Maryland Office of Minority Health and Health Disparities
13th Annual Health Equity Conference
December 13, 2016

Achieving Health Equity through Community Engagement and Innovative Health Care Delivery

AFTERNOON CONCURRENT BREAKOUT SESSION A

Educating Minorities on the Benefits Received After Consumer Enrollment (EMBRACE) - A Model Program to Address Health Equity

Moderator:

David Mann, MD, PhD, Epidemiologist, Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene

Panelists:

Janani Ramachandran, Social Services Coordinator, Mary's Center

Yvonne L. Bronner, ScD, Professor, Department of Behavioral Health Sciences, School of Community Health and Policy, Morgan State University

CHANGING Maryland for the Better
Department of Health and Mental Hygiene

Minority Health and Health Disparities
Maryland Department of Health and Mental Hygiene

Maryland's EMBRACE Program:

Educating Minorities on Benefits Received after Consumer Enrollment

David A. Mann, MD, PhD, Epidemiologist,

Office of Minority Health and Health Disparities

The "Ask" in Federal OMH FOA

- **Make a measureable difference …**
- **For a minority population …**
- **In an HP 2020 Leading Health Indicator …**
- **In a geographic hot spot.**

Maryland Response

- Make a measureable difference …
- For a minority population …
  - **Blacks and Hispanics** *(other groups rare in hotspot)*
- In an HP 2020 Leading Health Indicator …
  - **Access to health services** *(data exit for hotspot)*
    - **Persons with Medical insurance**
    - **Usual primary care provider**
- In a geographic hot spot.
  - **Six zip codes with high un-insurance rates before 2014 ACA rollout of exchanges.**

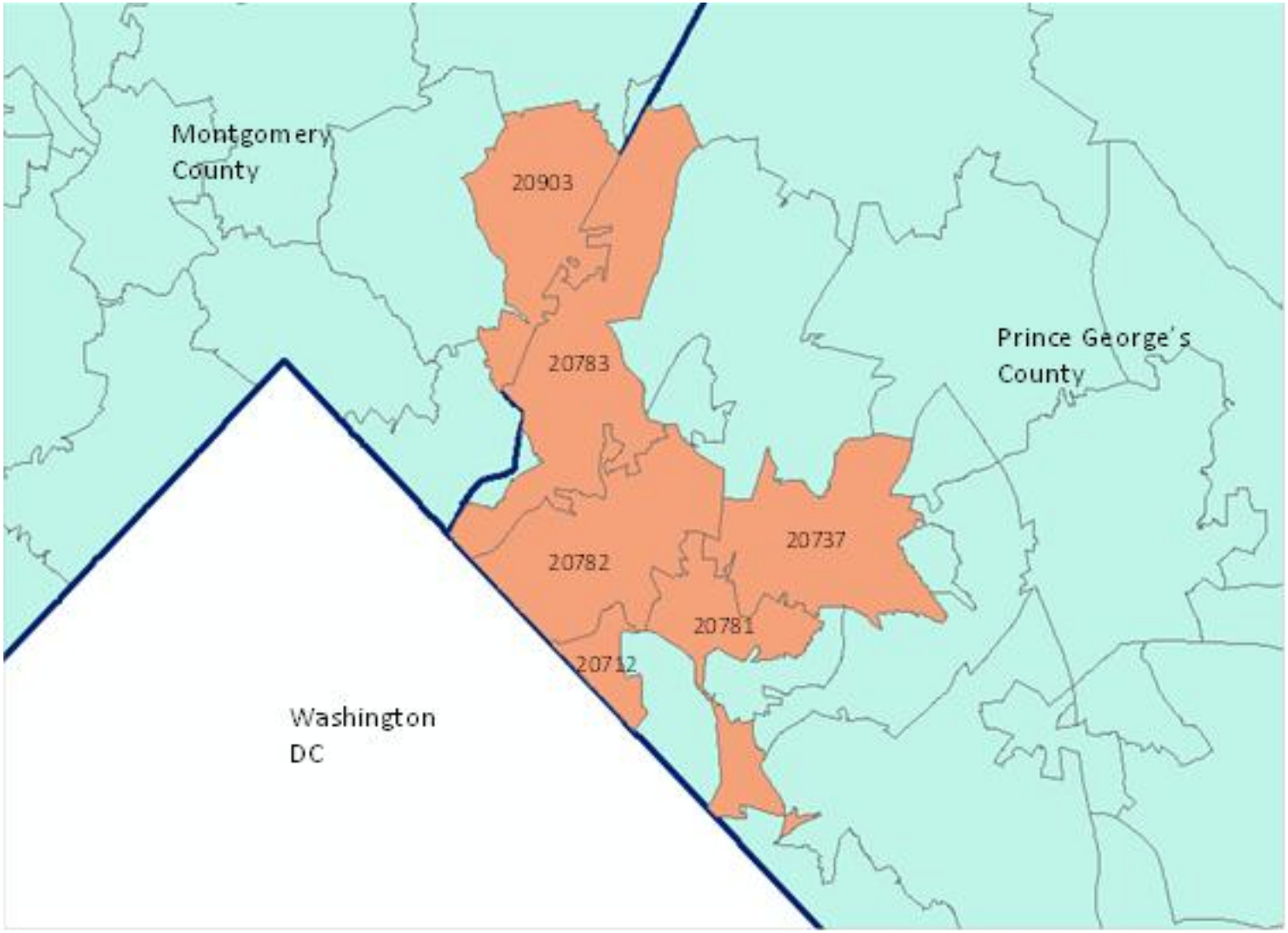
Step 1: Which LHI Can You Evaluate?

- Which HP 2020 LHI have readily available data?
  - **Medical insurance rate is collected/reported yearly by American Community Survey by ZIP code**
  - **Admission and ED utilization rates available for chronic disease and ACSC in Maryland by ZIP code**
- Persons with primary care not measured, but we assume that more primary care = less admission and ED utilization for ACSC conditions.
  - **Utilization reduction is a proxy for more primary care**

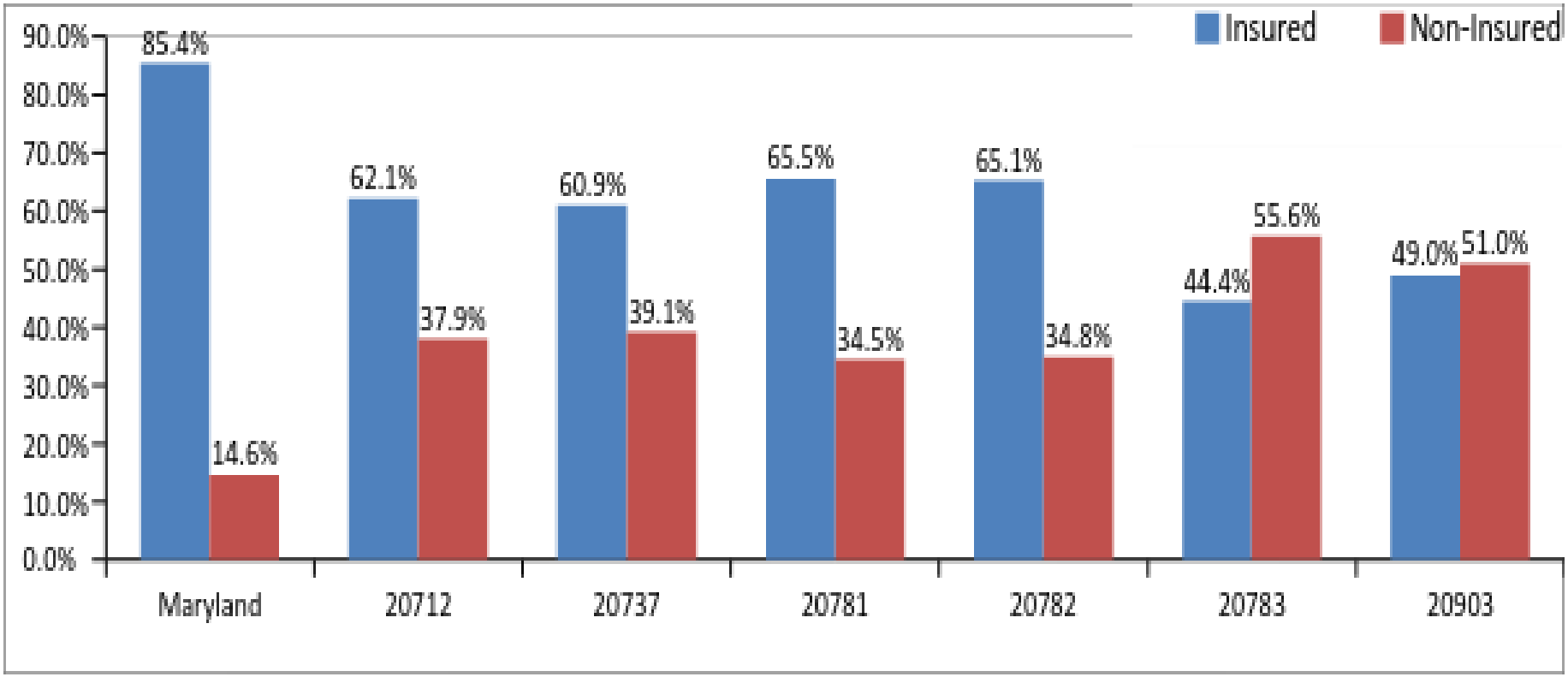
Step 2: Where is the Hotspot?

- Examined ACS data on insurance prior to 2014 ACA exchange rollout.
- Identified a cluster of six ZIP codes with high un-insurance rates in 2013
  - **Mostly in Prince George's County**
  - **Some overlap into Montgomery County**
  - **High Hispanic population; and 75% of uninsured there are Hispanic**
  - **Also significant Black or African American population.**

Maryland Un-insurance Hotspot



Rates of un-insurance in target ZIP codes, 5-year ACS data 2009-2013



Racial/Ethnic distribution of Maryland and target ZIP codes, ACS 2009-13

	Non-Hispanic White	Black/African American	Native American	Asian	Hawaiian/ Pacific Islander	Hispanic/ Latino
Maryland	54.10%	29.40%	0.30%	5.70%	0.00%	9.00%
20712	10.90%	54.40%	0.00%	0.90%	0.00%	31.40%
20737	13.40%	37.30%	0.50%	3.70%	0.40%	44.80%
20781	23.80%	32.60%	0.10%	0.50%	0.00%	41.30%
20782	14.20%	46.60%	0.00%	2.80%	0.00%	35.70%
20783	7.90%	24.70%	1.10%	3.60%	0.00%	62.90%
20903	9.10%	24.10%	0.30%	9.00%	0.00%	56.40%

Step 3: SMART Objectives

- **Goal**: Increase the number and percent of population appropriately utilizing primary care services
- ***Objective 1:*** Decrease the percent of persons without health insurance in the targeted zip codes
- ***Objective 2.1***: Decrease rate per 100,000 population in target ZIP codes of ED visits with a primary diagnosis that is a PQI condition.
- ***Objective 2.2***: Decrease the rate per 100,000 population in target ZIPs of hospital admits with a primary dx that is a PQI condition.
- ***Objective 3***: Decrease the percent of persons enrolled in Medicaid who have not had at least one primary care visit, in the targeted zip codes (particularly among high utilizers of ED and admit).

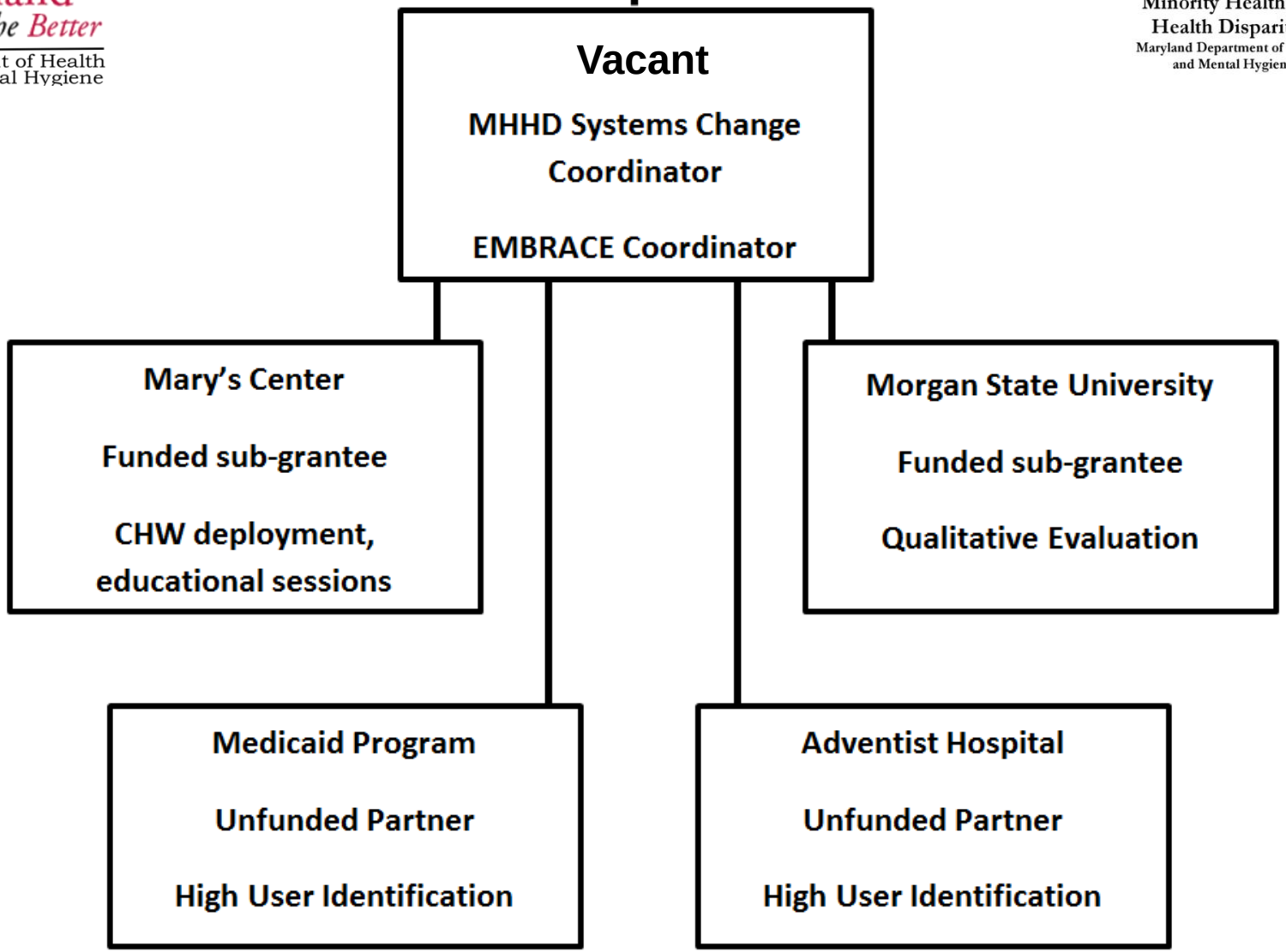
Step 4: Strategies - General

- **Community-Based Subcontractor Deploys CHWs**
- Outreach to the community to educate individuals about benefits of insurance and about enrollment resources for Medicaid and Exchange plans.
- *Measurable outputs*: Number of educational sessions held, number of attendees at educational sessions, number of informational materials distributed, number of one-on-one interactions with individuals, number of referrals/linkages of individuals to Connectors and Exchange. Pre-post test improvements in Knowledge, Attitudes and/or Beliefs.

Step 4: Strategies - Targeted

- **Hospitals** identify individuals without insurance who have ED visits or hospital admissions. Hospitals then link these persons to their own enrollment support systems, to Connector Entities and Exchange Navigators, or to our grant-funded CBO and CHWs.
- **Medicaid Program** identifies high utilizers without primary care visits, and link these persons to their own enrollment support systems, to Connector Entities and Exchange Navigators, or to our grant-funded CBO and CHWs
- *Measurable outputs*: Number of uninsured hospital utilizers or Medicaid zero primary care users identified, number connected to hospital or Medicaid internal support systems, number referred to grant-funded CBO and CHWs, number of persons achieving enrollment or primary care visits.

Partners

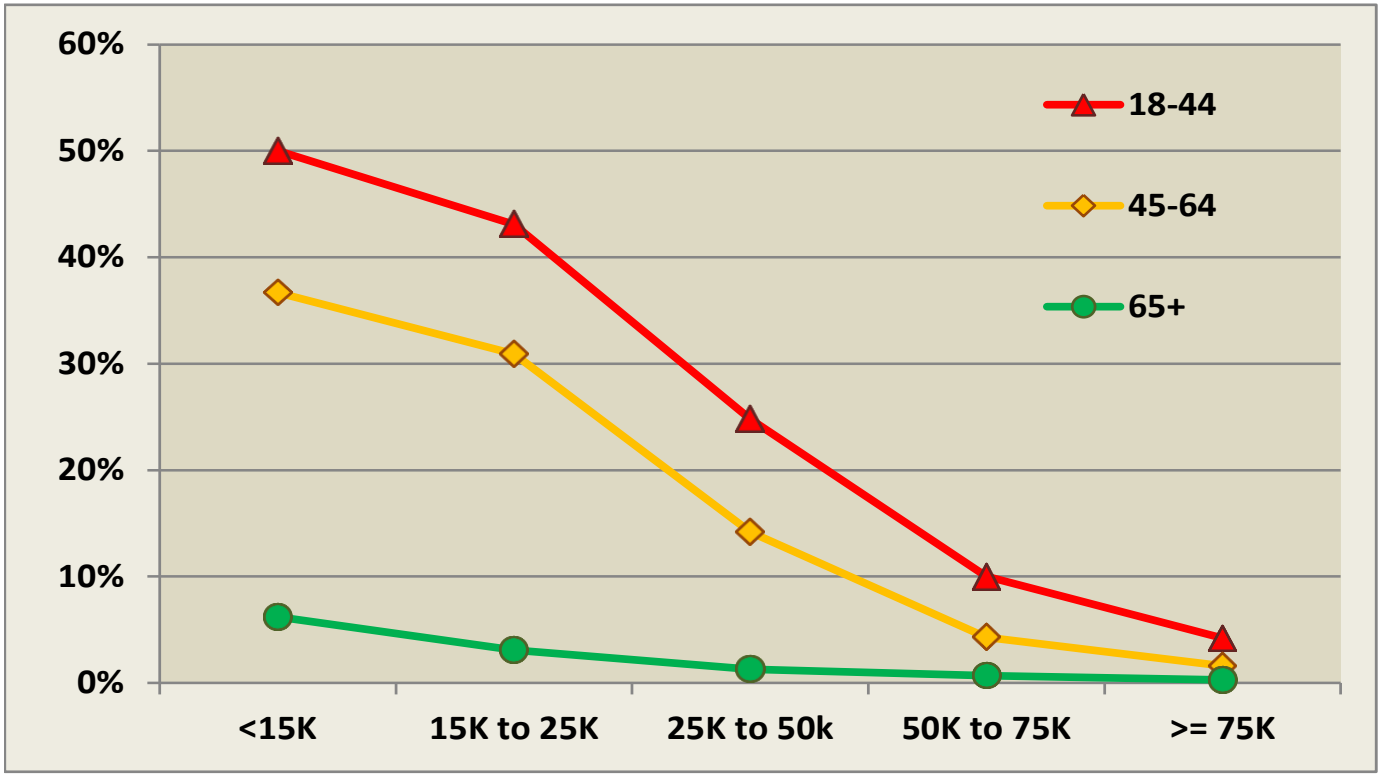

Vacant
MHHD Systems Change Coordinator
EMBRACE Coordinator
Mary's Center
Funded sub-grantee
CHW deployment, educational sessions
Morgan State University
Funded sub-grantee
Qualitative Evaluation
Medicaid Program
Unfunded Partner
High User Identification
Adventist Hospital
Unfunded Partner
High User Identification

Step 5: Evaluation

- ***Quantitative evaluation***
  - **Capacity**: Did we deploy the proposed resources?
  - **Productivity and Quality:** Did we reach the population? Change knowledge, attitudes, beliefs?
  - **"Health"**: Is the population better off in terms of insurance, ED and admits, and primary care use?
    - For the hotspot: Our SMART objectives (surveillance data)
    - For the touched cohort: If possible, we will try to assess impact on those individuals reached if follow-up contact can be maintained (longitudinal cohort data).
- ***Qualitative evaluation*** **–** focus groups and surveys for KAB assessment and intervention improvement.

