connections are extremely

1 strong. Our partnerships with other providers --
2 we're the only hospital in the county, so we have a
3 unique position, but there are so many other very,
4 very important organizations that partner with us to
5 help make sure we execute on the mission and vision.
6 DR. HAFT: Next question.
7 DR. MANN: I'm David Mann from the Office
8 of Minority Health and Health Disparities at DHMH,
9 and I want to kind of get to the question of whether
10 global budgets actually leave hospitals with the
11 money in hand to support HEZs and social determinants
12 of health and other similar things. There's a
13 perception I hear a lot that says under global
14 budgets, when volume goes down, hospitals save money.
15 I'm not 100 percent sure, so I'd like to
16 let you guys weigh in on that, particularly on an
17 example we had this morning where 545 ER diversions
18 were estimated to represent a $1.2 million savings.
19 In a fee-for-service system, I can believe that
20 that's 1.2 million less the payers had to pay, but
21 I'm not sure that a hospital under a global budget,
22 when it has one or two less ED visits a day, is

1 actually able to put $1.2 million in a vault and then
2 spend it on community health, social health, HEZs,
3 and social determinants.
4 DR. HAFT: Who wants to answer that
5 question?
6 (Laughter.)
7 DR. THOMAS: Who is the most --
8 DR. ROSS: Let the new lady answer that
9 question.
10 (Laughter.)
11 MS. SULLIVAN: This is hazing, I think.
12 I'm being jumped in up here.
13 I think that's a great point. No, you're
14 not going to get that 1.2 million, so I'm not going
15 to get that back into my budget, but we also do have
16 to, you know, divert those patients into a better
17 source of care. So in my limited time here, what
18 I've seen more is that, you know, we're not
19 necessarily setting our budgets to say, okay, we're
20 going to divert this many people from the ED and then
21 we're going to put this money into our budget to show
22 that it's my population health management budget.

1 Instead, we'll be more proactive in saying this is
2 the pot of money that you have to address population
3 health initiatives for your organization.
4 That's just my short version of the answer,
5 just kind of being new here and my understanding of
6 it. But no, I don't get that $1.2 million in my
7 happy little hands to work with.
8 MR. KOZEL: I think it's also important to
9 note that there are a few other levers within the GBR
10 budget that either add to our GBR budget or retract
11 from that budget that we get each year. Those levers
12 are things like patient satisfaction scores. How
13 well do we do as a hospital system compared to the
14 rest of the hospitals in the state? If we're in that
15 top quartile, we're likely to either sustain our GBR
16 rate for that portion of dollars, or we're likely to
17 either gain or lose that portion.
18 And the other pieces are quality
19 indicators. How are we doing from a quality
20 perspective with regard to the rest of the hospital
21 systems? How many hospital-acquired conditions have
22 we had with regard to other hospitals in the system,

1 and how do those rates, that one GBR rate fluctuate,
2 year after year, up or down, based on those measures?
3 So even within the GBR structure, there's levers that
4 are pulled to try to align us into better care.
5 But having said that, I think the other
6 piece I'd add is just that when we are able to reduce
7 avoidable utilization, and that's what all of you do
8 every single day with us, that's where I think we get
9 the most benefit from the GBR budget. That's when we
10 get the dollars that we can typically reinvest back
11 into our communities and back into our mission.
12 And back to the other question about the
13 boardroom, I think our board is quickly shifting from
14 the saying no margin, no mission to no mission, no
15 margin. So we're starting to shift in that
16 perspective. But hope that helps.
17 DR. HAFT: Ms. Bayless?
18 MS. BAYLESS: So if I put on my
19 commissioner hat for a minute, I could keep you here
20 all day talking about the methodology, but I think at
21 the highest level, the GBR and the methodology behind
22 that from a health policy standpoint, really it

1 starts with there's a belief that there is excess
2 utilization in the system and that patients can be
3 better cared for at lower-cost settings and that some
4 of that utilization can be in fact avoided.
5 So if a hospital's volume decreases, they
6 don't lose all of those dollars. Their budget will
7 get adjusted in the next year, including all the
8 levers that Ken spoke of, where you're kind of like
9 giving back 50 percent but you get to keep 50
10 percent. And some of those dollars are essentially
11 freed up.
12 So if you're not providing care that was
13 avoidable and could be rendered elsewhere, you can
14 then take those dollars and invest them in other
15 population health activities, such as HEZs or other
16 activities, opening up additional access points, care
17 coordination, partner with community resources
18 around, social services to support vulnerable and
19 marginalized populations.
20 So at a policy level, but to Sam's earlier
21 point, you know, you get to -- you know, you're three
22 years in, or you're three and a half years in, and

1 you're like, okay, you know, we have to continue to
2 revisit the policy and say is it really working,
3 where's the money going, who's saving the money?
4 Because ultimately, you're trying to improve care,
5 service, and quality, improve access and reduce
6 costs. And we could argue for a long time as to
7 whether those things are complementary or are they
8 mutually exclusive, are they in conflict or not.
9 I mean, we do believe, I think, as a
10 healthcare industry that we can improve care,
11 quality, and service, improve access, but also reduce
12 costs at the same time, and that's the objective of
13 the system in a broad way. But it'll have to be
14 adjusted and tweaked because it's not perfect. And
15 when any new policy comes into place, three and a
16 half, four years in, you have to make adjustments to
17 it, and we'll see those over the next several years,
18 including with Phase 2 of the waiver.
19 DR. HAFT: Thank you. I think because
20 we're getting close to lunch, why don't we do one
21 more question and then -- this has been an incredible
22 panel. I'd love to keep them up here all day because

1 the answers are so --

2 DR. THOMAS: Dr. Haft, if you could keep

3 the two -- because there's an economist in line.

4 DR. HAFT: Oh.

5 (Laughter.)

6 DR. THOMAS: We're going to get that

7 economist to say something here.

8 DR. HAFT: Absolutely fine.

9 MS. PETERSON: Wonderful discussion. I'm

10 Sadie Peterson, the Medical Director at the Center

11 for Chronic Diseases at DHMH. I wondered if you all

12 could talk a little bit about the jurisdictions and

13 areas in the state of Maryland that were not part of

14 HEZs, and if you could tell a little bit about how

15 you might recommend disseminating some of the

16 experiences that you've learned and some of the

17 successes and how to improve outcomes for patients

18 and patient populations to folks who have not been

19 participants in HEZs. As leaders of these

20 institutions, you might have some recommendations for

21 others across the state.

22 MS. BAYLESS: Stephen, you want to -- I'll

1 say something.

2 DR. MICHAELS: Well, I guess what I would

3 say about that is that you're absolutely correct,

4 we've learned a lot about -- the HEZ experience has

5 taught us a lot. And I think the collective wisdom

6 in the room here needs to be shared across the state

7 and even across the country because I think we are a

8 bit of an incubator in the state.

9 So specific recommendations: I mean, I

10 think each community faces some unique challenges, so

11 I'm not sure that broad strokes would necessarily

12 answer that question. But I mean, I think that at

13 the base, you know, my feeling is that HEZ and access

14 is a plank in a broader issue around the social

15 determinants, particularly, you know, racial,

16 cultural, and most importantly, educational

17 disparities that we face that continually breed the

18 kind of problems that we're trying to solve with the

19 HEZs.

20 So I mean, it's kind of a tough question to

21 give you a specific answer to.

22 DR. ROSS: So Tori and I were just talking

1 about the learning. So MHA had a population health
2 subgroup and, on a quarterly basis, would invite all
3 of the hospitals in the state and, at different
4 times, had HEZ leaders to present to those groups,
5 and that included lessons learned. So I think we've
6 had that kind of a forum, this kind of a forum, and
7 other things need to happen so we can spread, you
8 know, spread that learning more effectively.
9 The not HEZ issue also became the not
10 regional planning grant recipient issue, not a second
11 CHRC grant. So every time there is something given
12 out, you know, there are limitations because it's
13 really a zero sum game and not everybody gets. And
14 we would love to be in a place where there were
15 enough dollars that everybody could get. So I think
16 that'll continue to be a challenge as we go forth.
17 But there are education forums that have happened.
18 We need to do more to spread learning and then
19 continue to work on the funding aspect of it.
20 DR. HAFT: Next question from the
21 economist.
22 DR. CHEN: Yes, I'm an economist. My name

1 is Jie Chen. I'm faculty University of Maryland. So
2 my question is regarding the cost economic
3 evaluations. In my point of view, I think an
4 economic evaluation is a critical component to show
5 the sustainability of the primary care model and the
6 HEZ model. So if we can show if these models are
7 cost saving and it can improve population health and
8 reduce costs associated with health disparities, then
9 we can show it to convince those peers -- Medicare,
10 Medicaid, and other private foundations to continue
11 to, you know, invest in these great models.
12 So I'm interested to know, what is the
13 economic evaluation component that has been, in your
14 point of view, under this global budget revenue
15 model? And also, I think, you know, to do a
16 comprehensive economic evaluation, a comprehensive
17 data infrastructure is needed so the data across all
18 the players, patients, doctors, the hospitals, the
19 community workers, and also across jurisdictional
20 areas. So I also would like to know your effort, you
21 know, for this data infrastructure construction.
22 Thank you.

1 MS. BAYLESS: And we're out of time. No.
2 (Laughter.)
3 MS. BAYLESS: I'm just kidding. That was a
4 great question. No, it is a great question. And I
5 think it was interesting reflecting on Dr. Gaskin's
6 slides earlier this morning. You know, when he was
7 showing reductions in utilization for the HEZs, the
8 non-HEZs, and then across the state, and we're seeing
9 those reductions. So I think one of the difficulties
10 in assessing the impact of any one discrete program
11 is it's not operating in isolation. You've got other
12 activities coming through at the same time, so what
13 do you actually attribute all of the results to?
14 I mean, if we did a specific evaluation of
15 our HEZ, which we have, and I've got some of the
16 numbers here, so we've had a 17 percent reduction in
17 ED visits. So typically an ED visit for us is going
18 to be about $2,400 because, you know, you've got to
19 get a whole bunch of stuff done when you come to the
20 ED, right? It's not a primary care visit. We've had
21 a 26 percent reduction in 911 calls. We've had a 23
22 percent reduction in admissions, 37 percent reduction

1 in readmissions.
2 Now, that's a very -- it's a limited scale.
3 You know, this wasn't across, you know, hundreds of
4 thousands of people, but we were able to say, okay,
5 do the math on that, tie it back, and then we are
6 reducing all of this avoidable utilization. But it
7 doesn't necessarily come through screaming at us on
8 our financial statements as a huge success. So I
9 think some of the difficulty is carving out the
10 program discretely and saying this is exactly what is
11 saved because there's other stuff going on.
12 But in terms of data and analytics, one of
13 the big investments we've made, and many health
14 systems are, is in our data analytics, data science
15 and infrastructure, and also tapping into CRISP. So
16 I think many of you are familiar with CRISP, which is
17 our health information exchange here across the state
18 and is in fact one of the robust HIEs in the country.
19 So how do we continue to connect there? I also think
20 there are other platforms that we can share data
21 through, whether it's on the Epic platform. A lot of
22 systems across the state are on Epic, but there's

1 also demand for interoperability across systems that
2 aren't the same exact platform.
3 But we've got a whole unit here on data
4 analytics that's trying to mine not just the data
5 associated with HEZ but how is our ACO working. And
6 as the population health data comes from Medicare in
7 through the HSCRC to CRISP, we've got to understand
8 that as well. But those are investments as well.
9 Data scientists are as rare as hen's teeth. They're
10 hard to find. We're all trying to find them, and
11 they don't come cheap. Nor should they. They're
12 very talented people. So I'm going to continue to
13 work at it, but I think we struggle a little bit to
14 analyze discrete programs, because we can inventory
15 15 different things we're working on, and how do you
16 pin the results or the lack of results on any one
17 effort?
18 MS. SULLIVAN: And the only thing I would
19 add to that is we are looking at it at Dimensions in
20 terms of I can't show it as a savings.
21 DR. THOMAS: Just pull the mic a little
22 closer to you.

1 MS. SULLIVAN: Oh, sorry. I can't look at
2 it as a cost savings. So my finance people always
3 challenge me, show me the savings. But we're looking
4 at it in terms of cost avoidance. We avoided this
5 set of costs with this particular patient population
6 by implementing these programs and services with
7 partners to address their social and health needs.
8 And so I would challenge the term "savings," because
9 I get challenged on it quite a bit, that we are
10 actually avoiding costs.
11 DR. HAFT: So before I thank the panel, I
12 just wanted to point one thing out. I think this is
13 just such a great coincidence that in one week I
14 heard three times the same statement that housing is
15 health. I heard it from Dr. Ross today, I heard it
16 earlier in the week from Eric Lindamood, who's the
17 CEO of Health Care for the Homeless, and I heard it
18 from Secretary Holt, who is the secretary of our
19 housing division for the State. So if you hear it
20 three times, it must really be true.
21 But I wanted to just particularly thank
22 this incredible panel for the information that they

1 passed on and all of you for the great questions and
2 turn it over to Dr. Thomas.
3 (Applause.)
4 DR. THOMAS: What a wonderful panel. And I
5 ask you to please just stay seated there, because
6 when the boardroom and the front line start to align
7 themselves in ways that the mission margin
8 conversation switches and your healthcare
9 professionals start to say, hey, this is why I became
10 a healthcare professional, we don't want to lose
11 that. And I think that last question spoke to the
12 glass of the wrong size. You need new systems, new
13 frameworks, not the old frameworks, and that's why
14 it's so important that Senator Addie Eckardt here is
15 in the room from the 37th District representing
16 Caroline County, Dorchester, Talbot, Wicomico County.
17 Give her a hand, will you?
18 (Applause.)
19 DR. THOMAS: That's what she can take back,
20 talking about what other legislative levers that can
21 help move things forward. And you should also know,
22 again, that we're being watched around the country.

1 This is a big experiment going on, people. It's only
2 been four years. And we've moved the needle, and
3 we're moving the boardroom culture, and that's why
4 it's so important that Robert Wood Johnson is
5 watching. And Robert Wood Johnson has helped make
6 this conference not only possible, but also the
7 recording. The documentation that's according here
8 is to lay the roadmap for the nation. You are laying
9 a roadmap for the nation.
10 So help me thank Dr. Krol. You're going to
11 hear from him a little bit later.
12 Raise your hand, Dr. Krol, so they can see
13 you.
14 (Applause.)
15 DR. THOMAS: From the Robert Wood Johnson
16 Foundation, who has the campaign A Culture of Health.
17 This is what it looks like. It's hard work, but we
18 are moving that needle here in the state of Maryland.
19 So again, panelists, thank you. We are going to head
20 to lunch.
21 And, Dr. Haft, they're like the front line.
22 This is like your army out there moving things. Give

1 Dr. Haft a hand, will you?
2 (Applause.)
3 DR. THOMAS: And so we have a housekeeping
4 lunch announcement.
5 DR. DWYER: Thank you all. So you'll
6 notice we have just 30 minutes for lunch, and that's
7 because we have so many great speakers here today.
8 So please feel free to enjoy this beautiful campus,
9 but then also feel free to bring your food back in
10 here in 30 minutes, so as we restart. The eggplant
11 parmesan is vegetarian. The chicken and salad are
12 gluten free. The chicken pasta and salad are dairy
13 free. So thank you. And we want -- so if we could
14 be back by 1:30. Thank you so much.
15 (Whereupon, at 1:02 p.m., a lunch recess
16 was taken.)
17
18
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22

1 A F T E R N O O N S E S S I O N

2 (1:36 p.m.)

3 DR. THOMAS: If I can have you all begin to
4 grab your desserts, your drinks, take your seats.
5 We will do our best to pick up on some of
6 our time, but the energy in the room, the fellowship
7 is just wonderful, and we need more and more of that
8 actually. It's amazing what you can do breaking
9 bread together. And at least for me, I don't know
10 about you, I never knew hospital food could taste so
11 good.
12 (Laughter.)
13 DR. THOMAS: And you had all those options.
14 So while we heard in many of the presentations this
15 emphasis on mission and the recognition that at the
16 end of the day a lot of you, particularly those on
17 the front line, do this out of the goodness of your
18 heart, in fact, I think that one could say that at
19 the end of the day, to be successful, it doesn't
20 happen because it's your job. So we're talking about
21 the truly committed. And every now and then we get
22 an opportunity to acknowledge the truly committed.

1 So one of the ways that I believe that you
2 sustain efforts like this is to stay the course.
3 Yes, you applied for a grant; sometimes that's the
4 exercise and the discipline of putting your ideas
5 down on paper, and then lo and behold you get the
6 grant, and now you actually have to make those ideas
7 work and bring them into reality. And I don't think
8 that Dr. Hussein, Dr. Reece, many of us who were on
9 the commission writing the report had any idea of all
10 the ripple effects that occurred, including the
11 changes in the boardroom. So I say to you
12 Marylanders, stay the course. Stay the course.
13 And so it really does help when you have
14 national recognition. So I think it's very important
15 that you go back to your organizations, and you talk
16 about the significance of what you're involved in.
17 It is important that the Association of State and
18 Territorial Health Officers awarded the HEZ here in
19 Maryland, the model, the Vision Award for innovation
20 and effectiveness and replicability. There's a
21 keyword. All these elements can be replicated.
22 That's right, give yourselves a hand.

