Maryland’s Health Enterprise Zone Initiative
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
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
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

Maryland's Health Enterprise Zones

Legend
1 - Anne Arundel County/Annapolis
2 - Dorchester and Caroline Counties
3 - Prince George’s County/Capitol Heights
4 - St. Mary's County/Greater Lexington Park
5 - West Baltimore

Source: Maryland Department of Health & Mental Hygiene and Community Health Resources Commission, August 2013
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-ANNAPOLESIS (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
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
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
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

Inpatient Stays

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

Emergency Department HEZ and PQI Visits

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
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

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

<table>
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<tr>
<th>Legend</th>
<th>Expanded Site</th>
<th>Newly Opened Site</th>
<th>P</th>
<th>Primary Care</th>
<th>B</th>
<th>Behavioral Health</th>
<th>D</th>
<th>Dental</th>
</tr>
</thead>
</table>
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

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.

Health Equity Resource Communities

- Favor: 66%
- Oppose: 25%
- Not sure: 9%
Impact and Opportunity

Health Equity Coalition

Hundreds of faith, business, labor, community, and health care organizations
Opportunity: Health Equity Resource Act Passage

Average Life Expectancy by Neighborhood

- Clifton/Berea (Predominantly Black): 67 years
- Cross-Country/Cheswolda (Predominantly White): 87 years
- Suitland (Predominantly Black): 70 years
- Greenbelt (Predominantly White): 86 years

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

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Associate Scientist, Health Policy and Management
Associate Chair, Inclusion, Diversity, Anti-Racism and Equity
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Maryland Department of Health
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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

<table>
<thead>
<tr>
<th>HEZ</th>
<th>Licensed Independent Practitioner</th>
<th>Other Licensed or Certified Practitioner</th>
<th>Qualified Employees (CHWs/Interpreters)</th>
<th>Support Staff</th>
<th>Total as of Y4Q4</th>
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<tbody>
<tr>
<td>WBPCAC</td>
<td>3</td>
<td>16</td>
<td>1</td>
<td>2.8</td>
<td>22.8</td>
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<tr>
<td>PGCHEZ</td>
<td>4.4</td>
<td>4.83</td>
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<td>7.63</td>
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<td>GLP HEZ</td>
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<td>3.5</td>
<td>6.5</td>
<td>21.2</td>
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<td>CCC</td>
<td>4.3</td>
<td>6.45</td>
<td>3.25</td>
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<td>1</td>
<td>0</td>
<td>2</td>
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<tr>
<td>TOTAL</td>
<td>20.2</td>
<td>31.98</td>
<td>12.75</td>
<td>34.16</td>
<td>99.09</td>
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</table>
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

<table>
<thead>
<tr>
<th>Tax Year</th>
<th>HEZ</th>
<th>Number of Applicants that Received Final Certification</th>
<th>Amount of Funding Granted</th>
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<td>2013</td>
<td>WBPCAC</td>
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<td>$26,204.75</td>
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<td>Total</td>
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<td>2015</td>
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<td>CCC</td>
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<td>GLP HEZ</td>
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<td>Total</td>
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<td>GLP HEZ</td>
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<td>Total</td>
<td>19</td>
<td>$86,051.00</td>
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### HEZ Capacity: Recruitment Incentives (Loan Repayment)

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

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<thead>
<tr>
<th>HEZ</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Total by HEZ</th>
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<td>CCC</td>
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<td>2</td>
<td>1</td>
<td>4</td>
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<tr>
<td>GLP HEZ</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PGCHEZ</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>WBPCAC</td>
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<td>2</td>
<td>7</td>
<td>14</td>
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<tr>
<td>Total by Year</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>9</td>
<td>19</td>
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HEZ Reach: Patients and Patient Visits

Number of Patients and Patient Visits, by HEZ

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<thead>
<tr>
<th>Patient Totals as of Y4Q4</th>
<th>Patient Visits</th>
<th>Number of Patients</th>
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<tbody>
<tr>
<td>WBPCAC</td>
<td>210,951</td>
<td>132,857</td>
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<td>PGCHEZ</td>
<td>76,399</td>
<td>46,842</td>
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<td>GLP HEZ</td>
<td>23,534</td>
<td>4,539</td>
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<td>CCC</td>
<td>27,087</td>
<td>6,098</td>
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<tr>
<td>ACHP</td>
<td>8,366</td>
<td>4,871</td>
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<td>TOTAL</td>
<td>346,337</td>
<td>195,207</td>
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Patient visits are unduplicated within but not across quarters.
## HEZ Reach: Self-Management Supports

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

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<th>Participant Totals</th>
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