STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor; Boyd Rutherford, Lt. Governor
Edward J. Kasemeyer, Chair; Mark Luckner, Executive Director

TO: The Hon. Bill Ferguson, President, Maryland State Senate
The Hon. Adrienne A. Jones, Speaker of the Maryland House of Delegates

CC: The Hon. Guy Guzzone, Chair, Senate Budget & Taxation Committee
The Hon. Delores G. Kelly, Chair, Senate Finance Committee
The Hon. Shane E. Pendergrass, Chair, House Health & Government Operations Committee
The Hon. Vanessa E. Atterbeary, Chair, House Ways & Means Committee

FROM: The Hon. Edward J. Kasemeyer, Chair, Community Health Resources Commission

DATE: March 24, 2022

RE: Update: Maryland Health Equity Resource Act - Pathways to Health Equity Program

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This briefing memo provides an update on the implementation of the Maryland Health Equity Resource Act (Chapters 741 and 742 of 2021) and follows an update previously submitted to the Maryland General Assembly on December 22, 2021.

The Maryland Health Equity Resource Act provides significant new grant funding and state resources for local communities to address health disparities, improve health outcomes, expand access to primary care and prevention services, and help to reduce health care costs. The Pathways to Health Equity Call for Proposals issued by the Maryland Community Health Resources Commission (CHRC) generated 40 proposals requesting $42.3 million. Following a review period and applicant presentations, the CHRC Commissioners voted on February 15, 2022, to award nine Pathways grantees for a total of $13.5 million. A summary of each of these nine new program awards is provided below.

Of the nine new programs, three will serve Baltimore City, three will serve Prince George's County, and three will serve rural communities (Lower Shore, Western Maryland, and Southern Maryland). Of the nine programs, five will serve communities previously supported by the prior Health Enterprise Zone (HEZ) Initiative. As a reminder, these nine Pathways grants are designed to be two-year projects, and help lay the groundwork for the communities served to become future "Health Equity Resource Communities" that will be designated in a Call for Proposals to be issued by the CHRC in the future.

The Maryland Health Equity Resource Act requires the CHRC to provide a report to the Governor and General Assembly that includes:

1. A list and summary of the grants awarded;
2. An overview of key interventions in the grants awarded;
3. Specific health disparities that will be addressed by the grants; and
4. Key measures to evaluate the impact of each grant.

1. List and summary of the grants awarded

Baltimore Healthy Start (Baltimore City; total award: $875,000). This project will address disparities in hypertension, Substance Use Disorder (SUD), Low Birth Weight, and Severe Maternal Morbidity for pregnant and postpartum women and their infants in the Druid Heights and Walbrook areas of Baltimore City (zip codes 21216 and 21217). The project will expand existing service coordination and home-visiting projects and facilitate access to primary care and substance use treatment through referrals. Interventions include hypertension education administered by trained CHWs, home BP monitoring and tracking, peer support groups, and care coordination addressing clients' acute stressors and SDOH needs.

Greater Baltimore Medical Center (Baltimore City; total award: $1,500,000). This project will address disparities in diabetes and hypertension among the African American population in the Greenmount East, Harbor East/Little Italy, Inner Harbor/Federal Hill, Midtown, Oldtown/Middle East, and Waverly areas of Baltimore (zip codes 21202 and 21218). Key interventions include an expansion of the number of patients treated at GBMC Jonestown Clinic, where patients will receive comprehensive primary and preventive care services including vaccinations and screenings; disease management and care coordination services; at-home care for elderly participants; and support to address Social Determinants of Health (SDOH) needs. The project will also conduct public screenings and education at community events, and healthy lifestyle interventions such as community walks/runs, education workshops, patient support groups, peer challenges to support water and protein intake goals, and healthy cooking demonstrations.

University of Maryland School of Nursing (Baltimore City; total award: $2,400,000). This project will address disparities in hypertension, mental health, and social isolation in West Baltimore (zip codes 21201, 21217, 21223, and 21229). Key interventions include: establishing a learning collaborative, using nurse-managed health centers, leveraging mobile health care, and enhancing care coordination through a community health worker model. Targeted outcomes include decreasing the number of patients with uncontrolled hypertension and increasing participation in social support groups.