1 (Applause.)

2 DR. THOMAS: Can be replicated not only in
3 those places that applied but didn't get it, but
4 places around the country. And that's what we are
5 talking about now, replication around the country and
6 giving all those locales the ability to tailor to the
7 needs of their local constituents.

8 And so the Maryland Health Enterprise Zone
9 Initiative received the 2016 first place Vision Award
10 for innovation and effectiveness and replicability
11 from the Association of State and Territorial Health
12 Officers. And these were awards that have been
13 announced. And to kind of formally do that here at
14 this gathering, let's bring Dr. Spencer to the
15 microphone to accept this award on behalf of all of
16 you out there. Give her a hand, will you?

17 (Applause.)

18 DR. THOMAS: Now, where's that
19 photographer? Where's that photographer? Do one for
20 the social media. Start tweeting. There you go.

21 Got it? Can you say hold that pose?

22 UNIDENTIFIED SPEAKER: But I want the good

1 camera.

2 DR. THOMAS: Okay, here's the photographer.

3 Okay. Give her a hand. Thank you.

4 (Applause.)

5 DR. THOMAS: So if there's anything you

6 need to recognize is that documentation is important.

7 So the Twitter feeds, the Facebook pages,

8 documentation of the little milestones along the way,

9 do not take it for granted.

10 And now for the awarding of the Health

11 Enterprise Zone awards, I'm going to ask

12 Dr. Carlessia Hussein to come to the microphone.

13 Give her a hand while she's coming up here, will you?

14 (Applause.)

15 DR. THOMAS: As many of you know,

16 Dr. Hussein was a Director of the Maryland State

17 Office of Minority Health and Health Disparities from

18 2004 until she retired in 2014, and it's in that role

19 that she established a state of change to promote the

20 reduction of racial and ethnic health disparities in

21 Maryland.

22 She is truly a giant and a champion, and I

1 have known her for the greater part of my career
2 because Maryland was always in the forefront in
3 producing the kind of data documenting racial and
4 ethnic health disparities in the minority health
5 reports that came out. And so we were always
6 concerned, obviously, in her retirement somehow we
7 would lose that vision and wisdom.
8 And I think, Dr. Hussein, you have to be
9 very, very pleased to see that that momentum that you
10 helped set in motion continues to this very day.
11 And so it's really, really great to have
12 her give the Health Enterprise awards today.
13 (Applause.)
14 DR. HUSSEIN: They gave me the microphone,
15 so that was a mistake. I'm going to just take a few
16 moments to say how delighted I have been all day
17 sitting there listening to what has happened to the
18 idea. And I said to a few people, and I'll say it to
19 all of you now, I kind of felt like the mother and
20 the children are now graduating from high school.
21 And I'm like, oh my God, it worked, it's moving fine.
22 So I'm very, very proud and very, very pleased and

1 happy to see so many faces that I know.
2 When I got the call from Director Spencer
3 about coming to this, it made me stop the work I'm
4 doing in Howard County and to look back at HEZ. So I
5 quickly looked over my data. Do you know that it's
6 six years and a little over seven months to the day
7 that this all started with passage and signing of the
8 ACO by the President in March 23rd, 2010? I looked
9 at that and then looked at the events that occurred,
10 and Michelle has gone over some of them. And on
11 May 20th, 2012, a very important thing happened that
12 I heard all day today. And I just want to take a
13 second to share that.
14 I was part of the H-E-Z, or the HEZ -- I
15 keep up to date here now -- workgroup, and there we
16 were able to talk about and establish some HEZ
17 principles. And actually, it happened one evening,
18 late after work, with Dr. Mann. Is he still here?
19 He's right there.
20 He and I sat at my work table, and we
21 decided to look at all of the material from
22 Dean Reece's workgroup to kind of put it in context,

1 and we came up with the principles. I mean, we
2 didn't come up with them; the principles were in the
3 material. We just pulled them out and crystallized
4 them.
5 And then I've heard them all day today.
6 Provider-community balance, so there's a balance
7 between community participation and input and the
8 providers, the hospitals. Cultural, linguistic, and
9 health literacy competence, I've heard that several
10 times, and that, of course, relates to social
11 determinants of health. And community coalitions was
12 something that we struggled, and I think we did have
13 some fights at the workgroup that this must be in it
14 so there's a formal requirement that there must be
15 community coalitions, with diverse people on those
16 coalitions to help talk about the problems and be a
17 part of the solution. And then contributions from
18 local partners, and we heard the hospitals today,
19 local partners working. And finally we put in
20 planning for sustainability.
21 So that was wonderful. That has echoed
22 through, and I think it's made the difference. So

1 I'm asking all of you to give yourselves a round of
2 applause for doing a wonderful job and graduating
3 from high school.
4 (Applause.)
5 DR. HUSSEIN: Now, moving on with the task
6 that was given, we want to recognize the Health
7 Equity Awards. Maryland's five Health Enterprise
8 Zones have been awarded the 2016 Department of Health
9 and Mental Hygiene Health Equity Award.
10 The DHMH Health Equity Award, advancing
11 social justice through health equity, which
12 recognizes programs and organizations that have
13 successfully implemented efforts to promote justice
14 by addressing health equity and social determinants
15 of health in Maryland's most disadvantaged
16 communities, this award considers costs,
17 effectiveness, resilience, and impact on the State's
18 public health.
19 The HEZs have created communities in which
20 integrated healthcare systems led by community
21 coalitions are pioneering healthcare and prevention
22 efforts in a patient- and family-centered manner and

1 with a health equity approach. These systems work in
2 tandem with a variety of stakeholders to improve
3 health and decrease costs, expand access, empower
4 communities, and reduce health disparities. The HEZ
5 model aligns systems and incentives to broaden the
6 scope of care within Maryland's most underserved
7 communities to address social determinants of health.
8 This is the segment from our Department. I'm still a
9 part of it.
10 The Annapolis Community Health
11 Partnership -- and at the end of this, if someone
12 from that group will come up, and we will provide
13 your award -- based at Anne Arundel Medical Center
14 established a new primary care medical home in
15 collaboration with the Housing Authority of the City
16 of Annapolis and a number of other community partners
17 within the Morris H. Blum Senior Apartments facility.
18 And I remember visiting there and seeing the people
19 living there coming downstairs and going into the
20 area to see the nurse and the physician.
21 The health center has expanded primary care
22 and wraparound public health and social services for

1 the elderly and disabled residents of Morris Blum and
2 for low-income adults in the surrounding community
3 who were experiencing crisis-driven, episodic, and
4 fragmented care.
5 So if someone would come forth from this
6 HEZ so we could -- and more than one can come forth.
7 (Applause and cheering.)
8 DR. HUSSEIN: And this is awarded to you
9 for all your great work, and please take it back and
10 share with all of your staff and community residents.
11 UNIDENTIFIED SPEAKERS: Thank you. Thank
12 you.
13 (Applause.)
14 DR. HUSSEIN: The next center is the
15 Caroline and Dorchester's Competent Care Connection,
16 CCC, Health Enterprise Zone. The Caroline-Dorchester
17 HEZ based at the Dorchester County Health Department
18 has collaborated with organizations across the two
19 counties to integrate the efforts of seven partners
20 that provide direct services in seven of the Eastern
21 Shore's most underserved zip codes.
22 These communities experience significantly

1 limited access to primary care, higher Medicaid and
2 WIC enrollment rates, and among the worst chronic
3 disease outcomes in the state. The HEZ has worked to
4 expand the primary care and behavioral health
5 workforce, improve outcomes, and reduce diabetes,
6 hypertension, and behavioral-health-related risk
7 factors. Key strategies have included recruiting
8 providers, opening a community mental health clinic,
9 and expanding care coordination, school-based
10 wellness, and mobile behavioral health crisis
11 services, among others.
12 So would someone come forth, as well as our
13 Senator from that area?
14 (Applause.)
15 DR. HUSSEIN: This award is presented to
16 all of you this day.
17 (Applause.)
18 DR. HUSSEIN: The third award goes to
19 Greater Lexington Park Health Enterprise Zone. The
20 HEZ in this area, based at MedStar St. Mary's
21 Hospital, has worked to expand and integrate primary
22 care, behavioral health, and community health

1 resources to reduce unnecessary ED usage and improve
2 health outcomes across the three zip codes where
3 Medicaid panels were closed in most practices, and
4 uninsured and underinsured residents were forced to
5 seek both primary and crisis care in the emergency
6 department.
7 Key strategies have included opening a new
8 primary care practice, expanding care coordination
9 and mobile primary care services, integrating
10 behavioral health services, and developing a mobile
11 medical route, specialty transportation service, and
12 dental van.
13 Would representatives from Greater
14 Lexington Park come forward?
15 (Applause.)
16 DR. HUSSEIN: This award is presented to
17 you this day.
18 (Applause.)
19 DR. HUSSEIN: The next award goes to the
20 Prince George's County Health Enterprise Zone. It
21 has worked to increase accessibility and availability
22 of primary care services by establishing or expanding

1 five primary care home hubs in the Capitol Heights
2 target zip code, which are supported by a countywide
3 public health information network and a community
4 care coordination team.
5 Capitol Heights led the county in poor
6 health outcomes and ambulatory-care-sensitive
7 hospital admissions, experienced poverty rates nearly
8 double those of the county as a whole, and Medicaid
9 and WIC enrollment rates that exceeded state rates.
10 This enhanced primary care capacity is expected to
11 improve health outcomes, increase community
12 resources, and reduce preventable hospitalizations
13 and emergency department visits.
14 Would those individuals from Prince
15 George's County come forward?
16 (Applause and cheering.)
17 DR. HUSSEIN: This award is presented to
18 you this day.
19 I'm trying to get set up here. Hold on.
20 (Laughter.)
21 (Applause.)
22 DR. HUSSEIN: And finally, we offer an

1 award to the West Baltimore Primary Care
2 Collaborative. It has employed a variety of
3 strategies to increase primary care and community
4 health resource capacity in four zip codes in West
5 Baltimore in order to reduce risk factors, improve
6 health outcomes, and reduce preventable ED visits,
7 hospital admissions, readmissions, and related costs
8 among targeted high utilizers of hospital care.
9 These neighborhoods had higher disease
10 burden than most communities in Maryland and
11 established the lower extremes for health disparities
12 in Baltimore City and the state across all major
13 chronic illnesses. Key strategies have included a
14 two-tiered care coordination program targeting high
15 utilizers of five partner hospitals, extensive
16 training of HEZ residents, staff, and providers, mini
17 grants to community partners to provide self-
18 management and community supports, and a scholarship
19 to increase and diversify the local healthcare
20 workforce.
21 Would representatives from West Baltimore
22 come forward?

1 (Applause.)

2 DR. HUSSEIN: And let's give an even larger

3 round of applause to all of these winners of the

4 2016 --

5 (Applause.)

6 DR. THOMAS: Okay. Dr. Hussein, come down

7 here. Come this way, right in front of the stage.

8 Come in front of the stage, quickly, quickly. And

9 get tight. Get tight, Dr. Krol. Can we get you in

10 this photo? And the State HEZ Team, you can't be in

11 one big line. Get on the other side, too. Get on

12 the other side. Come on. Here, get right there in

13 the middle. There we go. Tight. Now, hold those

14 awards up now. Come on. Now, who's the official

15 photographer with the good camera?

16 Okay, if you can see them.

17 MS. SAMMONS HACKETT: We can't see the main

18 camera. Where's the main photographer? Okay, if you

19 can't see Donna, Donna can't see you.

20 DR. THOMAS: Okay, here we go. This is the

21 one.

22 Okay, give them a hand, will you?

1 (Applause.)

2 DR. THOMAS: And don't worry, people, we'll
3 get caught up on time. But we have to acknowledge
4 and reward one another so that you can get back in
5 the fight when you get back home; am I right?

6 (Applause.)

7 DR. THOMAS: So yes, take the photos, post
8 them on your social media, and give us all an
9 opportunity to like your page and to retweet. We've
10 got to learn how to use all these things to get the
11 message out about the great work happening here in
12 the state of Maryland.

13 And so it's actually a real honor to
14 introduce our next speaker, who is going to talk
15 about how Maryland's Health Enterprise Zones are
16 building a culture of health, extremely important
17 that you've tapped into something that's occurring
18 across this country.

19 Dr. David Krol is a pediatrician, and he's
20 a Senior Program Officer for the Robert Wood Johnson
21 Foundation. He's focused on developing health and
22 healthcare leaders who will build and sustain a

1 culture of health. He is passionate about improving
2 the physical, mental, social health and well-being of
3 all infants, children, adolescents, and young adults.
4 Dr. Krol received his B.A. degree from the University
5 of Toledo. He was drafted by the Minnesota Twins,
6 and he played professional baseball for three years.
7 What a great game. It doesn't matter what team you
8 are rooting for, what a wonderful World Series.
9 Dr. Krol received his M.D. degree from Yale
10 University School of Medicine and completed his
11 residency in pediatrics at the Rainbow Babies and
12 Children's Hospital in Cleveland. And he received an
13 M.P.H. degree from the Mailman School of Public
14 Health. Dr. Krol has been a partner with the
15 Department in support of efforts to promote the
16 Health Enterprise Zone initiatives. This conference
17 is financially supported by the Robert Wood Johnson
18 Foundation through the support of Dr. Krol's efforts.
19 Please give him a hand as he comes to the
20 microphone.
21 (Applause.)
22 DR. KROL: Well, thank you, everybody.

1 It's a pleasure to have the opportunity to speak to
2 you today. So I grew up just outside of Cleveland,
3 so you probably perceived the sense of loss that I
4 have today.
5 (Laughter.)
6 DR. KROL: But as a big baseball fan and a
7 former professional baseball player, I recognize how
8 great that was for baseball. That's the big picture,
9 and what I'm going to focus on today is the big
10 picture.
11 So in 2014, the *Merriam-Webster Dictionary*
12 declared "culture" its word of the year because
13 people use it so broadly. It can mean art or music.
14 It can mean history and heritage. But basically, it
15 boils down to this: Culture is how we do things, how
16 we do things within our families, within our
17 communities, and within our workplaces, and how we do
18 things as a nation.
19 Now, as you may already know, the Robert
20 Wood Johnson Foundation, for over 40 years, has been
21 working to bring health and healthcare issues to the
22 forefront. So what's different now? Now, we're

1 focusing all of our efforts on building a culture of
2 health. So what is a culture of health and why do we
3 need one?
4 When we at the Robert Wood Johnson
5 Foundation talk about building a culture of health,
6 it means recognizing that health is an essential part
7 of everything that we do. Consider this: Culture
8 filters every aspect of our everyday life. It's what
9 we think and feel and care about. It's how we learn
10 and teach. It's how we relate to one another.
11 Now, picture if being healthy, as healthy
12 as you can be, was part of our everyday culture,
13 baked right into the very core of our existence in
14 these United States. What if claiming, reclaiming,
15 or sustaining health was a priority for everyone, no
16 matter how much you earn, where you live, what you
17 do, or where you come from. That's what we mean by a
18 culture of health, and we're striving to build a
19 national culture of health that will enable all of us
20 to live longer, healthier lives now and for
21 generations to come.
22 Now, my guess is that that sounds very

1 familiar to you all that have been working on the
2 Health Enterprise Zones for these past years. And
3 you're right; health means something different to all
4 of us. But we know one thing for sure: Being as
5 healthy as we can be helps us lead more productive,
6 prosperous lives, and that's something we all should
7 value.
8 Good health gives people the opportunity to
9 be their best, to fulfill their potential, and to
10 thrive in an environment that supports their goals
11 for themselves and their families. Good health fuels
12 our nation's economy. It helps make businesses more
13 competitive, today and tomorrow. Caring about health
14 helps build neighborhoods in cities with green space
15 and public transportation. It means reducing
16 violence, and it means making sure our kids can enter
17 school strong and ready to learn.
18 Over the past two years, the Foundation
19 developed an action framework that translates our big
20 vision for a culture of health into specific
21 measurable benchmarks and shows how everyone has a
22 role to play to help catalyze change on the ground.