Health Equity Profile Data

Income and Health Un-insurance

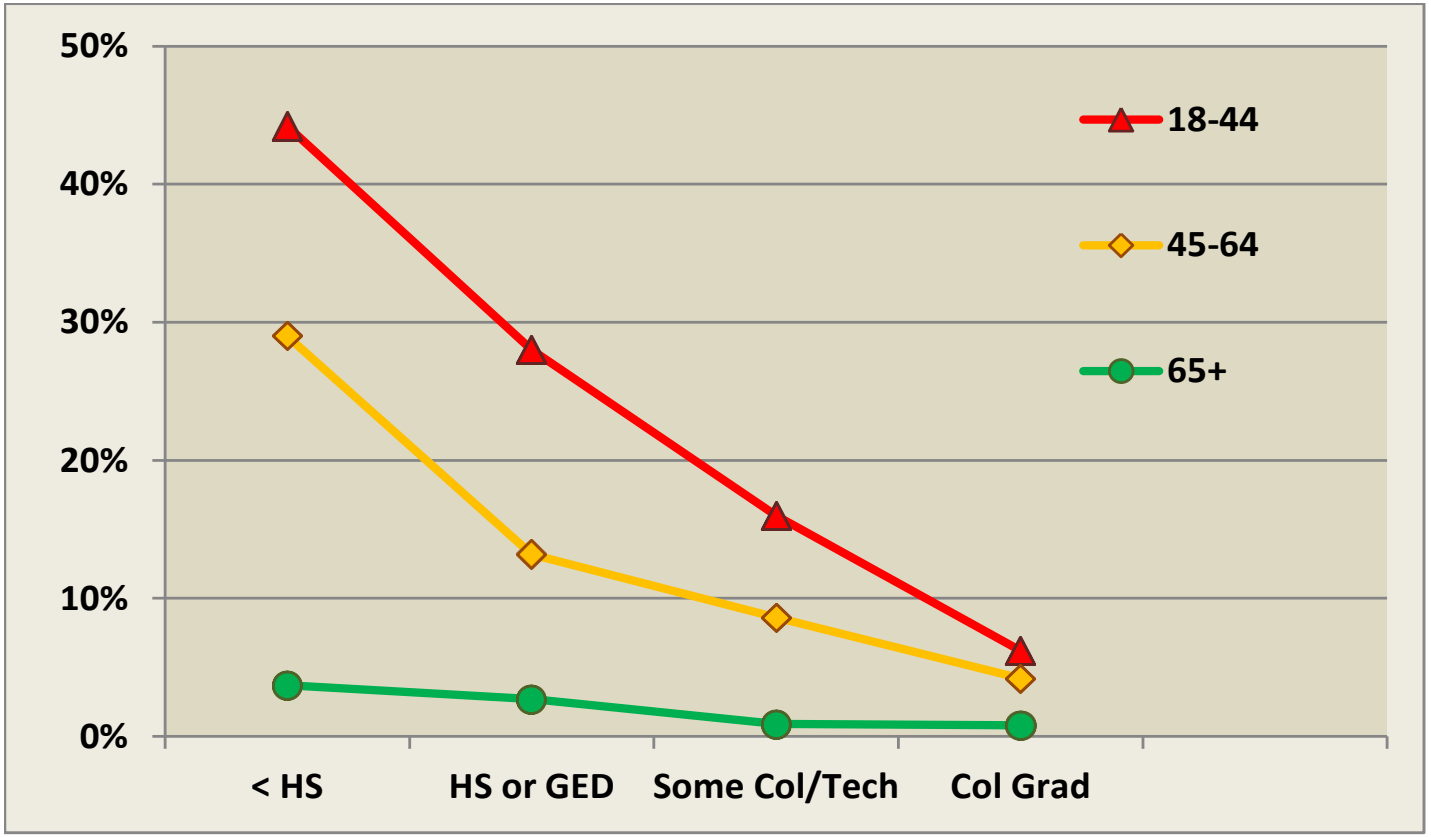


K = $1,000

Figure : % without Health Insurance by Income and Age Group, Maryland BRFSS, 2006-2010

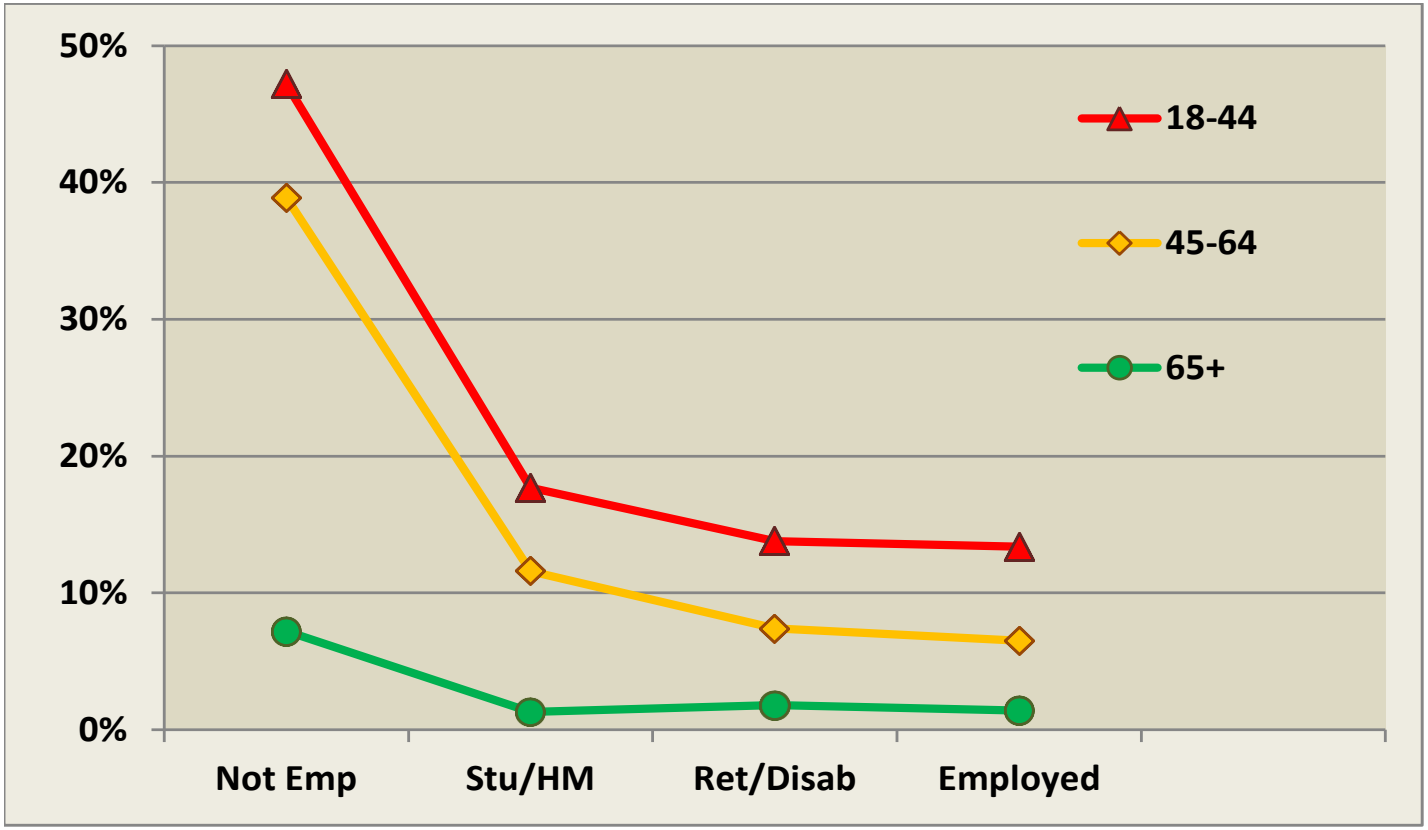
Health Equity Profile Data

Figure : % without Health Insurance by Education and Age Group, Maryland BRFSS, 2006-2010



Health Equity Profile Data

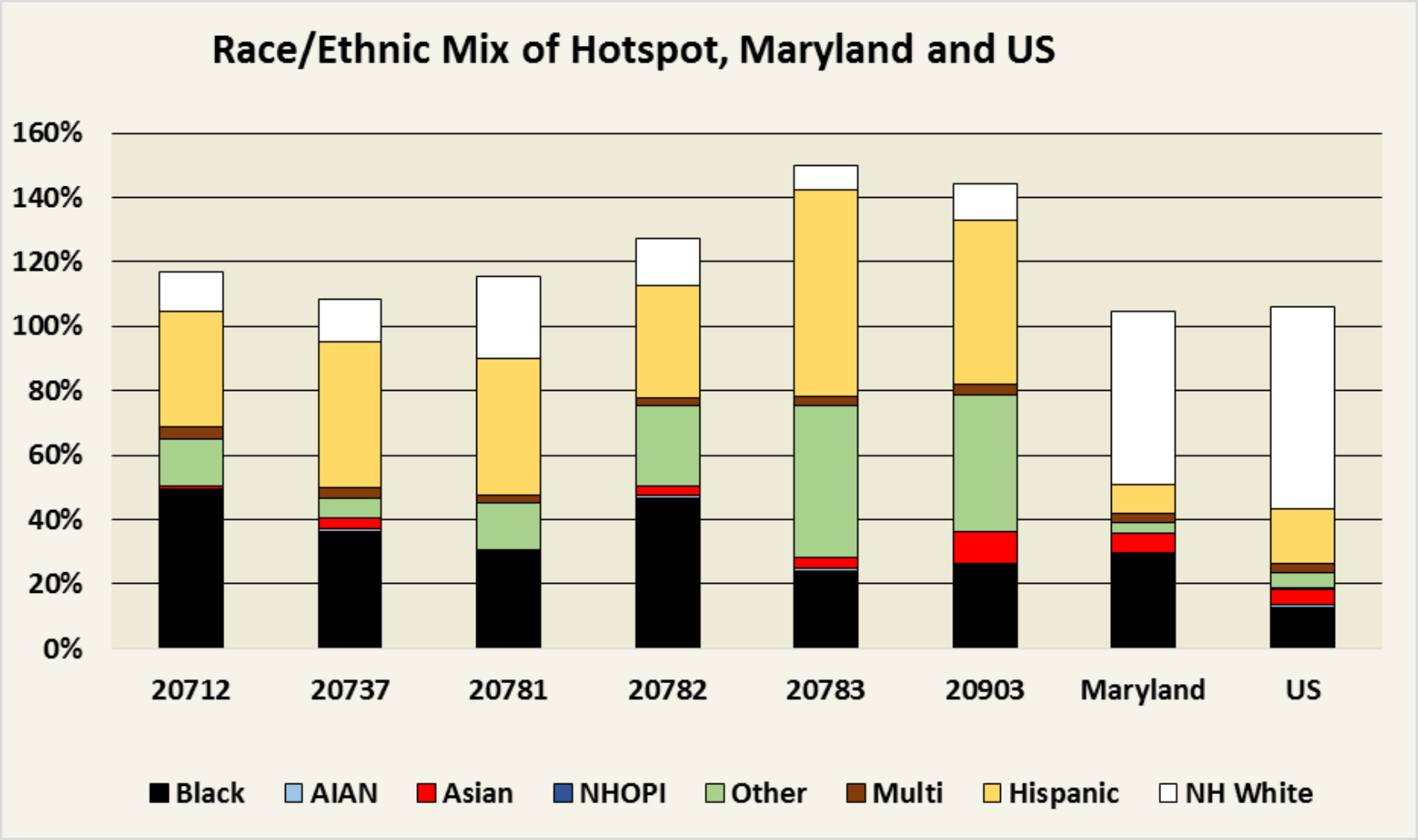
Figure : % without Health Insurance by Employment and Age Group, Maryland BRFSS, 2006-2010



Stu = Student; HM = HomeMaker; Ret = Retired; Disab = Disabled/Unable to work

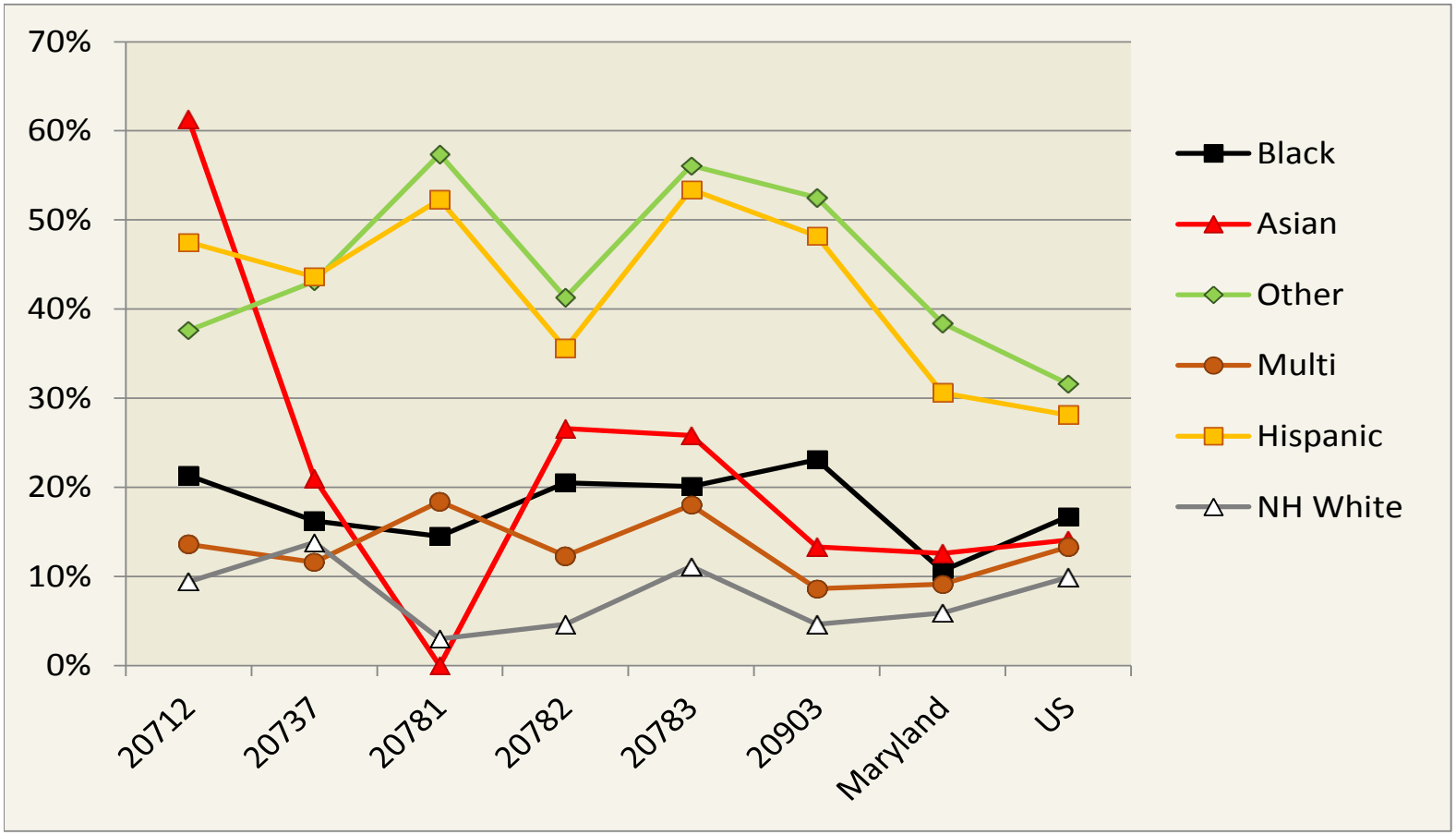
Health Equity Profile Data

Racial and Ethnic Makeup of the Un-insurance Hotspot, of Maryland, and of the US, 2010-2014 pooled data from the American Community Survey



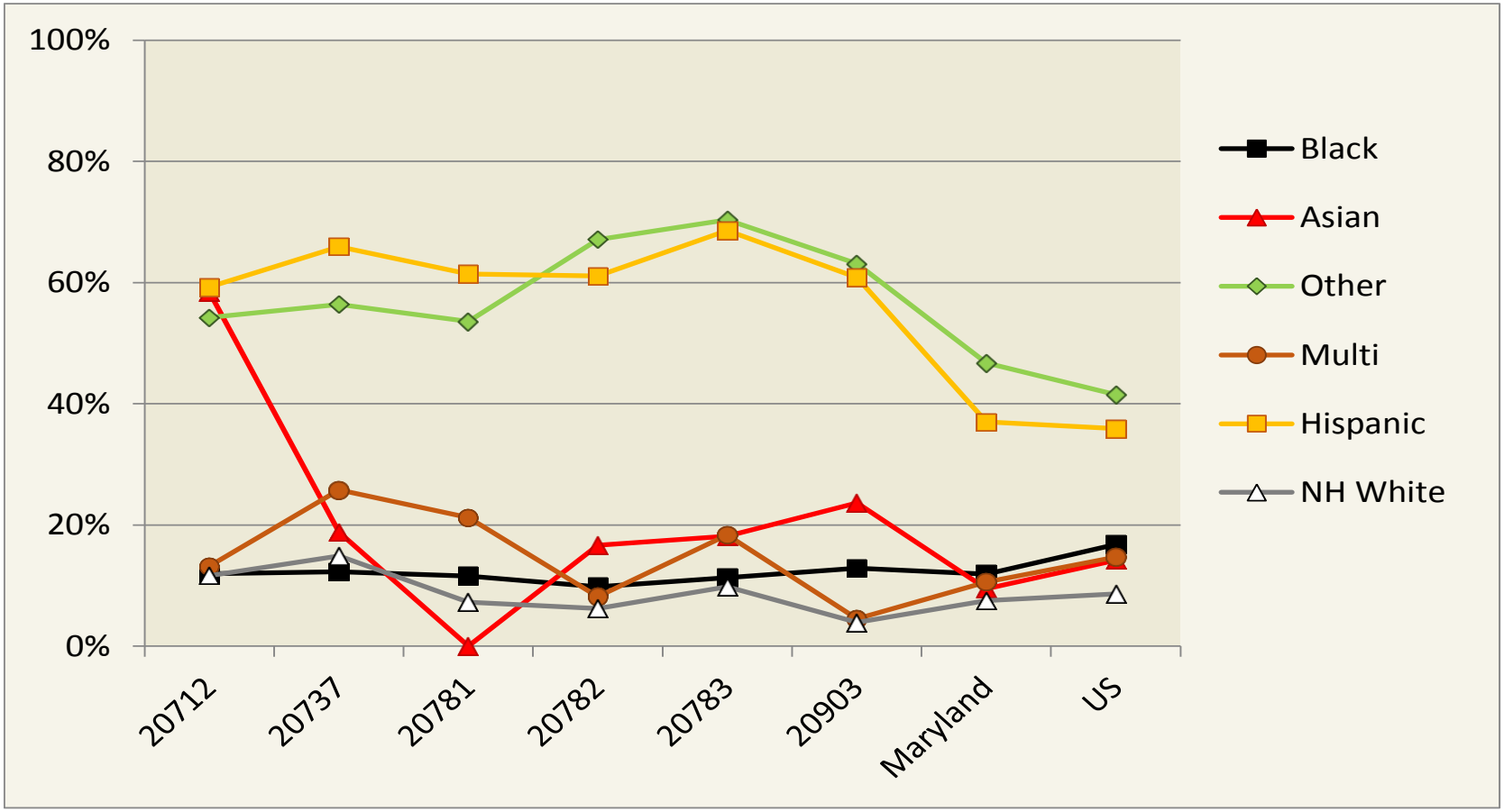
Health Equity Profile Data

Figure : % Without Health Insurance, by Race/Ethnicity in the Un-insurance Hotspot, Maryland, and the US, 2010-2014 pooled data from the American Community Survey



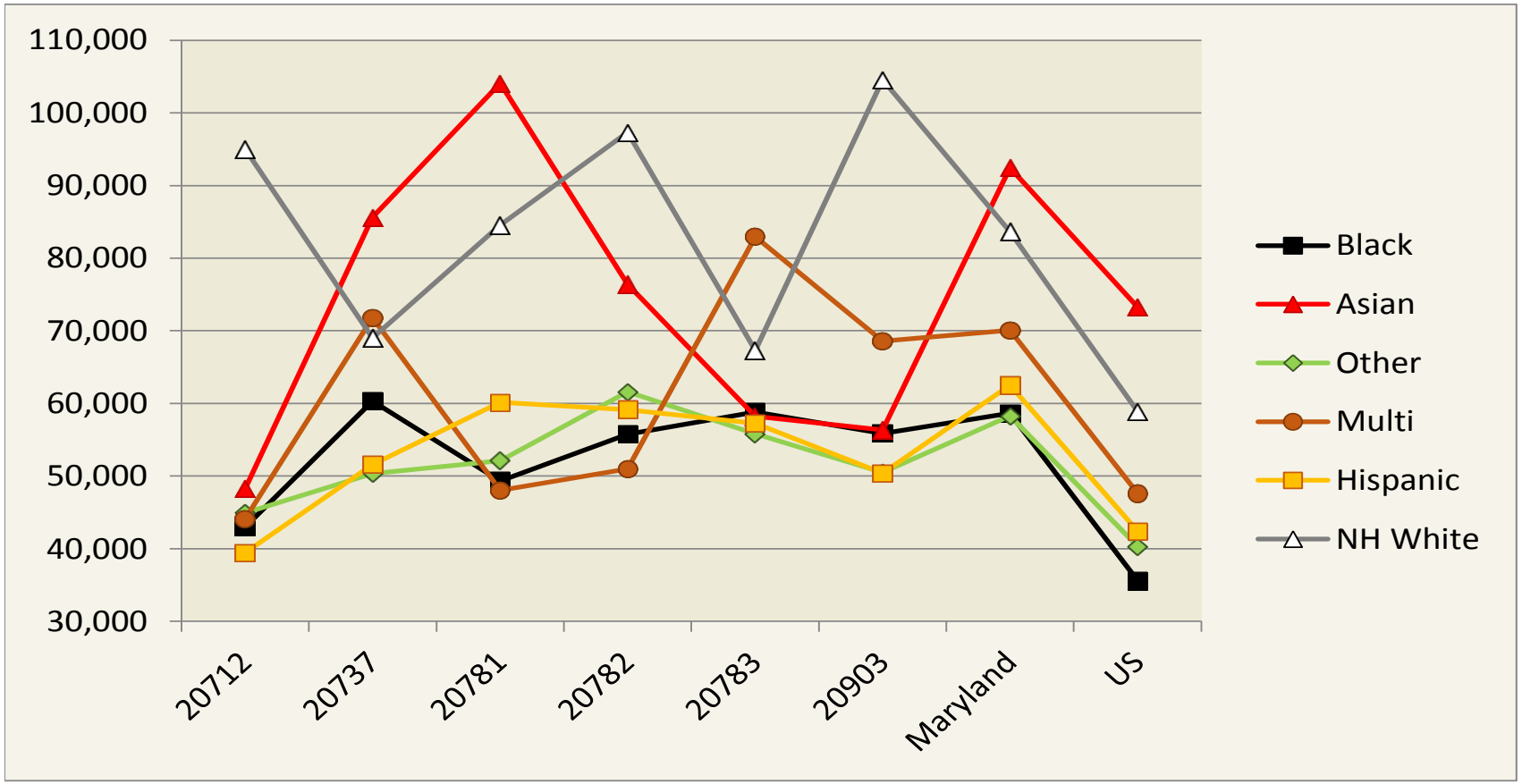
Health Equity Profile Data

Figure : % Without High School or GED, by Race/Ethnicity in the Un-insurance Hotspot, Maryland, and the US, 2010-2014 pooled data from the American Community Survey