La Clínica del Pueblo (Montgomery & Prince George's Counties; total award: $1,500,000). This project will address disparities in diabetes for the Hispanic population in areas of Montgomery and Prince George's Counties (zip codes 20703, 20706, 20710, 20712, 20722, 20737, 20740, 20770, 20781, 20782, 20783, 20784, 20785, 20901, 20903, and 20912). Interventions will include remote diabetes monitoring, peer-led diabetes self-management, diabetes health screenings via the Luminis mobile clinic, navigation to primary care, addressing barriers to access such as lack of insurance and transportation, access to fresh produce, peer-led walking groups, health system navigation and legal services support, medical interpretation, and a comprehensive community health education, awareness and outreach campaign.

Johns Hopkins School of Medicine (Prince George's County; total award: $2,000,000). This project will address disparities associated with the high prevalence of sickle cell disease (SCD) and lack of access to a local comprehensive sickle cell project in Prince George's County, with specific focus on Upper Marlboro, Laurel and Capital Heights (zip codes 20773, 20707, and 20743). This project aims to reduce the number of adults who present to UMCP hospital for acute pain requiring hospital admission, and to improve access to SCD modifying treatment and transition services for adolescents and young adults to reduce hospitalizations. This comprehensive sickle cell project includes a new infusion clinic at UM Capital Region Medical Center. CHWs will identify participants who lack resources to facilitate access, coordinate their care, and provide SCD education. A nurse navigator will facilitate interventions to address SDOH needs, and a nutritionist will develop a food plan for each participant.

Prince George's County Health Department (Prince George's County; total award: $1,600,000). This project will address disparities in heart disease and diabetes in the Capitol Heights, Bladensburg, Hyattsville, and Riverdale areas (zip codes 20710, 20737, 20743, and 20785). Key interventions include Community Health Worker (CHW)-driven outreach and care coordination, bi-directional e-referrals among health and social service providers, and technical assistance to improve providers' ability to bill for care coordination. The project will promote delivery of culturally and linguistically sensitive services, and utilize EMR, CRISP, and telehealth services including through telehealth hubs. Targeted outcomes include reductions in disparities related to heart disease and diabetes, improved diabetic control as measured by A1c or blood glucose levels, and increased access to primary care.

St. Mary's County Health Department (St. Mary's County; total award: $1,600,000). This project will address disparities in Behavioral Health (mental health and SUD) and heart disease in the Lexington Park area (zip codes 20634, 20653, 20667). Key interventions include the opening of a new facility to provide primary care, counseling, and other Behavioral Health services; law enforcement referrals and ED diversions; case management to connect clients to partner organizations addressing SDOH; and respite care post-hospital discharge. Target outcomes include a reduction in ED admissions for chronic conditions and mental health and substance use disorders, increased access to primary and preventative care, decreased recidivism in the criminal justice system, and a reduction in overdoses.

Tidal Health (Somerset, Wicomico & Worcester Counties; total award: $1,100,00). This project will address disparities in diabetes experienced by the Black and Haitian population on the Lower Shore (zip codes 21801, 21804, 21822, 21853, 21851, and 21863). Key interventions identified include expansion of Mobile Integrated Health, connections with primary care, expansion of culturally linguistic and evidenced-based diabetes programming, and deployment of CHWs. Target outcomes include reduced rates of uncontrolled diabetes and hypertension among Black adults (18+) in the prioritized zip codes.

Horizon Goodwill Industries (Washington County; total award: $925,000). This project will address health disparities in diabetes and mental health in the Hagerstown area (zip code 21740). The project will provide on-site access to dietary and diabetic educators, healthcare navigation, wrap-around case management, and job training services; walk-in testing for diabetes (HgA1c) and retinal neuropathy; and referrals to mental health services. The goal is to decrease the rate of emergency department utilization for ambulatory care sensitive conditions, improve management of diabetes, and help reduce the rate of new diabetes diagnosis.

2. Overview of key interventions in the grants awarded

Community Health Workers: Seven of the nine Pathways projects will use Community Health Workers (CHWs) for a variety of clinic and community-based interventions including community member outreach and engagement to assist in accessing primary health care and care coordination services, screenings for Social Determinants of Health (SDOH) to identify and address needs (e.g., food security), and health education.