1 It was designed to build on the energy and legacy of
2 those of you who have worked tirelessly in the health
3 and health equity arenas for years. It also opens
4 the door to new allies, especially those who haven't
5 realized their role in building a culture of health
6 until now.
7 That's why it's called a framework and not
8 a model. Rather than serve as a rigid blueprint, the
9 action framework invites individuals, organizations,
10 and communities to see how their goals and their
11 priorities align with the goals of others. The
12 action framework will guide our work and investments
13 for the next 20 years or more, and it's intended to
14 be a broader framework for the nation.
15 We will invest in creating communities
16 where health is a shared value. This means
17 positioning our nation's goals about health front and
18 center by increasing the demand for healthy places
19 and practices that benefit everyone.
20 We will support cross-sector collaboration
21 so that leaders from different fields and industries,
22 health systems, private businesses, local health

1 departments, community organizations, individuals,
2 government agencies, and other sectors like
3 transportation, housing, and urban planning will all
4 see opportunities for alignment.
5 We'll work to achieve healthier and more
6 equitable communities by addressing head on the
7 chronic environmental and policy conditions that hold
8 back too many Americans from living in good health.
9 We'll strengthen the health and healthcare systems,
10 which means balancing medical treatment with social
11 services, and increasing the coordination between
12 care, cost, and prevention.
13 Equity and opportunity are overarching
14 themes in this framework and in everything the Robert
15 Wood Johnson Foundation does, because to build a
16 culture of health in America, we cannot leave anyone
17 behind.
18 Now, I sense, again, many of you see your
19 work on the Health Enterprise Zones in this culture
20 of health, and so do I. At the Robert Wood Johnson
21 Foundation, we're stressing collaboration across
22 fields and industries and asking the organizations we

1 work with to find ways to work with new and perhaps
2 unlikely allies. One of the greatest strengths of
3 our foundation is our ability to create alliances
4 with strange bedfellows.
5 We're asking our partners and our allies to
6 do the same, and you have been. We want everyone to
7 break down silos, reach out to unconventional
8 partners who can help accelerate the movement and
9 build a greater sense of shared accountability. We'd
10 like you to think about who else you could be working
11 with to create real systems, real systems that last,
12 and real systems that are changing. Building a
13 culture of health means creating a society that gives
14 every person an opportunity to live the healthiest
15 life they can, whatever their ethnic, geographic,
16 racial, socioeconomic, or physical circumstances
17 happen to be.
18 We hope this framework and the culture of
19 health movement will spark a productive national
20 conversation about the physical, social, economic,
21 and emotional conditions that influence health. It's
22 a big task, but we know that when people in Maryland

1 and the rest of the United States put their minds to
2 it, we can accomplish anything. Of course, we need
3 your ingenuity, your innovation and inspiration to
4 make it happen. We need your deep connections to
5 your communities, your neighborhoods, and your
6 guidance on how to spread the word. It may take us a
7 generation to achieve, but we're committed to seeing
8 it through, and we hope you are as well.
9 The seeds of a culture of health have been
10 planted. Now we all just need to help them grow so
11 the health of everyone in America can rise to the
12 level that this great nation deserves.
13 Thank you very much.
14 (Applause.)
15 DR. THOMAS: Dr. Krol, can I get you to
16 help me?
17 DR. KROL: Sure.
18 DR. THOMAS: Could you come and help me for
19 a second? You know, RWJ is a big foundation. You
20 probably get a lot of phone calls, but one day you
21 got a phone call and you picked it up, and on the
22 other end of the line was Dr. Michelle Spencer. And

1 out of that came all of this. So I'm asking Dr. Krol
2 to help me thank Michelle.
3 You headed up here? Grab them, please.
4 Here they come.
5 Michelle, come on up here.
6 Give Michelle a hand, will you?
7 (Applause.)
8 DR. THOMAS: Where's our good photographer?
9 Thank you very much, Michelle.
10 (Laughter.)
11 DR. THOMAS: Every now and then the hope is
12 real and things happen.
13 And, Dr. Krol, thank you so much for
14 picking up the phone and recognizing on the other end
15 of that phone call you had somebody who could make a
16 difference and move the needle. And thank you so
17 much for making this possible.
18 So Marylanders, you've got to keep the
19 spotlight on what's happening here. And our next
20 panel is so important. What I'd like to have is our
21 next panel to begin making their way to the table as
22 I begin to set the stage.

1 This next session is titled New and
2 Emerging Opportunities in Maryland for Addressing the
3 Social Determinants of Health.
4 Michelle, do I have the right one?
5 Okay, we're just a little -- ooh, we're way
6 behind. And so now we will hear from David Weinman,
7 Senior Program Manager for the -- uh-oh, hold on.
8 So we're going to hear from David Mann,
9 epidemiologist at the Department of Health and Mental
10 Hygiene and the Office of Minority Health and Health
11 Disparities and a founding member of the State HEZ
12 Team, who will now moderate this session on the New
13 and Emerging Opportunities in Maryland for Addressing
14 Health Disparities.
15 Let me just say this in terms of Dr. Mann:
16 I've known Dr. Mann, and he and Dr. Hussein were like
17 tied at the hip, with Dr. Mann generating that kind
18 of unassailable data from an epidemiologist's point
19 of view, and Dr. Hussein literally translating that
20 data into the voices of the people that were
21 suffering. And together, that's how Maryland
22 positioned itself to be one of the state leaders in

1 using data to shape policy and to advance a better
2 state of health.
3 So if you would help me welcome Dr. Mann to
4 the microphone.
5 (Applause.)
6 DR. MANN: Well, I'm glad to be here, and I
7 might be the other person who it's a mistake to give
8 the microphone to, but I'm going to try to keep
9 myself really brief since we --
10 DR. THOMAS: We didn't give you any
11 PowerPoints.
12 DR. MANN: Well, I do have two slides, and
13 they're going to kind of quickly lay some groundwork
14 for, I think, the discussion we're hopefully going to
15 have from this panel.
16 And as an epidemiologist, I'm the data guy,
17 and although I'm not an economist, I play one on TV.
18 So I'm going to bring the kind of ruthless financial
19 perspective. So if we can go to the next slide,
20 please?
21 Because I've thought about so what are the
22 rationales of sustaining programs if HEZ wants to go

1 out and market itself, what's it going to be
2 marketing on? So there's two options I think.
3 There's a business case. If you produce a tangible
4 dollar return on investment, that's one kind of
5 marketing strategy, and it's important then to
6 realize that whoever reaps the return should make the
7 investment. So I think we're going to want to ask
8 ourselves, as we think about this, is the savings we
9 get from global budgets accruing to hospitals, or is
10 it accruing to the payers? Because whoever gets most
11 of that savings ought to be the ones investing into
12 HEZs and the similar social determinants programs.
13 If you don't have a tangible return on
14 investment, or if it's too far in the future to bring
15 that money in and actually pay for the program, then
16 you're in an altruism, philanthropy, or good public
17 funding kind of model. And so in that case,
18 sustainability truly requires some kind of a
19 perpetual subsidy.
20 So what's a good example of perpetual
21 subsidy? The Department of Defense we sustain with a
22 perpetual subsidy. It doesn't actually generate ROI.

1 It has value, but not ROI. Public television,
2 they're fundraising constantly, so that's their
3 sustainability model. So I think the big question is
4 are the insurers, the providers, or the regulators in
5 a position to provide support to HEZ components under
6 a non-ROI rationale? I don't know what the answer
7 is, but I think that's something we want to know as
8 we think about sustainability.
9 And the next slide.
10 So we slip into suppose you do have the ROI
11 rationale, how does that relate to global budgets?
12 And this relates a little bit to my earlier question
13 today. I think global budgets give us a different
14 concept of what the relevant cost is to be
15 discussing.
16 In the old fee-for-service, cost was the
17 price that was paid by a payer for services, and that
18 was very volume dependent. Under global budgets, the
19 cost that matters is the production costs that a
20 provider, a hospital, or as you move to the
21 outpatient system has to actually pay to produce the
22 service. And I think there's a different

1 relationship to volume. So fee-for-service was
2 tightly linked to volume. I think in global budgets,
3 the change in production costs may be uncoupled from
4 change in volume to a degree.
5 It's important not to confuse average costs
6 with marginal costs. I've heard people say that
7 average cost in hospitals is about half fixed cost
8 and half variable cost, but I think marginal cost is
9 a completely different discussion. If you think if
10 it costs $100,000 to do 100 MRIs, what's it cost to
11 do 101 MRIs? Probably the same $100,000. What's it
12 cost to do 99? Probably the same $100,000, because
13 you can't really add or subtract the operational cost
14 from one or more added at the margin.
15 I think that's important for understanding
16 do hospitals save money with small degrees of volume
17 reduction under global budgets, or is that really
18 accruing somewhere else? So who holds the savings?
19 Is it the hospitals, the payers, both, or neither?
20 And then are these savings real or just kind of
21 actuarial?
22 So we can value out things that have value,

1 but it's not money we can get our hands on and
2 transfer to another place. I think we have to be
3 very careful that we're talking about real savings
4 that we can then transfer into the social
5 determinants of health programs.
6 And so with that background and those
7 questions in mind, I'd like to turn to our panel to
8 give us some insights on their perspectives on all
9 this. And so our first speaker is going to be
10 Stephen Ports, who is the Director of our Center for
11 Engagement and Alignment at the Maryland Health
12 Services Cost Review Commission.
13 MR. PORTS: Well, test. Are we working
14 here? Check, check, check, check. Test, test. All
15 right, got it.
16 All right, well, thank you, Dr. Mann. It's
17 very good to be here today. And thanks for pulling
18 up the slides. You can go to the next slide.
19 If you haven't noticed, there -- oh, that
20 would be great, yeah. If you haven't noticed, there
21 are changes afoot. There are major changes in
22 healthcare delivery. From hearing some of the

1 activities that you all have been doing, you are in
2 the forefront of that. And Maryland is ahead of all
3 of the other states, I would say, in this delivery
4 system reform.
5 I think Dr. Krol had talked earlier about
6 the silos, and Maryland is really trying to break
7 down some of these silos. And the silos really have
8 multiple impacts. It's a payment silo that's been
9 created many years ago through an incremental payment
10 system, but it's also delivery silos that people
11 aren't talking. In the past, it was really a
12 provider-based system. We are moving toward a
13 patient-centered system, one where the patient is the
14 epicenter of care.
15 And in Maryland, one of the reasons why
16 Maryland is a little bit ahead of some of -- many of
17 the other states is because of the all-payer model.
18 Granted, it only involves regulation of hospitals,
19 but hospitals really influence about 75 percent of
20 all care that takes place in the system. Really 55
21 or 56 percent is the hospital care, but of course
22 most acute care, after folks leave the hospitals,

1 they also have influence over the physicians that
2 work at those hospitals. So this is a significant
3 change that we're working on.
4 What I thought I'd do today, briefly, as
5 briefly as I can, give a real brief background on the
6 all-payer system, how the system is doing so far in
7 its first three years, talk about global budgets, as
8 Dr. Mann had talk about, and then also some of the
9 things that you all are doing to help. And I do want
10 to say through these awards. I heard a lot of terms
11 like care coordination, like primary care, like
12 potentially avoidable utilization. Three years ago,
13 we never -- this group would have never been using
14 these terms. And I think, really, it's because of
15 the incentives in the system and with the movement
16 that the federal government is moving to as well.
17 So let me briefly just talk about the
18 all-payer system. The HSCRC, which I work for, is
19 the entity that kind of facilitates the all-payer
20 system. We regulate the rates that are paid for
21 hospital service, and we've done that for about 40
22 years, actually more than 40 years. But in 2014,

1 things changed significantly when we received a
2 waiver, an all-payer model demonstration project from
3 the federal government, from CMS.
4 And when I look around the room, there are
5 a lot of people that have heard this presentation
6 many times and who actually have boots on the ground
7 trying to implement some of the incentives in the
8 system.
9 And it really modernizes this Medicare
10 waiver that we used to have for years and moves it
11 away from one that was volume based, one that was
12 really around the per inpatient cost just for
13 Medicare, actually, to one that is really looking at
14 all payers, doesn't matter if you're a Medicare
15 patient, Medicaid, commercial, and it looks at it on
16 per capita basis. And this is the basis that brings
17 this patient-centered orientation that hospitals now
18 have the incentives to look outside of the hospital
19 and ensure that patients, when they leave, have what
20 they need to ensure that they don't come back and
21 that folks that are a rising risk that may be future
22 admissions, to help them so that they don't become

1 admissions in the first place.
2 Again, we oversee the regulation, been
3 doing that for quite some time. And there's huge
4 value in the system in that it includes the cost of
5 uncompensated care in the rates that we set. That
6 means that you don't have public hospitals like you
7 have in other states, and there's no reason for
8 hospitals to dump patients because they don't have
9 insurance or something like that, or based on acuity
10 of the service.
11 So, in 2014, what happened? The new all-
12 payer model created some requirements. One is that
13 the all-payer total cost of per capita revenue growth
14 cannot grow more than 3.58 percent in any given year.
15 It's a five-year project that we're working under,
16 and we're currently working on the next phase,
17 Phase 2 of the all-payer model, which kind of moves
18 away from the metrics I'm going to talk about right
19 now, which are more hospital based, and to ones that
20 are total cost of care based.
21 Medicare, of course, wants to ensure that
22 they see savings of at least $330 million for

1 Medicare patients in terms of the trend compared to
2 the nation. And we have a total cost of care
3 guardrail to ensure that costs don't pop out, if you
4 will, on the non-hospital side. But most important,
5 and I would say even more important are the
6 readmission requirements that you all are working so
7 hard to address, other potentially avoidable
8 utilization like preventable PPCs, potentially
9 preventable conditions, and things that happen in the
10 hospital to patients that aren't the normal course of
11 a disease, so complications, in essence. And many
12 other, there are many other quality provisions that
13 we have to look at.
14 So what's happened so far? So far, we've
15 done very well on the all-payer revenue growth test.
16 We've saved Medicare compared to the national trend
17 by reducing unnecessary and potentially avoidable
18 utilization. The quality metrics are on track, and
19 there's been much stakeholder participation.
20 Let's think about it in three buckets. One
21 is care delivery. The way we're looking at it is we
22 need to change the care delivery system, improve care

1 coordination activities. This is what we're told by
2 the workgroups. This is the first phase of doing
3 this.
4 The second is through health information
5 exchange. CRISP is the train that we are latching
6 onto, and I would suggest that if you're not engaged
7 with CRISP, that you get engaged with CRISP,
8 understand how you can use CRISP to show value for
9 the programs that you are implementing to your
10 community hospitals.
11 And then finally provider alignment. We
12 only set rates for hospitals. We want to make sure
13 that the other providers in the systems are incented
14 as well under the same system that hospitals are
15 incented under. So we are working actually on a care
16 redesign program that will allow for gain sharing and
17 some incentives for other providers for doing the
18 same things that hospitals are working toward.
19 So Dr. Mann talked about global budgets.
20 What is that? Before, all we set were the rates per
21 unit, and we had no control over how many units, in
22 other words how many admissions, would come to a

1 hospital. So it was very difficult to manage to that
2 3.58 percent growth, so we created voluntarily a
3 global budget structure, which said to hospitals we
4 are going to provide you with the revenue from your
5 previous year, which included very high readmissions,
6 included complications, and if you get those down,
7 you'll get the same amount of overall revenue, your
8 cost would be less, and therefore, money will drop to
9 the bottom line. And this is what Dr. Mann was
10 talking about: Money would drop to their bottom line
11 to invest in those strategies to continue reducing
12 readmissions and potentially avoidable utilizations.
13 And this has been a concept that CMS has
14 very much liked. They've used this, actually put
15 regulations in place in rural hospitals around the
16 nation to allow -- it's a safety net for hospitals,
17 but at the same time making sure that hospitals are
18 focused on the patient holistically.
19 So what does it mean to hospitals? It
20 means incentives to reduce potentially avoidable
21 utilization like readmissions, complications,
22 ambulatory-sensitive conditions, which many of you

1 are very focused on right now, but also to prevent
2 new admissions by spearheading some of the efforts
3 that are happening in the community. It also helps
4 payers by reducing utilization and providing some
5 predictability over cost growth.
6 So the other thing you asked us to do is to
7 talk about some of the regional partnerships and
8 things that have been encouraging. And again, I see
9 folks in the room who are involved with some of the
10 implementation grants and the regional programs that
11 we have been providing some support for. I do want
12 to remind you that in Fiscal '14 and '15, the
13 Commission included about $160 million in rates over
14 and above what normal inflation is to support care
15 transitions and care coordination activities. So
16 there were dollars in hospitals, and they are
17 permanent, meaning that they stay and are updated
18 every year to support things like 30- to 60-day
19 discharge -- or 30- to 60-day support programs after
20 someone leaves the hospital and other discharge
21 planning and providing medications upon discharge.
22 In addition to that, we also provided 2.5

1 million to get regions, hospitals and regions to plan
2 around patients, because in the past they've been
3 competitors. They've been financial competitors.
4 And today, we tell hospitals, yeah, we'd like you to
5 be competitors, but we'd like you to compete on
6 quality around the patient and not about just volume,
7 as they have in the past. And they are getting the
8 message, and we've had actually eight planning grants
9 that we've provided $2.5 million to.
10 And I know these are difficult to see, but
11 I'm running out of time, so I'm just going to go
12 through these very quickly.
13 The next program is where do we go? We
14 have these planning grants; now let's move towards an
15 implementation process. Let's provide some
16 additional dollars for systems, hospital
17 partnerships, regional partnerships, as well as
18 partnerships with community providers that are, I'm
19 going to call, next generation care coordination
20 activities, reaching out into the community and
21 working with providers to ensure that we are reducing
22 potentially avoidable utilization and providing best

1 care.