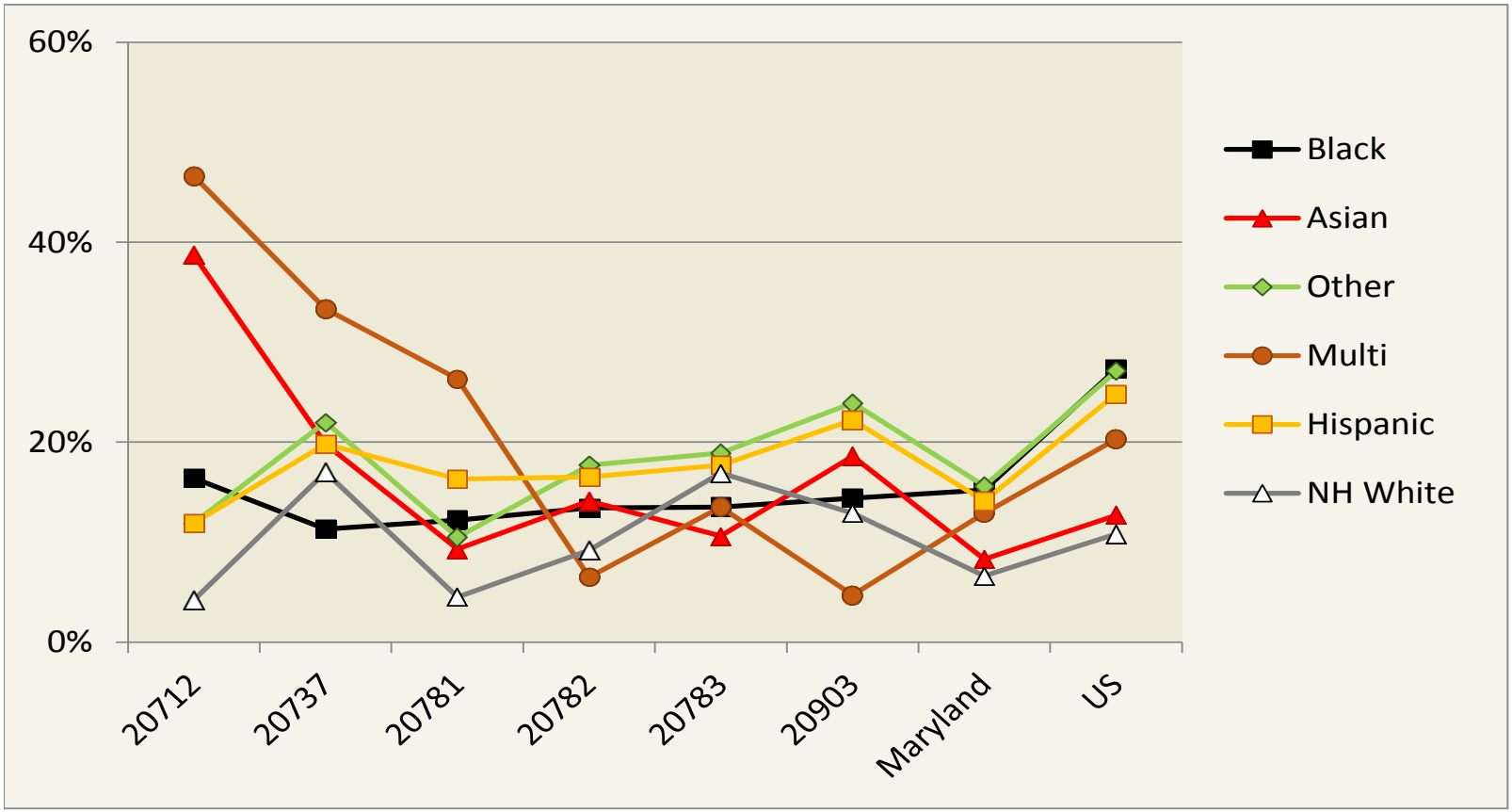
Health Equity Profile Data

Figure : Median Household Income, by Race/Ethnicity in the Un-insurance Hotspot, Maryland, and the US, 2010-2014 pooled data from the American Community Survey



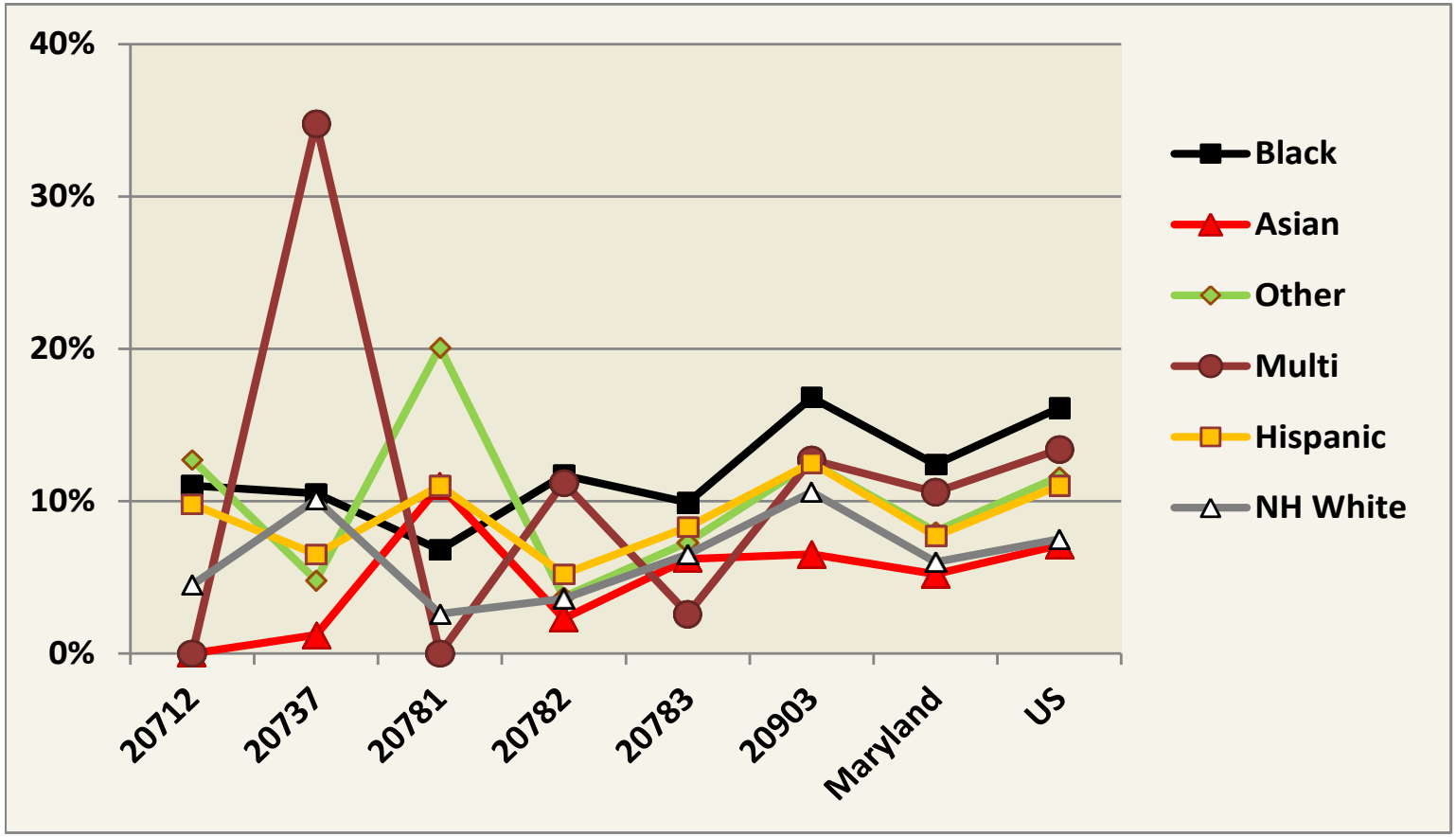
Health Equity Profile Data

Figure： Percent of Persons in Poverty, by Race/Ethnicity in the Un-insurance Hotspot, Maryland, and the US, 2010-2014 pooled data from the American Community Survey



Health Equity Profile Data

Figure : Percent Unemployed, by Race/Ethnicity in the Un-insurance Hotspot, Maryland, and the US, 2010-2014 pooled data from the American Community Survey



Saving Lives, Creating Stronger Communities, One Family at a Time

Mary's Center

EMBRACE
Community Health Education Program

December 13th 2016

Janani Ramachandran
Social Services Coordinator

Mary's Center Overview (con't)

Social Change Model

Saves Lives

Stabilizes Families

Strengthens Communities

Mary's Center Locations

Washington, DC
2333 Ontario Rd, NW (Adams Morgan)
3912 Georgia Ave, NW (Petworth)
100 Gallatin St, NE (Fort Totten)

Maryland
8709 Flower Ave, Silver Spring (Montgomery County)
8908 Riggs Rd, Adelphi (Prince George's County)

Saving Lives, Creating Stronger Communities, One Family at a Time

Mary's Center Overview

Our mission is to build better futures through the delivery of health care, education, and social services. We embrace culturally diverse communities to provide them with the highest quality of care, regardless of ability to pay.

Key Facts:

- ✓ Served over 36,000 participants in 2016
- ✓ 28 year history of providing quality care in the Greater DC Region
- ✓ Provided $3.8 Million in free care in 2015
- ✓ Serving 67% publicly insured, 26% uninsured and 7% Privately insured
- ✓ Innovative Social Change Model

HEALTH
- •Adult Medicine
- •Prenatal
- •Pediatrics/Adolescents
- •Psychiatric
- •Dental
- •Health Promotion
- •Chronic Disease Management

EDUCATION
- •English and Computer Classes
- •Civic Education
- •Early Childhood Education
- •Preschool
- •Child Care Licensing
- •Adolescent Tutoring and College Preparation
- • Medical Assistant Training

SOCIAL SERVICES
- •Case Management
- •Behavioral Health
- •Senior Health and Wellness
- •Early Intervention for Children with Special Needs
- •Home Visiting
- •Benefits Enrollment Assistance
- •WIC Program

Educational Content

Goal 1: *Enrollment:* Provide general education to the community regarding the value of having health insurance and about resources for enrollment.

Goal 2: *Accessing Care:* Provide general education to the community regarding how health insurance works and about how to properly use health insurance and primary care to maintain health and manage illness.

Populations Encountered

- Newly insured participants who have limited healthcare proficiency
- Insured participants who have a clear understanding of the healthcare system
- Individuals who are ineligible for health insurance

Individualized Information Sessions

- Formal group education sessions
- Informal group education sessions
- One-on-one education
- Health and resource fairs

Where is E.M.B.R.A.C.E?

- Community centers
- Department of Social Services
- Prince George County Public Schools
- Prince George's Health Department
- Health Fairs
- Faith-based groups
- Amerigroup
- University of Maryland

Cultural Awareness

- Immigrant communities and acculturation
- Stages of change
- Messaging workshops

Resources

- Primary Care Coalition
- MD Health Exchange
- Primary Care Progress

Mary's Center

Thank You!

EMBRACE PROJECT
A MODEL: EVALUATION PHASE

Yvonne Bronner, ScD
Professor
School of Community Health & Policy
Department – Behavioral Health Science

Charge

- Conduct a **focus group (FG) process** to learn from newly insured Affordable Care Act (ACA) insurance enrollees the nature of their experience:
  - Obtaining health care
  - Using their new coverage

Elements of the FG Model

- Research team
- Background research
- Research questions & instruments
- Institutional Review Board approvals
- Implementation plan and iterations
- Data collection
- Data analysis and report
- Lessons learned

The Research Team

- PI - Role – to manage the research project such that it delivers the intended results
  - PI: Behavioral Scientist + Statistician +
    - Graduate students with course work in qualitative methods
  - Recognized need for CHANGE –need experience in bilingual research
  - Engaged consultant

Background Research

- Research team met weekly to review
  - ACA legislation + Obamacarefacts.com
  - Online PPT of ACA elements & enrollment
  - Online overview documents on ACA implementation
  - Customer satisfaction articles

Research Questions

- What is your understanding of the benefits and barriers of using your insurance?
- What has your experience been using your insurance related to; primary care provider, emergency room, medical home etc.?
- What do you know about costs and maintenance of your insurance?
- What are your opinions of Obamacare health care services?
- What are your recommendations for improving the ACA health insurance?

Research Instruments & Plan

- Demographic form
- Focus group guide
- Logistics – when, where
- Recruitment – **problems**
- Incentives
- Refreshments
- Real time translation to facilitate probing

Institutional Review Board Approvals
IRBs – DHMH & MSU

- Describe not only
  - what you plan to do -- **but also**
  - how it will be done
- Need to have all client interactive instruments translated to Spanish
  - Recruitment materials
  - Disclosure form
  - Materials used during the focus groups – definitions, etc.

- **<u>Build research team consensus on all elements</u>**

Implementation plan and iterations

- Six focus groups organized by demographic
  - 2 - African American
  - 2 - Spanish Speaking Hispanic
  - 2 - English Speaking Hispanic

- Meeting sites considered
- Consensus - Meet at Mary's Center
  - Problem – only available after clinic closes – 5:00
  - Advantage: - routine established for research team
    - adequate space

Data collection

- Sign – in form
- Demographic data form
- Focus Group – facilitated by moderator
  - Hand notes
  - Tape recorded notes
  - Real time translation

Data Analysis and Report Process

- Demographic profile
- Format of focus group analysis
  - Topline
  - In-depth
    - Single group
    - Within group
    - Across group
  - Synthesis of all group findings
  - Recommendations

Demographic Profile

Item	Spanish Speaking	African American	English Speaking
# participants = 39	15	11	13
Males	3	8	3
Females	12	3	10
Marital Status m/s	7/4	4/7	8/4
Children no/yes	0/15	5/5	4/9
Education <HS	7	0	1
Education -> HS	7	11	12
Income - -< $20,000	7	4	7
Income >$20,000	8	5	6
Study Zip Codes	20783; 20712; 20737; 20781; 20782; 20903		

Representative Findings

- How did you learn about Obamacare?
  - All groups – family, friends & Clinic
  - AA – parent's plan, social services
  - Hispanics – internet, work, flyer, when completing income tax

Representative Findings

- Benefits of Obamacare
  - Everyone has access to health care
  - Don't have to pay penalty for not having insurance
  - LSES families can get insurance free
  - Don't have to pay for surgeries
  - Receive free medicine
  - Pay less for services
  - Higher premium = lower co-pay and deductibles

Representative Findings

- Disadvantages of Obamacare
  - Many doctors do not accept Obamacare
  - Patients are treated poorly in medical offices due to having Obamacare
  - Patients face very high medical costs that change.
  - Obamacare is not affordable to some people.
  - Obamacare's customer service system is error-prone
  - Long waiting time for appointment only to find that insurance is now cancelled due to end of year

Representative Findings

- Methods for finding primary care doctor:
  - Clinic, parents plan, assigned at sign-up, booklet with list of doctors, internet
- Reason for not having primary care doctor
  - Too much waiting time to schedule appointment
  - Prefer to just go to community clinic and take whoever you are assigned

Representative Findings

- Most still use ER with Obamacare – Why?
  - Even though you have to wait a long time, care is provided the same day
  - They think that they will be served better by going to a hospital
  - They do not trust their doctor
  - A hospital inspires more trust
  - The hospital is open at night, while the primary care doctor is not

Representative Findings

- Why do you let insurance expire?
  - Not notified of end/due date
  - Notified only days before the end date
  - Lack money
  - Increasing cost of Obamacare – too expensive
  - Insurance not used so why pay
  - Prefer to pay penalty
  - Can't find Spanish speaking staff
  - Too much difficult paperwork

Representative Findings

- Didn't know what a 'medical home' was
- Co-pay/co-insurance, deductibles
  - Too complicated and expensive
- Didn't know about free preventive services
- **Recommendations for Obamacare**
  - less complicated, more user friendly, services be delivered in a more respectful manner, more bilingual services
  - Need more doctors that will take Obamacare
  - Reduce wait time
  - Eliminate internet "crashing" after data entered = start over
  - Limit phone "wait time" for appointments and enrollment

Lessons Learned from the Model

- Include evaluators from the beginning to ensure desired outcomes.
- allow time in **first year** for **administrative details** of bringing the grant into the primary funded institution + awarding partners.
- Have a process to build and maintain consensus
  - BIG difference between the **written project** and the **fielded project** = need for ongoing project meetings.

Lessons Learned from the Model

- **Monitor all aspects of the research project** when it is in the field = weekly meetings.
- **Document all aspects of the project** through meeting minutes – especially changes that are made and the rationale for these changes.
- **Be alert to changes and challenges** in the Program that the qualitative research is addressing at federal and local levels (ACA).

Lessons Learned from the Model

– **Be committed to producing findings that can have impact** –

- this means that you have to be sure that you have correctly identified the problems **and**
- that the FG address the real problems by probing.

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Achieving Health Equity through Community Engagement and Innovative Health Care Delivery

AFTERNOON CONCURRENT BREAKOUT SESSION B

Health Enterprise Zones - Lessons Learned about Community Engagement

Moderator:

Maura Dwyer, DrPH, MPH, Senior Health Policy Advisor, Health Enterprise Zone Initiative, Maryland Department of Health and Mental Hygiene

Panelists:

Maha Sampath, MHSA, Director, West Baltimore CARE Health Enterprise Zone, Bon Secours Baltimore Health System

Ernest L. Carter, MD, PhD, Deputy Health Officer, Prince George's County Health Department

Angela Mercier, Health Education Program Manager, Dorchester County Health Department

Maryland's Health Enterprise Zones

History and Background

Maura Dwyer, DrPH, MPH

HEZ Program Director

What is a Health Enterprise Zone (HEZ)?

- 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.

- Created through the MD Health Improvement and Disparities Reduction Act of 2012

- There are 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)

Critical Dates in the History of Health Enterprise Zones Legislation

October 2010:

The Office of Minority Health and Health Disparities: Presentation to the Health Care Reform Coordinating Council (HCRCC) on Maryland Health Disparities

January 2011:

HCRCC's report noted *Recommendation # 14*: "*Achieve reduction and elimination of health disparities through exploration of financial, performance-based incentives and incorporation of other strategies*".

March 2011:

Maryland Health Quality and Cost Council established

Health Disparities Workgroup Chaired by Dean Reece of University of MD School of Medicine and included diverse experts on minority health from across the State

- Report Recommendations:
  - Health Enterprise Zones (HEZs)
  - Maryland Health Innovation Prize
  - Racial and Ethnic tracking of health care delivery performance

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

- In 2012 SB 234, the Health Improvement and Disparities Reduction Act was singed into law, establishing the Health Enterprise Zones and providing $4 million per year 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**.

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

HEZ Eligibility Criteria

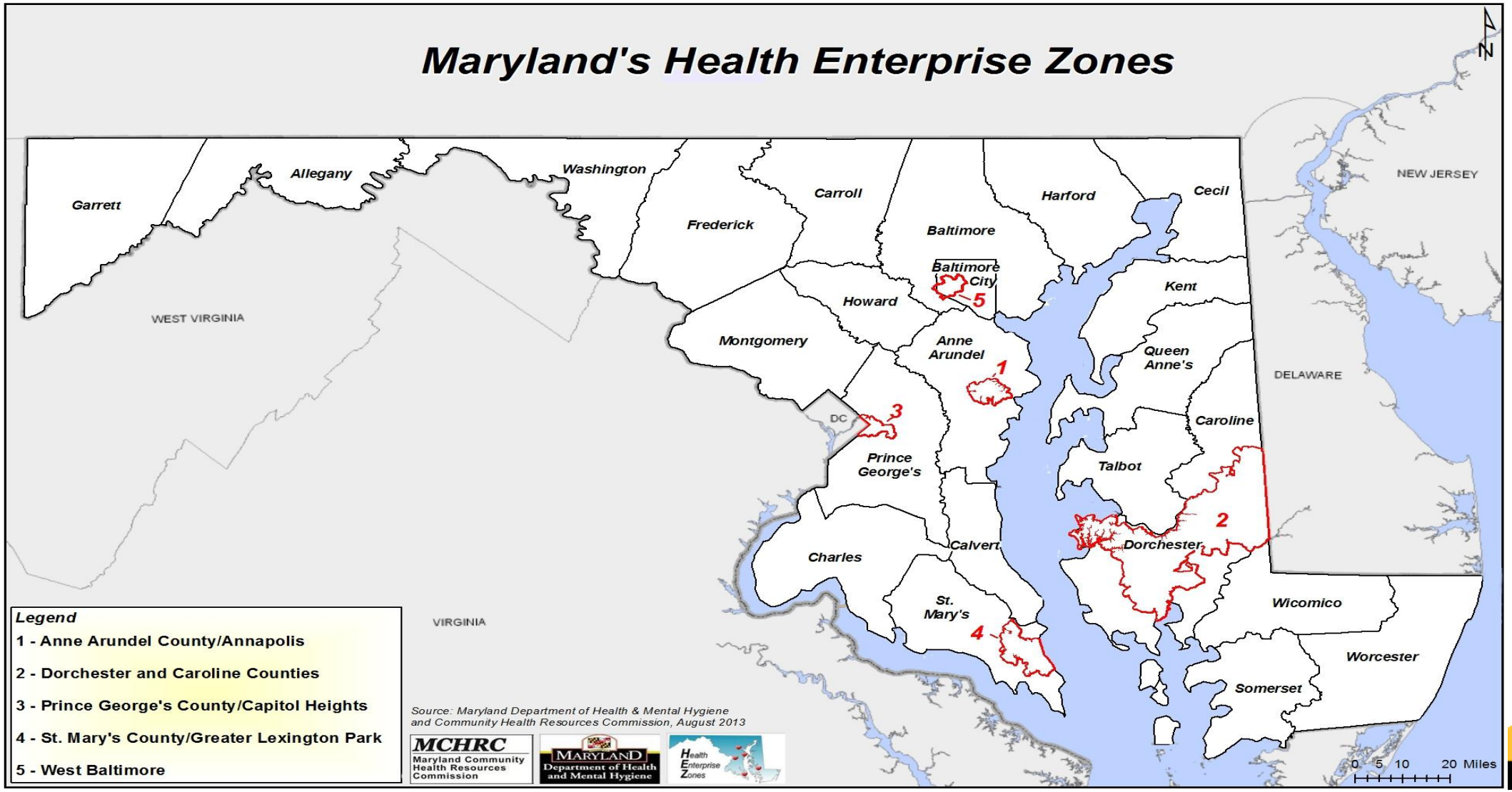
1) An HEZ must be a community, or a contiguous cluster of communities, defined by zip code boundaries (one or multiple zip codes).

