Maryland's Health Enterprise Zone Initiative

HEALTH EQUITY RESOURCE COMMUNITY ADVISORY COMMITTEE

AUGUST 11, 2021

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Presentation Outline

- Background
- Response
- The Zones
- Monitoring Progress and Outcomes
- Lessons Learned
- Progress and Next Steps

"…the determinants of health are beyond the capacity of any one practitioner or discipline to manage…we must collaborate to survive, as disciplines and as professionals attempting to help our communities and each other."

-Institute of Medicine, 1999

Cost of Disparities in Maryland

Minority Health Disparities cost Maryland between 1 and 2 Billion Dollars per year *of direct medical costs.*

Excess charges from Black/White hospitalization disparities alone were $814 Million in 2011.

- *These represent hospital charges and do not include physician fees for hospital care, emergency department charges, or any outpatient costs.*

Cost of Disparities

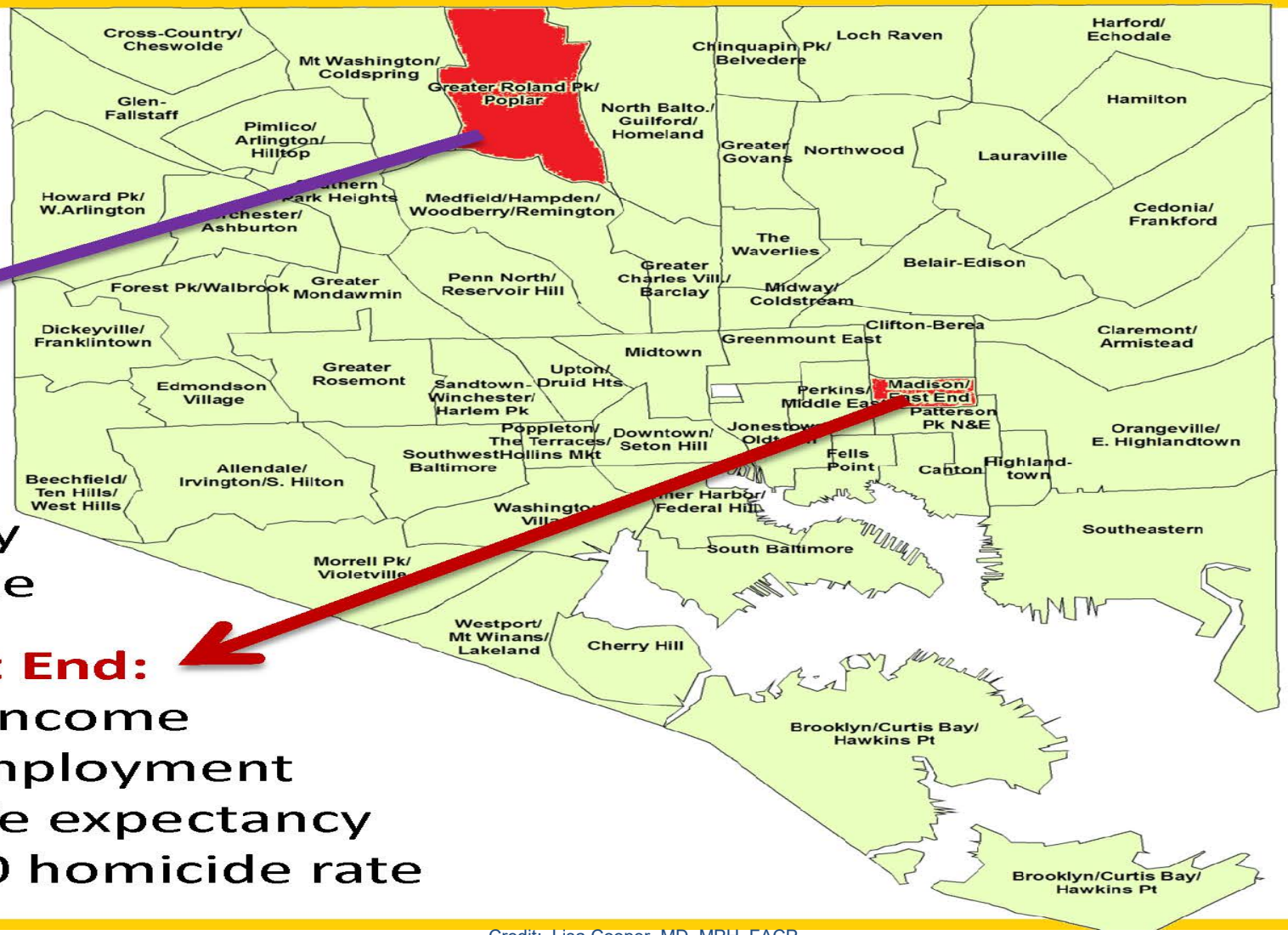
In Baltimore, even 5 miles makes a world of difference...

Roland Park:

- $90,492 in income
- 3.4% unemployment
- 83.1 year life expectancy
- 4.1/10,000 homicide rate

Madison/East End:

- $30,389 in income
- 14.4% unemployment
- 64.8 year life expectancy
- 46.3/10,000 homicide rate



Credit: Lisa Cooper, MD, MPH, FACP
Bloomberg Distinguished Professor
Johns Hopkins University Schools of Medicine, Nursing, and Bloomberg School of Public Health

Need for Focused Attention

We realized that the areas with the worst health outcomes and the most health disparities, also cost the State the most money

RESPONSE

SB 234: Maryland Health Improvement & Disparities Reduction Act of 2012

In 2012 SB 234, the Health Improvement and Disparities Reduction Act was signed into law, establishing the Health Enterprise Zones and providing $4 million per year for 4 years to support the HEZs

As legislatively mandated, the purpose of establishing Health Enterprise Zones is to target State resources to **reduce health disparities, improve health outcomes, and reduce health costs and hospital admissions and readmissions in specific areas of the State**.

What is a Health Enterprise Zone?

- A designated local community with documented poverty, health disparities and/or poor health outcomes, where special incentives and funding streams are available to address poor health outcomes by using healthcare-level, community-level and individual level interventions.