2 The Commission approved 9 of 22 proposals

3 in Round 1. As you can see, there's a partnership

4 here, a community health partnership with Hopkins,

5 MedStar Franklin Square, Harbor, Mercy, Sinai, in the

6 first round. And there's also an opportunity -- what

7 we required was going to be reporting, and we're

8 going to be providing public reporting on the status

9 of those. But also, we wanted to provide some

10 savings to payers, so we reduced the amount over

11 several years.

12 The second round is before our Commission

13 next week, and we are proposing to provide another

14 $6.5 million in rates for several hospitals, which

15 includes the West Baltimore Collaborative. I know

16 there's a group from West Baltimore that's here

17 today.

18 I'm going to have to skip through this very

19 quickly, but what I want to say is that when we --

20 and Dr. Haft could have presented this when he was

21 here, but what I want to say about this is we are

22 proposing by the end of this calendar year a model

1 for the next phase of this waiver, which would begin
2 in 2019. And part of that model is total cost of
3 care. Instead of just looking at the hospital side,
4 let's look at what's happening to patients
5 holistically everywhere, no matter who the provider
6 is. But as part of the model, we also are proposing
7 a primary care model, which is sort of like a PCMH, a
8 Primary Care Medical Home type model for individuals
9 that need -- with high needs. And Dr. Haft is
10 championing this and will be providing more details
11 in the coming months before we present that to CMS.
12 And I know Tricia will talk later about a
13 model for dual eligibles as well.
14 Last slide here. What can HEZs do to
15 participate in this system? As I mentioned before,
16 show data, get involved with CRISP, find out how --
17 what value CRISP has for you in terms of accessing
18 data and being able to show hospitals that you, the
19 boots on the ground can actually help reduce
20 potentially avoidable utilization. They have an
21 incentive now to -- they can't do everything at once.
22 And I know that Nicole's going to say that. And it

1 takes time. It does take time for these things to
2 achieve ROI. They are going to be interested in
3 those projects that achieve ROI on a fairly quick
4 turnaround basis because that's the way that the
5 system works.
6 And if there are folks that you are serving
7 that have -- that are working with and providing care
8 coordination activities that are chronically ill, and
9 particularly if they are Medicare patients, I would
10 think hospitals want to hear if you are having
11 success in care coordination and provider alignment
12 and addressing social determinants. I'm sure they'd
13 be interested to understand how that is working.
14 So with that, I will stop, and David can
15 introduce the next contestant.
16 (Applause.)
17 DR. MANN: Thanks, Steve. So while we're
18 swapping out slides, our next speaker will be Nicole
19 Dempsey Stallings, who is the Vice President of
20 Policy and Data Analytics at the Maryland Hospital
21 Association.
22 MS. STALLINGS: Great. Thank you. I have

1 to say, I'm humbled for two reasons. First, as I was
2 saying to Dr. Hussein, I participated in Dean Reece's
3 workgroup on maternity leave, and my son, Holden,
4 just entered kindergarten this year. So, for me,
5 you're talking about grandkids, I'm talking about
6 babies, and that's how it feels. The other thing
7 that I guess is a little depressing is Steve just
8 went through everything that's dominating my life
9 right now in about 15 minutes, and that's a little
10 depressing.
11 So when I knew who I was going to be
12 presenting with and the topics that would be covered
13 in my role as an advocate for Maryland's hospitals, I
14 thought that I would start by talking about social
15 determinants and how they impact payment policies for
16 Maryland hospitals, because we all know that health
17 is more than clinical care. We all know that living
18 in a severely disadvantaged neighborhood is a higher
19 predictor of a re-hospitalization in the presence of
20 an illness. We all know that nationally, safety net
21 hospitals are penalized more frequently for
22 re-hospitalization programs.

1 But then I thought, rather than talk about
2 how those payment programs need to account for social
3 determinants and tell the State what I thought and
4 what Maryland's hospitals thought they could do
5 better, I would instead be really candid and honest
6 with you all and talk about where Maryland's
7 hospitals can do a better job. And that is around
8 diversity and disparities.
9 So this is a report that came out in 2013
10 from the Health Research and Education Trust of the
11 American Hospital Association. This group and Health
12 Enterprise Zones really founded understanding about
13 healthcare disparities. But for diversity, what
14 we're really talking about is do your leaders reflect
15 the communities that you serve?
16 And the report found that while hospitals
17 were actively collecting data, that only 22 percent
18 of those hospitals were using it to identify
19 disparities and to treat outcomes. We found that
20 while 86 percent of hospitals were educating around
21 cultural competency at orientation, a much smaller
22 percent were actually having that ongoing training

1 with their staff. And we found that while minorities
2 represent 31 percent of patients nationally, when you
3 see the numbers, 14 percent represented on our
4 boards, 12 percent in executive leadership positions,
5 and 17 percent in first- and mid-level management.
6 The NAACP, in 2015, came out with their
7 Opportunity and Diversity Report Card, and I know
8 this is difficult to see, but they graded Maryland --
9 or excuse me, national hospitals that were part of
10 these large systems, Ascension, Catholic Health, et
11 cetera, and you can see the grades on there. So if
12 Holden is coming home with those kinds of grades,
13 we're going to have a conversation. And we realized
14 that we needed to have a conversation with all of our
15 hospitals.
16 So a few excerpts from that report. "In
17 study after study, we see that although some of these
18 less-skilled positions are highly diverse, the middle
19 and upper reaches of management and the so-called
20 C-suite of corporate governance remain almost
21 exclusively the domain of white men.
22 "It is paradoxical that an industry more

1 aware of the concrete benefits of diversity than most
2 industries has been unable to achieve it."
3 "The monitoring of procurement diversity is
4 lacking or at best rudimentary, and reflects a blind
5 spot that is more pronounced in the healthcare
6 industry than any other industry the NAACP has
7 surveyed to date."
8 We call this holding up a mirror. And
9 that's what we needed to do.
10 These five organizations came together
11 around a national call to eliminate healthcare
12 disparities. It was founded on the commitment that
13 equitable care for all patients is not just the right
14 thing to do but is central to the ongoing quality
15 improvement work that our hospitals are committed to
16 and part of a business imperative.
17 And this is the basis of the Equity of Care
18 campaign that came together to focus on three core
19 areas: increasing the collection and use of race,
20 ethnicity, and language preference data; increasing
21 cultural competency training; and increasing
22 diversity in governance and leadership.

1 We asked the Maryland Hospital Association
2 and hospital associations across the country, asked
3 hospitals to sign the pledge to do four things in
4 four months. In the first month, choose a quality
5 measure and stratify it by race, ethnicity, and
6 language preference. By the second month, determine
7 if there was a disparity, and if so, implement a plan
8 to address the gap. By the third month, provide
9 cultural competency training for all staff. And by
10 the fourth month, to have a dialogue with the
11 hospital board and leadership team.
12 I'm pleased to tell you that Maryland's
13 hospitals have universally committed to this
14 initiative. We are the only state in the nation that
15 has 100 percent of all of our community hospitals
16 that have signed up for this initiative.
17 (Applause.)
18 MS. STALLINGS: Thank you. So where do we
19 go next? Now, it's all about continuing to hold that
20 mirror up, it's continuing to put data back in front
21 of our hospitals, it's to collect stories, it's to
22 convene in gatherings like this and share resources

1 and tools and struggles. This is the tip of the
2 iceberg. We know that we have more work to do. But
3 if we are asking our community partners to help us in
4 this work, we have to make sure that we are holding
5 ourselves to the same standard within our governance.
6 Thank you.
7 (Applause.)
8 DR. MANN: Okay, and our final speaker is
9 going to be Tricia Roddy, who is the Director of the
10 Office of Planning in the Maryland Medicaid Program.
11 MS. RODDY: Good afternoon, everyone. I'm
12 here today to talk about what we're doing -- walked
13 in right when the pediatrician -- happy to talk more
14 about --
15 DR. THOMAS: Let me have you bring the mic
16 a little closer to you. And just get it real close.
17 There you go.
18 MS. RODDY: -- can you hear?
19 DR. THOMAS: There you go.
20 UNIDENTIFIED SPEAKER: Is it on?
21 DR. THOMAS: It's on.
22 MS. RODDY: Sorry about that. So again,

1 I'm going to give you a background on the dual
2 eligibles and why we think it's a critical piece in
3 all the state healthcare reform activities that are
4 going on in Maryland, talk about the guiding
5 principles in the integration with the all-payer
6 progression strategy, give you a highlight of our
7 proposed model, and then open it up for questions
8 obviously at the end.
9 Again, so just to give you some background
10 on what kind of prompted us to look at the dual
11 eligibles and where some of our funding is coming
12 from, the Center for Medicare and Medicaid
13 Innovations gave Maryland a $2.5 million design grant
14 to help us complement all the activities that were
15 already happening in Maryland. They were very, very
16 clear to us that it had to be in partnership with the
17 HSCRC and all the work that they were already engaged
18 in, with the ultimate goal of moving beyond hospital
19 expenditures and looking at per capita costs.
20 So how are we spending that $2.5 millions?
21 We highlighted a couple of areas. We wanted to focus
22 on developing a dual eligible model. We wanted to

1 spend some money and figure out how we could connect
2 the skilled nursing facilities with our health
3 information exchange. There's been a lot of work on
4 the hospital side in the health information exchange,
5 and there's been some work on the ambulatory side,
6 but it's pretty much been silent on the skilled
7 nursing side. And obviously, to control total costs,
8 you really have to have that component connected to
9 the HIE. And our counterparts in the public health
10 program have been working on the public population
11 health planning activities.
12 And again, just to emphasize again, they
13 have been very clear over and over to us that
14 everything we do can't be separate and apart from all
15 the other work that's happening.
16 So why are the dual eligibles important to
17 us in this discussion around healthcare reform and
18 what's happening at the all-payer model? You know,
19 first of all, we serve about 1.3 million residents in
20 the Medicaid program today. Over 84 percent of our
21 population is already enrolled in managed care. And
22 the people that are outside of our managed care

1 program are those that are eligible as well as for
2 Medicare, so they're dual eligibles, they are
3 individuals who are 65 and older, and there's a few
4 other populations. But that's generally the main
5 cohorts that are served outside of our managed care
6 program. We have a very mature managed care program.
7 It's been operating since 1997.
8 So for the dual eligibles, what we're
9 talking about is there are 73,000 individuals. We
10 have excluded the individuals who have developed
11 mental disabilities from this discussion for the time
12 being. At some point, they will be integrated into
13 the discussions and the planning activities.
14 The average age of a dual eligible is 66
15 years old. Again, you know, characteristically
16 they're aged, blind, or disabled. They have a wide
17 range of needs. Some of them are, you know, in the
18 nursing facility, some are in the home and community
19 based settings, and some are receiving long-term care
20 supports and services that are helping them stay in
21 their home, and then there's a cohort that's just
22 living on their own in the community.

1 So to give you -- I don't know if you can
2 see this. I'll actually have to turn my page to
3 actually see it. Again, just to emphasize, you know,
4 the type of individuals that we're serving that are
5 called dual eligibles, again they have a wide range
6 of needs. You know, some of them are costing almost
7 8,500 per member per month, and then there are some
8 that are about $1,600 per member per month. So
9 again, there's a wide range of needs within this
10 group. Some of them are seriously mentally ill.
11 Some of them are, you know, 80 years old, in a
12 nursing home, to give you an example.
13 Again, why we think it's so important for
14 the discussions that are happening at the all-payer
15 focus is when we -- as you heard before, they are
16 focusing on Medicare. A lot of it is focused on
17 Medicare. And we think it's really important to
18 connect the services that those individuals are
19 getting on the Medicaid side so that it's not just
20 talking about the Medicare services. And if you can
21 see here, it's roughly -- the Medicaid side for dual
22 eligibles is about 51 percent of the total costs for

1 these individuals.
2 So again, in order to really manage the
3 Medicare population for the dual eligibles, you
4 really have to see both sides of the pie and connect
5 those two systems.
6 So we have been working with a stakeholder
7 group since last February. And we laid out many,
8 many different options. We talked about a capitated
9 managed care program. We talked about a fee-for-
10 service kind of primary care model, as well as what's
11 called a dual eligible accountable care organization.
12 And we really kind of landed on a dual eligible
13 accountable care organization as well as a managed
14 fee-for-service program.
15 We had guiding principles. We wanted to
16 make sure that we were coordinating care for the
17 dually eligibles. We wanted to make sure that we
18 were utilizing CRISP and other health IT tools
19 throughout the state. Again, when we are talking
20 about total cost of care, we're not just talking
21 about the Medicare side of things; we're talking
22 about the Medicaid as well in that. And we were

1 talking about the whole person, patient-centered
2 care, again, value-based payment. And then we wanted
3 to make sure that we were working alongside the
4 all-payer model.
5 You know, there's a lot of things that are
6 happening with the HSCRC, with Dr. Haft's primary
7 care model. So this kind of gives you a flavor, this
8 slide, and I'll just touch about it really quickly.
9 Some of the different models that are
10 emerging from our discussions, there's this dual-
11 based ACO that I'm talking about for the dually
12 eligible. There's the primary care model. There's
13 regional partnerships. There's some of the amendment
14 programs that the hospitals and HSCRC are working
15 through that will be incentivizing community-based
16 providers as well as specialists. And then there's
17 the existing Medicare ACOs that are already out there
18 in the community. And there's common features
19 throughout these models that we want to promote:
20 MACRA, population health, care coordination,
21 person-centered health home, and data and analytics.
22 It's really important to all these models.

1 So where we've kind of landed is that we
2 would like to pilot the dual ACO in two regions,
3 Baltimore City, Baltimore County, and then Montgomery
4 County and Prince George's County would be the two
5 areas. And again, our stakeholders felt it was
6 important to not move to a managed capitated program.
7 They really wanted a dual ACO program. And, you
8 know, we were a little bit concerned about reaching
9 out to all parts of the state, and we thought that
10 these two areas made sense in terms of getting the
11 number of lives that would be -- that would make
12 sense in order to develop an ACO in those regions.
13 So if you're falling outside those regions,
14 we're hoping and working with Dr. Haft's primary care
15 program to make sure that there is some coordination
16 for the duals in those areas. So in the two pilots
17 that we're talking about, we're really talking about
18 linking the long-term care side of the shop with the
19 acute care side of the shop, which is really, really
20 important.
21 So again, some of our goals: We want to
22 move back to -- we want to basically make sure, which

1 doesn't exist today, is that the patient has a
2 designated provider that's going to be coordinating
3 all of their care across these two settings, that
4 there's seamless coordination, that there's an
5 incentive to actually coordinate care, and that they
6 have the data and tools available for them to
7 actually manage these two separate systems that exist
8 today.
9 Again, you know, similar to what Dr. Haft
10 is developing, we want to make sure that there's a
11 primary care medical home. What might be a little
12 bit different with our program, and what the
13 stakeholders are asking for is it might not be a
14 primary -- what's typically a primary care provider
15 or even a specialist. They might want to reach out
16 to behavioral health providers or even the nursing
17 home to be that quarterback that's going to be
18 managing and coordinating their care.
19 And this one just depicts that it's really,
20 again, a patient-centered approach that we're
21 coordinating all these different disparate services
22 and programs and putting them all in one place for

1 the individual and the providers.

2 Timeline in the discussion: We are trying
3 to coordinate the timing for this program to be
4 launched when the next phase of the waiver takes
5 place in 2019. We have lots of work still ahead of
6 us. You know, we envision we're going to be
7 submitting a concept paper to CMMI at the end of
8 December, but we really, really know that we need to
9 spend the next year really planning this out and
10 getting the details behind the program. So we'll be
11 working with stakeholders again throughout all next
12 calendar year on this. We'll be, probably in 2018,
13 looking for waivers and just special permissions to
14 operate the program from the federal government, and
15 then with the goal to really launch this program in
16 2019.

17 We're all really, really excited about it.
18 I think there's tremendous opportunity to pilot,
19 again, two really disparate programs and actually put
20 all the investments that we've made in the long-term
21 care system and connect it to the acute care system
22 so that when a patient shows up in the hospital,

1 instead of just developing a care plan, that you
2 actually get an alert that says, oh, this person
3 already has a care manager and they're receiving all
4 of these services, and you need to contact X, Y,
5 and Z and make sure that you are coordinating those
6 two systems. So we do, we think there's tremendous
7 opportunity here, and we're really excited to work
8 with you all on this program.
9 And, you know, I was asked, you know, how
10 can the Health Enterprise Zones kind of connect with
11 the work that we're doing? And I think real simply,
12 I mean, we're not here to recreate anything that's
13 already developed. We want to leverage the
14 infrastructure that you guys are already building in
15 the communities. We're interested in putting new
16 dollars into the program, both on the Medicaid side
17 as well as the Medicare side, but we don't want to
18 pay twice. You know, if the systems already exist,
19 we want to make the ACOs connect with those systems
20 and make sure that they're leveraging all the good
21 work that you guys have already been working on.
22 So with that --

1 (Applause.)