2) An HEZ must have a resident population of at least 5,000 people.

3) An HEZ must demonstrate greater economic disadvantage than MD average:
   - Medicaid enrollment rate or
   - WIC participation rate

4) An HEZ must demonstrate poorer health outcomes than MD average:
   - A lower life expectancy or
   - Percentage of low birth weight infants

January 2013 – Health Enterprise Zones 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 principles:
  - Cultural, linguistic and health literacy competency
  - Workforce diversity
  - Outreach to and targeting of minority populations
  - Racial, ethnic & language data collection/reporting
  - Addressing social determinants of health
  - Balance between provider and community focus

HEZ Incentive Program

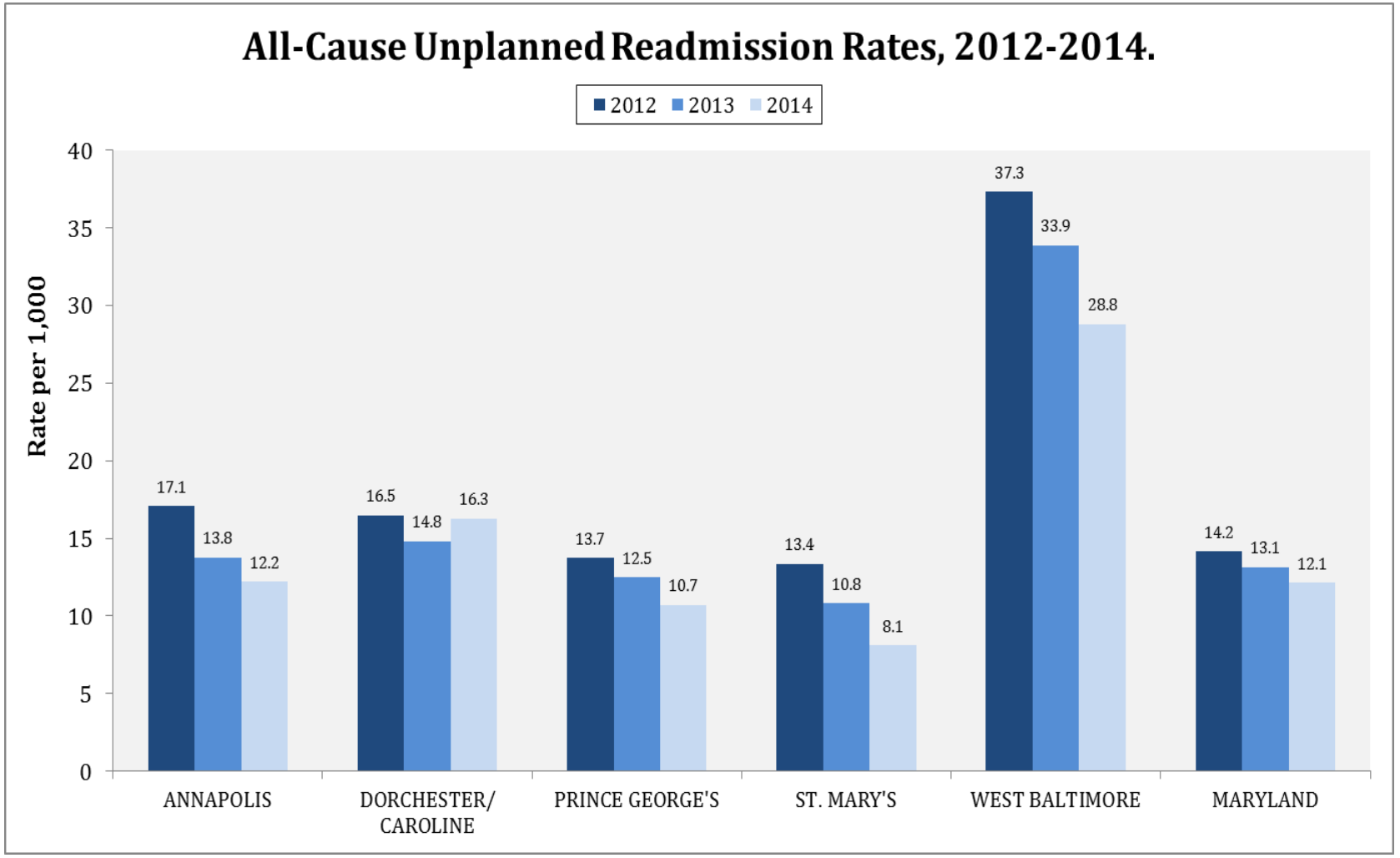
- HEZ enabling legislation provides a number of incentives and resources to attract providers to the Zones:
  - State income tax credits
  - Hiring tax credits
  - Grants for program support, equipment purchase or lease
  - Loan repayment assistance programs
- Practitioners must meet the following criteria to access tax credits:
  - Cultural competency training
  - Accept Medicaid and uninsured patients
  - Letter of support from the Coordinating Organization

Need for Focused Attention

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

Health Enterprise Zone Initiative

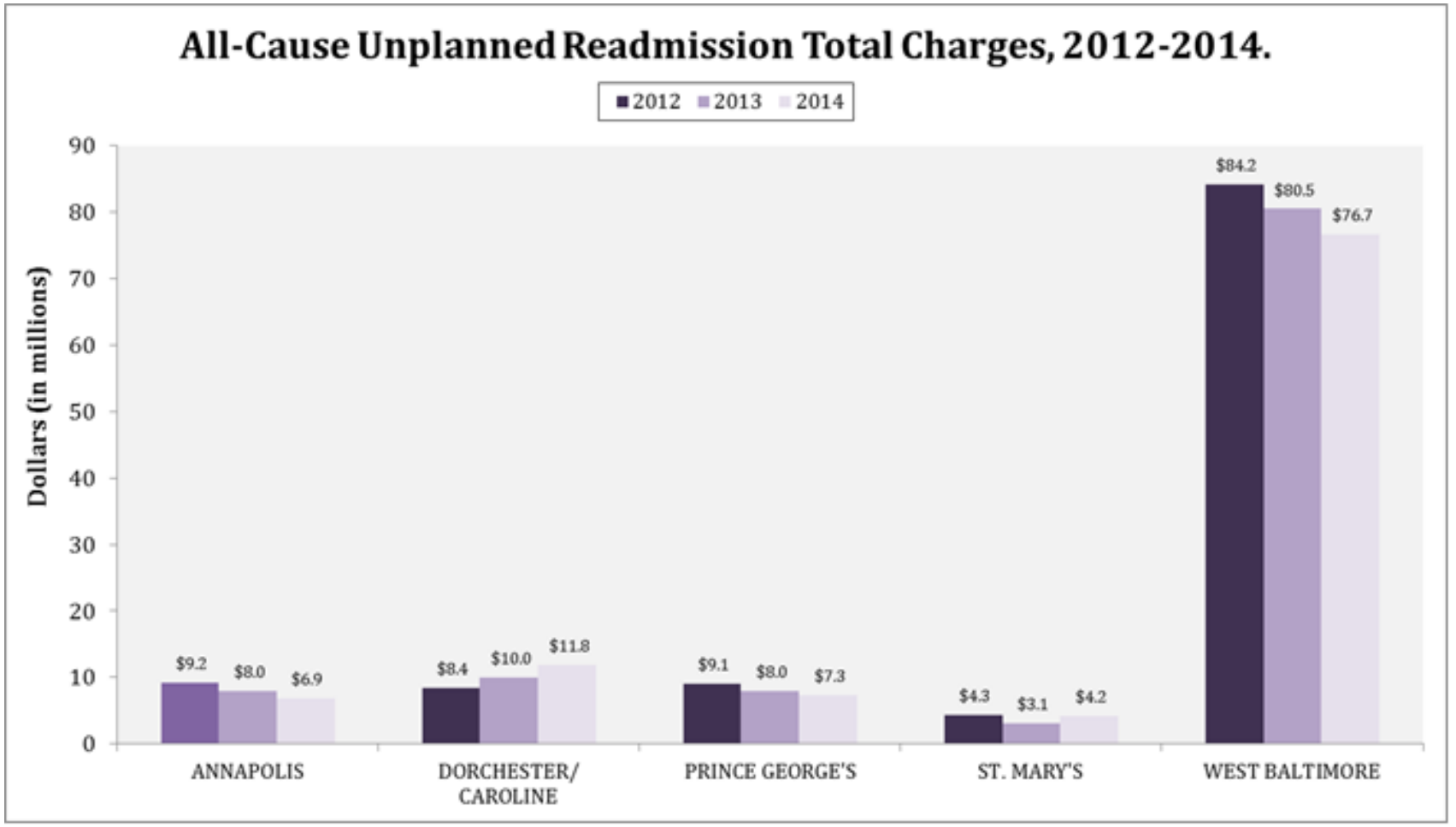
Reducing health care cost and disparities while improving the health of socially disadvantaged communities



Source: HSCRC data reported by the Chesapeake Regional Information System for our Patients and the DHMH Vital Statistics Administration

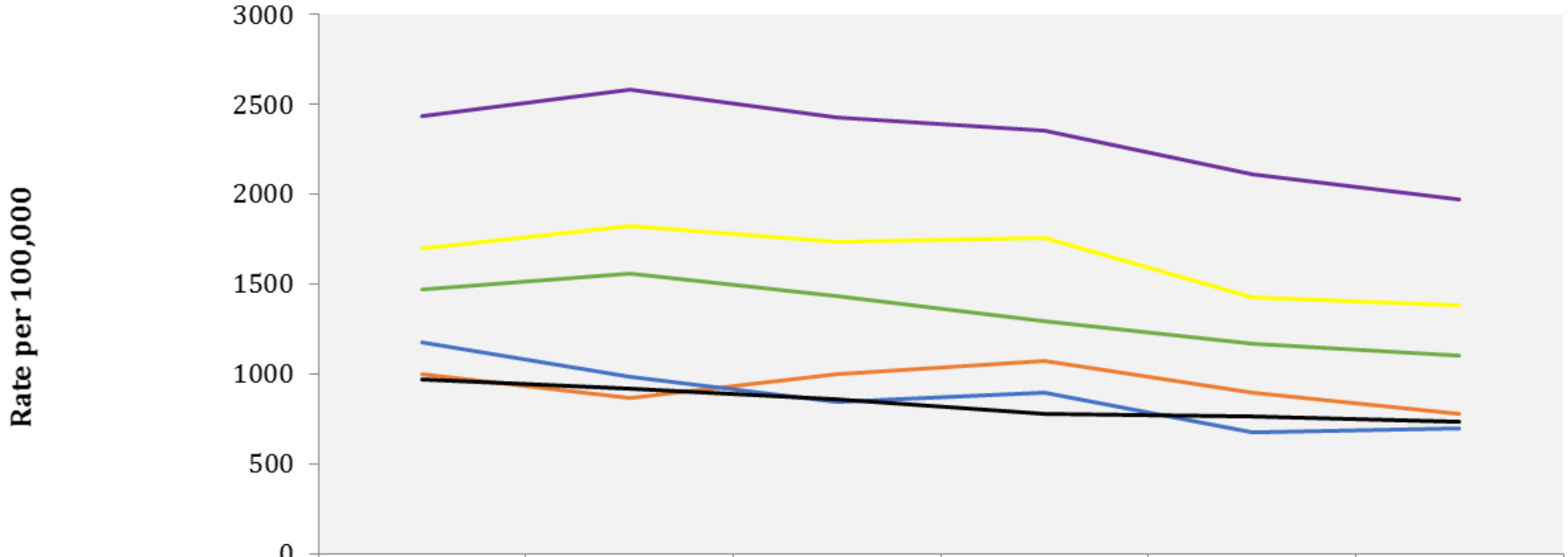
Health Enterprise Zone Initiative

Reducing health care cost and disparities while improving the health of socially disadvantaged communities



Source: HSCRC data reported by the Chesapeake Regional Information System for our Patients and the DHMH Vital Statistics Administration

Prevention Quality Indictors (PQI) Chronic Composite, 2009-2014.



	2009	2010	2011	2012	2013	2014
ANNAPOLIS	1001.4	862.7	997.3	1070.5	895.1	774.0
DORCHESTER/CAROLINE	1696.1	1826.5	1737.2	1753.6	1425.8	1383.4
PRINCE GEORGE'S	1469.2	1558.1	1435.0	1294.5	1168.7	1099.3
ST MARY'S	1176.7	986.8	840.0	893.2	674.7	697.1
WEST BALTIMORE	2433.9	2579.2	2425.3	2351.6	2111.3	1966.9
MARYLAND	971.4	920.2	854.6	775.7	766.1	736.0

West Baltimore
Health Enterprise Zone
MHHD Health Equity Conference

December 13, 2016

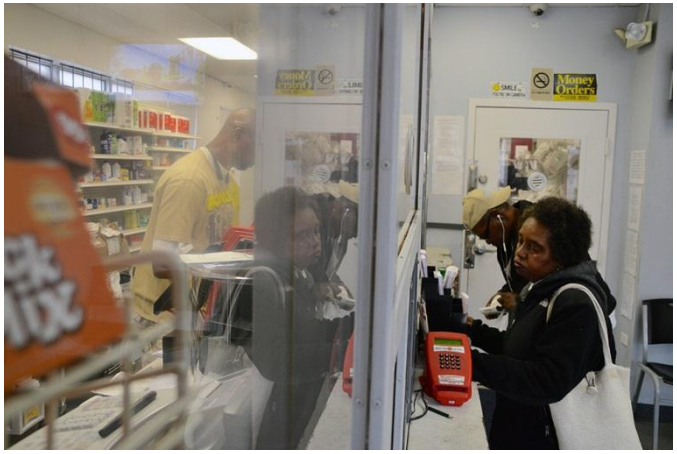
Prepared By: Maha Sampath, HEZ Director

West Baltimore Community Profile

- Approximately 86,000 Residents
- African-Americans comprise more than 76%
- Average median income in this area is $27,158
- **Highest disease burden and worst indicators of social determinates of health than any other community in Maryland**

West Baltimore Patient Profile

- Often unemployed or “working poor”
- Living in and out of crisis
- Frequently on the edge of homelessness
- Three times more likely to have cardiovascular disease than in any other area in the state of Maryland



Our Focus

Legislative Mandate

- Reduce health disparities among racial and ethnic minority populations and among geographic areas
- Improve health care access and health outcomes in underserved communities
- Reduce health care costs and hospital admissions and re-admissions

West Baltimore CARE's Focus

- **HEZ Geographic and Subset Target Population:**
  - **86,000** West Baltimore residents within the 21216, 21217, 21223, and 21229 zip codes
  - **1,200** High Utilizers*
- **Core Disease and Target Conditions:** Cardiovascular disease (CVD) and CVD risk factors (i.e., diabetes and hypertension)
- **Overarching Strategies:**
  - Care Coordination (hospital high-utilizers)
  - Community-Based Risk Factor Reduction

***High Utilizers are derived from High Risk Diagnoses and Social Determinant Risks**

- **High Risk Diagnoses as defined by previous hospital root cause analysis completed by Berkley Research Group**

West Baltimore Primary Care Access Collaborative (WBPCAC)

FQHCs

- Baltimore Medical System
- Park West Health System, Inc.
- Total Health Care, Inc.

Hospitals

- Bon Secours Baltimore Health System
- University of Maryland - Midtown
- St. Agnes Hospital
- Sinai Hospital of Baltimore
- University of Maryland Medical Center

Community-Based Organizations

- Equity Matters
- Light Health and Wellness Comprehensive Services, Inc.
- Mosaic Community Services

Academic Institutions

- University of Maryland
- Coppin State University
- Baltimore City Community College

City and State

- Senator Verna Jones-Rodwell
- Baltimore City Health Department

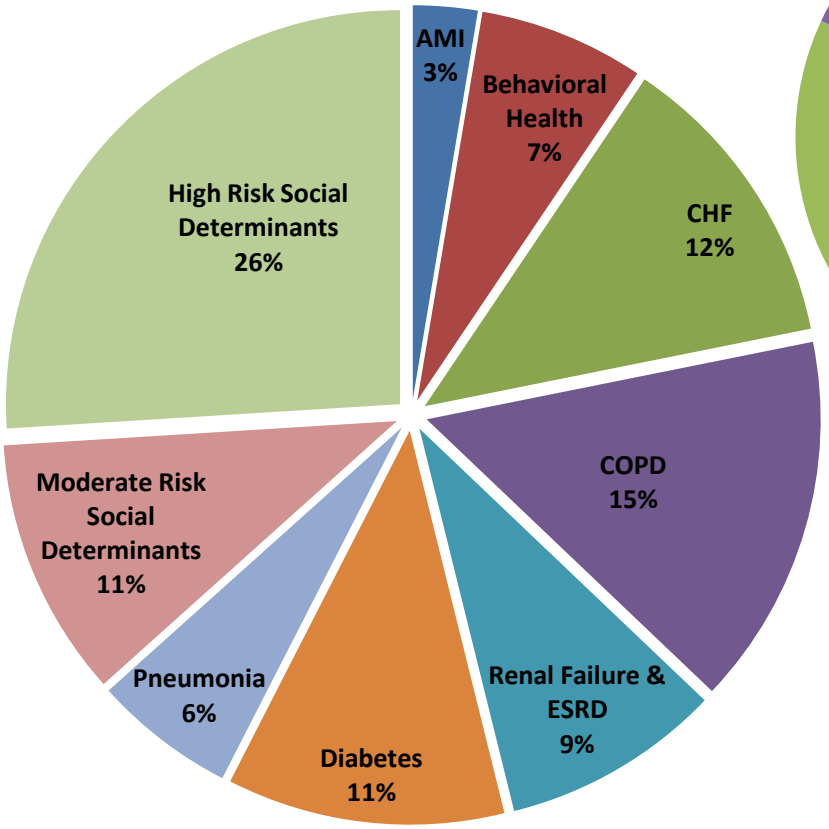
West Baltimore CARE

Strategy 1: Care Coordination

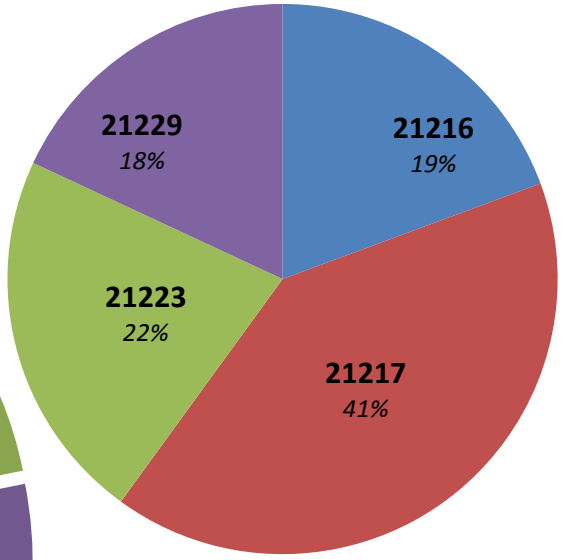
DEMOGRAPHICS of Population Enrolled

- Over 50% between ages 50 – 69 years
- 60% Female vs. 40% Male
- 95% Black or African American