- There were 5 HEZs in MD, based at:
  - Anne Arundel Medical Center (suburban)
  - Prince George's County Health Department (suburban)
  - Bon Secours Hospital (urban)
  - Caroline/Dorchester County Health Departments (rural)
  - MedStar St. Mary's Hospital (rural)

HEZ Eligibility Criteria

1. Community, or a contiguous cluster of communities, defined by zip code boundaries (one or multiple zip codes)

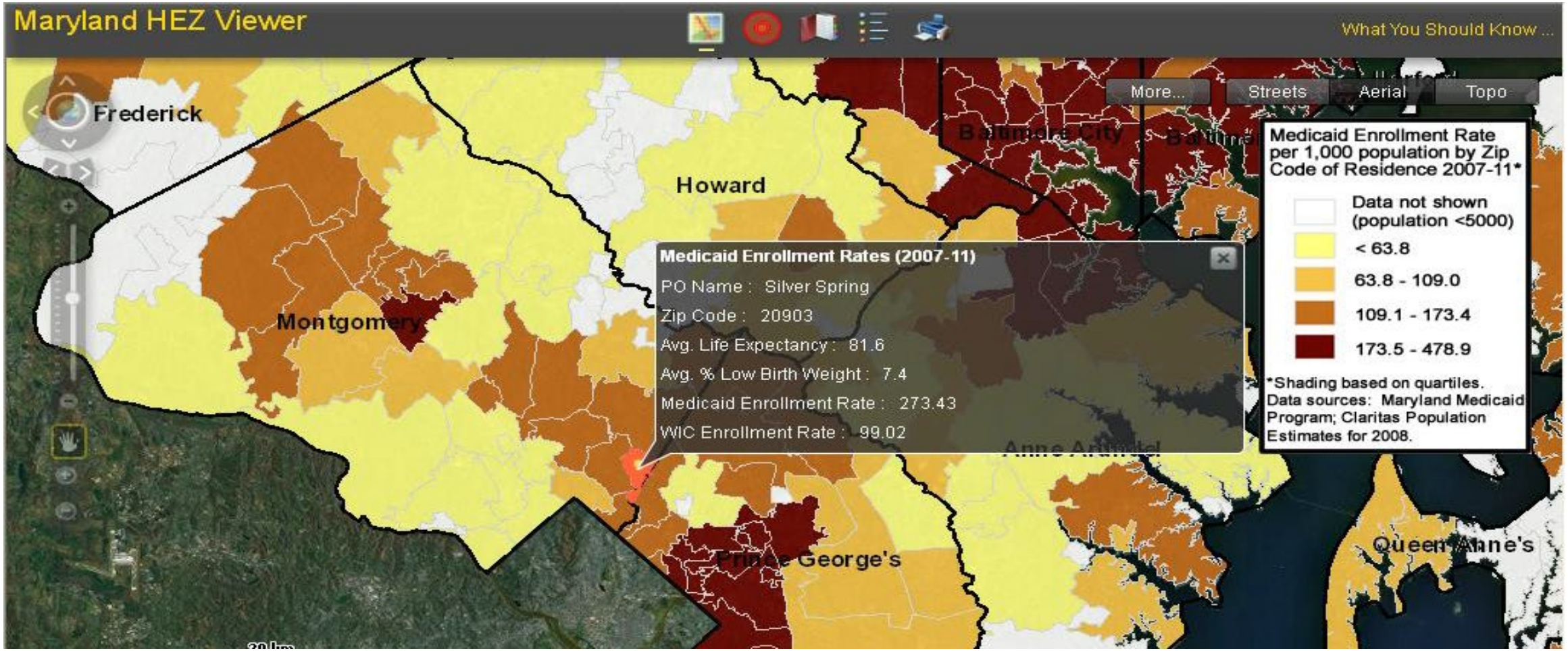
2. Resident population of at least 5,000 people

3. Demonstrate greater economic disadvantage than MD average:
   i. Medicaid enrollment rate or
   ii. WIC participation rate

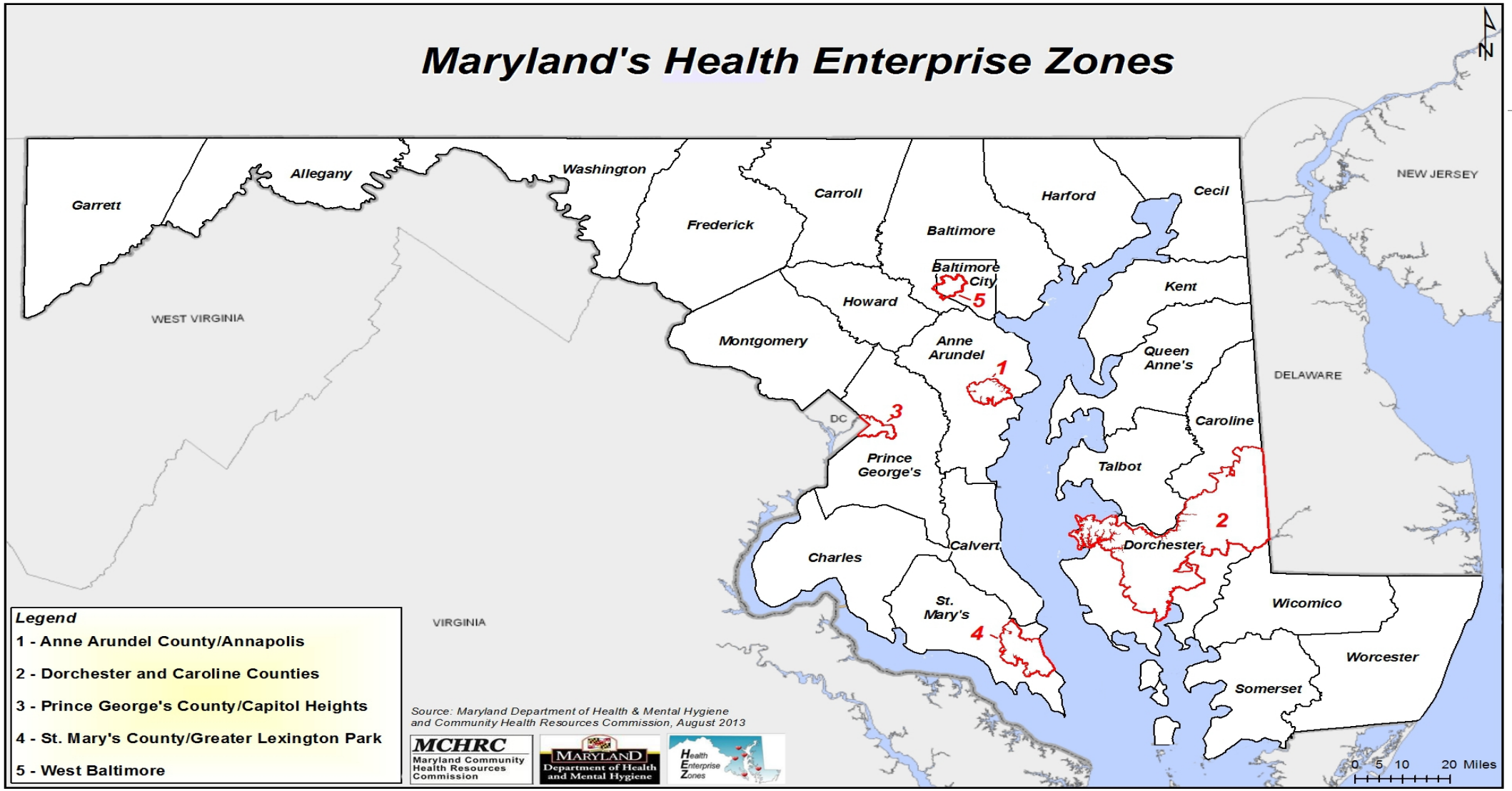
4. Demonstrate poorer health outcomes than MD average:
   i. A lower life expectancy or
   ii. Percentage of low birth weight infants

HEZ Eligibility Criteria and Data

Based on these criteria DHMH developed dynamic maps with data at the zip-code level



Health Enterprise Zone Designation



MHHD Logic Model Incorporated into HEZ

The MHHD Logic Model has six key strategies that are generally applicable to programs.