Additional key interventions include:

- Helping community members address non-medical barriers to usual care such as lack of health insurance, limited access to transportation, and low health literacy;
- Referrals and linkage to primary care providers to establish a usual source of care;
- Expansion of home-visiting programs serving at-risk pregnant and postpartum women to facilitate access to a unified system of primary care and substance use treatment including medication-assisted

treatment (MAT) through referrals, at-home blood pressure monitoring and care coordination to address acute stressors and SDOH needs;

- Expanding clinic and provider capacity to improve access to comprehensive primary and preventive care including at-home care services provided to frail elders;
- Establishing a community-based "hub" to provide one-stop, one location access to health services (e.g., health insurance, primary care) and social support services with health education, dietary consultations, healthcare navigation, wrap-around services, walk-in testing for A1c and screening for retinal neuropathy, and a full service grocery store in a healthy food priority area;
- Establishing a new place-based network of care through a county HUB Alliance, to provide access to behavioral health crisis management, counseling and primary care services;
- Offering evidence-based lifestyle programs that address the presenting health needs of the target communities (e.g., Diabetes Prevention Program);
- Healthy lifestyle interventions including health education on diabetes, hypertension and obesity, access to sponsored community walks, weight loss support groups and healthy cooking demonstrations;
- Conducting a comprehensive health education, awareness and outreach campaign to provide diabetes and other health screenings using a mobile clinic;
- Establishing a peer-led diabetes self management programs based on the Chronic Disease Self-Management Program (CDSMP) model;
- Expansion of Mobile Integrated Health services to increase linkage with primary care and social services;
- Expanding the availability of remote/home diabetes monitoring;
- Providing access to a pharmacist for diabetes medication reviews;
- Offering blood pressure, blood glucose and weight screenings at community events (e.g., health fairs, town halls);
- Behavioral health crisis management including law enforcement diversions and referrals, youth outreach, and job training;
- Case management services to connect clients to partner organizations addressing SDOH and respite care post-hospital discharge;
- Expansion of language interpretation services and culturally and linguistically competent evidenced-based programming; and
- Providing technical assistance to care providers to improve billing for care coordination, use of electronic medical record systems to their full capabilities and leveraging CRISP data.

3. Specific health disparities that will be addressed by the grants

- Diabetes
- Heart disease and hypertension
- Mental health
- Substance Use Disorder
- Maternal and child health
- Sickle Cell Disease

4. Key measures to evaluate the impact of each grant

As provided in the Act, the CHRC is working closely with Chesapeake Regional Information System for our Patients (CRISP) to develop process and outcome measures to monitor and evaluate the impact of each Pathways grant. Some measures will be standardized and applied across all grantees, while other measures will be tailored to each grantee's targeted health disparities and intervention strategies. The list below summarizes the key measures.

Standardized process metrics (apply to all Pathways grantees)

- Number of unduplicated individuals who receive grant-funded services, disaggregated by race and ethnicity
- Number of service encounters
- Number of participants newly enrolled in health insurance
- Number of participants newly linked with primary care services
- Number of participants screened for SDOH services
- Number of participants referred for SDOH services
- Number of clinical staff hires (by type)

Customized process metrics (differ among Pathways grantees)

- Number of participants screened for HbA1c
- Number of participants screened for blood pressure
- Number of participants screened/evaluated for targeted health disparity(ies)
- Number of participants who receive each kind of service supported by the grant
- Number of participants enrolled in a multi-week lifestyle program (e.g. Diabetes Prevention Program, tobacco cessation program, etc)
- Number of participants completing a multi-week lifestyle program
- Number of participants in peer support groups
- Number of participants in education programs
- Number of individuals diverted from law enforcement

Standardized outcome metrics (apply to all Pathways grantees)

- Percentage reduction in in-patient hospital visits 6 months after Pathways program enrollment
- Percentage reduction in ED visits 6 months after Pathways program enrollment

Examples of customized outcome metrics (differ among Pathways grantees)

- Number of participants who achieved diabetic control based on HbA1c < 7%
- Number of participants who achieved control based on BP 140/90 or below
- Number of participants who achieved reduction in body mass index (BMI)
- Number of participants who achieved SDOH goals (obtained employment, housing, etc)
- Percentage reduction in the rate of newly diagnosed diabetes or other targeted health disparity
- Percentage reduction in Low Birth Weight, Very Low Birth Weight, and Severe Maternal Morbidity diagnoses
- Percentage reduction in overdoses
- Percentage reduction in recidivism in the criminal justice system

We hope this update on the implementation of the Maryland Health Equity Resource Act is helpful and responsive to the information requested by the Maryland General Assembly. We are happy to respond to requests for additional information as these nine new programs move forward in implementation. For additional information, please contact Mark Luckner, CHRC Executive Director, at (410) 299-2170.