High Utilizer Targeting



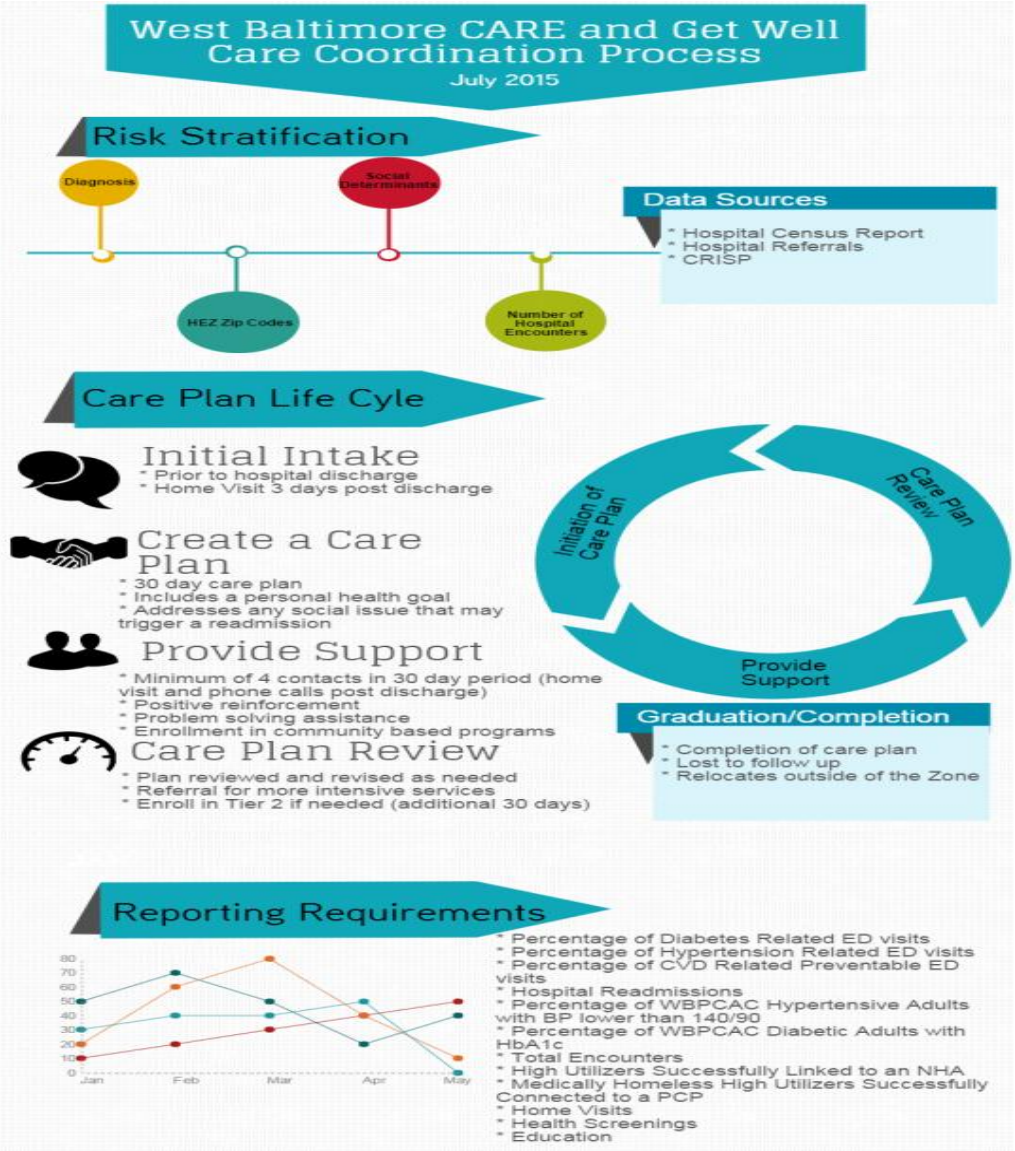
Distribution by Zip



THE COORDINATING CENTER
INSPIRED SOLUTIONS

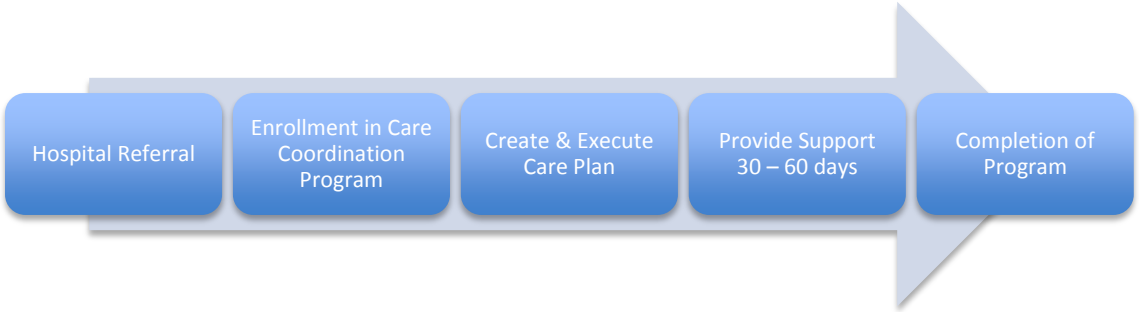
Strategy 1 – Care Coordination

- Partnered with The Coordinating Center
- Two-tiered Care Coordination to Meet **High Utilizer** Needs with Care Plans and Behavior-Based Goals
- Currently Enrolling Hospitals: University of Maryland Medical Center, University of Maryland Midtown, St. Agnes, Bon Secours, and Sinai
- Provided Care Coordination services to **871** HEZ residents as of April 2016 with **2066** encounters
- Average Readmission Rate is **12%** for high utilizers
  - Baseline 17%
  - Prior Year 15%



Care Coordination

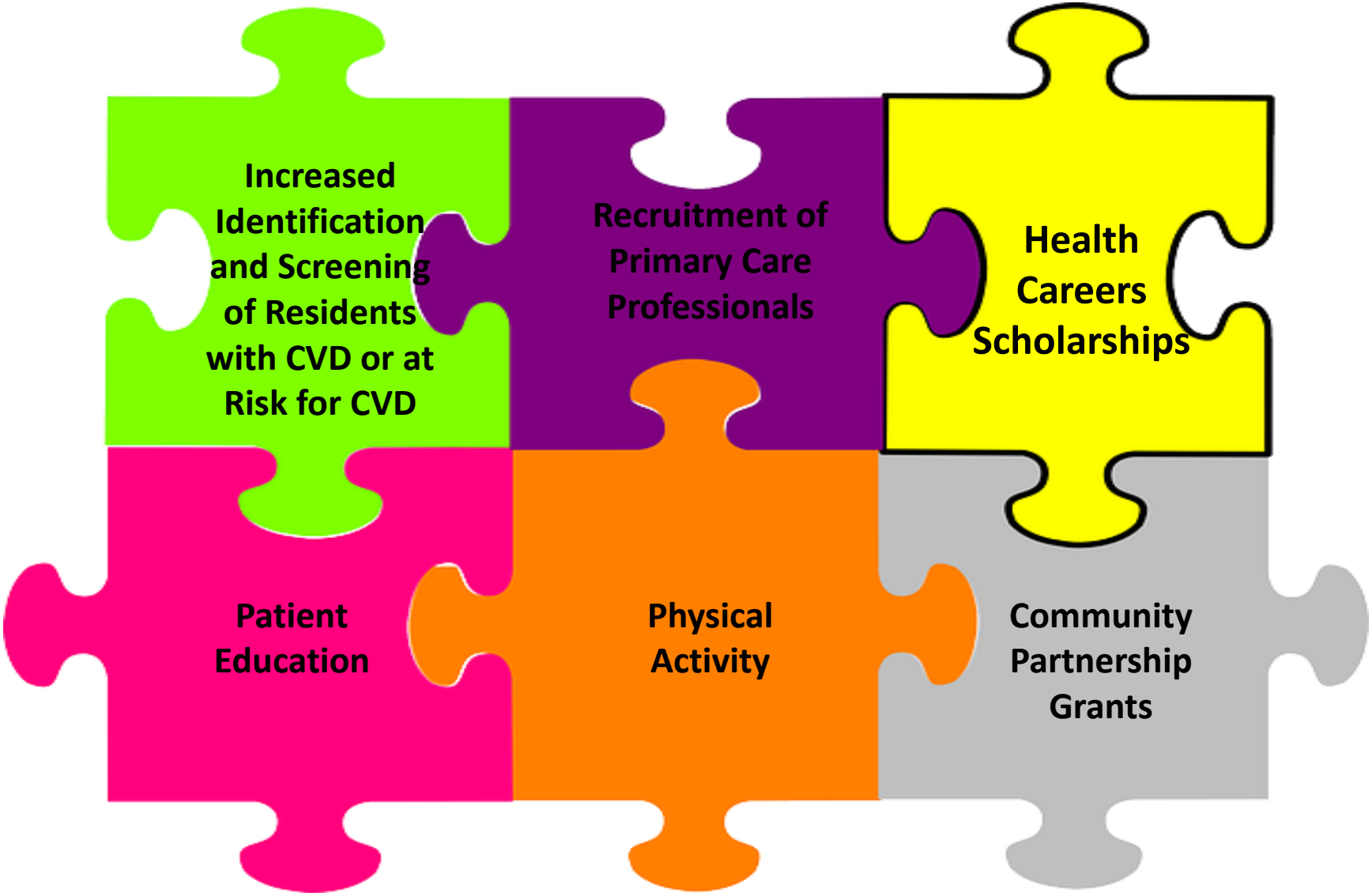
Program Component	Description
Target Population	High Utilizers
Referral Source	HEZ Hospitals (5)
Staffing Model	Includes Program Coordinator, Scheduler, Nurse Care Coordinator, Community Health Workers/Health Coaches
Program Elements	Two-Tier System • 30 Day Intervention – All High Utilizers • 60 Day Intervention – Subset of High Utilizers requiring additional support post 30 day intervention
Tools and Technology	Three complimentary technology systems: CARMA, Care at Hand and CRISP
Evaluation	6 Months Pre-Intervention and 6 Months Post-Intervention using CRISP Reporting



West Baltimore CARE

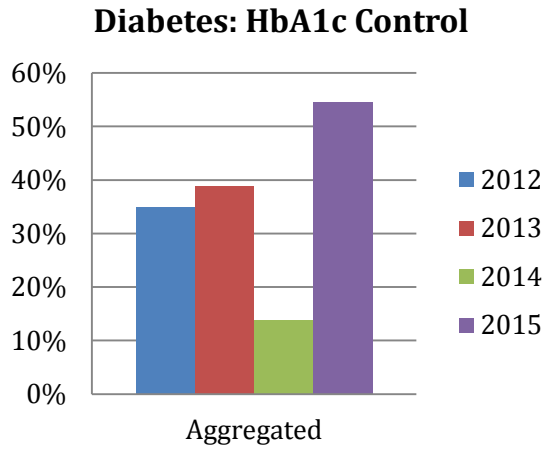
Strategy 2: Community-Based Risk Factor Reduction

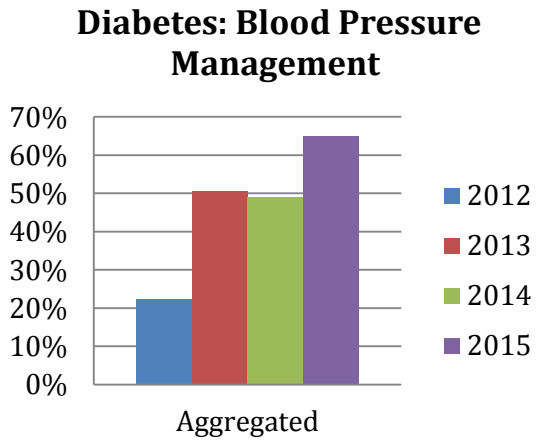
Strategy 2 – Community-Based Risk Factor Reduction

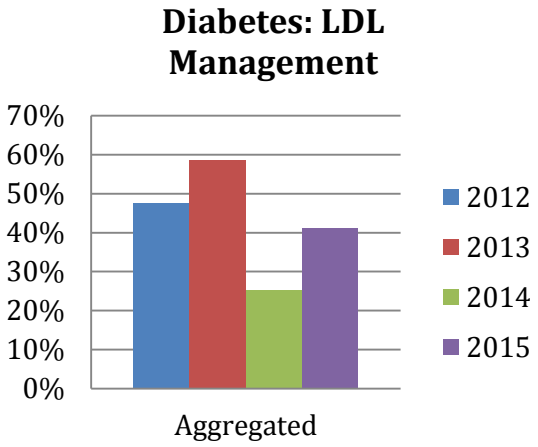


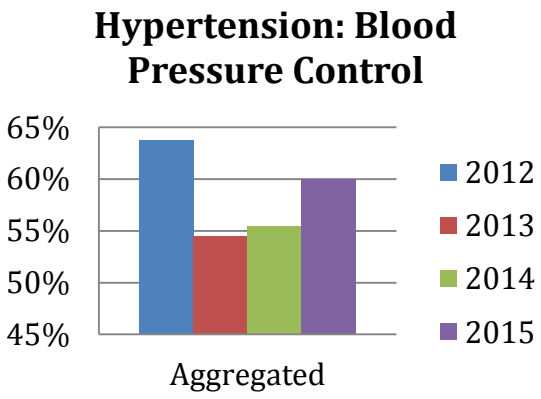
Increased Identification and Screening of Individuals with CVD or at risk for CVD

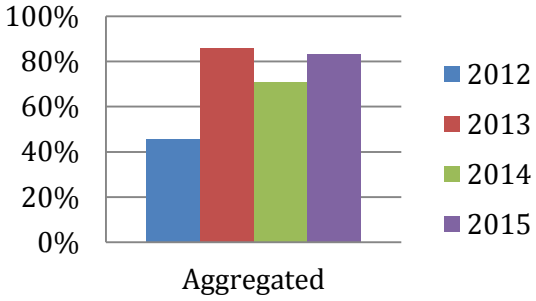
- HEZ Providers use NQF and UDS quality measures to track their identification, screening, and management efforts of individuals with risk factors for CVD

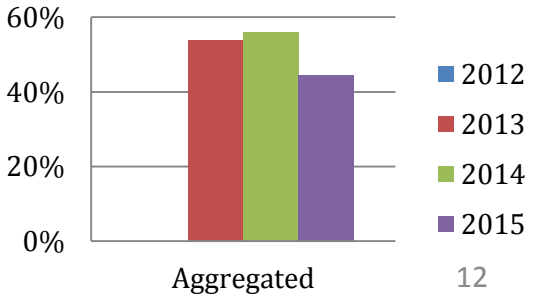












Recruitment of Primary Care Professionals

Assist the State in promoting the use of HEZ State tax credits and loan repayments by eligible HEZ providers by conducting informational sessions and providing letters of support to interested HEZ providers completing the application process

- To date we have spent **$116k** in tax credits for **17** providers in the Zone

Community Health Workers (CHWs)

- Starting a Baltimore Chapter of CHW Association to attract and identify community members and secondary, undergraduate and graduate students to serve as volunteer CHWs and interns in member offices.
- Provided four training sessions
- Providing monthly webinars/technical assistance

Health Careers Scholarship Program

- ***Offer scholarships up to $8,000 to community members to support enrollment in technical professional programs for health and social service careers (e.g., Cardiovascular Technician, Nursing Assistant, Social Worker, Phlebotomist, etc.)***
- Goal is to help increase the number of health professionals who live and work in West Baltimore
- Individuals that receive the scholarship promise to work as a health care professional in West Baltimore for two years
- Awarded a total of **85** scholarships to date totaling **$250k**

10/14/16 Scholarship Information Session

Scholarship Candidate Interview

Patient Education

- ***Offer free CVD health promotion courses on nutrition, physical activity, smoking cessation, and stress relief to the entire West Baltimore community***
- Partnered with St. Agnes chronic disease management program (Heart to Heart and Diabetes Prevention Program)
- Placing cooking classes and diabetes classes in senior buildings beginning January 2016
- Nutrition workshop offered in October 2016

Care Coordination in Housing Facilities

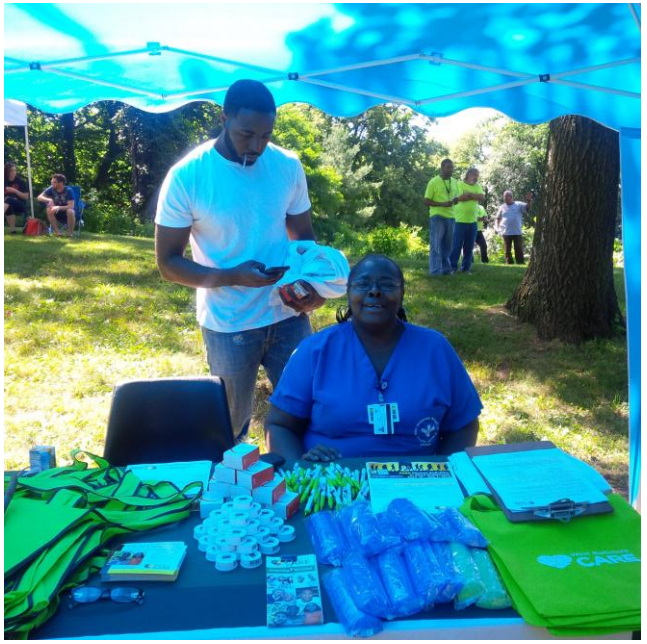
- ***Provide care coordination and community health outreach services at the public and senior housing sites to support the HEZ goal to "Reduce Preventable Emergency Department Visits and Hospitalizations."***
- WB CARE Neighborhood Health Advocate (NHA) is available on-site at each of the public and senior housing locations one day a week. Sites include: Hollins Terrace, Smallwood Summit, The Allendale and Wayland Village
- The NHA works with community organizations (e.g., American Diabetes Association, etc.) and health organizations (e.g., Wilmer Eye clinic, and the John Hopkins Eye Clinic, Good Shepherd HealthCare Services, etc.) to host outreach events at the public and senior housing to provide services such as eye exams and/or educational sessions on diabetes management education to address CVD risk factors.

Community Outreach

- ***Sponsor and participate in Community Outreach activities/events in the WB Health Enterprise Zone (HEZ) zip codes of 21216, 21214, 21223, and 21229 throughout the year***
- In conjunction with community partners, sponsors community outreach activities focused on health and wellness, capacity building and nutrition that advance the goals of the HEZ
- The community outreach activities are focused on the broader community and HEZ residents with CVD or CVD risk factors

Community Day

Tim's Day



Physical Activity

- ***Partner with neighborhood Recreation Centers and churches to offer free fitness classes (11 one hour weekly classes for 12 weeks) to West Baltimore residents***
- Fitness classes include ZUMBA, Kick-boxing, Boot Camp, Total Body Fitness, Yoga, Line Dancing, and Swimming Lessons.
- Tied with "Passport to Health" program which provides nominal rewards to participants based on their participation in fitness activities
- Provided Biometric Assessments to all fitness participants
  - From 2015-2016, avg. wt. decrease ~15lbs, avg. BMI decreased ~1.5
- Over **1514** participants with **3430** encounters in fitness activities since April 2016

Community Partnership (mini) Grants

- ***Partner with and award grants up to $10,000 to community-based organizations to support community programs that align with WB CARE goals and strategies to improve cardiovascular health and to reduce CVD risk factors***

- Grantees include:
  - American Diabetes Association
  - Ames Shalom Community Inc.
  - Baltimore Medical System at St. Agnes
  - Coppin State University, College of Health Professionals Helene Fuld School of Nursing
  - Health Freedom Inc.
  - Paul's Place
  - St. Agnes Foundation
  - SRWCB and Chesapeake Center for Youth Development
  - No Boundaries Coalition
  - Thomas Jefferson Elementary/Civility Music
  - The Joel Gamble Foundation
  - Reservoir Hill Improvement Council

- Programs have focused on health education and screenings, nutrition and healthy eating, and physical activity

Community Partnership Grants continued

Program Metrics	2013 Cohort	2015 Cohort	2016 Cohort	Cumulative
Total Number of Grants Awarded	7	3	6	16
Total Dollar Amount Awarded	$70,000	$30,000	$30,000	$130,000

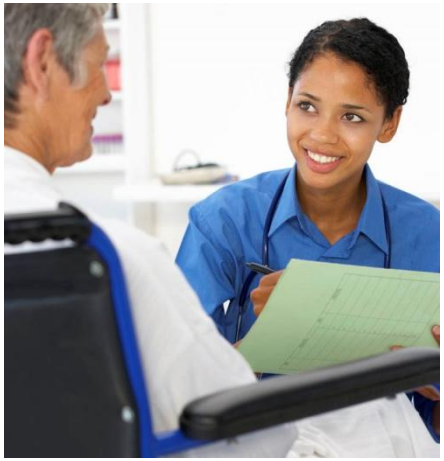
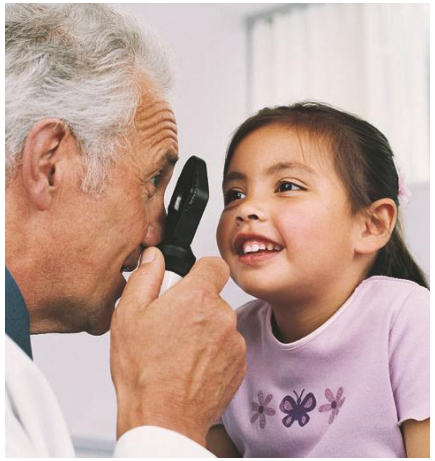
Paul's Place "Kids in the Kitchen"

West Baltimore CARE

Health Enterprise Zones

DISCUSSION & QUESTIONS

PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT


HEALTH ENTERPRISE ZONE
Lessons Learned about Community Engagement

Ernest L. Carter MD PhD
Deputy Health Officer

13th Annual Health Equity Conference
December 13, 2016

Rushern L. Baker, III
County Executive

Building a Healthier Prince George's County

HEZ Overview

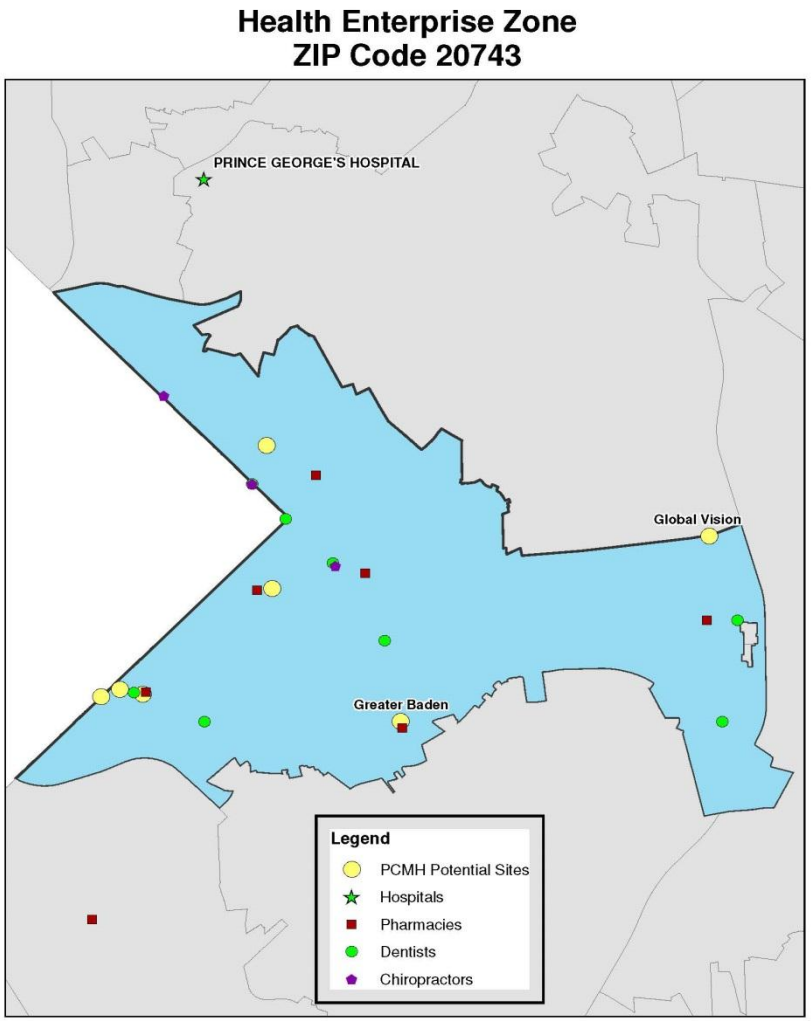
- Capitol Heights Zip Code 20743 with ~ 40,000 residents
- Much less that 1 physician per 3500 residents
- Diverse population presents particular challenges that are exacerbated by the lack of reliable, robust data on residents' health care needs, utilization and outcomes.
- Given that over 90% of the population belong to a racial and/or ethnic minority a comparison of the Maryland median with the values for Capitol Heights on several health indicators demonstrates significant disparities (see Table 1).