These six strategies became HEZ guiding principles:

1. Cultural, linguistic and health literacy competency
2. Workforce diversity
3. Outreach to and targeting of minority populations
4. Racial, ethnic & language data collection/reporting
5. Addressing social determinants of health
6. Balance between provider and community focus

HEZ Incentive Program

Legislation provided incentives and resources to attract providers:

- State income tax credits
- Hiring tax credits
- Grants for program support, equipment purchase or lease
- Loan repayment assistance programs

Practitioners must meet the following criteria to access tax credits:

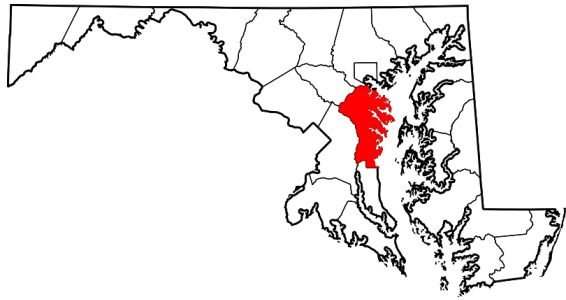
- Cultural competency training
- Accept Medicaid and uninsured patients
- Letter of support from the Coordinating Organization

Broader Health Care Environment

- Affordable Care Act
- Maryland Medicaid Expansion
- Global Budgets
  - Maryland All Payer model – payment reform/delivery system reform
  - Emphasis on care coordination and community clinical linkages
  - Community-integrated medical model

THE ZONES

MORRIS BLUM-ANNAPOLIS (Suburban)



Community: Annapolis, Morris Blum Public Housing Building (zip code 21401)

Coordinating Organization: Anne Arundel Medical Center

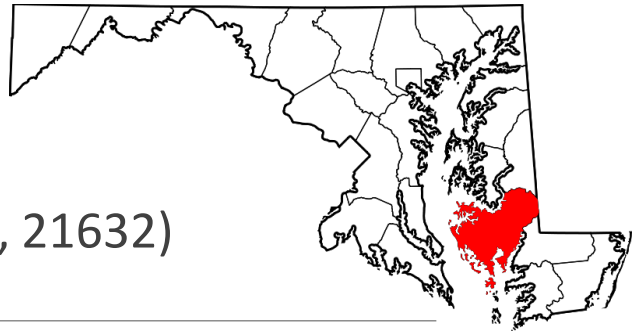
Key Strategies:

- Established a new patient-centered medical home embedded in Morris Blum, a public housing senior citizen facility that is home for 184 residents
- Provided capacity to see non-resident patients
- Care coordination and CHW services
- Community enabling interventions – walking groups, blood pressure screenings, specialty behavioral health access, smoking cessation workshops, nutrition classes, medication reconciliation

Target Outcomes:

- Improved chronic disease management and patient health outcomes
- Decreases in 911 calls, emergency room visits, hospital admissions, and readmissions
- Focus on diabetes and smoking prevention

DORCHESTER-CAROLINE COUNTIES (Rural)



Community: Mid-Shore Region (zip codes 21613, 21631, 21643, 21835, 21659, 21664, 21632)

Coordinating Organization: Dorchester County Health Department

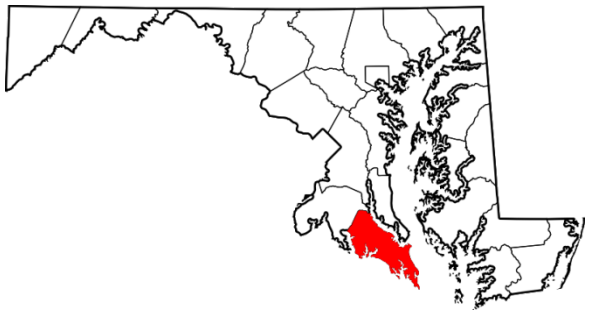
Key Strategies:

- Created a new mobile mental health crisis team for Dorchester and Caroline Counties
- Expanded Chesapeake Women's Health with 3 FTE PCPs
- Expanded School Based Wellness Center clinical services
- Expanded Care Coordination and CHW programs
- Expanded access to peer recovery support specialists
- School-based asthma management program
- Weight management program
- Open adult mental health clinic

Target Outcomes:

- Decrease hospital and ED utilization rates
- Focus on behavioral health, diabetes, hypertension, and adult/childhood obesity

GREATER LEXINGTON PARK (Rural)



Community: Greater Lexington Park (zip codes 20653, 20634, 20667)

Coordinating Organization: MedStar St. Mary's Hospital (MSMH)

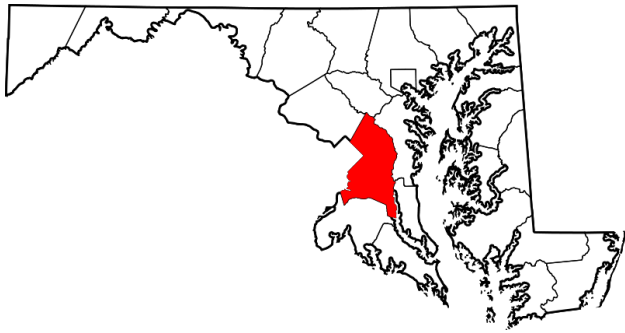
Key Strategies:

Implemented Care Coordination/CHW program targeting high utilizers
Created a new community health care center in Lexington Park and MSMH private practice
Developed a "health care transportation route" and specialty transportation service
Provided access to mobile dental services
Integrated behavioral health and somatic health services

Target Outcomes:

- Reduce preventable hospital emergency department visits, admissions, and readmissions for chronic diseases
- Focus on diabetes, cardiovascular disease, asthma, and behavioral health

PRINCE GEORGE'S COUNTY – CAPITOL HEIGHTS (Suburban)



Community: Capitol Heights (zip code 20743)

Coordinating Organization: Prince George's County Health Department

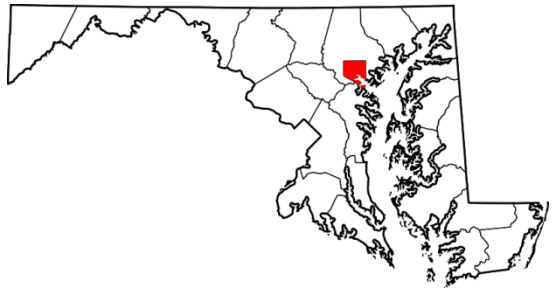
Key Strategies:

- Established five new patient-centered medical homes (PCMHs) in zip code 20743
- Developed county health information exchange
- Implemented Care Coordination/CHW program targeting high utilizers and Community Care Coordination Team
- Health literacy campaign
- Prime Time Sister Circles

Target Outcomes:

- Reduce preventable hospital admissions and emergency department visits for chronic conditions
- Generate sustainable expansion of the primary and community health workforce in the Zone
- Focus on diabetes, cardiovascular disease, and asthma

WEST BALTIMORE PRIMARY CARE ACCESS COLLABORATIVE (Urban)