2 DR. MANN: So I'll ask if we have time for

3 questions, or are we trying to catch up on the

4 schedule a bit, or what's the plan?

5 DR. THOMAS: Yeah, we are trying to catch

6 up on the schedule a bit, but there may be a burning

7 question. Yeah, please, grab that microphone. Real

8 loud.

9 MS. WILLIAMS: Yeah, thank you. And this

10 is for Tricia since I didn't get to ask you this the

11 last time I saw you. So how do the MCOs play into

12 the duals model, right? Many of these patients are

13 in MCOs today. How does this work?

14 MS. RODDY: So yes, they're completely

15 outside of our managed care organizations, so they're

16 not --

17 MS. WILLIAMS: But they're in managed

18 care --

19 MS. RODDY: Does not apply, right. Yeah,

20 it's --

21 DR. THOMAS: Yes, question? Introduce

22 yourself, please.

1 MS. SHINE: My name is Tomiko. I'm a
2 research anthropologist, and I volunteer with the
3 RAPP Campaign. We advocate for the release of
4 elderly people in prison. These are folks that have
5 been in 30, 40, 50 years. And we're here in
6 Baltimore, Maryland.
7 But my question to you is, like, what
8 happens a lot when our folks first come out after
9 being in 30, 40, 50 years, it's just like a total
10 disconnect, and a lot of them go straight to, of
11 course, Medicaid, the social agencies. But because
12 they're in such dire health when they come out, they
13 need surgeries, some of them have cancer, and there
14 seems to be a disconnect when they talk to the
15 Medicaid person as far as where they go for the
16 specialists, for surgery, and then you have Medicare.
17 And so I'm wondering, in your working groups, do you
18 have in there where you're beginning to talk about
19 these folks that are coming out after all this time
20 in prison?
21 MS. RODDY: So we do have an initiative
22 that's going on right now that's addressing everyone

1 that's coming out of prisons. We're doing what's
2 called a presumptive eligibility determination to get
3 them directly into the Medicaid program before they
4 leave prisons and jails, and we're hoping to get
5 special permission from the federal government to
6 enact that by next July.
7 But you're touching upon exactly why it's
8 so important to focus on the dual eligibles, because
9 they are in our fee-for-service program. They don't
10 have a contact. And so what we're hoping with a dual
11 ACO is that we can provide you with a person that can
12 help you -- help them navigate the system. But
13 you're right; we don't have a contact today.
14 DR. THOMAS: Last question, and then we're
15 going to open this up after we get through our next
16 speaker. Quickly, yes?
17 DR. CZAPP: Hi, Pat Czapp. You've heard
18 from me before. Tricia, quick question: Will the
19 duals ACO take downside risk?
20 MS. RODDY: We are talking about downside
21 risk.
22 DR. THOMAS: Explain for those of us not in

1 that field what downside risk means. You can do it.
2 MS. RODDY: Yeah, it just means that if
3 they don't hit certain cost metrics, that there is
4 some risk, financial risk that these dual ACOs will
5 have to be accountable for.
6 We are, again, not talking about a managed
7 capitated program where they're at risk for all the
8 services that are provided; we're talking about
9 probably the level of risk that's being discussed to
10 comply with MACRA and alternative payment models. So
11 we're talking about maybe 5 percent risk for
12 services, but not the entire Medicaid expenditures or
13 Medicare expenditures.
14 DR. THOMAS: Dr. Mann, can you close this
15 out here?
16 DR. MANN: Yes. I think if I'm an HEZ
17 shopping around for sustainability dollars, it sounds
18 like HSCRC basically can make money available to
19 hospitals but probably not to anybody else, so I've
20 got to shop at the hospital for any funding from that
21 perspective. It sounds like the Medicaid program,
22 the place to shop is probably at the MCO level,

1 because they are the ones who have been kind of
2 capitated for the patient care, and so that's who the
3 HEZs would want to talk to, to see if the Medicaid
4 system could help sustain their operations.
5 I guess the final thought is, and I haven't
6 quite gotten my clear answer to this yet, do
7 hospitals feel like global budgets have given them
8 some discretionary income or discretionary funding
9 left that they could then invest in something like an
10 HEZ?
11 MS. STALLING: So I think we heard Tori
12 Bayless answer that question a little earlier in
13 terms of this is difficult. There are a lot of
14 initiatives right now that are going on that are
15 producing savings under a global budget: accountable
16 care organizations, investments in primary care,
17 quality improvement programs, et cetera. And so the
18 challenge will be to demonstrate that ROI, and that's
19 why it's so important to collect the data and to
20 really be able to show how you are helping support
21 the hospital's goals.
22 But it's a challenge because there's so

1 much. It's a great thing. It's a good problem to
2 have. There's a lot of innovation going on right
3 now, a lot of collaboration, so it's hard to have
4 that one-to-one.
5 DR. THOMAS: Let's give this panel a hand.
6 (Applause.)
7 DR. THOMAS: Thank you, Dr. Mann. What a
8 wonderful panel of experts that you have in front of
9 you. And this is obviously not easy, but progress
10 comes by embracing the challenge.
11 Well, now we're going to hear from David
12 Weinman, who is the Senior Program Manager for
13 Organizational Operations at the Camden Coalition of
14 Healthcare Providers, a coalition of Camden
15 healthcare providers, community partners, and
16 advocates committed to elevating the health of
17 patients facing the most complex medical and social
18 challenges. The Camden Coalition has over a decade
19 of experience innovating and testing healthcare
20 delivery models to improve patient outcomes and
21 reduce the cost of care using data-driven,
22 human-centered practices. Mr. Weinman will share

1 their sustainability strategies, successes, and
2 lessons learned. Please welcome Dr. Weinman to the
3 microphone.
4 (Applause.)
5 MR. WEINMAN: Good afternoon. Can you all
6 hear me okay?
7 One point of clarification, and I think
8 this will become clear as we go about -- I'm not
9 actually a doctor. Before I started working at the
10 Camden Coalition, I had zero experience in the
11 healthcare industry. But I think that ties in a
12 little bit to what methods we're using to achieve
13 sustainability with the Coalition.
14 I'm going to talk a little bit about -- and
15 you might see this --
16 DR. THOMAS: You might want to just -- you
17 might pick that up and pull it closer to you.
18 MS. RODDY: Pick it up?
19 DR. THOMAS: There you go.
20 MR. WEINMAN: Thank you. The title of this
21 is our Super-Utilizer Interventions, and we call it
22 our operational journey because really what it does

1 is it goes over our timeline of growth as an
2 organization, how it grew from a fairly new and young
3 nonprofit that was working the way that a lot of
4 nonprofits work, where everybody would just run to a
5 problem and run to a problem, and we didn't really
6 have any organization across the organization.
7 And so we talk about how we put business
8 systems in place to structure ourselves and get the
9 results that we need so that we can take our findings
10 and our results out to the public and to potential
11 funders to talk about what we're going to do in the
12 future.
13 A little bit more about our organization.
14 We are the Camden Coalition of Healthcare Providers.
15 We have our mission and vision up there. We've grown
16 quite a bit over the past few years. We now have 85
17 full-time staff. When I started at the Coalition two
18 years ago, a little over two years ago, I think I was
19 employee number 36. So give you a sense that we tend
20 to double every couple years. We're probably going
21 to be close to 100 people by the end of 2016 or early
22 2017.

1 So with that fast growth, we've obviously
2 gone through quite a bit of growing pains, and we do
3 a lot of work to talk to people across the country so
4 that they can learn from our mistakes and hopefully
5 not repeat them.
6 And I'll talk a little bit about our
7 background and what we were doing. You may have
8 heard of our Founder and Executive Director,
9 Dr. Jeffrey Brenner. An article that came out in *The*
10 *New Yorker* called "The Hot Spotters" kind of burst
11 him onto the scene with quite a bit of fame and
12 attention. With that attention, more and more people
13 wanted to do stories on us and to talk about us. And
14 so Dr. Brenner's a great speaker, and he does amazing
15 work, and so we had story after story published on
16 the Coalition and all the great work that Dr. Brenner
17 had set up and that we were doing.
18 However, the only problem with that is it
19 didn't necessarily reflect reality. We had gotten
20 this great reputation as this shining organization
21 and this leader in innovative healthcare and
22 providing help for high hospital utilizers, but in

1 reality it looked a little bit more like the slide on
2 the right. We were still figuring it out as we went
3 along.
4 What we did is we went and got patients the
5 way we knew how. We'd go talk to nurses on the
6 hospital floor, say who are the people that you see
7 here a lot, you know, and then we'd go to their homes
8 and spend hours with them finding out what it was
9 that was keeping them getting readmitted into the
10 hospital. We didn't really have a process. We were
11 just kind of figuring it out as we went. And then
12 the outcome was we think we helped them improved
13 their quality of life, we think we had decreased
14 their utilization of the healthcare system, but we
15 really didn't know whether what we were doing was
16 working.
17 But along with that kind of fame and
18 notoriety we achieved, a lot of people were
19 interested in our work, and so we got quite a bit of
20 different funding sources mixed from government
21 funding and private funding as well. And with that
22 new demand, we needed new structures because we had

1 now accountability to all these people that were
2 funding our work.
3 And so I want to show you a little bit
4 about what we're doing now. I took out, to shorten
5 the presentation, a couple other of the humorous
6 slides, but it showed a cat with a ball of yarn but
7 still covered in yarn itself. We're figuring it out,
8 and we're a lot better than we were two years ago,
9 but we're still very much figuring this out as we go.
10 But some of the things that we've had the
11 most success with are defining ourselves and the
12 problems we solve, improving project and program
13 management, defining and tracking our efforts,
14 aligning and motivating our staff, and then planning
15 for our sustainability.
16 I talked a minute ago about how our
17 original interaction and our intervention with
18 patients was just to go into their homes and spend
19 time with them, get to know them, find out what it
20 was that was causing their high utilization. And we
21 realized that we couldn't just do it on a one-off
22 patient because that wasn't repeatable, which means

1 it wasn't sustainable.
2 If we couldn't do it over and over again,
3 you know, we were just recreating the wheel every
4 time we met a new patient. And with such a complex
5 population, that's obviously very challenging to do,
6 because, you know, if you're figuring out someone's
7 social determinants and everything each time, it's
8 going to be hard to do it on a case-by-case basis and
9 will never be able to scale.
10 So what we built is a coach framework. One
11 of my colleagues built this framework, and it's what
12 we go through with each patient. We go and observe
13 how they're living their life. You know, the way we
14 say it is if you went to someone's house and they
15 offered to cook you dinner, you wouldn't go over to
16 their house and start telling them they were doing
17 everything wrong, like no, that pot should go over
18 there, you should have the soup in there. You'd look
19 at how they were doing it and you'd enjoy the meal,
20 and then maybe talk about it afterwards.
21 But then we take on a coaching style with
22 these patients. We talk a lot about motivational

1 interviewing, find out what's important to the
2 patients, what are the pain points in their lives,
3 what are the problems that they're trying to solve,
4 and then work with them to make sure that we're
5 addressing what they want to work on and not what
6 we're dictating to them that they need to work on.
7 And then highlighting progress with data:
8 We go through an I-do/we-do/you-do approach. And so
9 when we're helping people set follow-ups with their
10 primary care, you know, show them how, like here's
11 what you do if you're on hold and waiting to get an
12 appointment. And, you know, then the next time you
13 get on the phone with them, if they start getting
14 frustrated with being on hold or not being able to
15 get their appointment, just work with them through it
16 and then have them do it on their own. So we're
17 teaching them these skills of how to interact with
18 the health system, something that's typically been
19 very frustrating to them in the past.
20 And we standardize our workflows. This is
21 where people like me that don't come from the health
22 sector were able to help. We realized, you know,

1 people were just like, well, this is just what we do.
2 We had all the knowledge in these people's heads, but
3 they couldn't really describe what they were doing
4 over and over again. And as you can see, we've got a
5 really long process, but it puts out something that
6 we can now repeat over and over again. We at least
7 know what are all our inputs, what are all the people
8 that we connect with along the way, and, you know, if
9 this happens, do we need to loop back and try again
10 so that we're not moving on if we haven't achieved
11 the result that we're looking for.
12 Protocolizing our work, and again, this
13 shows something that we -- a project that we did with
14 a site called Aunt Bertha that we're really just
15 getting off the ground that really standardized all
16 of the community resources that we put forth for our
17 patients that we work with so that it's not every
18 time running around like I have this patient who
19 needs a bus pass because they're having trouble
20 getting to their primary care appointments, who do I
21 go to? Oh, I think Jim on the eighth floor knows
22 where that is, maybe go talk to him. We've got a

1 database now where you can go to and find all these
2 resources and get in contact with them, or even
3 better, put the patient in contact with them
4 directly.
5 Solving the right problems: This is our
6 fun whack-a-mole slide because, again, we didn't
7 really -- it took us some time to figure out what it
8 is we were trying to do. We have a very exploratory
9 culture. We have people who like to think big and
10 dream big, and I call it chasing balloons because
11 it's like a kid running after a balloon, and he gets
12 it and he's like, oh, this is great, I'm going to do
13 such great things with this balloon, and then they
14 see another balloon in a different color, let that
15 one go, and run and get the other one.
16 But we had to focus and realize that we are
17 a small, a fairly small nonprofit, now growing to a
18 mid-size nonprofit, and we only had so many resources
19 that could work on so many things. So we had to
20 prioritize what projects we were working on.
21 Project and program management. Again,
22 this is -- we now have a different balance of M.B.A.s

1 in our organization than most nonprofits have. And
2 as you can imagine, working with nurses and social
3 workers and community health workers and health
4 coaches, we weren't very welcome in the beginning
5 because, you know, they want to be out in the field
6 and working with patients and helping to make people
7 better. And I'm trying to protocolize these systems
8 with them and be like, well, if we do this now, it's
9 going to make your life much easier down the line, I
10 promise.
11 So what we did is we kind of paired up. We
12 started having dyadic relationships on all our teams.
13 The lady writing on the white board here is one of
14 our nurses. She's a director on our care teams. And
15 the guy to her left is one of my counterparts. He's
16 a senior manager who also works in an operational
17 role. And so we harnessed that power of, you know,
18 someone who knows the care and really wants to get
19 out there and help with someone who makes sure that
20 the help is effective and that it's not just running
21 and chasing balloons or, as the slide showed, playing
22 whack-a-mole.

1 We also learned to fail fast, is what we
2 say. We started using the lean startup approach,
3 where we go and don't -- we always say don't let
4 perfection get in the way of progress. And so we
5 would -- you know, again, we have a lot of scientists
6 that work for us, a lot of doctors that work for us,
7 people that want to build something perfect in order
8 to stand it up, and we have to teach people to just
9 put enough together to make it work and then slowly
10 build and build and live a continuous cycle of
11 improvement.
12 Finding digital processes and efficiencies
13 after analog iteration: This is, again, to the same
14 point. We do have, we have several databases that we
15 use now that help track and streamline our work, but
16 we started all of this on white boards. You know, we
17 didn't let the lack of technology keep us from
18 innovating on our processes. You can't say I want to
19 go out and do things this way. Well, first, we need
20 a million dollars to go buy a database system and
21 user licensing and training, and so three years from
22 now we'll get to it. We started on post-it paper and

1 white boards, and then once we found a system that
2 worked for us, we then went out and looked for the
3 systems, the digital systems that would better help
4 us achieve our work within those processes.
5 And so, again, this is just another one
6 of -- I love workflows, so I'm going to put as many
7 of them in as I can.
8 Assigning all projects to owners: We use
9 what we call a RACI, a responsible, accountable,
10 consulted, and informed approach. And so I go around
11 and I work with all the different departments on
12 their project lists, and each of these bulleted items
13 here is a project that they're working on. And what
14 this helps us do is understand our capacity as an
15 organization so that we're not trying to do too much.
16 So if I go sit down with Renee and Andrew
17 and say talk to me about your projects, they're just
18 like we have too many of them, and they'll show me
19 500 projects, all of them that are moved this far.
20 And I say, well, if you just focused on these one or
21 two projects, because that's what you have the
22 bandwidth to handle, you can push those to being

1 closed, and then you've improved that part of our
2 care operation, and that will be running successfully
3 and you don't have to think about it anymore; then
4 you can move on to the next process.
5 So we're really trying to bring business
6 best practices into our clinical environment to help
7 focus our efforts, knowing that money is finite.
8 We're a nonprofit organization. We can't just keep
9 growing and expanding and adding more resources. We
10 need to find efficiencies in the things that we're
11 doing.
12 Defining and tracking our efforts: I know
13 we've talked about being able to show the results of
14 the work that you're doing because that's a big part
15 of finding continued funding. And holding onto your
16 sustainability as an organization is showing that
17 what you're doing is working. And again, before we
18 just knew -- we could see subjectively that we had
19 helped someone, and we could see that their health
20 had improved, but we didn't have any -- we couldn't
21 show causality, we couldn't show, you know, that it
22 wasn't just regression to the mean and they were