Table 1: Health Disparities in Capitol Heights

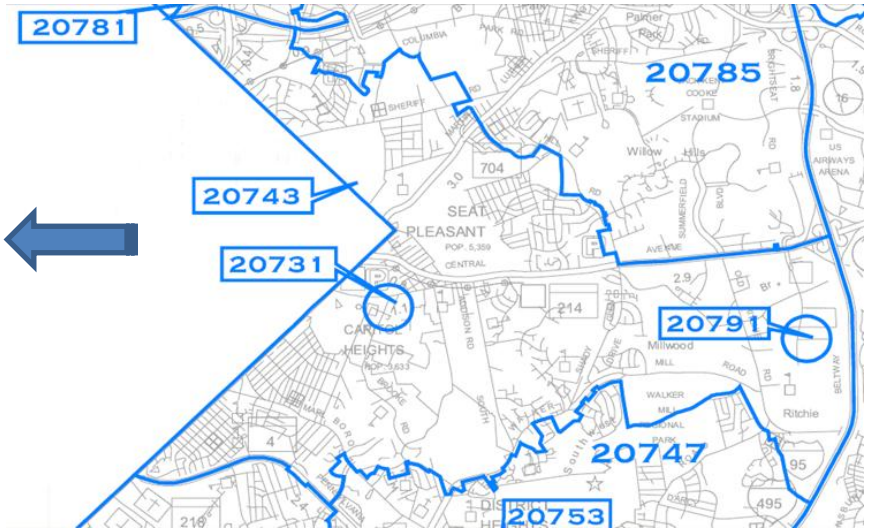
	Life Expectancy (2006-2010)	Average LBW Rate	Medicaid Enrollment	WIC Participation
Maryland Median	79.2	6.3	109	17.9
Capitol Heights	72.16	11.8	201.33	29.72

- Need to address social determinants of health

Capital Heights: zip code 20743

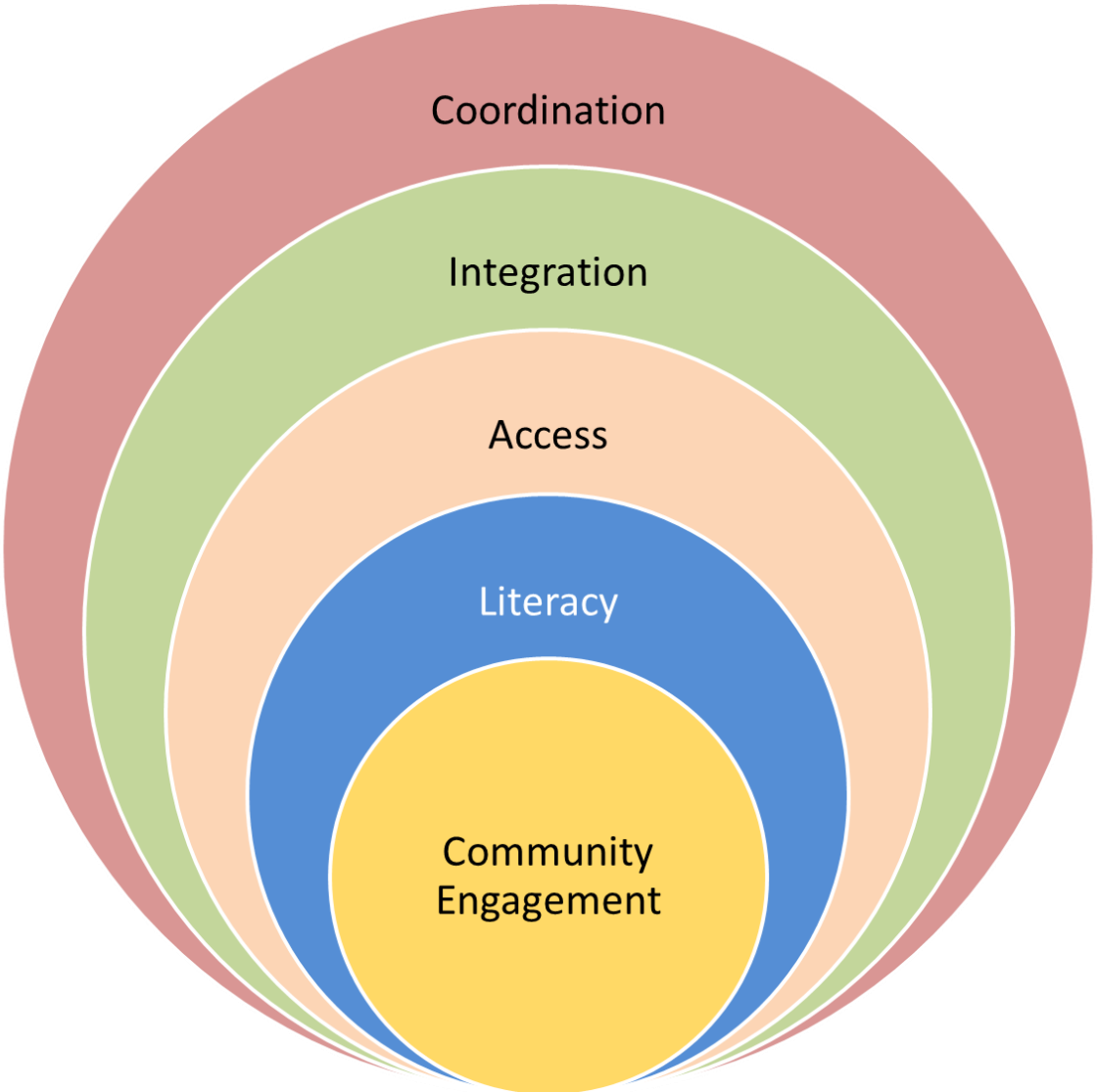


Density Map of HEZ



- Kingdom Square: Capitol Heights
- Southern Capitol Heights
- Coral Hills
- Seat Pleasant
- Fairmount Heights

Building a healthcare system to coordinate care in a community



Health Enterprise Zone Overview

- Improving health in the community by engaging the community: elected officials, civic associations, faith based leaders, residents

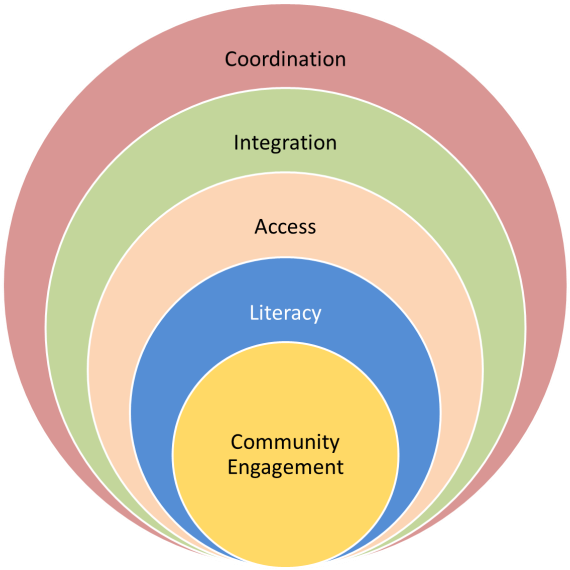
- Improving Health Literacy with the assistance of the University of Maryland School of Public Health

- Reducing healthcare costs

Health Enterprise Zone Overview

- Building a healthcare system to coordinate care in a community

- Transition from hospital, ER, Nursing home or NSF to home
- Public Health/Health Department Services
- Community/County resources and services
- Community Health Workers
- Health Information Exchange & Technology
- Insurance Connection
- Preventing illness and treating chronic diseases



Health Enterprise Zone Overview

- Establish 5 Patient Centered Medical Homes (PCMHs) with a minimum of 1 physician and two nurse practitioners per PCMH within 4 years
  - Greater Baden, Gerald Family Care, Global Vision, Dimensions Ambulatory Care Center and Family Medical Services
- Care Coordination Team (CCT/CHW) "Bridge Entity"
  - Health Department CHWs integrated into the 2 Hospitals (Doctor's Community Hospital and Dimensions Healthcare System) and Primary Care Practices (Patient Centered Medical Homes)
- Establishment of a Community Care Coordination Team (CCCT/Oversight)
- Health Literacy Campaign
- Behavioral Health and Social Services Integration
- Evaluation and Quality Improvement

Health Literacy Campaign

- Health literacy dialogic aid developed to encourage communication with providers. Titled, "*Medical Action Plan*" (MAP) booklet
  - ✓ *Communicate with health care team*
  - ✓ *Ask important questions*
  - ✓ *Get good health information, understand it and use it*
- 10,000 MAP booklets printed.
- 80% of MAP booklets distributed: to every household in City of Capitol Heights through:
  - *Community events*
  - *Civic Association Meetings*
  - *Fire/EMS responses*
  - *Shoppers pharmacy*
  - *Churches*
  - *FQHCs and Provider Practices*
  - *CHWs*

- 5 Health Literacy Advocate trainings: Steering Committee, CHWs, Fire/EMS, Police Departments
- 5 Health Literacy Community Forums held: 250 residents reached
- 4,000 cards and fliers with patient rights, questions to ask and additional resources distributed
- Mobile application in development: local health literacy resource guide through app on mobile phone
- Conference presentation at American Public Health Association annual conference.

Behavioral Health Intervention: Prime Time Sister Circles (PTSC)©

PTSC designed to assist African American women to take control of their health by use of a cognitive behavioral modality to reduce unmanaged stress, improve diet, increase exercise, and monitor key biometric health indicators, i.e., weight, body mass index, and blood pressure.

Highlights:

- Partnerships developed with Community Services Foundation, Pleasant Homes Apartment Complex, Seat Pleasant Police Department
- Transportation provided by the City of Seat Pleasant and the Police Department
- Self-report and clinical data documented that:
  - ✓ 87% of women gained additional knowledge and skills; significantly decreased their stress and unhealthy nutrition habits while increasing their exercise behaviors.
  - ✓ Improvement in blood pressure ratings
  - ✓ Approximately 41% lost two or more pounds
  - ✓ Overall weight loss ranged from 2 to 9 pounds.
- Over 75% of women attended at least 9 of the 13 meetings

Figure 3. Participants' satisfaction with Circle, knowledge and usefulness

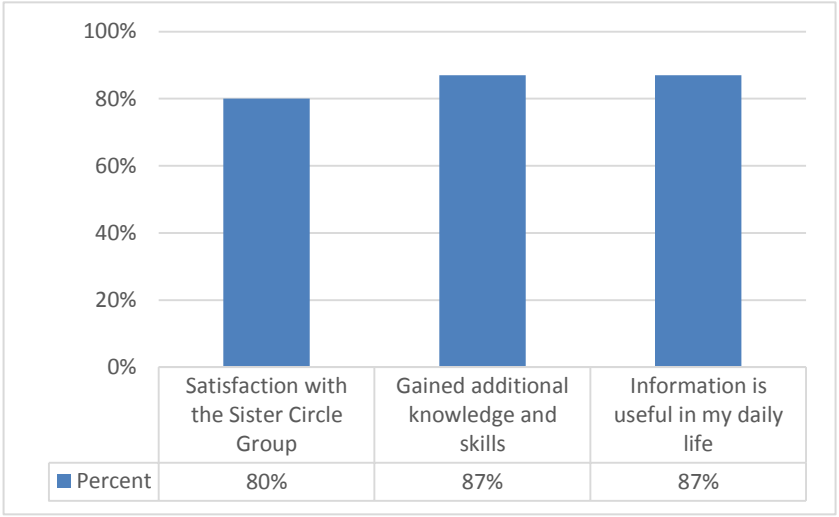
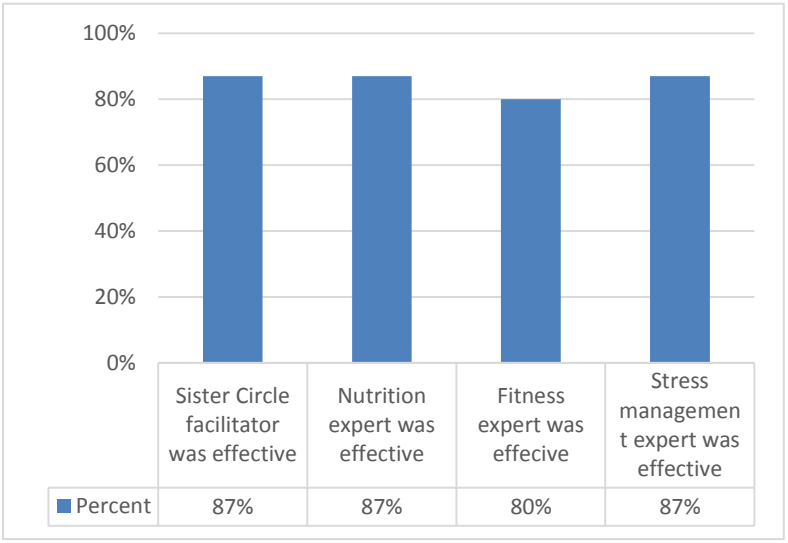


Figure 4. Participants' satisfaction with facility and experts



Community Care Coordination : Function

1. Establishes accountability and agreed upon responsibility of each member of the care team.
2. Communicates/shares knowledge about the patients' needs.
3. Helps with transitions of care: hospitalizations, emergency visits.
4. Assesses patient needs and goals.
5. Creates a proactive, comprehensive and coordinated care plan.
6. Monitors and schedules follow-up with the patient, including responding to changes in patients' needs.
7. Supports patients' self-management goals.
8. Links to community resources.
9. Works to align resources with patient and population needs.

Resource: Agency for Healthcare Research and Quality (AHRQ)
Department of Health and Mental Hygiene

Care Coordination Team: Evidence-Based Care Transitions and Care Coordination

Hospital

Inpatient Clinical Coordinator

Hospitalist

Care Transition

Home

Patient

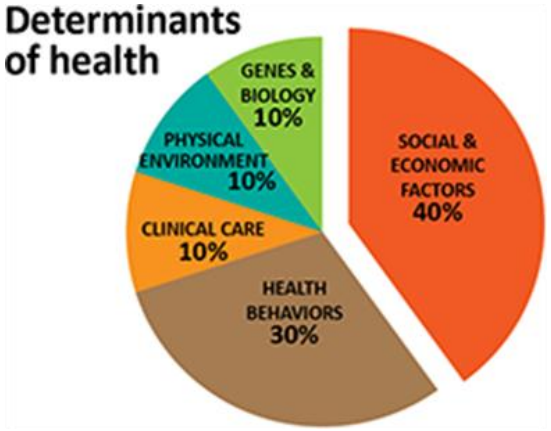
Community Health Worker

Care Coordination

Patient Centered Medical Home

Patient's Doctor

Outpatient Clinical Coordinator



Community Care Coordination Team (CCCT) – "Bridge Organization"

Care coordination team that deliberately organizes patient care activities and shares information among all of the participants concerned with a patient's care to achieve safer and more effective care.

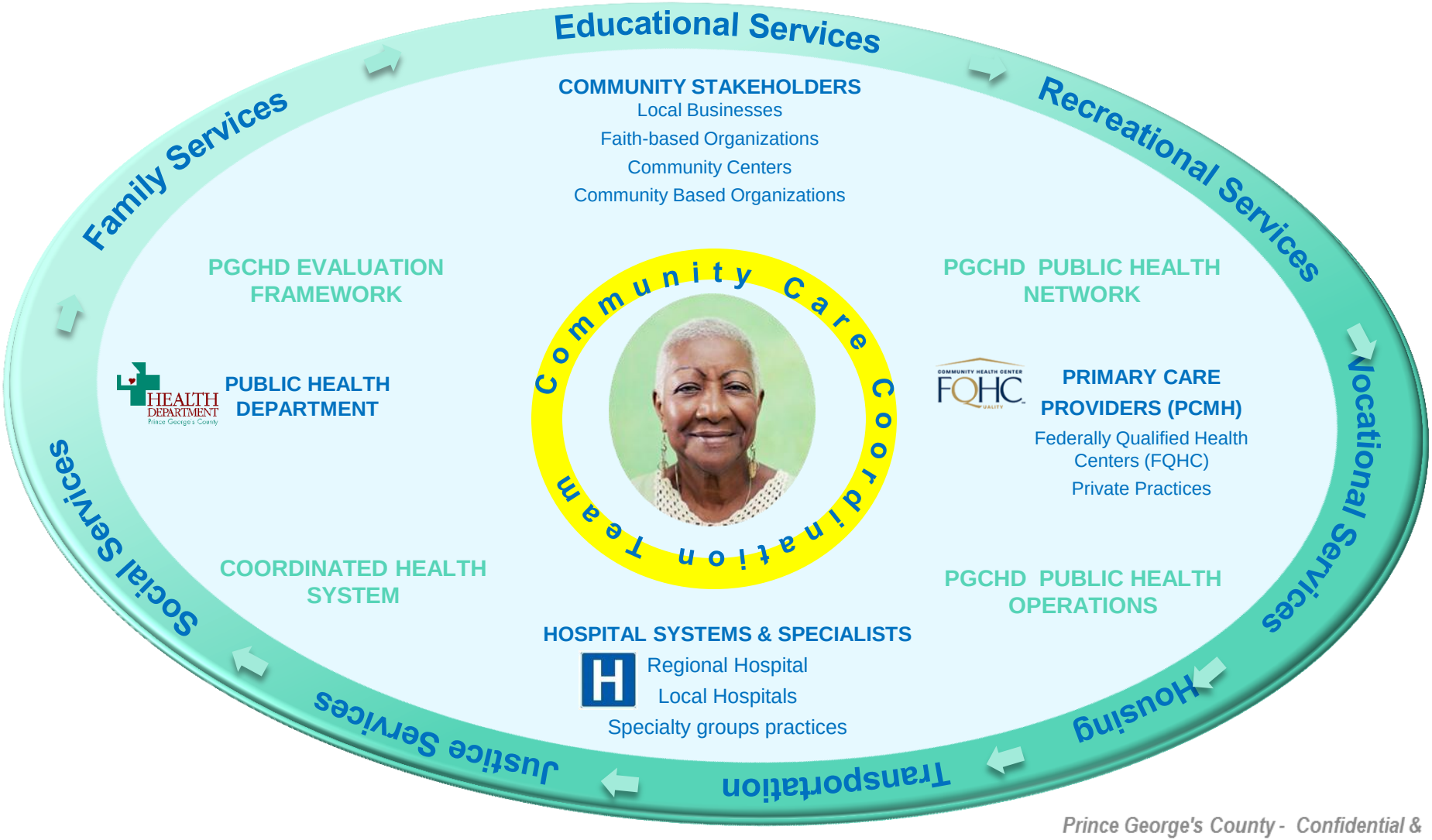
- Identifies needs
- Sets coordination priorities
- Quality Assurance
- Establishes communications among stakeholders

The patient's needs and preferences are known ahead of time and communicated:

- *at the right time*
- *to the right people*

Resource: Agency for Healthcare Research and Quality (AHRQ)
Department of Health and Mental Hygiene

Care Coordination Expanded Model



Case Example

Real Case

- 56 y.o. AA female
- 4 hospitalizations
- Referred to CHW
- Issues
  - Diabetes poor control
  - No PCP
  - No Transportation
  - Not taking medications
  - Depressed
  - Introverted
  - No Family Support
  - Unable to take care of home

CHW Intervention

- At intake: Multiple needs, Illiterate, family abandonment
- Pathways Completed:
  - Medical home
  - Transportation
  - Medication Assessment
  - Medication Reconciliation/Pictorial Aids
  - Specialty referrals for home health, behavioral health, cardiology, pulmonology, nephrology, ophthalmology
  - Diabetes self-management
  - Referral for Adult Evaluation Review Service
  - Linked to:
    - Adult daycare
    - Personal care assistant
    - Diabetes group classes
    - Prime Time Sister Circle

Outcomes: PCP visits, specialty visits, support services, socializing, thriving… No ED visits, No Hospitalizations

Successes

- The PGCHEZ created an effective value-based system of care in an significantly underserved zip code (20743) of ~40,000 residents that:
  - Established a Model for Care Coordination
  - Engaged the community and established effective partnerships (CCCT)
  - Increased access to PCMHs
  - Increased Community Health Literacy
  - Increased Community Workforce
  - Introduced Behavioral Health Integration
  - Demonstrated a significant reduction in:
    - hospital visits between 16% - 42%
    - hospital cost between 30%-54%

Benefits of Community Engagement

- Increases ability to translate goals, strategies and research into useable elements for the community
- Two way communication, but also two-way knowledge: not just “top down”
- Reduces risk of incompatible language use and misunderstood intent
- Empowering
- Helps build trust, which increases likelihood of sustainability of project

Health Literacy Campaign in the HEZ

- Resident Steering Committee guides decisions, logistics and actions
- Links to community assets, harnessing of neighborhood capacity
- Involvement of local non-profits, grocery, churches
- Community history and community assessments used to build campaign
- Trust developed between residents and HEZ
- Police engagement based on needs of Steering Committee

Principles Learned

1. The project may not be a community priority; be flexible and listen.
2. The community drives the logistics and procedures.
3. Reach people where they are; centralize and address social determinants.
4. The burden to get it right is on us.
5. Incorporate health literacy to empower participants.
6. Community stakeholders and residents have decision making power and affect outcomes.