Community: West Baltimore (zip codes 21216, 21217, 21223, 12129)

Coordinating Organization: Bon Secours Baltimore Health System

Key Strategies:

Expanded access to primary and preventative care

Implemented Care Coordination/CHW program targeting high utilizers with 5 partner hospitals

Provided residents with scholarship opportunities; promoted entry-level work force opportunities for residents

Addressed “food deserts” in Zone, cooking classes, fitness classes, chronic disease self-management courses

Mini-grants to community partners

Target Outcomes:

Reduce emergency department visits related to cardiovascular disease

- Focus on diabetes, cardiovascular disease, obesity, and smoking prevention

Monitoring Progress and Outcomes

Published Findings

RESEARCH ARTICLE DETERMINANTS OF HEALTH

HEALTH AFFAIRS > VOL. 37, NO. 10 : SOCIAL DETERMINANTS, DRUG & DEVICE PRICES & MORE

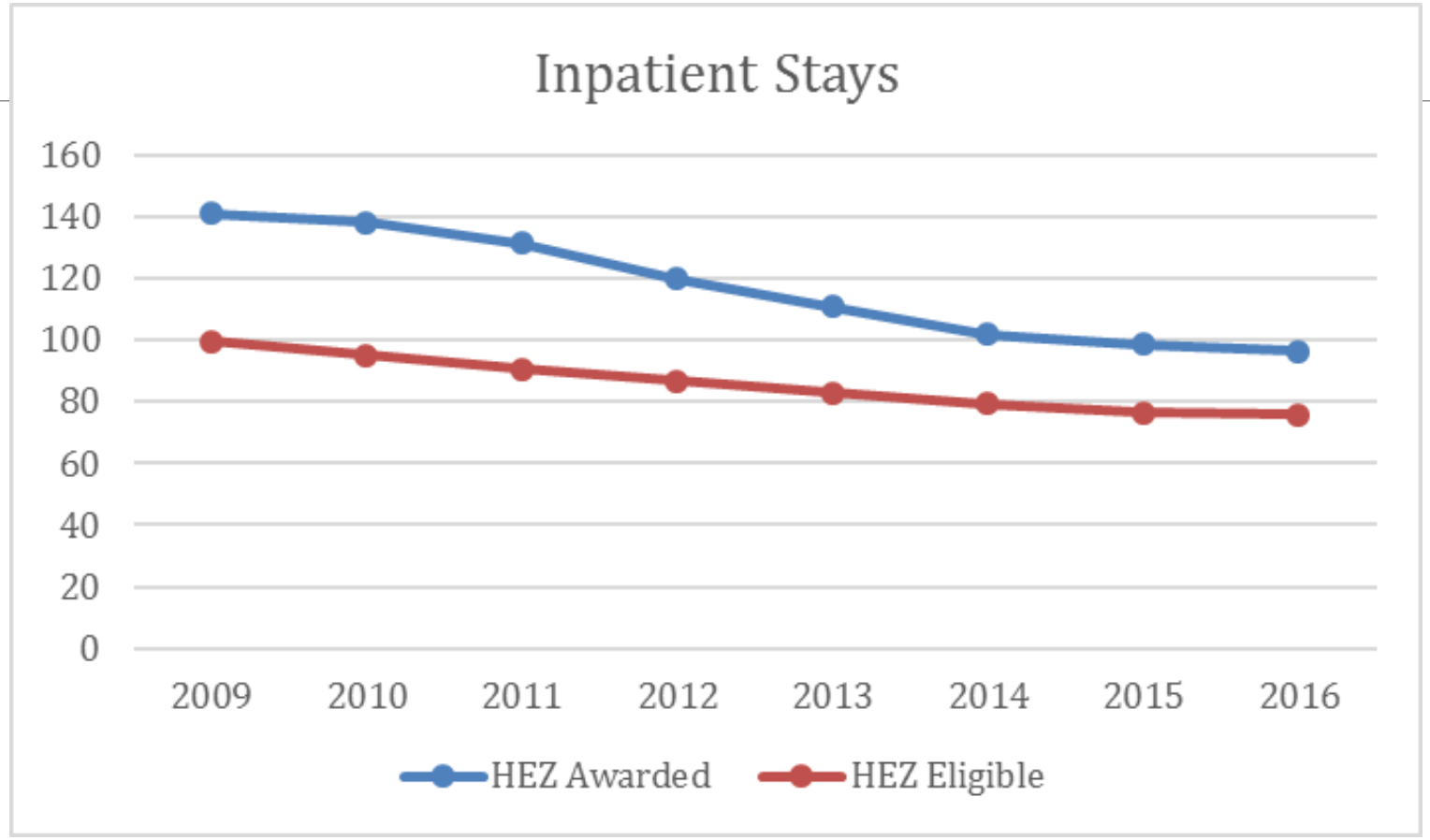
The Maryland Health Enterprise Zone Initiative Reduced Hospital Cost And Utilization In Underserved Communities