1 going to get better and have lower utilization
2 numbers with or without the Camden Coalition.
3 So what we did is we actually -- we have a
4 huge data team. So on top of the business
5 perspective, we also have a very large data and
6 statistics team that tracks all of our patients,
7 tracks where we get them from, what their utilization
8 was before we started working with them in our
9 interventions, and then what it is during the
10 intervention, if it goes down, and then we also do
11 follow-ups with them, as well, to see how their
12 utilization is going afterwards. And it's helping us
13 build an evidence base that our intervention is
14 working, and it also helps us highlight things that
15 may or may not be working.
16 Tools to drive our work: Again, four or
17 five years ago, the idea of scorecards and dashboards
18 would have been absolutely alien, and you would have
19 been chased out with torches and pitchforks. But
20 now, when people can see, you know, they can actually
21 see the progress of what they're doing and the impact
22 of the work that they're having and they can see

1 their numbers moving -- like we track how many of our
2 patients get reconnected to their primary care doctor
3 within seven days after being discharged from the
4 hospital. And when you can actually see those
5 numbers moving, it really builds morale in the
6 workforce, and people say, oh, I'm actually making an
7 effect, and you know, if I do these processes more
8 efficiently, I can reach more people with this very
9 effective intervention.
10 But again, to my point earlier, this is
11 where we started. We probably are the largest
12 consumer of post-it notes in the state of New Jersey.
13 (Laughter.)
14 MR. WEINMAN: Most of our meetings, I start
15 to get a lot of anxiety when I see someone walk in
16 carrying a stack of post-it notes that high, because
17 by the end of that meeting, I know they're going to
18 be stuck up all over the wall, and I'm wondering how
19 anybody is going to document what the heck we just
20 talked about. But the point of the story is don't be
21 afraid to go analog. Don't let the lack of systems
22 keep you from measuring your data and looking at the

1 information that you need to look at to make your
2 processes and your workflows more effective. And
3 again, obviously what that does is helps us evaluate
4 our progress.
5 With these tools, we've built dashboards
6 across the teams that help us see what our
7 readmission rates look like, what our ED utilization
8 looks like, and how they are affected based on the
9 timing of our intervention.
10 And this is key one, I think. We expanded
11 our evaluation beyond our clinical programs. I've
12 mentioned that we brought on data teams. We have a
13 lot of operational people and business people in the
14 organization. Our first focus was obviously to apply
15 our data practices to the care teams themselves
16 because that was most important, if we were
17 effectively deploying and utilizing our care teams
18 and making an impact on the lives of the patients
19 that we were working with. But we also wanted to
20 make sure that we were effectively using these
21 support systems that we had put in place as well.
22 And so we're still in the process of

1 building key performance indicators across all teams
2 of our organization, again to make sure that -- money
3 doesn't grow on trees in the nonprofit world -- make
4 sure that we're using our resources effectively so
5 that we can continue to provide the services that
6 we're providing in the community.
7 Invested in operational analysis: That's
8 one of the things that I do, is we sit back and we
9 look at the numbers so that we don't just have nurses
10 and social workers out in the field; we have people
11 who are there to crunch some of the numbers and see
12 are we making an impact, is this working, and what
13 levers might we need to pull or knobs might we need
14 to turn differently in order to create a better
15 impact for our patients.
16 Aligning and motivating staff: I think I
17 heard when I came in this morning someone talking a
18 little bit about this. But we really focused on
19 building a team for population health, and we
20 started -- well, we just hired our second M.D., but
21 in an 85-person organization, for most of its life we
22 only had one medical doctor on staff, and that was

1 Dr. Brenner. Most of our team is around nurses and
2 care workers, but we also want -- we have a
3 psychologist that works with us four days a week. We
4 have several behavioralists, and we have obviously
5 our community health workers, and our health coaches
6 as well. It takes a team to work with these
7 patients, and that way we're not solely relying on
8 one point of contact within our organization to help
9 these patients, and that way it's not -- we have
10 redundancy in what we do.
11 And I think I heard someone mention this
12 earlier also. A big thing that we push is hiring for
13 attitude, not licensure. Our interview process is
14 pretty robust. You can see someone's résumé, they
15 can have a string of letters behind their name, and
16 they could have done all sorts of things, but this is
17 such a complex and hard population to work with, we
18 need to make sure that they're empathetic and that
19 they're able to relate to the people that we work
20 with.
21 And so we -- I mean, just for a community
22 health worker job, we'll bring someone in and make

1 them go through a day and a half of interviews
2 because we want to build up their stress and see how
3 they react under stress, because what we can't have
4 is them sitting in someone's home and something
5 stressful or dramatic happen and have them act out or
6 not be able to handle it and then make things worse
7 for that patient or their stressful situation than it
8 already is.
9 And so we do take them even on home visits
10 to see how they react, how they interact with a
11 patient that they've never met before. Can they be
12 trauma informed? Can they show compassion and
13 respect for those patients? Because we don't want to
14 figure that out once they're working with our patient
15 population. We want to know that before we bring
16 them in the door.
17 And also expanding the capacity of our
18 staff. We've recently invested quite a bit in
19 organizational development and growing the skill sets
20 of our staff. Our COO likes to say we've now gotten
21 to the point where our M.B.A.s are walking around
22 talking about trauma-informed care and our social

1 workers are complaining about how they didn't hit
2 their KPIs last month.
3 (Laughter.)
4 MR. WEINMAN: And so we're trying to share
5 these knowledge bases across everyone so that our
6 entire organization is focused on not only
7 performance but in taking the best care of our
8 patients that we possibly can.
9 This is just a chart to show how we measure
10 the different parts of the attitude, aptitude, and
11 availability for growth within our organization. And
12 we also want people to live our core values. Again,
13 you can have degrees from everywhere in the world.
14 If you're not a good person who cares about the work
15 that we're doing and is willing to put themselves
16 aside and be patient-centered in your approach to
17 what you're doing, the Camden Coalition is probably
18 not the right place for you. And we want to make
19 sure that we're always there for the patient first
20 because that is the main goal in what we're trying to
21 accomplish as an organization.
22 And I mentioned redundancy a moment ago.

1 We want to make sure that we have backup for anything
2 so that any part of our information -- or excuse me,
3 intervention doesn't come to a stop if someone wins
4 the lottery or decides to walk out the door or if
5 someone is out sick for a week. We teach self-care
6 quite a bit within our organization because this is
7 very stressful work for our employees, and it can
8 become -- it's very emotionally attached work, and so
9 it can be stressful for the employees as much as the
10 patients. And so we want to make sure that we give
11 people the time that they need to take care of
12 themselves but that the Camden Coalition doesn't stop
13 working while they're gone.
14 Improving business planning: Again,
15 planning for the future, and I think it's the next
16 slide.
17 Driving funding through strategy and not
18 strategy through funding: This is something we were
19 guilty of several years ago. We would take anyone
20 who offered us money but then realized that what they
21 wanted for that was something completely different
22 than what we were doing, and so we'd have to shift

1 our focus away. Then we'd end up having to hire
2 people to do this tangentially related project that
3 the funder wanted to have done. And we realized that
4 we were again taking away from our core mission as an
5 organization.
6 And I am at time. I just wanted to say
7 building an evidence base is also important as well.
8 I loved listening to the patient stories earlier. As
9 we were going out and looking for funding -- this is
10 our randomized control trial, so we're in the middle
11 of that now. It's been going on for about two years
12 now, so we hope to have some evidence behind our
13 intervention.
14 But in the meantime, we'd go out and tell
15 those individual stories to potential funders, talk
16 to people about -- you know, that's why our slides
17 are all pictures and there are no words and graphs
18 and charts. We like to talk about the individuals.
19 We'll show their utilization before, their
20 utilization after, talk about the improved quality of
21 life, and talk about the people that we're able to
22 engage with, because while we're building our

1 evidence base, just being able to tell subjective and
2 really touching personal stories is a great way to
3 build interest in the work that you're doing and to
4 show the importance of the full patient-centered
5 approach to care.
6 Quickly, we're also -- we know that our
7 model within Camden, every health system is
8 different, every city is different, every state is
9 different. So we don't try to go around and tell
10 other people to do exactly what we're doing. We just
11 teach them the basics. You know, talk to this
12 hospital, this hospital, the acceptance framework,
13 using a trauma-informed approach, making sure to
14 interact with your community resources. I don't know
15 that there's any way that you can succeed in this
16 work without involving the community resources. And
17 make sure, again, that you're human-centered in your
18 approach to the work.
19 And that is part of activating the
20 Coalition. We're just making sure that we get all of
21 the local, state, and national resources that are
22 available to us aligned towards making our patients

1 lives better.
2 And just to review, we're defining
3 ourselves, defining and tracking our efforts, and
4 really just standardizing processes across the
5 organization so that it's not only repeatable but
6 improvable, so that we can continue our cycles of
7 continuous improvement.
8 And we're certainly not done learning. I
9 don't want to stand up here and paint a picture that
10 our Cookie Monster cupcake is perfect and ready to
11 eat. We've suffered from growing pains like any
12 other organization, and it continues to be a struggle
13 every day. We're going through a revisit of our
14 strategy and our org chart and everything now, again,
15 to make sure that we're aligned to the patients in
16 Camden and to be able to spread the learning that
17 we've achieved through our work to people around the
18 country because we can't grow the Camden Coalition
19 outside of Camden. We do want to share, let others
20 learn from our mistakes so that they don't repeat the
21 same.
22 And I am at time, so I will stop on these

1 last few. There's post-its again.
2 (Laughter.)
3 (Applause.)
4 DR. THOMAS: That's great. What we'll do,
5 we'll bring up our -- you're going to be with us?
6 MR. WEINMAN: Yes.
7 DR. THOMAS: We're going to have our next
8 speaker, and then we'll open up for both of you. But
9 what I was so impressed with was to hear your
10 organization's mission and vision and recognize that
11 it's not a -- you're not a faith-based organization.
12 And so that in a secular organization, you have those
13 kind of core values is just very, very impressive.
14 Next, we're going to hear from Dr. Glen
15 Mays from the University of Kentucky, College of
16 Public Health. Dr. Mays will also be joined by
17 Douglas Scutchfield. And if they'll make their way
18 to the stage here?
19 Dr. Mays's research centers on the
20 delivering of financing systems for healthcare and
21 public health services, with a special focus on
22 estimating health and economic effects in these

1 efforts. He directs the Systems for Action Research
2 Program funded by the Robert Wood Johnson Foundation,
3 which tests strategies for aligning delivery and
4 financing systems for medical care. The topic here
5 is going to be delivery and financing of systems for
6 healthcare and public service delivery. Let's give a
7 hand to our next speakers.
8 (Applause.)
9 DR. MAYS: Greetings. Well, it's wonderful
10 to be with you here this afternoon. And you just get
11 me today. My good friend and colleague Doug
12 Scutchfield is back in the home front and taking care
13 of our work in Kentucky. I have the privilege of
14 actually occupying the professorship that's named
15 after him, though, so I get to take his name with me
16 everywhere I go.
17 (Laughter.)
18 DR. MAYS: But this is really great to be
19 with you, and I think, you know, among many, many
20 other feelings I've had in listening to this session
21 today and thinking about where we are in Kentucky
22 with regard to delivery and finances and

1 transformation, we're very, very envious. And I
2 think all of us all around the country are well
3 positioned to learn from the great work that you're
4 doing here.
5 But I do lead a research program funded by
6 the Robert Wood Johnson Foundation that focuses on
7 studying ways of aligning delivery and financing of
8 healthcare and public health and social services.
9 And I wanted to share with you a little bit of what
10 we're learning about the value of those activities,
11 about how we can document the impact of those kind of
12 activities, and also about what we're learning about
13 ways of building sustainability models for those kind
14 of multi-sector population health improvement
15 strategies.
16 I don't think I need to motivate the
17 reasons for undertaking these kinds of multi-sectoral
18 population health work. In this audience, you all
19 know it well and have articulated it well throughout
20 the conference today, but we know, again, drivers of
21 health and well-being exist far outside of the
22 medical care sector. And so we're looking for ways

1 of bringing together the sectors that can address
2 multiple fundamental determinants of health and
3 helping to reconnect medical care delivery with
4 public health services and supports, and also with
5 the broader constellation of social services and
6 supports that can drive health and well being.
7 That's what I know a lot of your efforts
8 here in Maryland are about these days. And there's a
9 growing constellation of these types of multi-sector,
10 multi-stakeholder initiatives that are being
11 implemented around the country now designed to
12 improve population-wide health data.
13 We call these population health improvement
14 strategies. They're the kinds of things that we
15 study. They're designed to achieve large-scale
16 health impact at the level of a neighborhood, a city,
17 a county, a region. They're designed to target
18 multiple fundamental determinants of health and
19 well-being, and they're designed to do that not
20 through a single organization or a sector but trying
21 to align and support collective actions across
22 government and the private sector, building the

1 infrastructure that we need to support collective
2 actions, building the information systems, and
3 building in the incentive structures to make that
4 happen.
5 We also know through about 50 years of good
6 social science research that supporting collective
7 actions in health or in other sectors is really hard.
8 There are lots of problems, challenges, barriers to
9 collective actions. And this is some work from
10 Elinor Ostrom, who won a Nobel Prize in economics for
11 her work studying these kinds of issues even though
12 she's not an economist.
13 So, again, we've got a lot of evidence to
14 build upon in terms of what are those challenges we
15 have to overcome to support collective action work,
16 trying to align incentives, trying to balance cost
17 and benefit flows, dealing with time lags,
18 uncertainties, information imbalances, all of those
19 kinds of challenges.
20 The work that we're doing: And we come at
21 this work from more of a traditional public health
22 perspective and thinking about what are the public

1 health supports and infrastructure that we can build
2 in to potentially help to solve those collective
3 action problems that can help hold together different
4 organizations and sectors and help them stay focused
5 on common health objectives.
6 And we've begun to focus, as many others
7 are, around what's being called foundational
8 capabilities in population health. What are the
9 capabilities you need to be able to engage
10 stakeholders in the community? What are the
11 capabilities you need to be able to assess health
12 needs and risks for the population at large? And
13 then to identify evidence-based strategies that are
14 connected to those health needs that are identified
15 in the community.
16 And then what's the infrastructure you need
17 to develop shared priorities and plans across the
18 constellation of health needs you identify? How can
19 you identify shared priorities from that? How can
20 you support multi-sector roles and responsibilities
21 in implementing evidence-based strategies? And then
22 importantly, how can you build systems to monitor

1 progress, evaluate the impact of the work that you're
2 doing in population health, feed the results back to
3 those stakeholders to support the cycle.
4 These are the kinds of things that we are
5 now measuring through our research work, measuring
6 the extent to which these kind of infrastructures and
7 supports exist in communities and the impact they
8 have in terms of supporting multi-sector population
9 health activities.
10 So we also have developed some metrics now
11 around measuring those kind of capabilities at the
12 population level across communities across the U.S.
13 And we heard earlier today about the Robert Wood
14 Johnson Foundation and their culture health strategy.
15 Our research center is a part of that strategy.
16 And actually, one of the metrics, one of
17 the national metrics that RWJF has developed to track
18 progress over time in the culture of health action
19 framework is this measure of the extent to which
20 these population health foundational capabilities
21 exist across communities. We also call this a
22 measure of comprehensive population health delivery

1 systems.
2 These are systems -- these are communities
3 that implement a broad array of those activities I
4 just mentioned, stakeholder engagement, assessment,
5 priority setting, planning, collaborative
6 implementation, and evaluation. Communities that
7 implement a broad set of those activities through
8 dense, multi-sectoral networks of relationships among
9 organizations meet our definition of a comprehensive
10 population health or public health delivery system.
11 That's one of the national metrics now a part of the
12 culture of health strategy. As of 2014, not quite
13 half the U.S. population lived in a community that
14 had those attributes of a comprehensive system.
15 So how are we learning about these types of
16 multi-sector population health work? Well, one of
17 the tools we use in my research center is a national
18 survey, this national longitudinal survey of public
19 health systems. This is a survey we've been fielding
20 across the U.S. now for 18 years. We started it back
21 in 1998.
22 We started following a national cohort of

1 communities to measure the extent to which these
2 population health activities were available and being
3 implemented in those communities, and also to measure
4 the range of organizations, both public and private,
5 both medicine and population health and social
6 services, the range of organizations that help to
7 support those activities, assessment, planning,
8 priority setting, implementation, evaluation.
9 So we've now been following a cohort of
10 about 360 communities now, over time, measuring
11 changes in those population health activities,
12 changes in the organizations that contribute to them,
13 and then now attaching those measures of activity to
14 measures of health and economic outcomes so we can
15 start to learn the potential health and economic
16 effects from communities to build strong networks to
17 support those kind of activities.
18 And again, these are the kind of -- these
19 are the activities that we measure, the measures of
20 population health, infrastructure, and capabilities
21 that we've now been measuring over time across a
22 broad array of communities, now for 16 years. So we