Lessons Learned

- Addressing access gaps in the community are essential for effective care coordination and improving population health outcomes
- Addressing social determinants of health contribute to reducing hospital readmissions and frequent ED visits and costs
- Building collaborative partnerships with hospital systems, county agencies, Fire/EMS, providers and payers promotes information sharing and improves care coordination
- Community Health Worker (CHW) home visits are key to assessing the patient environment, identifying patient and family needs, and address social determinants affecting their health, facilitate resource connections and implement the right interventions
- Standardized evidence-based pathways guide CHW interventions and improve health outcomes

Lessons Learned, and Sustainability Challenges and Strategies.

Lessons Learned

- Creating an atmosphere of compassion in all aspects of the project creates better performance
- Establishing PCMHs in depressed areas require public/ private funding
- Care coordination requires an overlap of clinical, behavioral, social determinants and medication therapy management interventions
- A Bridge Organization (CCCT) is needed to assure optimal communication and quality assurance in care coordination
- The Bridge organization should be a neutral trusted source
- Community engagement is critical
- Health Literacy is the foundation for community health transformation
- Public Health involvement is important

Sustainability Challenges and Strategies

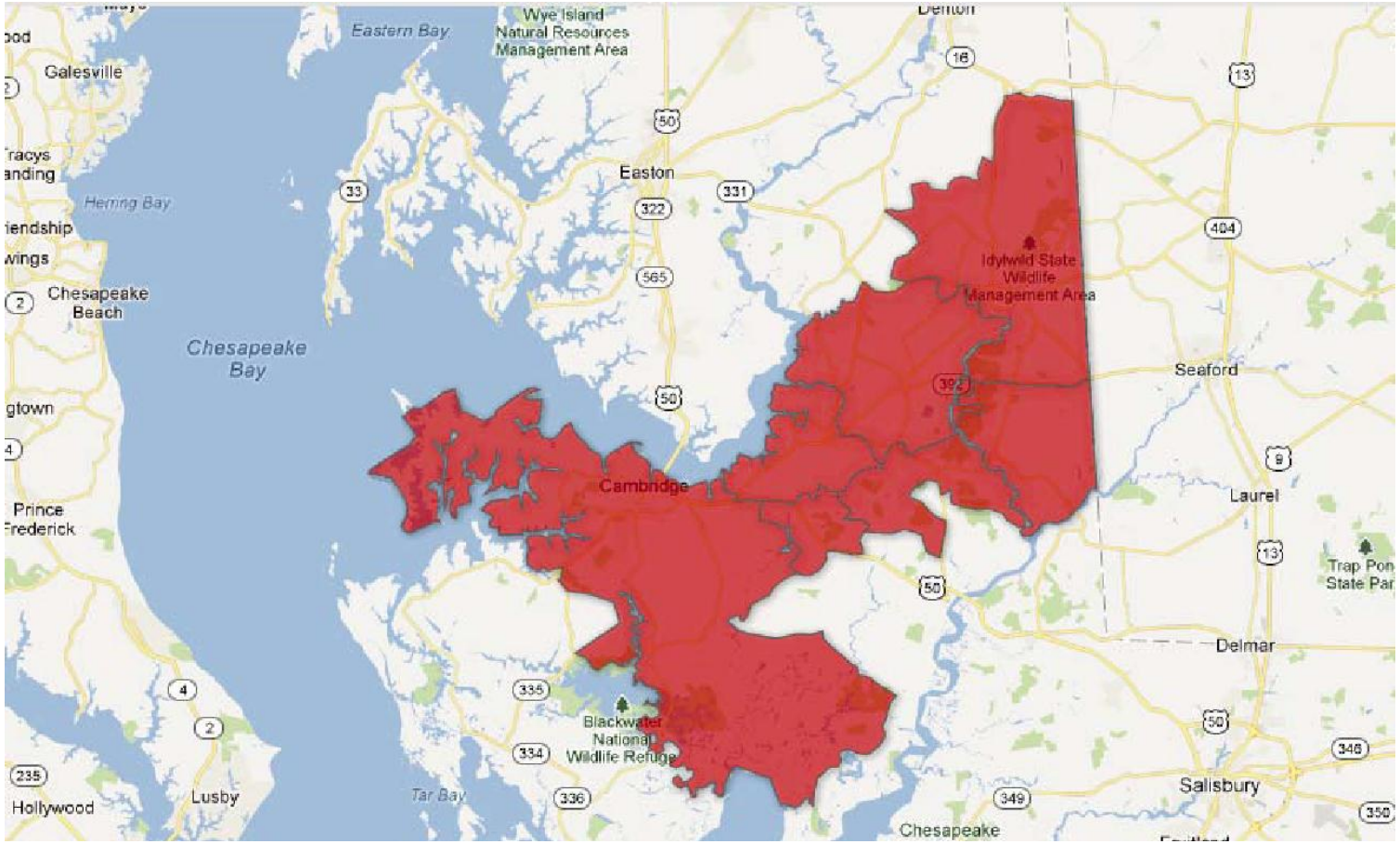
- Establishing a public /private "bridge" entity
- Consider social impact bonds in depressed areas
- Short Term Gap funds from investors, foundations, local, state and federal government
- Long Term: Establish Business Case: adjunct to value based purchasing for hospitals, nursing homes, NSF's, ACOs, PCMHs, employers, payers.

Questions

Caroline-Dorchester HEZ Competent Care Connections

13th Annual Health Equity Conference
December 13, 2016

Competent Care Connections Region



Population Health Approach

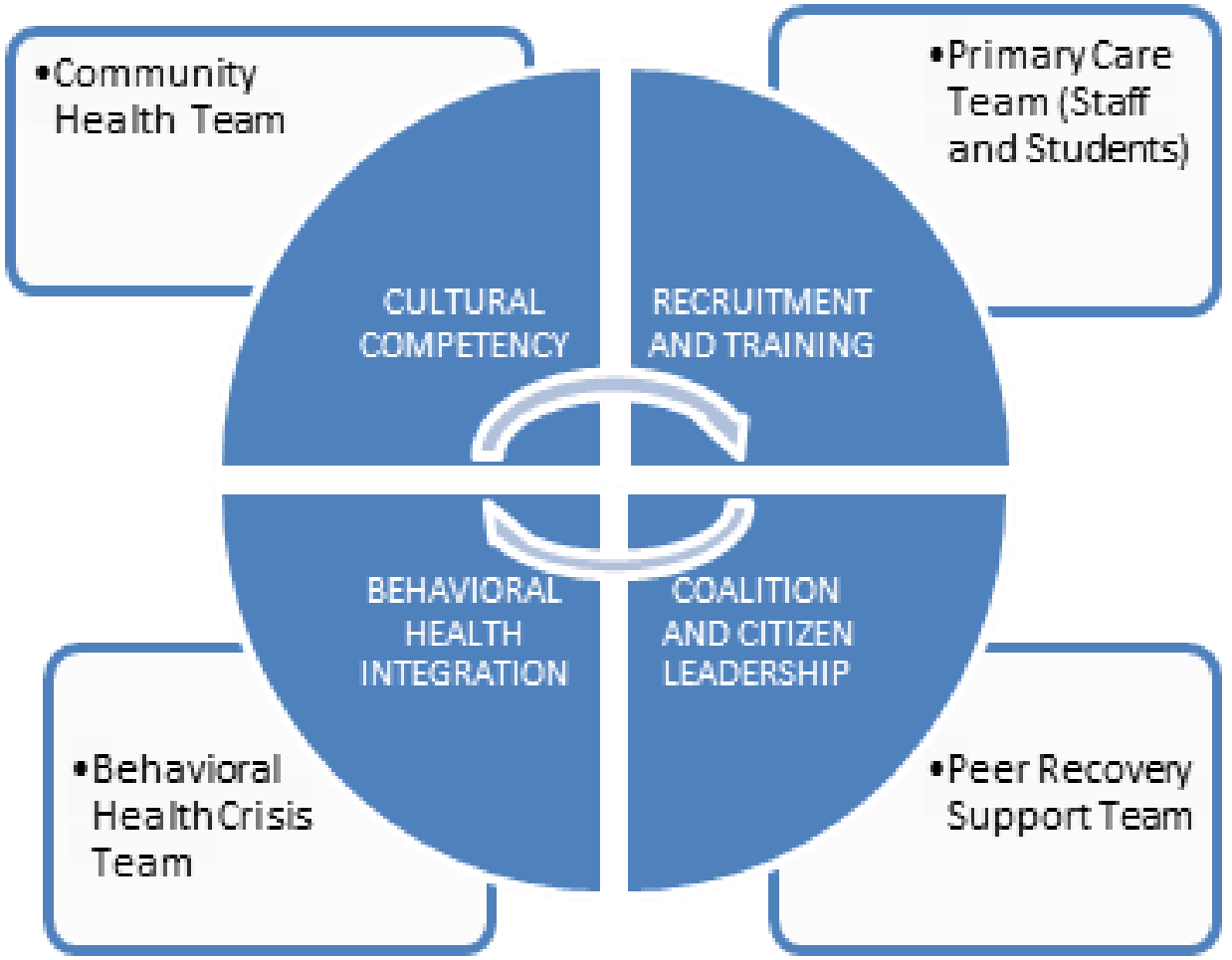
- Collaborative effort among different types of organizations
- Shared values and goals
- Coordination to address complex health determinants
- Coalition made up of 23 leaders, community members, advisory partners, etc. with different skill sets and resources meets monthly to strategize

Goals for HEZ 4-Year Grant Period

1. Improve outcomes and reduce risk factors related to diabetes, hypertension, asthma, and behavioral health issues
2. Expand the primary care workforce
3. Increase the community health workforce
4. Increase community resources for health
5. Reduce preventable emergency department visits and hospitalizations
6. Reduce unnecessary costs in healthcare

FUNDED PARTNERS	SERVICES PROVIDED
Associated Black Charities (ABC)	Community health workers, integrate w/ healthcare system
Caroline County Health Department (CCHD)	School based mental health services, adult outpatient mental health therapy
Chesapeake Voyagers, Inc. (CVI)	Mental health peer recovery support services
Choptank Community Health System (CCHS)	Care coordination, wrap-around services
Dorchester County School Based Wellness Center (DSBW)	Somatic and behavioral health care, including asthma management
DRI-Dock (DD)	Substance use peer recovery support services, drop-in center
Eastern Shore Area Health Education Center (ESAHEC)	Working to establish CHW training institute, provide training, advocacy for preceptor bill, mini-residencies
Maryland Healthy Weighs (MHW)	Weight loss (Phase I) and weight management (Phase II) obesity treatment program
Maryland State Medical Society (MedChi)	Provider recruitment, HEZ marketing
Affiliated Sante Group Eastern Shore Crisis Response (receives funding through BHA)	Crisis response, resource help

Strategies for Indirect and Direct Care/Access



Primary Care

Choptank Community Health System

- FQHC with 2 clinics in Zone
- Contracted for care coordination efforts in Sept. 2015
- FT Nurse Care Coordinator ensures patients referred appropriately and assists patients with navigating healthcare system

Dorchester County School Based Wellness Center

- Expanded access to pediatric care in school setting (in collaboration with providers)
- Nurse Practitioner at middle school provides primarily somatic, but also primary mental health services
- Implemented Asthma Management Program

Community Health

Associated Black Charities

- Established Community Health Worker Team to solidify reach into homes and communities through various services
- Build trusting relationships to connect individuals to needed care and resources

Maryland Healthy Weighs

- Obesity treatment program proven to reduce BMI
- Allows access for low income patients by offsetting costs not covered by insurance

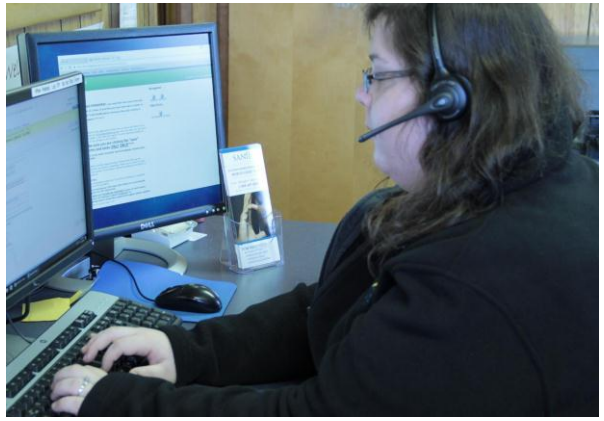
Behavioral Health

Caroline County Health Department

- Opened Federalsburg Mental Health Clinic in Nov. 2015
- Licensed clinical social workers and psychiatrist provide adult outpatient mental health services
- Provided school-based mental health services

Affiliated Sante Group Eastern Shore Mobile Crisis Response

- Established Dorchester/Caroline Team to reduce dispatch crisis response time and divert from hospitalization or incarceration
- Resource help for people in crisis with mental health issues, substance abuse, etc.



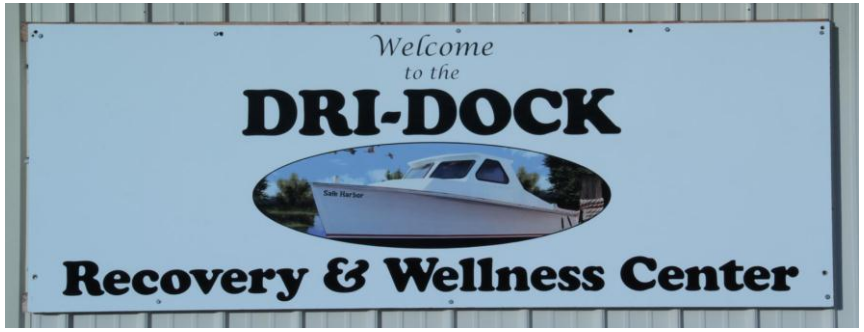
Peer Recovery

Chesapeake Voyagers, Inc.

- Provides mental health peer recovery support services

DRI-Dock

- Drop-in center
- Provides substance abuse peer recovery support services



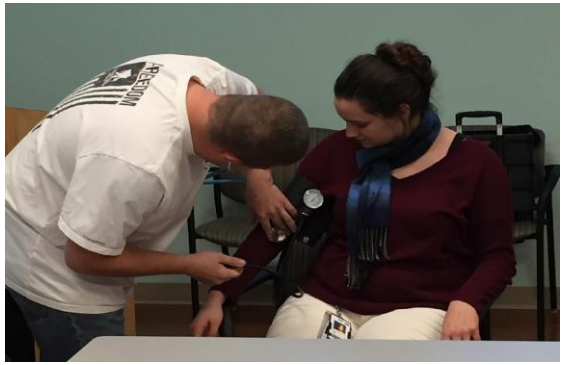
Recruitment & Training

Eastern Shore Area Health Education Center

- Developing CHW workforce by providing core training and updates and working to establish CHW training institute
- Advocated for preceptor tax credit bill
- Assisted with 2 mini-residency rotations in one of our high schools

MedChi

- Promotes incentives to providers to open/expand services in Zone
- Recruited satellite office – Chesapeake Women's Health and 3 additional physicians



HEZ Participants Receiving Services

HEZ Metrics	Year 1	Year 2	Year 3	Year 4 Q1	Total to Date*
Total Number of Unduplicated Patients	591	1,253	1,550	855	**4,249**
Total Number of Patient Visits	2,687	7,899	9,240	1,903	**21,729**

Number of New/Retained Jobs = 25.98 FTE

(Includes Licensed Independent Practitioners, Other Licensed/Certified Health Care Practitioners, Qualified Employees, and Other Support Staff)

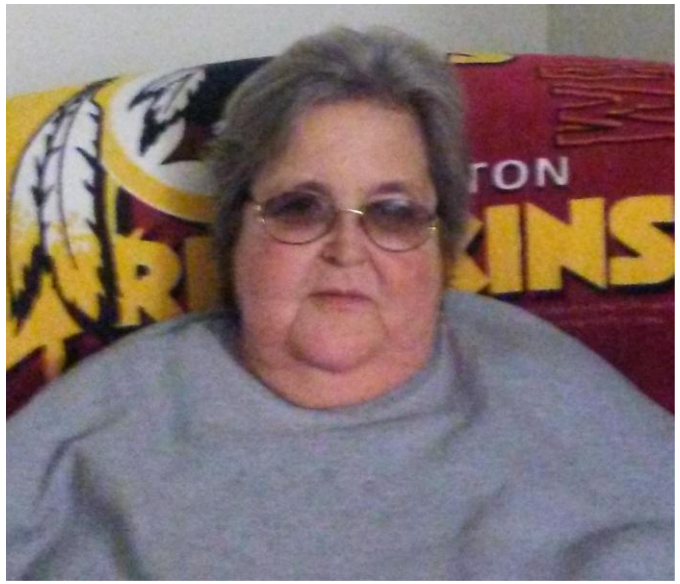
*as of June 30, 2016

Lessons Learned & Sustainability Challenges

- Data capabilities – significant challenges with data collection, HIPAA, CRISP access
- ROI is not always tangible, and it is too soon to effectively demonstrate
- Need to continue advocating for and educating about the effectiveness of CHWs
- Success due to committed program leaders and strong partnerships
- Need multi-faceted approach because of complexity of issues
- Provider recruitment
- All of this takes time and is not easily resolved!

Participant Testimonials

ABC CHW Team – Melody



"She's my angel. Several times I've thought about suicide because I'm tired of being sick. Without Ms. Joyce, I don't know what I would have done. She's helped me in so many ways…moral support, gone to the doctor with me, taken me to the grocery store because I don't have anybody."

DSBW Asthma Management Program – "D"

- 8th grader
- Multiple asthma attacks, sometimes in same week
- Missing school and not doing well
- Initial Peak Flow measurements <100 (Red Zone)
- After much teaching, new medication, peak flows closer to 200

Contact Information:

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Maryland Office of Minority Health and Health Disparities
13th Annual Health Equity Conference
December 13, 2016

Achieving Health Equity through Community Engagement and Innovative Health Care Delivery

AFTERNOON CONCURRENT BREAKOUT SESSION C

Community Health Workers and Other Innovative Community Care Models

Moderator:

Dwyan Y. Monroe, Program Coordinator, Community Health Worker Initiatives, Institute for Public Health Innovation

Panelists:

Elda Woldemichael, CHES, Community Health Worker, Baltimore Medical System, Inc.

Lenora Wright, Community Health Worker, Institute for Public Health Innovation, Program Site: Heart to Hand, Inc.

Jared Smith, MA, NRP, EMS Program Director, Mobile Integrated Community Health, Queen Anne's County Health Department

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Community Health Workers and Other Innovative Community Care Models

Maryland Office of Minority Health and Health Disparities
13th Annual Health Equity Conference
"Achieving Health Equity through Community Engagement and Innovative Health Care Delivery"

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Session Objectives:

- Highlight Current **Community Health Worker Initiatives** and other **innovative community care models** taking place in Maryland that **focus on reducing health disparities**.

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Community Health Worker Definition: American Public Health Association (1)

- The CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.

- This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

- APHA Policy Statement 2009-1, November 2009

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Community Health Worker Definition: American Public Health Association(2)

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- The CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as:
- outreach,
- community education,
- informal counseling,
- social support and
- advocacy.

APHA Policy Statement 2009-1, November 2009

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CHW Scope of Practice to Reduce Health Disparities

Inform. Involve. Inspire.

- Provide cultural mediation between community and health/social service agencies
- Show cultural sensitivity through education and materials
- Educate about common illnesses and cultural norms
- Educate about prevention and access to health care
- Identify and understand social determinants to care

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CHW Scope of Practice to Reduce Health Disparities

Inform. Involve. Inspire.

- Fight for equity in health care systems and refine the approaches of providers
- Sets realistic goals that are tailored to the clients needs
- Provide culturally appropriate outreach and advocacy
- Connect clients to appropriate and tailored referrals

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Maryland Organizations: Community Health Worker Programs

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- Special Statewide Initiatives:
  - Maryland Health Enterprise Zones
  - Patient Centered Outcomes Research (PCORI)-UMM School of Pharmacy
- Maternal Child Health Programs:
  - Baltimore Healthy Start
  - Access to Wholistic and Productive and Productive Health Institute
- Area Health Education Centers (AHEC):
  - Eastern Shore AHEC
  - Baltimore AHEC- UMM
- Health Systems/Hospitals
  - Johns Hopkins Health System
  - Saini life Bridge
  - Bon Secours Hospital

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Maryland Organizations: Community Health Worker Programs

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- Local Health Departments:
  - Charles County
  - Howard County
  - Prince Georges County
  - St. Mary's County
- Health Insurance Plans:
  - United Health Group
- Community Based Organizations:
  - Sisters Together and Reaching- Baltimore
  - Heart to Hand(WeConnect)- Prince Georges County
- Federally Qualified Heath Centers:
  - Baltimore Medical Systems- Baltimore
  - Total Health Care- Baltimore
  - Park West Medical Center-Baltimore
  - Greater Baden Medical Centers-Prince Georges County
  - CCI Health and Wellness Services- Prince Georges and Montgomery County

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CHWs in Maryland: Movement and Future

Inform. Involve. Inspire.

- Maryland Statewide CHW Network:
  - Central MD Chapter
  - Baltimore City Chapter
- MD CHW Workforce Development Work Group:
  - DHMH and MD Legislation
- Baltimore City Health Department
- Baltimore Area Health Education Centers
- Department of Health and Mental Hygiene
  - Office of Minority Health and Health Disparities
  - Office of Population Health

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Other Innovative Community Care Models

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Similar Innovative Community Programs that Address Health Disparities

- The best of these approaches have the virtue of empowering and mobilizing community resources and residents, but at the same time implementing systematic, sustainable and clinically sound approaches to health behavior, screening, prevention and promotion, and treatment.