Darrell J. Gaskin, Roza Vazin, Rachael McCleary, and Roland J. Thorpe

ABSTRACT

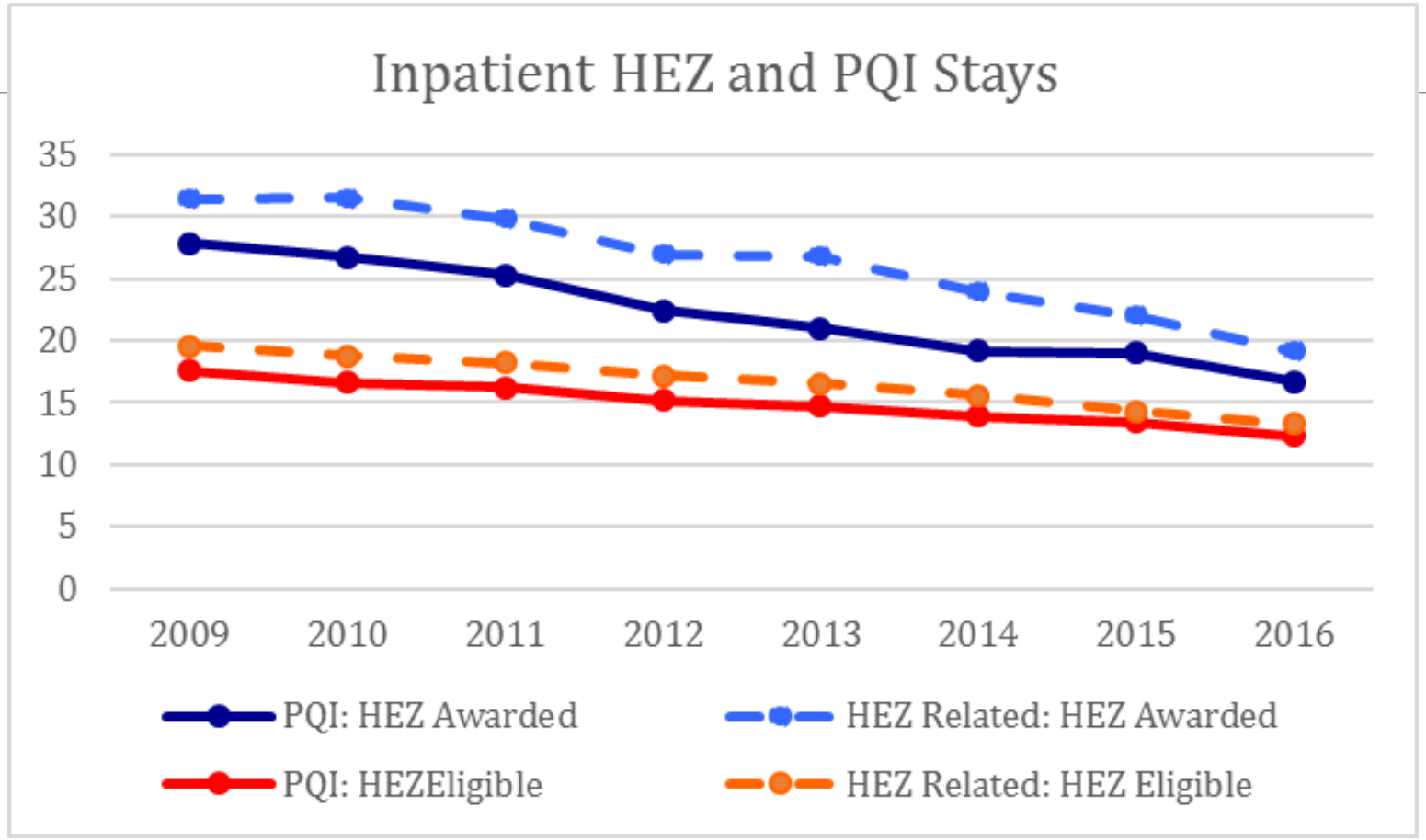
The State of Maryland implemented the Health Enterprise Zone Initiative in 2013 to improve access to health care and health outcomes in underserved communities and reduce health care costs and avoidable hospital admissions and readmissions. In each community the Health Enterprise Zone Initiative was a collaboration between the local health department or hospital and community-based organizations. The initiative was designed to attract primary care providers to underserved communities and support community efforts to improve health behaviors. It deployed community health workers and provided behavioral health care, dental services, health education, and school-based health services. We found that the initiative was associated with a reduction of 18,562 inpatient stays and an increase of 40,488 emergency department visits in the period 2013–16. The net cost savings from reduced inpatient stays far outweighed the initiative's cost to the state. Implementing such initiatives is a viable way to reduce inpatient admissions and reduce health care costs.

Total Discharges per 1,000 Residents for HEZ and HEZ-Eligible Zip Codes 2009-2016



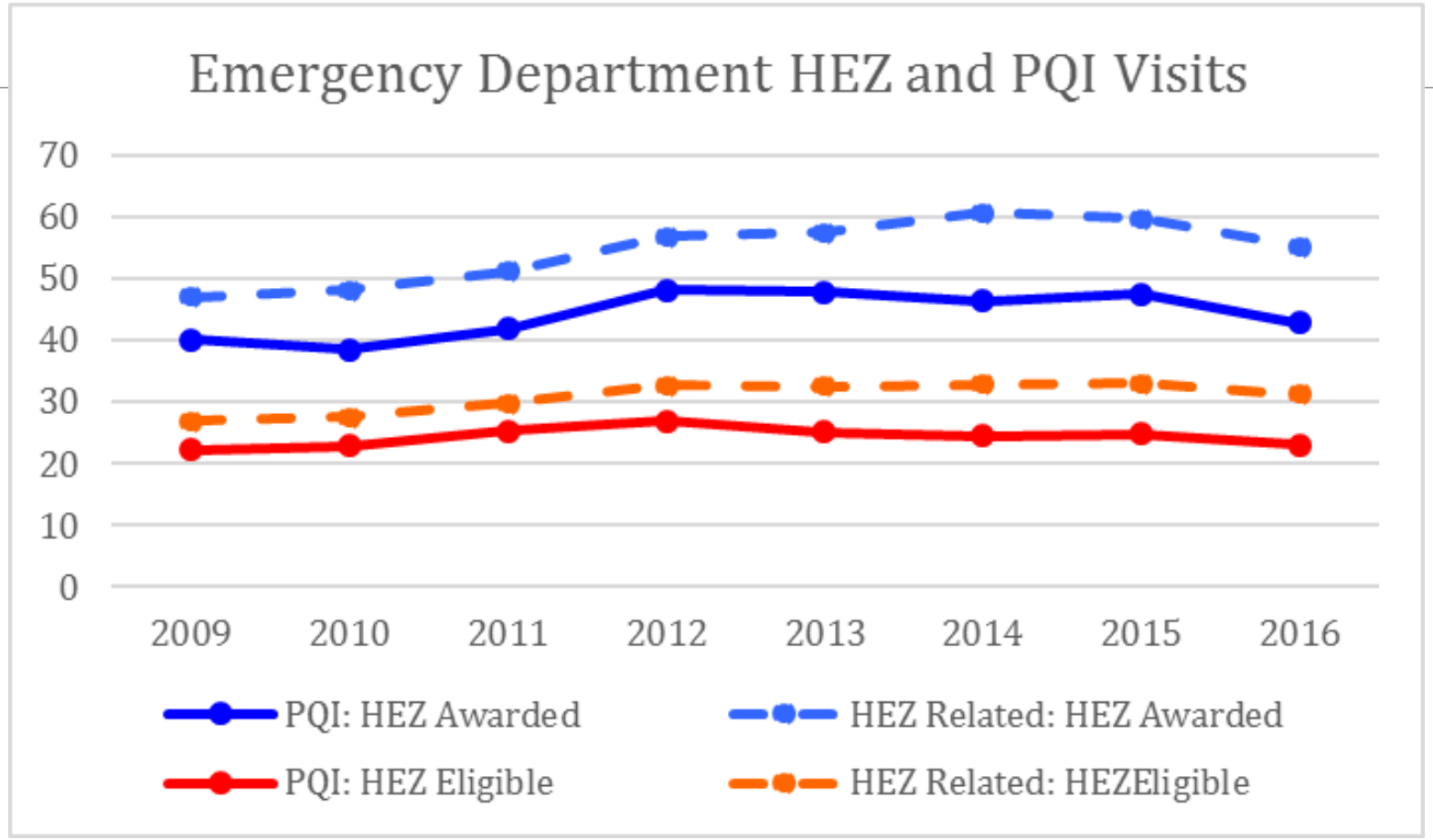
HSCRC data prepared by the Johns Hopkins Center for Health Disparities Solutions

Discharges for HEZ-related and PQI Conditions per 1,000 Residents for HEZ and HEZ-Eligible Zip Codes, 2009-2016



HSCRC data prepared by the Johns Hopkins Center for Health Disparities Solutions

Emergency Room Visits for HEZ-related and PQI Conditions per 1,000 residents for HEZ and HEZ-Eligible Zip Codes, 2009-2016



HSCRC data prepared by the Johns Hopkins Center for Health Disparities Solutions

Process Evaluation

Expanding capacity to deliver services:

- 21 health care delivery sites opened or expanded
- 99.09 FTEs added or retained including
  - 20.2 licensed independent practitioners
  - 32 other licensed or certified health care practitioners
  - 12.75 CHWs
- $326,985 in income tax credits awarded to 34 HEZ practitioners through 63 awards and 19 HEZ practitioners awarded loan repayment assistance

Process Evaluation

Provided new or expanded primary care, behavioral health, dental and wrap-around public health and social services:

- 346,337 visits provided to 195,207 patients
- Care coordination programs targeted to ‘high utilizers’
- Linked HEZ data systems to facilitate data sharing and co-management of complex patients
- Self-management and community supports to address social determinants of health

HEZ Capacity: Health Care Delivery Sites

HEZ	Year 1				Year 2	Year 3	Year 4		Total
W. Baltimore Primary Care Access Collaborative	St. Agnes Outpatient (P)	Baltimore Medical System (P, B)	Bon Secours Family Health and Wellness (P)	Total Health Care (P, B, D)					4
Prince George's County HEZ	Gerald Family Care (P)	Greater Baden Medical Services (P, B, D)	Global Vision (P, B)				Family and Medical Counseling (P, B)	Dimensions Specialty Care Center (P)	5
Greater Lexington Park HEZ	Get Connected to Health Mobile Clinic (P, B)	Walden Sierra, Inc. (B)			MedStar St. Mary's Hospital Primary Care Practice and Dental Van (P,B, D)		East Run Medical Center (P, B, D)		5
Competent Care Connections HEZ	Chesapeake Women's Health (P)	Caroline School Based Wellness (P, B)	Dorchester School Based Wellness (P, B)	Mobile Crisis Team (B)	Federalsburg Adult Mental Health Clinic (B)	Choptank Community Health (P, D)			6
Anne Arundel Community Health Partnership	Morris Blum Clinic (P)								1
							TOTAL		**21**

Legend	
	Expanded Site
	Newly Opened Site
P	Primary Care
B	Behavioral Health
D	Dental

LESSONS LEARNED

Lessons Learned

- **Time and Timing:**
  - Planning year - refine strategic plans, develop relationships and performance measures
  - Early sustainability planning
  - 4 years is not long enough – building trust, acquiring and rehabbing building space
  - Leverage new incentives in the health care system
- **Data:**
  - Collecting and connecting data across multiple provider sites
- **Innovation:**
  - Accounting for the broader health care environment
  - Incorporating equity into the design of the initiative
  - More flexible recruitment and retention incentives
  - Funding for equipment purchase or lease

Lessons Learned

- **Providers:**
  - Provider recruitment and retention
  - Identifying experts
  - Working with complex patients
- **Patient and Community Engagement:**
  - Importance of health literacy, social marketing and other patient activation efforts
  - Importance of understanding and accounting for a community's history and underlying structural, social and system factors
  - Policy and advocacy efforts
- **Clinical and Community Care:**
  - Community integrator organizations leading diverse, multi-stakeholder coalitions with common agenda and shared data
  - Balance between community and provider focused interventions
  - More than additional provider care
  - Tailored models: high impact, evidence-based and innovative practices

PROGRESS AND NEXT STEPS

Awards and Impact

Awards:

- 2016 RWJF kickoff and sustainability planning summit grant awards
- 2016 ASTHO Award for Innovation
- 2016 Maryland Department of Health and Mental Hygiene Health Equity Award: *Advancing Social Justice through Health Equity*

Consultations:

- Big 10 Coalition: Infant and Maternal Mortality focused-initiative
- New York Department of Health
- Rhode Island Departments of Health

Replicability:

- HEZ-Like Models: Rhode Island, Philadelphia

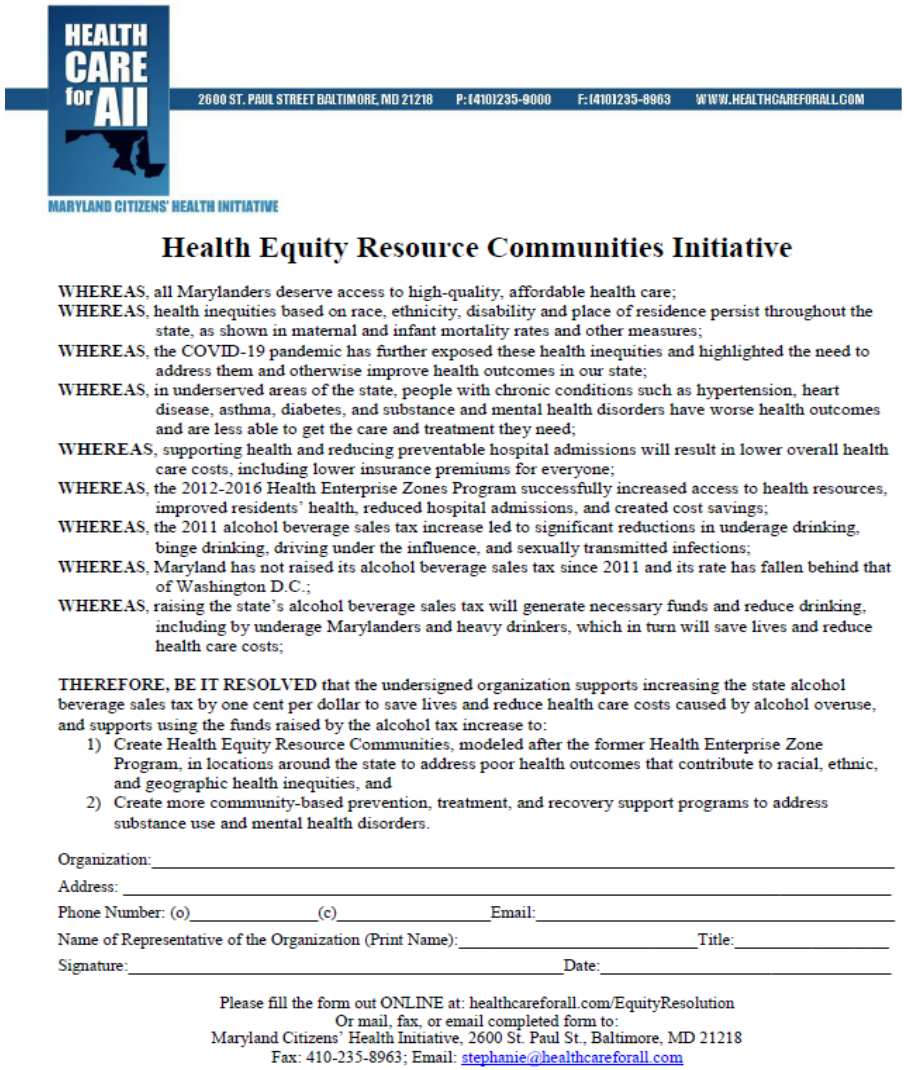
Proposals:

- RWJF Policy for Action Proposal submitted

Publications

- Journal articles
- Manuscripts

Impact and Opportunity



HEALTH CARE for All

2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM

MARYLAND CITIZENS' HEALTH INITIATIVE

Health Equity Resource Communities Initiative

WHEREAS, all Marylanders deserve access to high-quality, affordable health care;
WHEREAS, health inequities based on race, ethnicity, disability and place of residence persist throughout the state, as shown in maternal and infant mortality rates and other measures;
WHEREAS, the COVID-19 pandemic has further exposed these health inequities and highlighted the need to address them and otherwise improve health outcomes in our state;
WHEREAS, in underserved areas of the state, people with chronic conditions such as hypertension, heart disease, asthma, diabetes, and substance and mental health disorders have worse health outcomes and are less able to get the care and treatment they need;
WHEREAS, supporting health and reducing preventable hospital admissions will result in lower overall health care costs, including lower insurance premiums for everyone;
WHEREAS, the 2012-2016 Health Enterprise Zones Program successfully increased access to health resources, improved residents' health, reduced hospital admissions, and created cost savings;
WHEREAS, the 2011 alcohol beverage sales tax increase led to significant reductions in underage drinking, binge drinking, driving under the influence, and sexually transmitted infections;
WHEREAS, Maryland has not raised its alcohol beverage sales tax since 2011 and its rate has fallen behind that of Washington D.C.;
WHEREAS, raising the state's alcohol beverage sales tax will generate necessary funds and reduce drinking, including by underage Marylanders and heavy drinkers, which in turn will save lives and reduce health care costs;

THEREFORE, BE IT RESOLVED that the undersigned organization supports increasing the state alcohol beverage sales tax by one cent per dollar to save lives and reduce health care costs caused by alcohol overuse, and supports using the funds raised by the alcohol tax increase to:

1) Create Health Equity Resource Communities, modeled after the former Health Enterprise Zone Program, in locations around the state to address poor health outcomes that contribute to racial, ethnic, and geographic health inequities, and
2) Create more community-based prevention, treatment, and recovery support programs to address substance use and mental health disorders.

Organization:_____

Address: _____

Phone Number: (o)_____(c)_____Email:_____

Name of Representative of the Organization (Print Name):_____Title:_____

Signature:_____Date:_____

Please fill the form out ONLINE at: healthcareforall.com/EquityResolution
Or mail, fax, or email completed form to:
Maryland Citizens' Health Initiative, 2600 St. Paul St., Baltimore, MD 21218
Fax: 410-235-8963; Email: stephanie@healthcareforall.com

2021 Legislative Agenda:

- **Health Equity Resource Act SB172 HB463**
  - Maryland Health Care for All
  - 2021 Maryland General Assembly
  - 10-year Initiative
  - Supported by all 5 HEZs
  - 223 supporters (CBOs, Insurers, Faith-based organizations, MHA, advocacy groups)
- **Health Enterprise Zones: HR4510**
  - Sponsored by Congressman Anthony Brown
  - Reintroduced in the 117th Congress

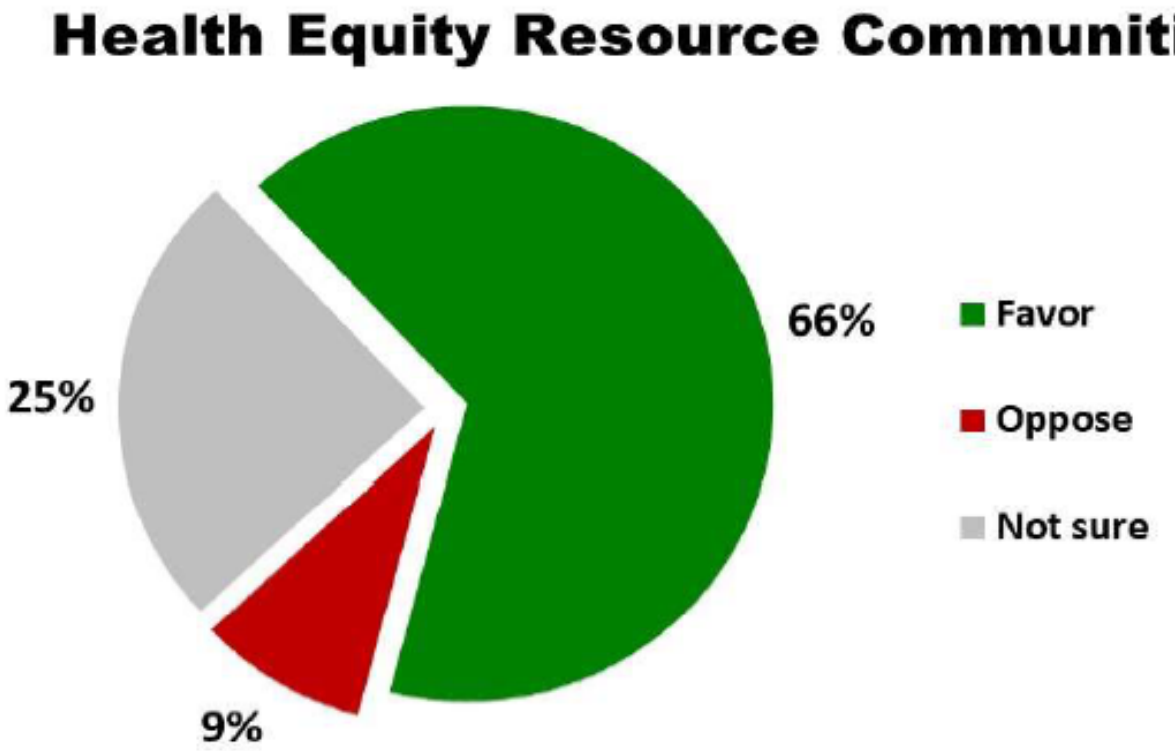
Publications

- Journal articles
- Manuscripts

Impact and Opportunity

Widespread Support for Health Equity Resource Communities

By an overwhelming margin of 66% to 9%, Maryland voters support the creation of Health Equity Resource Communities to provide grants, tax incentives, and loans for health care providers in parts of the state with poor health outcomes. One-quarter of the state's voters said they were not sure.