1 can start to look at both short-term and longer-term
2 health effects.
3 So a few things that we're learning from
4 this work. One not surprising finding is that
5 communities vary widely in the extent to which they
6 have these population health capabilities and
7 services and supports across the country. On
8 average, the average U.S. community implements about
9 two-thirds of these activities. But as this slide
10 shows you, we've got communities that have 100
11 percent of these population health activities and
12 supports in place; we've got other communities that
13 have less, you know, less than 10 percent of them.
14 And so there's a wide variation in population health
15 activities, just like we see wide variation in
16 medical care practices in social services safety nets
17 across communities.
18 We can map out what the delivery systems
19 for these population health activities look like in
20 terms of which organizations contribute to them and
21 which organizations play larger and smaller roles,
22 and which organizations are working together in

1 supporting these kind of activities using diagrams
2 like this network analytic diagram to kind of provide
3 a map of what the delivery system for population
4 health activities looks like in individual
5 communities across the country and how this changes
6 over time.
7 We've used these data to classify
8 communities in terms of the strength of their
9 delivery system for population health activities and
10 find out that communities basically fall into one of
11 these seven kinds of categories in terms of the
12 strength of their population health delivery system.
13 The first three of these categories we call
14 comprehensive delivery systems because they deliver a
15 broad scope of those population health activities,
16 and they do so through dense, multi-organizational,
17 multi-sectoral networks. They are strong
18 relationships that exist between organizations that
19 play a role in supporting those activities. We call
20 those systems comprehensive systems. And again,
21 about 47 percent of the U.S. population now resides
22 in a community that has that strong delivery system

1 for population health.
2 This is another way of looking at that
3 definition as we see we're graphing the portion of
4 these activities that are implemented in the
5 community and the density of relationships that exist
6 among organizations. And it's just the communities
7 in that upper right-hand quadrant that support a
8 broad scope of activity through dense, multi-
9 organizational networks that meet our definition of a
10 comprehensive delivery system for population health
11 activities.
12 And we see improvements over time in the
13 proportion of communities that meet that definition
14 of a comprehensive delivery system. In 1988, about
15 24 percent of communities fell into that category,
16 and now we're up to about 33 percent or so of
17 communities falling into that category and, again,
18 about not quite half the U.S. population living in
19 one of those communities.
20 So this begins to allow us, from a research
21 perspective, to look at, well, what are the health
22 consequences and what are the economic consequences

1 associated with reaching that, building a
2 comprehensive multi-organizational delivery system
3 for population health activities? And I can share
4 some of those results with you shortly.
5 But I first want to focus on the equity
6 dimension of this aspect as well. Just like there
7 are inequities in medical care delivery, we see large
8 inequities in the strength of delivery systems for
9 population health activities as well.
10 The bottom 20 percent of U.S. communities
11 that we track over time can implement only about 40
12 percent of these population health activities. And
13 those communities have actually lost ground in recent
14 years in their capacity to support population health,
15 whereas the top 20 percent of communities, you can
16 see here, are implementing nearly 90 percent of the
17 population health activities, and they've seen growth
18 over time in the strength of their delivery systems.
19 So we are, at the national picture, we are seeing
20 actually greater inequity, kind of a wider gap
21 between the stronger and the weaker delivery systems
22 for population health. And this is something that

1 is, you know, certainly worthy of concern, and just
2 as inequities and the strength of medical care
3 delivery systems and access to medical care are of
4 concern.
5 In the interest of time, I'm going to skip
6 through a few of the details here so I can get to the
7 punch line.
8 So now we've been studying communities for
9 16 years and looking at how the strength of delivery
10 systems for population health activities evolve over
11 time and looking at changes in the communities that
12 meet our definition of a comprehensive, strong,
13 multi-organizational delivery system. And what we
14 found from very careful studies linking our measures
15 of activity to measures of health outcomes, that
16 clearly communities that move into building strong,
17 comprehensive population health systems see sizeable
18 gains in population health and well-being over time.
19 Here, I'm showing you measures of, several
20 measures of potentially preventable mortality over
21 time. Communities over the 16-year period that reach
22 our threshold of comprehensive delivery systems see

1 about almost a 20 percent reduction in all-cause
2 mortality compared to communities that don't reach
3 that comprehensive status.
4 And we see even larger effects on some of
5 the preventable cause-specific mortality measures:
6 Heart disease mortality, about a 14 percent reduction
7 there; diabetes, about a 12 percent reduction; about
8 a 13 percent reduction in cancer mortality; and large
9 reduction in influenza mortality as well. So we're
10 beginning to build, again, stronger evidence that
11 there are real health consequences, real health
12 benefits that we can attribute now to the ability to
13 implement population health activities, and doing so
14 through multi-organizational networks, assessment,
15 planning, priority setting, implementation
16 collaboratively.
17 We've also taken a look at some economic
18 outcomes as well, attached economic outcomes to these
19 measures of population health capacity across
20 communities. And here, by attaching measures of
21 medical care spending at the community level for the
22 same 360 communities that we've been tracking over

1 time, we show that, again, communities that reach the
2 status of having a comprehensive population health
3 delivery system see substantial reductions in their
4 medical care costs growth for Medicare compared to
5 communities that are less comprehensive in their
6 ability to support population health activities.
7 You can see here almost a six percentage-
8 point difference in medical care spending for
9 communities that meet that definition of
10 comprehensive population health systems.
11 Most recently, we've also taken a finer-
12 grain look at the issues of equity in population
13 health to learn -- to examine the extent to which
14 these population health activities are related to
15 equity. And we've linked our data up with very
16 recent data from Raj Chetty and his colleagues at
17 Stanford to give us community-specific, income-
18 related -- income-specific measures of life
19 expectancy, life expectancy by income quartiles.
20 So we can look at -- in our case, we
21 estimated the effect of communities that moved to
22 comprehensive population health status, how that

1 affects life expectancy for the bottom quartile of
2 the income distribution compared to the top income
3 distribution. Not surprisingly, we see a large
4 effect, about a four-year increase in life expectancy
5 for the bottom 25 percent of the income distribution,
6 not much of an effect on the top quartile of the
7 income distribution. So the overall effect on the
8 disparity, the income-related disparity in life
9 expectancy, we see about a three-year reduction in
10 the disparity in life expectancy between low-income
11 and high-income populations, again, attributable to
12 communities that build that broad, strong delivery
13 systems for population health. So again, there
14 appear to be some real benefits in terms of reducing
15 equity from building these kinds of models.
16 I think I'm going to stop there because I
17 know we're running short on time, but I look forward
18 to questions.
19 DR. THOMAS: Thank you very much.
20 (Applause.)
21 DR. THOMAS: Yes, and please join us.
22 Everyone wants to know where Maryland is in all your

1 big data, okay?
2 DR. MAYS: They're in there. You guys are
3 in there.
4 DR. THOMAS: So if we can tease that out,
5 that would be great.
6 Finally, we're going to hear from Stephen
7 Pratt, President of Impact Catalysts, a benefit
8 corporation.
9 Stephen, if you'll start heading this way.
10 Providing management consulting services to
11 social enterprise. And Stephen will actually be
12 helping us in preparing the actual report coming out
13 of this meeting. So put your hands together for
14 Stephen Pratt.
15 (Applause.)
16 MR. PRATT: The clicker is here, is that
17 right?
18 DR. THOMAS: Yes.
19 MR. PRATT: So I'm standing between you
20 guys and interstate whatever, Route 50?
21 DR. THOMAS: These are the truly committed.
22 MR. PRATT: I like it. I like it. My

1 first title when I got into consulting was Director
2 of Financial Sustainability, which I always thought
3 was a great title because it's one of those things
4 that everybody is in favor of even though nobody has
5 any idea what it is.
6 (Laughter.)
7 MR. PRATT: So that's a nice kind of upbeat
8 kind of way to start this presentation. So I think,
9 you know, one of the things that --
10 Actually, it was you, sir, I think that --
11 I'm sorry, your name, again, was?
12 DR. MANN: David Mann.
13 MR. PRATT: David Mann, right. Your
14 conversation actually quite perfectly set the stage
15 for the message that I want to bring in. When David
16 was talking about taking either a utilitarian or
17 altruistic play with revenue, I think that's the core
18 of the question around sustainability, although I
19 also think that part of the challenge here is to
20 figure out a way if we can split the difference or
21 blend the two into some sort of hybrid model.
22 So what the heck am I talking about? The

1 standard approach to revenue planning, which is one
2 that I've been on the receiving end of and also, you
3 know, to some degree, been guilty of earlier in my
4 nonprofit career, is entirely on the need side. So
5 we start with this notion of who needs us, how many
6 people need us, what's that universe of need, and
7 what's our aspiration for growth into that, and then
8 we build our revenue aspirations around it.
9 The problem with that is it assumes that
10 you're only working toward success on the
11 programmatic side. Really, if the only thing that we
12 needed to do here was to deliver a great programmatic
13 model, our lives would easier. I'm not saying they'd
14 be easy, because clearly, just sitting here hearing
15 all the work that's been done over the course of this
16 day, there's nothing easy about developing an ACO for
17 dual eligibles in the current environment. But if
18 all you had to do was create a great program model
19 and not think about the financial model, you'd
20 probably sleep a lot better.
21 The issue is this dichotomy between who
22 pays for the work we do and who is the beneficiary,

1 who receives the benefit of the work that we do. And
2 we call this the difference between customers and
3 clients.
4 So the clients are the beneficiaries of the
5 work, the customers are who pay. And then in the
6 for-profit world, it's usually one and the same. So
7 you're running a dry-cleaning business, so the person
8 who pays is also the person who's picking up the
9 shirt at the end of the day, right? So it's pretty
10 straightforward. If any of you have read Peter
11 Drucker, who is kind of a guru of strategy, he's
12 talked about this notion of customer-centric
13 strategy. Well, that's what it is. You figure out
14 how to deliver great value to that customer in that
15 dry-cleaning business.
16 You know, when I describe what I do, doing
17 management consulting to nonprofits, sometimes people
18 screw up their face and say really idiotic things
19 like is there such a thing as management in
20 nonprofits, and things like that. But mostly, they
21 assume that it's actually easier because there's less
22 zeros involved on the balance sheet.

1 And I explain, no, it's actually a lot
2 harder because in the nonprofit world we have what is
3 called a decoupled strategic framework. You have to
4 deliver value to both your customer and your client,
5 and they're not one and the same. And the trick in
6 nonprofit strategy is to get the things that you're
7 doing as closely aligned to both of those values as
8 possible. In other words, the more space there is
9 between what you're promising to your customer and
10 what you're promising to your client, the more
11 headaches you're going to have. The closer you can
12 align those interests between the two, the better off
13 you are, which is why I'm suggesting that finding a
14 blend between the altruistic and the utilitarian in
15 the strategy that you're developing is really
16 critical.
17 So our sustainability hypothesis is this:
18 So you remember that prevailing approach, you start
19 with what you need, you figure out how to grow into
20 the need. What we think is that you need to take a
21 market-based approach to this, which is -- the
22 starting point is understanding how much revenue is

1 actually out there in the market, what's the size of
2 the market.
3 So if, God forbid, I was going to try to
4 start an Olive Garden franchise tomorrow, and I mean
5 for a lot of reasons, not -- I wonder if Olive Garden
6 is a social determinant of health. It may very well
7 be. Certainly the breadsticks are.
8 (Laughter.)
9 MR. PRATT: But if I were trying to start
10 an Olive Garden down the road tomorrow and I wanted
11 to go into the bank for money, the first thing the
12 bank would ask me is, so how many people are in this
13 income bracket that's the typical Olive Garden
14 customer within, say, a 50-mile radius of where you
15 want to put this in? How many of those people go out
16 for casual dining on a Saturday or Friday, that sort
17 of thing? In other words, they want to know what the
18 market potential is, and then they'd want to know how
19 many competitors are out there that also want to
20 provide a kind of mediocre meal on a Friday evening
21 for a midlevel price, right?
22 (Laughter.)

1 MR. PRATT: So that would be the basis for
2 the strategy. So in our world, it's actually kind of
3 the same idea; just it's a different set of things.
4 So, you know, part of it is understanding. So if
5 you're trying to address social determinants of
6 health, certainly, first of all, I want to understand
7 who are the customers? Who out there is actually
8 buying that intervention? Who has an interest in
9 that?
10 I think there's been a lot of talk in the
11 room today about some suggested hypotheses of who has
12 skin in this game, right? State government, CMS,
13 hospitals, communities, cities. So really, what
14 we're going to be testing out here is how true that
15 is, first of all, who has skin in that game. I think
16 we're also going to have to test out who else is
17 making a play that they're serving that need for
18 whatever that skin is in the game.
19 So, you know, one of the things that I've
20 been struck by, and we talked about it a bit over
21 lunch, a few of us at the table, was, you know, as we
22 talk about things like the decline in utilization.

1 So, you know, I pulled up a White House report on my
2 laptop while I was sitting here listening to this,
3 and we've seen declines in utilization across the
4 country, not just in places that have Health
5 Enterprise Zones.
6 Now, that's a really reductionist way to
7 think about this stuff, but on the other hand, the
8 fact of the matter is, as several people have said
9 when using this term "ROI," we need to figure out a
10 way to make the case that Health Enterprise Zones are
11 uniquely providing value and addressing that issue,
12 right, the changes in utilization rates. And it's
13 true across the board. What are you uniquely
14 contributing to this that convinces that customer
15 that buying you is better than buying something else
16 that may also address the problem?
17 The other related issue, which I think is
18 more unique to our world than it is to the for-profit
19 world, are two principles: one, the tragedy of the
20 commons, and the other the free-rider principle. And
21 they're kind of related to one another. How many of
22 you have heard the phrase the "tragedy of the

1 commons"?

2 Yeah, a few. So basically, what this means

3 is that you have something that collectively is good

4 for all of us but that individually it may not --

5 there may not be any incentive for you to do anything

6 about it.

7 And so I'll give you a concrete example

8 from our world. I'm doing a project nationally with

9 an effort that's associated with the Alliance for a

10 Healthier Generation working on obesity prevention.

11 And so I've been talking to a bunch of public and

12 private payers around the country about basically

13 whether they would invest in efforts on obesity

14 prevention.

15 And these are like payers in places like

16 Louisiana, with some of the highest obesity rates in

17 the country. And basically, what the payers have

18 said is, collectively, yes, this inures to all of our

19 benefits. If we invest in this stuff that these guys

20 are doing, within 5 years or 10 years, there's going

21 to be dramatic reductions in obesity rates, and we're

22 going to save money, great.

1 The problem with that is there's so much
2 subscriber churn that investing in an individual
3 patient getting that kind of obesity treatment
4 doesn't really inure to the benefit of that
5 individual payer. So that's the tragedy of the
6 commons. Everybody in the commons has an interest in
7 changing that arc, but the individual kind of
8 self-interest of that individual payer is not clearly
9 there.
10 And so I think part of what you want to do
11 is figure out a way to construct an argument for
12 payers that overcomes that temptation to just act
13 nakedly in the self-interests of the individual
14 organization. And this can be true, by the way, for
15 government, not just for private players as well. So
16 that's just a little bit about the ideas that we're
17 going to be working on, on this.
18 I'm actually going to jump past this one
19 because we're running low on time here and just
20 quickly describe what the project is that we're going
21 to be doing.
22 So over the next three months, first off,

1 what we're going to be doing is a review of the
2 overall Health Enterprise Zone model. We're going to
3 look at the financials, we're going to look at some
4 of the results.
5 And let me just say, having this conference
6 today has been a fantastic opportunity for me. I was
7 saying to the fellow from RWJ, you know, typically
8 when we start off a project, this could be three or
9 four weeks of my time to get the information that I
10 got in this room today, so just what a wonderful
11 piece of timing and opportunity for us.
12 So it means that when I start talking to
13 individual sites, and that's what's going to happen
14 in December, I don't have to waste your time asking
15 some basic questions about what you do, because I got
16 to hear from all of you today and talked to some of
17 you in the hallway, and we can dive into some of the
18 more particular things about, so who are the entities
19 in your zone who have skin in the game with you? Who
20 are the folks that you believe you're benefiting?
21 How would you make the case for it? What makes you
22 unique?

1 And then from that, what we're going to be
2 doing is building out the framework in this report
3 that will be due in January for what a sustainability
4 plan might look like. The idea is that there is
5 going to be some follow-on work that comes from this
6 first phase early in 2017 to develop out what that
7 sustainability plan would look like, what the
8 structure of it would be, that sort of thing.
9 So that's it. That's my spiel. I did it
10 nice and quickly so that we could still be here on
11 time. Should I take questions or something like
12 that?
13 (Applause.)
14 DR. THOMAS: Yeah.
15 MR. PRATT: Yeah. Thanks.
16 DR. THOMAS: So again, and line up to the
17 microphone. It is not often at the beginning -- I'll
18 put it like this: Things have fallen in place and
19 have just been quite amazing. And this report that's
20 going to be done, and analysis specifically around
21 sustainability, is just really a blessing.
22 So if you'll introduce yourself because

1 we're recording everything. Yes?
2 MS. WILLIAMS: Thank you. Hi, my name is
3 Antoinette Williams. This question is for the last
4 speaker. So you talked about the work that you're
5 going to do in December specific to a sustainability
6 plan and the individual HEZ interviews that you're
7 going to do, and I know this is probably all still
8 being fleshed out.
9 Maryland is an interesting state, right,
10 like every state, in that stakeholders, investors
11 tend to want to focus on communities or the things
12 that are important to them. And so, in coming up
13 with an aggregate plan or an all-HEZ sustainability
14 plan, you might get a different set of results than
15 you would if you were looking at, let's say, our HEZ
16 in West Baltimore, right?
17 MR. PRATT: Yep.
18 MS. WILLIAMS: And then as Maha mentioned
19 this morning, there may be some funding that's there,
20 you know, already just because of some of the work
21 that she's done. Are you going to be doing
22 individual HEZ sustainability planning, or are you

1 really planning to look at the aggregate?
2 MR. PRATT: The answer is all of the above.
3 I'm certainly hoping that there's enough commonality
4 that we discover across them that I can make some
5 recommendations that transcend the entire system.
6 Honestly, a bias of mine would be that the more we
7 can find in common, the more scalable this model will
8 be, more sustainable it will be. But I'm not coming
9 in with a presupposition or something like that about
10 what I'm going to discover. I think that's part of
11 what I'm trying to figure out.
12 MS. WILLIAMS: And also keep in mind (off
13 microphone) --
14 MR. PRATT: Right. I mean, I certainly
15 heard loud and clear today how diverse and distinct
16 these models are. And I had some sense of that just
17 knowing that you're talking about rural, suburban,
18 and urban settings. So in and of itself -- yeah,
19 exactly.
20 DR. THOMAS: And that was by design, and so
21 what you have is a tailoring. But again, if my
22 friend looked at the workflow and systems, you would

1 find some core elements that truly could go across
2 and truly could scale. So being true to the local
3 and the tailoring and yet having a systems approach
4 that could be scaled is excellent. Yes?
5 MS. LICHTENSTEIN: Hi. First of all, thank
6 you to all three of you for very wonderful
7 information for an older adult this late in the day.
8 But very impactful, and we're sitting to hear it all.
9 My question is for David.
10 Oh, I'm sorry. I'm Karen-Ann Lichtenstein,
11 and I'm the CEO of an independent nonprofit care
12 coordination entity, not dissimilar to the work that
13 you all do. And we love the Camden Coalition, and
14 thank you for sharing your information and your model
15 and what you do beyond the borders of New Jersey.
16 Maybe I missed it, but could you touch a
17 little bit about how you're funded? With such a
18 wonderful and rich and robust data collection and
19 business side to your organization as a nonprofit,
20 how your work is funded?
21 MR. WEINMAN: Absolutely. And we've just
22 recently gotten a great round of funding from the

1 Robert Wood Johnson Foundation as well as Atlantic
2 Philanthropy and the AARP to start a national center
3 for population health, which we're in the middle of
4 standing up. Thank you. Our conference is in
5 December. It's coming up, if you'd like to go to the
6 website and sign up.
7 MR. PRATT: Tickets are still available.
8 (Laughter.)
9 MR. WEINMAN: And we also do a lot of
10 technical assistance contracts as well. I talked a
11 little bit about how we can't share -- you know,
12 every system is going to operate differently than it
13 operates in Camden, but we also -- we have a team
14 that's called our Cross-Site Learning Department that
15 builds a lot of curriculum to go out and work with
16 communities.
17 We've worked with systems in Puerto Rico
18 and California, in the Pacific Northwest, in the
19 Midwest, all across the country, just to really go
20 and work with them and learn about their models. And
21 it's anything from people that are still in the
22 planning stages to people that have been trying to

1 get off the ground for a little while, and we tailor
2 a curriculum for them to help them teach some of the
3 things that have been successful to us as well.
4 And then we do have some contracts with --
5 we have some shared savings contracts as well, where
6 we're trying to help improve outcomes for the payers,
7 also, that are still working along. But we have --
8 (Off microphone comment.)
9 MR. WEINMAN: Like Horizon. Horizon. Yep.
10 And we have several smaller funders, some
11 specifically who want to help with the data aspect.
12 We had a grant with Nicholson that helped a lot with
13 our data funding, and so people that are interested
14 in helping us build up our dataset.
15 DR. THOMAS: And again, the powerful role
16 that philanthropy plays in getting things started.
17 Yes?
18 DR. MANN: David Mann, Office of Minority
19 Health and Health Disparities at DHMH. Going back to
20 my ruthlessly fiscal perspective, I'm curious in
21 getting the answer to the question of where is the
22 money and how do I tap it, because I think that's the

1 question the HEZs came here asking. At least that's
2 what I would ask if I was an HEZ.
3 So question for Mr. Weinman is, so what
4 proportion of what Camden does do you think you can
5 sell to funders under an ROI model? What proportion
6 do you think you have to market to them under a
7 perpetual subsidy, its altruistic model, and what
8 sources do you tap to do that?
9 And then for Dr. Mays, what things could
10 you say about what your research has told you about
11 the kind of ways to try to put together that where's
12 the money and how do you tap it, question and answer?
13 MR. WEINMAN: Great question. I'll do my
14 best to answer it. And what we try to sell to them
15 is the overall impact. I mentioned that we're doing
16 the randomized controlled trial to try and show the
17 effectiveness of our intervention, but at the same
18 time, and with our shared savings models, as well,
19 we're trying to save money, not only -- of course,
20 our main focus is increasing -- improving the health
21 of people with complex social situations, but at the
22 same time, if that reduces their utilization, we do

1 work with a Medicaid population. And so the
2 reimbursement rate for that is lower, from what I
3 understand.
4 And so by reducing their utilization and
5 connecting them back with the primary care, it's
6 cutting down on a lot of costs for things. And so we
7 try to look at it from a payer perspective, from an
8 institution perspective, and then also from the
9 overall health of the customers perspective. Sorry,
10 in this case I was meaning the customers as the
11 patients that we work with.
12 Sorry, what was the other part of the
13 question?
14 DR. MANN: (Off microphone) can you sell on
15 an ROI basis -- really good for me --
16 MR. WEINMAN: Yeah. And to the point that
17 I mentioned about the patient stories is sometimes a
18 lot of our sales tactic is it's really good for
19 people, please give us some money, we're making a big
20 impact. But at the same time, when we do show -- a
21 lot of what we do when we take out with our pitches
22 is show like -- we haven't established a true ROI

1 yet, but what we do show is we had this person with
2 this many hospitalizations that were costing the
3 institutions this much money. After our
4 intervention, you know, they've only been back to the
5 emergency department twice, whereas they were going
6 every other week before, just to show how that
7 savings has affected across all the people in the
8 ecosystem.
9 DR. THOMAS: This is going to be an ongoing
10 tension, David. I think you should keep asking the
11 question, because fundamentally it's going to come
12 down to is what we do a market and operate like a
13 market and therefore sometimes face the kind of false
14 question of return on investment.
15 Some of this, as our colleagues in other
16 parts of the world have already figured out, is the
17 common good. It's what it means to live in a modern
18 society. And we're going to continue to have to play
19 around that before we figure it out, but it's clearly
20 both, which is why I'm so impressed by the fact that
21 some of you, your organizations have core values that
22 sound like some of our faith-based core values, and

1 yet you're in this world of ROI.
2 So I think you're going to have to make
3 sure that the voices of those citizens really get
4 lifted up at the end of the day, because you may not
5 have the metric in four years to prove these things.
6 And I think that's simply part of the tension here.
7 Yes, ma'am?
8 UNIDENTIFIED SPEAKER: Oh, I thought --
9 DR. MAYS: Oh, I was just going to add kind
10 of the --
11 DR. THOMAS: No, please.
12 DR. MAYS: Reflect on that. I agree. I
13 think a lot of our work shows these are public goods,
14 and so there's an important role for thinking about
15 public financing for these kind of activities as
16 well. And I think for a good public financing model
17 to work, you want to first of all make sure you've
18 got a strong governance model in place to make sure
19 the decision making around how those resources flow
20 is well made and transparent.
21 And you also want to make sure you can
22 articulate clearly how much it costs to implement

1 your activity, so how much money you need, and very
2 specifically what the public is getting from those
3 investments, what specific activities are being
4 delivered. And in the arrangements that we studied
5 around the country, those core elements have been
6 very important to launch successful public financing
7 mechanisms, to get legislators and others willing to
8 invest.
9 DR. THOMAS: So no one wants to hear the T
10 word, the tax word. And, you know, whether financing
11 it through sugar tax or other kind of things, but
12 that's the other kind of side to this equation. And
13 then there's this effort to say, David, that you
14 build it back into your rate benefits and your
15 bonuses. You should be able to follow the money and
16 see where it goes. You should be able to.
17 But be mindful, there are unintended
18 consequences. Your emergency medical operation, they
19 make their case on how many runs they make. Now, we
20 need a budget to cover the costs. These are all the
21 911 calls we're doing, and now you guys are out there
22 reducing 911 calls. Do you know that that might have

1 a ripple effect on your emergency medical
2 infrastructure? These are unintended consequences.
3 We need to monitor those, because out of that group
4 might be voices opposing you because we're not making
5 the shift totally all together at the same time.
6 We're on the right track, but we've got some real
7 bumps along the way.
8 Yes, ma'am?
9 DR. ALPEROVITZ-BICHELL: Hi, I'm Kari
10 Alperovitz-Bichell. I'm the other physician at the
11 Morris Blum Clinic here in Annapolis. And my
12 question is for David, and it's a very practical
13 question. There were all those little boxes and
14 flowcharts, and I would like to read what the details
15 of those are and like maybe with some paragraphs and
16 stuff like that. Is there a particular place, a
17 particular article or something to read about what
18 you actually do?
19 MR. WEINMAN: I don't know. If I can get
20 your contact information, I'll be sure to get it to
21 you. I can actually share those flowcharts with you
22 and all of the work that we did to build them, just

1 how our intervention works. We like to be open
2 sources at the Coalition, and any works that we've
3 done and information that we've put together, we're
4 happy to share with anyone, anytime. And so if you
5 want to stop afterwards and get your contact
6 information, I'll be glad to find articles that we've
7 put out or actually just share the workflows with you
8 so that you can see what our intervention looks like.
9 DR. ALPEROVITZ-BICHELL: Yeah, I'm
10 interested in the paragraphs too.
11 MR. WEINMAN: Sure.
12 DR. THOMAS: And you're also hearing the
13 terms "workflow," "open source." This is language
14 coming out of the software industry and design
15 thinking, and I think that's probably the new thing
16 for you HEZs to be incorporating. This whole notion
17 of design thinking could be a new way in which we
18 come up with innovative solutions.
19 MR. SHIRD: I just wanted to interject.
20 Vern Shird, DHMH. All of the attendees here will get
21 an e-mail of the different presentations so that they
22 will have them for their records and they can review

1 at their leisure.
2 DR. THOMAS: Yes. Yes, ma'am?
3 MS. SAMMONS HACKETT: Well, I guess I get
4 the closing question or remark. Doreleena Sammons
5 Hackett, Directors of Health Promotion and Education.
6 Good to see you again, Dr. Mays. I really wanted to
7 say, first of all, I really appreciate the
8 presentation because "Show Me the Money" could have
9 been the subtitle, and that's what a lot of the
10 people in this room needed to hear. I was the
11 chronic disease director for the State of New Jersey
12 for 23 years. And so seeing the Camden Coalition,
13 I'm saying, really? And how long have you been
14 around? And thank you for coming to Maryland now and
15 sharing your information.
16 And hint for all of you: Anything you
17 heard about money, write it down. Read my lips;
18 write it down, because these are important things to
19 help you to be able to grow and to move and to tap
20 resources that you might not have tapped previously,
21 might have been afraid to tap previously, or might
22 not have had the data to show you how to tap it. So

1 you've gotten a whole lot of hints throughout this
2 day that I'm just amazed at and I really do
3 appreciate. And documentation is a lot of what's
4 been shown today as well.
5 Return on the investment, you know, I've
6 heard that up my wazoo. And a lot of times you get
7 disheartened for return on the investment. The
8 return on my investment is somebody not losing a foot
9 to diabetic amputation, not losing an eye to diabetic
10 retinopathy, somebody not, you know, having to have
11 a, you know, triple or quadruple bypass. You know,
12 those are the return on the investment to people who
13 are working in the communities, but actually melting
14 together and showing them, okay, this is what you
15 have to say, this is what you have to do to get the
16 money, sustain the money and get it beyond what
17 you're currently funding it for.
18 That's just my comments of appreciation.
19 And some of you all who haven't been in health 36
20 years, those are things that you really need to catch
21 onto quickly as the train is rolling.
22 DR. THOMAS: And indeed the train is

1 rolling. I'm going to have our speakers have the
2 last word, if there is a take-home message that you
3 want to leave here in this great state of Maryland
4 based on what you've heard today and the insights
5 that you offer. Let's start at the end of the table
6 and move this way. What's the take-home?
7 DR. MAYS: Yeah, I guess one take-home is
8 to -- and there's a lot focus on looking to these
9 short-term benefits and a lot of pressure, and
10 there's good reasons for that, but I guess I would
11 say don't lose sight of the long-term, much larger
12 health and also economic benefits that can flow from
13 these kind of collaborative endeavors. They're
14 tougher to galvanize support for, but they're -- but
15 the cumulative effects of these activities over time
16 really can be very dramatic.
17 MR. WEINMAN: And I would echo that as
18 well, but also just say, sitting through the panels
19 this morning and hearing about what great work
20 everyone's doing, I know it can be frustrating and
21 there is a lot of asking where the money is going to
22 come from, but to not lose faith and remember that

1 the work that we're doing is great. And people are
2 more and more, as the healthcare systems and the ACA
3 is in the news more and more every day, people are
4 looking for those improved outcomes and also cost
5 savings across the organizations. So don't lose
6 heart; people are very interested in this, and we're
7 doing great work. And kudos to you all, I guess, is
8 my take-away.
9 DR. THOMAS: Yes, sir?
10 MR. PRATT: My last thing is I don't want
11 people to come away from some of the exchange we just
12 had thinking there's something inherently wrong with
13 altruism, with trying to make the case that the
14 reason to invest in something is because it's good
15 and meaningful. But what I would say is this: The
16 important thing is then to answer the question so who
17 out there feels altruistic? Show me the evidence
18 that that body exists.
19 So I have one client in Boston called
20 Rosie's Place, which is a sanctuary for poor and
21 homeless women. They get 35,000 people a year to
22 write checks for about 50 bucks each. And that's

1 fantastic. It's also a total outlier, but I mean,
2 that's altruism. That's why those people are writing
3 those $50 checks.
4 But, you know, what I would be looking at
5 here is not, oh, there is this body of individuals
6 who exist out there who are altruistic. What I'd
7 look at is show me the evidence there's a body of
8 individuals who want to give to this, to this kind of
9 work. Show me a pattern out there that would do
10 that. That's what market analysis is. But we're not
11 going to give up the ghost on altruism as we look at
12 this. We're going to look at both that along with
13 the ROI stuff.
14 DR. THOMAS: Oh, I can't wait to read your
15 final reports. This is going to be great.
16 Let's give our speakers a hand, will you?
17 (Applause.)
18 DR. THOMAS: Thank you, gentlemen. Thank
19 you very, very much. And let me call Dr. Spencer up
20 to close us out here.
21 What a wonderful meeting. I am so proud to
22 be here and to say that Maryland -- call myself a

1 Marylander.

2 (Applause.)

3 DR. THOMAS: And listen, again, Dr. Mann,
4 you were in the room where it happened, okay? Who
5 could have imagined we would be here right now? So
6 do not lose faith, do not lose hope. You're on the
7 right track, and the nation is watching. So I'm
8 going to let Michelle close us out.

9 MS. SPENCER: So really, really quickly,
10 can we just give a huge round of applause to
11 Dr. Thomas for just being so incredibly awesome this
12 afternoon, all day.

13 (Applause.)

14 MS. SPENCER: And then a huge round of
15 applause for yourself, to yourselves for your passion
16 and your commitment and your dedication and for just
17 moving this work forward. I am in awe of each of
18 you, and I am so impressed and I feel so great about
19 this day, and certainly we couldn't be here without
20 your leadership and your commitment. So kudos to you
21 and keep the good work going. Take care.

22 (Applause.)

1 (Whereupon, at 4:10 p.m., the meeting was
2 adjourned.)
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1 C E R T I F I C A T E

2 This is to certify that the attached proceedings

3 in the matter of:

4 HEALTH ENTERPRISE ZONES SUMMIT:

5 SUSTAINING SOCIAL DETERMINANTS OF HEALTH PROGRAMS

6 November 3, 2016

7 Annapolis, Maryland

8 were held as herein appears, and that this is the

9 original transcription thereof for the files of the

10 Maryland Department of Health and Mental Hygiene.

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15 TOM BOWMAN

16 Official Reporter

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