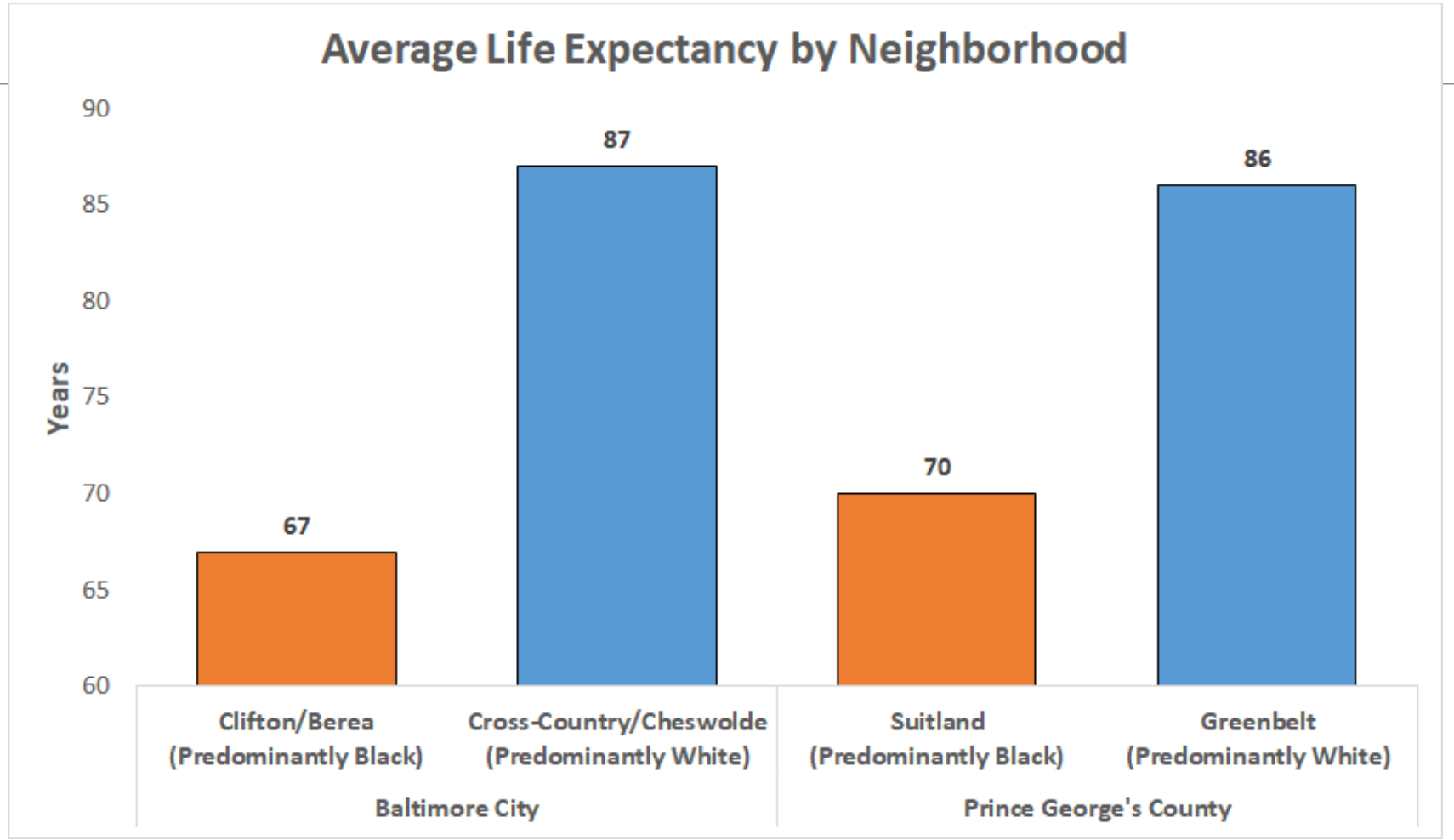
Credit: Vinny DeMarco
Health Care for All
www.healthcareforall.com

Impact and Opportunity

Health Equity Coalition

Hundreds of faith, business, labor, community, and health care organizations

Opportunity: Health Equity Resource Act Passage



Credit: Vinny DeMarco
Health Care for All
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Opportunity: Health Equity Resource Act Implementation

- Evidence-based, community-led efforts to improve health care access in disadvantaged communities
- $59 million in new funding over the next five years
  - $14 million now for Pathways to Health Equity Grants
  - $45 million later for Health Equity Resource Communities
- Administered by the Community Health Resources Commission and assisted by the HERC Advisory Committee
- Technical assistance, grants, and health care provider loan repayment assistance

QUESTIONS

Michelle Spencer, MS

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Additional Slides For Reference Only

HEZ Capacity: Jobs Added

Number of Jobs Added (Recruited or Retained) by HEZ and Job Type, in FTEs, as of Y4Q4

HEZ	Licensed Independent Practitioner	Other Licensed or Certified Practitioner	Qualified Employees (CHWs/ Interpreters)	Support Staff	Total as of Y4Q4
WBPCAC	3	16	1	2.8	22.8
PGCHEZ	4.4	4.83	5	7.63	21.86
GLP HEZ	7.5	3.7	3.5	6.5	21.2
CCC	4.3	6.45	3.25	15.23	29.23
ACHP	1	1	0	2	4
TOTAL	20.2	31.98	12.75	34.16	99.09

HEZ Capacity: Recruitment Incentives (Income Tax Credit)

Number of Practitioner Income Tax Credit Awards and Amount Granted per Tax Year, by HEZ

- Total of $326,985 in income tax credits awarded
- 63 awards
- 34 practitioners
- One $10,000 hiring tax credit awarded
- $45,000 in hiring bonuses

Tax Year	HEZ	Number of Applicants that Received Final Certification	Amount of Funding Granted
2013	WBPCAC	5	$26,204.75
	Total	5	$26,204.75
2014	WBPCAC	11	$84,006.00
	CCC	9	$27,190.00
	GLP HEZ	1	$659.00
	PGCHEZ	0	$0.00
	Total	21	$111,855.00
2015	WBPCAC	8	$66,408.00
	CCC	9	$32,899.00
	GLP HEZ	1	$3,567.00
	PGCHEZ	0	$0.00
	Total	18	$102,874.00
2016	WBPCAC	8	$43,381.00
	CCC	8	$28,348.00
	GLP HEZ	2	$11,295.00
	PGCHEZ	1	$3,027.00
	Total	19	$86,051.00

HEZ Capacity: Recruitment Incentives (Loan Repayment)

Number of Loan Repayment Assistance Awards, by HEZ and by Year

HEZ	2013	2014	2015	2016	Total by HEZ
CCC	0	1	2	1	4
GLP HEZ	0	0	0	1	1
PGCHEZ	0	0	0	0	0
WBPCAC	3	2	2	7	14
Total by Year	3	3	4	9	19

HEZ Reach: Patients and Patient Visits

Number of Patients and Patient Visits, by HEZ

Patient Totals as of Y4Q4	Patient Visits	Number of Patients
WBPCAC	210,951	132,857
PGCHEZ	76,399	46,842
GLP HEZ	23,534	4,539
CCC	27,087	6,098
ACHP	8,366	4,871
TOTAL	346,337	195,207

Patient visits are unduplicated within but not across quarters.

HEZ Reach: Self-Management Supports

AACHP	Initiative Total
Blood pressure screening participants	1,284
Diabetes self-management program	82
Healthy lifestyle activities	410
Community health events	1,225
Smoking cessation workshops	573
CCC	
CHW Screenings	1,316
Maryland Healthy Weighs	635
Dri-Dock Peer Recovery	244
Chesapeake Voyagers Peer Recovery	291
GLP HEZ	
Rides on HEZ Mobile Medical Route	17,554
Medical specialty rides	738
PGCHEZ	
Wellness Plans created for Global Vision patients	1,495
Wellness Plans created for Greater Baden patients	1,187
Wellness Plans created for Gerald Family Care patients	291
Completed client resource connections	15,956
WBPCAC	
Stanford Disease Management Program	590
WB CARE Fitness Program	4,618
Passport to Health program	6,588

HEZ	Care Coordination Participant Totals
ACHP	268
CCC	430
GLP HEZ	2,085
PGCHEZ	1,213
WBPCAC	2,046