- Invite community, public health, policy, and research experts into the clinical setting in order to make clinical care more responsive to vulnerable populations and to make clinical interventions more effective in improving their health.

Community Approaches to Addressing Health Disparities, Carol Horowitz, M.D., M.P.H.1 Edward F. Lawlor, Ph.D.2Institute of Medicine (US) Roundtable on Health Disparities. Washington (DC): National Academies Press (US); 2008

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Summary

- Utilization of care programs that incorporate both community engagement and care systems working together have been effective in decreasing health disparities and are beginning to show promise in decreasing health inequities

- Innovative care programs incorporating and supporting new health professions such as CHWs and reinventing other health professions' roles to focus on client centeredness and the social determinants of health are the growing and emerging approaches in MD that are making a difference in the lives of Marylanders facing chronic health issues.

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Let's Hear From the Panel

Community Health Worker Integration to Primary Care Setting

Outpatient Support

- Target population are low income individuals, seniors, patients with chronic conditions, and uninsured individuals.
- CHW works with patients to develop goals and related action plans and provide customize support.

Improving Access to Health Care

- Helps patients navigate the health care system and work to address their social and economic needs.
- Helps patients schedule appointments.
- Arranging transportation to and from appointments.
- Placed for the use of primary and follow- up care for preventing and managing diseases.
- Provides referrals for needed services, such as home health, outpatient alcohol treatment.

Improving Health

- CHW connects with patients at least twice a month through home visit, phone calls or mail.
- CHW provides coaching, helps to coordinate chronic disease care, encourages self-monitoring behavior.
- Identify and address issues that create barriers for specific individuals.
- Integrating with patient care team to support progress in care.

Continues…

- CHW provide culturally appropriate health education.
- Assist with enrolment in insurance and social programs.
- Measuring and monitoring blood pressure.

Lenora Wright, Community Health Worker

Institute for Public Health Innovation,

Program Site: Heart to Hand, Inc.

Heart to Hand

- Nonprofit CBO based in Largo, MD
- Provides community non-medical support services to those with HIV/AIDS and other health disparities.
- (1) Screening
- (2) Linkage to Care and Retention in Care
- (4) Case Management Services
- (5) Support Groups
- (6) Advocacy
- (7) Treatment Adherence & Pharmacy

Heart to Hand: WeConnect

- As a CHW based out of H2H, Lenora is a trusted support to individuals living with HIV.
- She helps these individuals reduce and overcome social barriers to accessing healthcare and other services they need to maintain health.
- Address and provide information and resources to help clients manage social barriers that may include access to:
  - housing,
  - drug abuse services,
  - food, and more.

Stories of Health Equity from the Field

Mobile Integrated Community Health

Overview

A team approach to population health.

Jared Smith MA, BS, NRP

Mission Statement

To improve health outcomes among citizens of Queen Anne's County through integrated, multi-agency, and intervention-based healthcare.

Vision Statement

To provide mechanisms for citizens to have better access to healthcare and to enhance individual health outcomes.

MICH Criteria

Inclusion

Adults 18 years and older.

Five 911 calls in any 6 month interval

Resident of Queen Anne's County

Exclusion

Receiving Home Health Care or Visiting Nurse Agency services.

Refusal to participate in the program.

Referral Phases

- First Phase - Frequent 911 Callers
- Second Phase - EMS Referrals
- Third Phase - ED Referrals and QA ER Referrals
- Fourth Phase - Shore Regional Health Post Discharge
  &
  AAMC Post Discharge

MICH Team

Combination Field Team

Department of Health Nurse / Nurse Practitioner

Queen Anne's County Paramedic

Behavioral Health Professional

Management

Health Officer / EMS Medical Director
Joseph A Ciotola, Jr., M.D.

MICH Home Visit

QAC DES Paramedic

- Program introductions and overview
- Physical examination assessment of physical health
- Health and home safety assessment
- Discuss home safety issues with the patient and need to modify identified hazards

QAC DOH NP / RN

- Program introductions and overview
- Assessment of health history, Rx inventory, review of systems and current status
- Assessment of patient education and assessment of support system
- Referrals to appropriate health and community services

Health and Home Safety

- **The EMS Provider utilizes four evidenced based scales to determine home and personal safety of each patient.**

- **The four assessment scales that will be utilized are:**
  - **The Hendrich II Fall Risk Model**
  - **The Physical Environment Assessment Tool**
  - **Alcohol Use Disorder Identification Test**
  - **Drug Abuse Screening Test**

Telehealth

Mobile WiFi secured through oMG Mobile Gateway by Sierra Wireless.

- Verizon Hotspot used as a back-up

Panasonic Toughbook

- Very durable. Will stand up to most rigorous environments

VIA3 Unity

- Provides several layers of end-to-end AES encryption
- Willing to sign a BAA to satisfy HIPAA HITECH Act
- Interoperablility and provides 720p HD video and file sharing

Data and Demographics

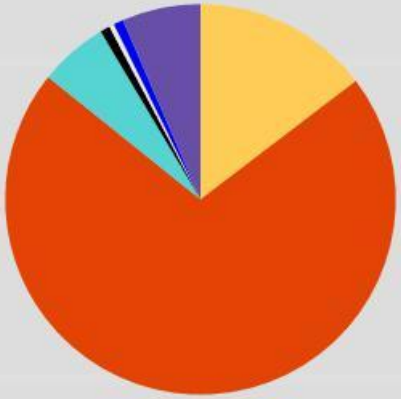
Total time spent on home visits

225 hours

Avg. time spent per home visit

79 minutes

Referral Sources



911 CAD Data (14.63%)

QA DES (71.14%)

QA ER (5.69%)

Self-Referral (0.81%)

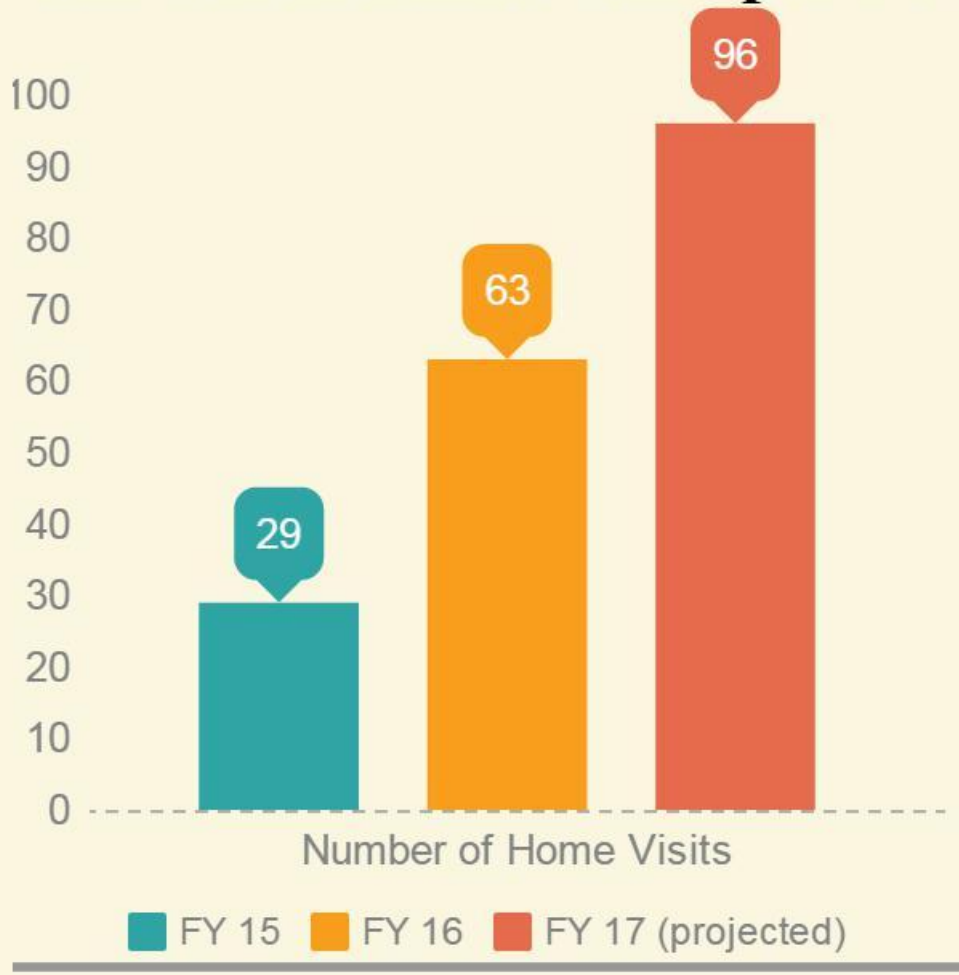
Chestertown ED (0.41%)

AAMC D/C (0.81%)

Easton SPACC (6.50%)

Data and Demographics

Growth in Home Visits per FY



Growth Percentage

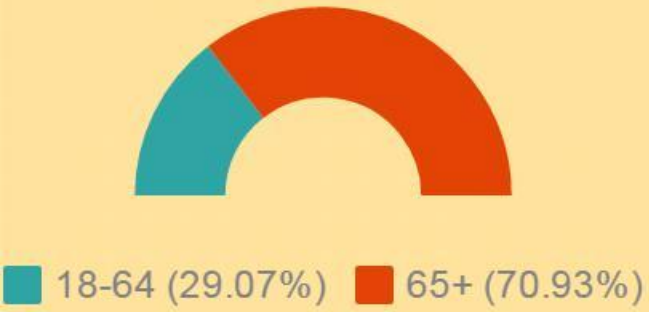
From FY 15 to FY 16: **117%**

From FY 16 to FY 17: **52%**

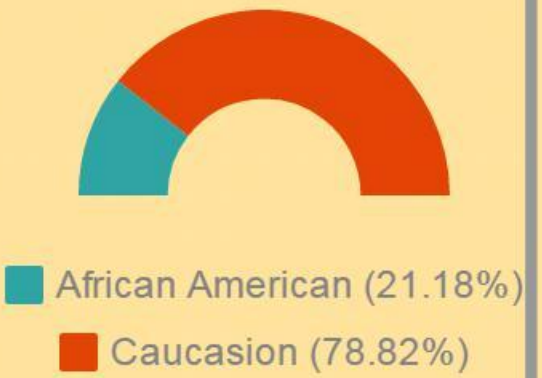
From FY 15 to FY 17: **231%**

Data and Demographics

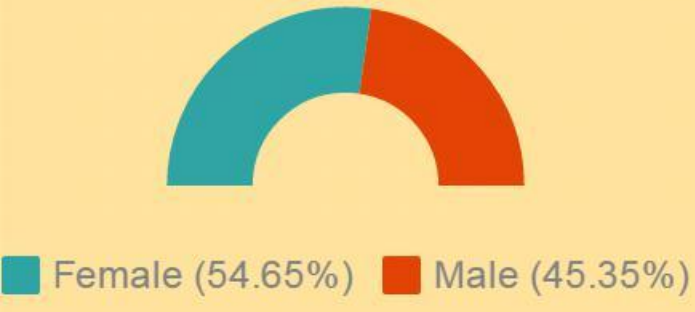
Age



Race



Gender

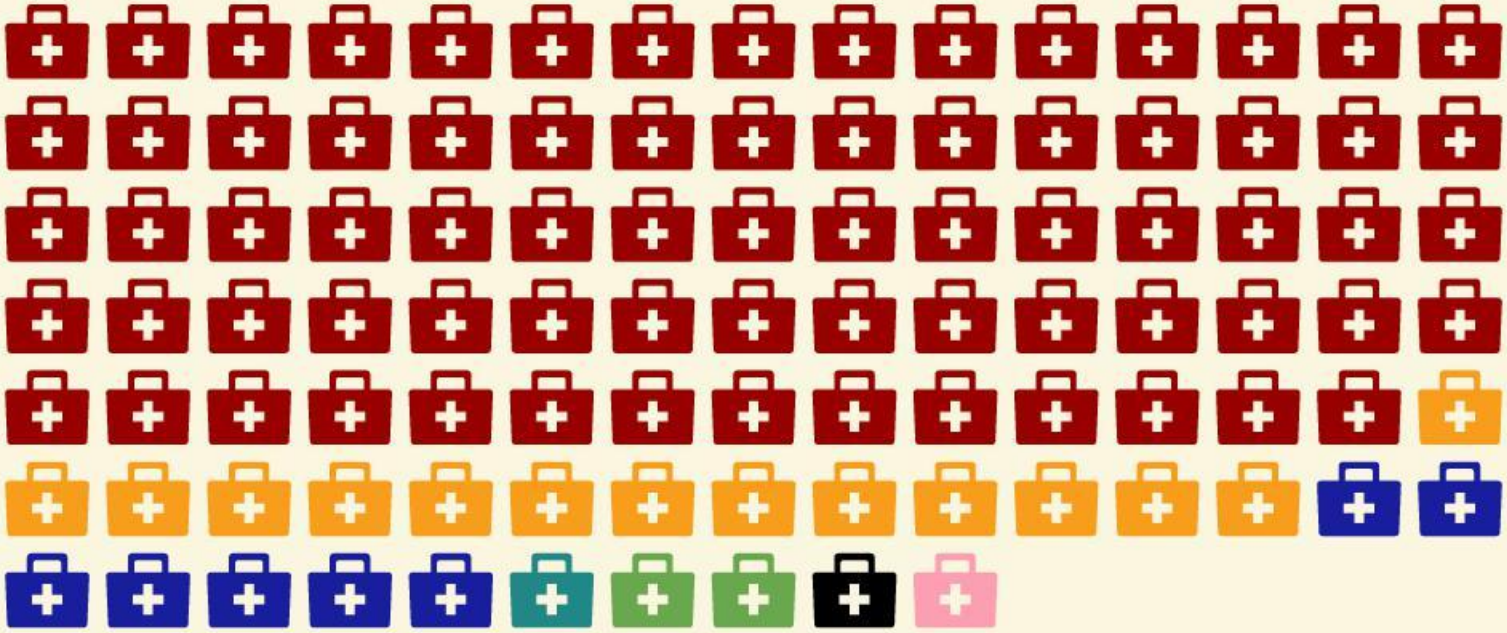


Age Statistics

Oldest Patient:	97
Average Age:	68
Youngest Patient:	32

Data and Demographics

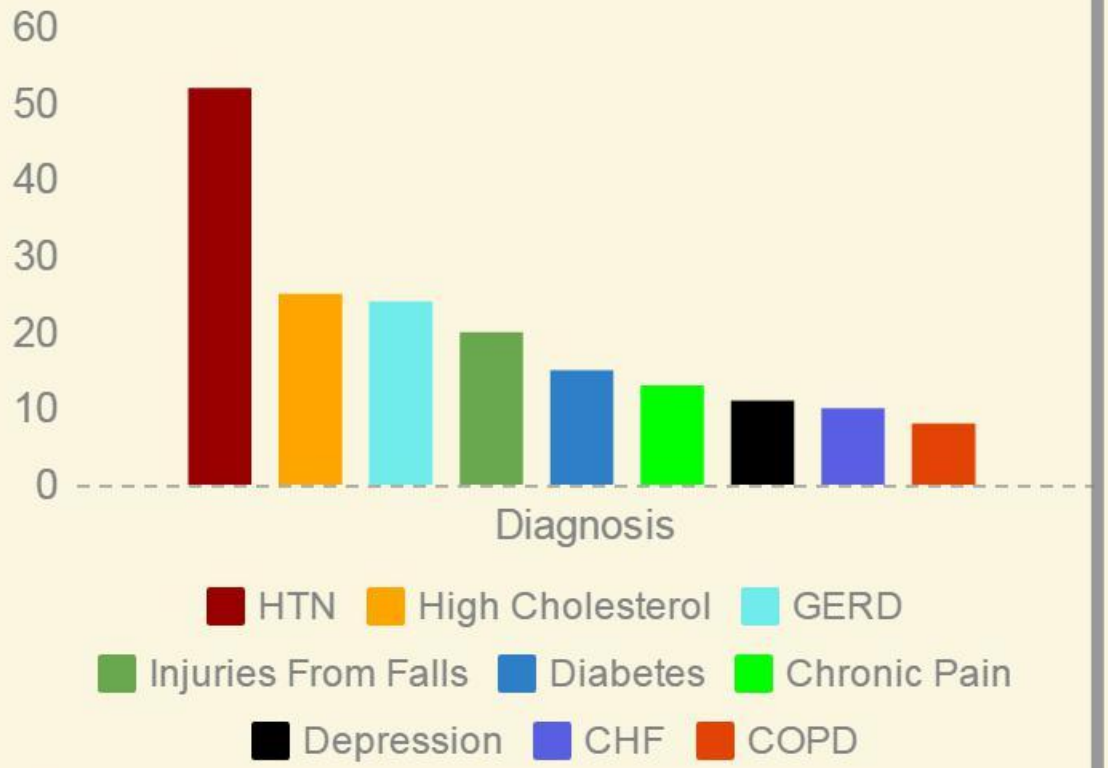
Insurance Breakdown



Medicare (73.53%) Medicaid (13.73%) BC /BS (6.86%)
United Healthcare (0.98%) Aetna (1.96%) Self Pay (0.98%)
Priority Partners (0.98%) Evergreen (0.98%)

Data and Demographics

Top 10 Existing Diagnosis



Avg. Number of Comorbidities

5.86

Data and Demographics

Results From Rx Inventories

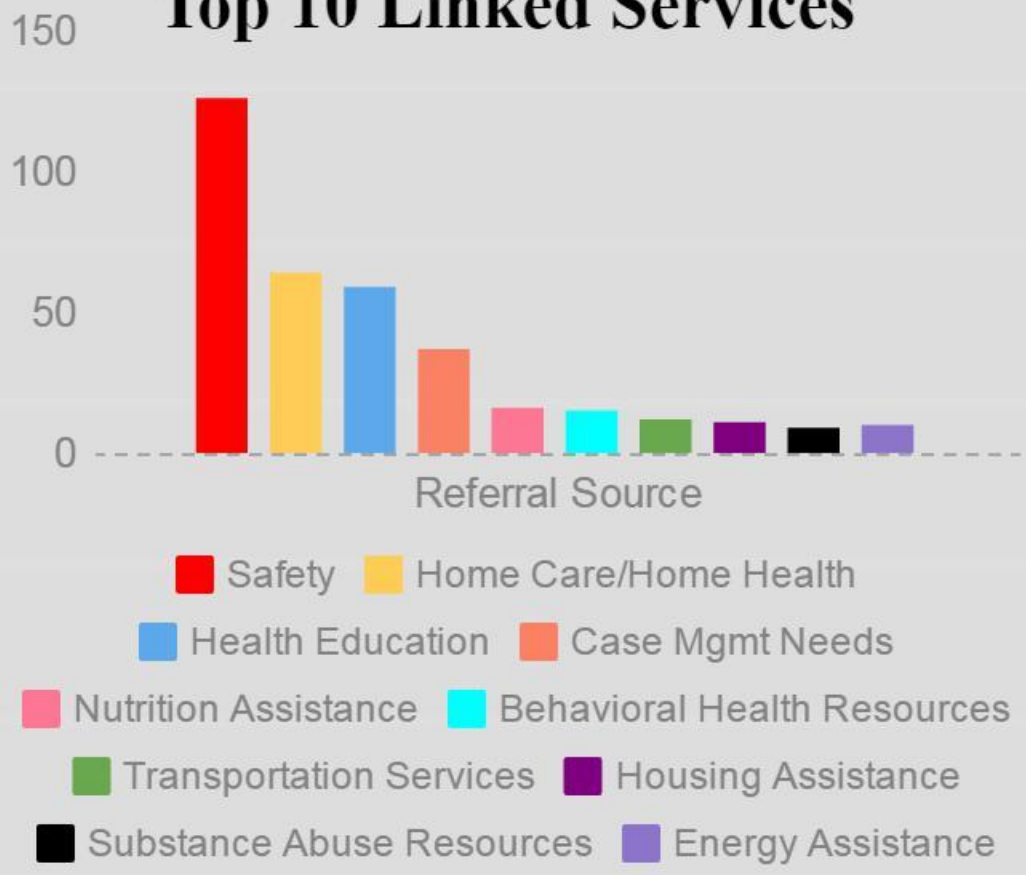
No Problems Identified (77.50%)

Problems Identified (22.50%)

Avg. Number of Medications/Patient

Data and Demographics

Top 10 Linked Services



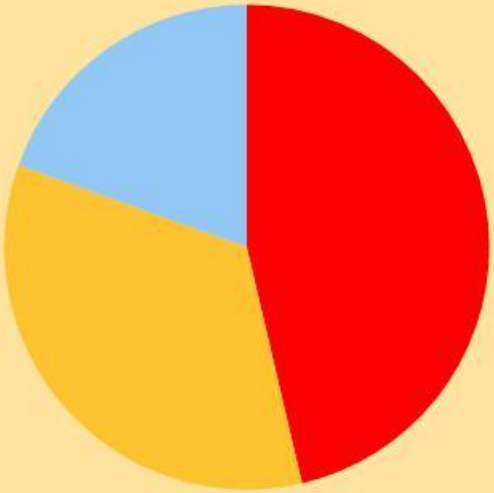
Total Services Linked to Patient

422

Avg. Linked Services/Patient: 4.9

Data and Demographics

PEAT Score Results



Healthy (46.34%) Less than Optimal (34.15%)
Referral Assistance (19.51%)

Safety Hazards

Unmarked prescription pill bottles

Space heaters next to curtains

Complete lack of smoke detectors

A light plugged into an outlet and dangling over the bath tub

Soft floors and sagging ceilings

Multiple layers of throw rugs

Extension cords running across rooms from wall to wall

Data and Demographics

911 Transport Data

Reduction of 911 transports for patients who have been in MICH for at least one year:

37.01%

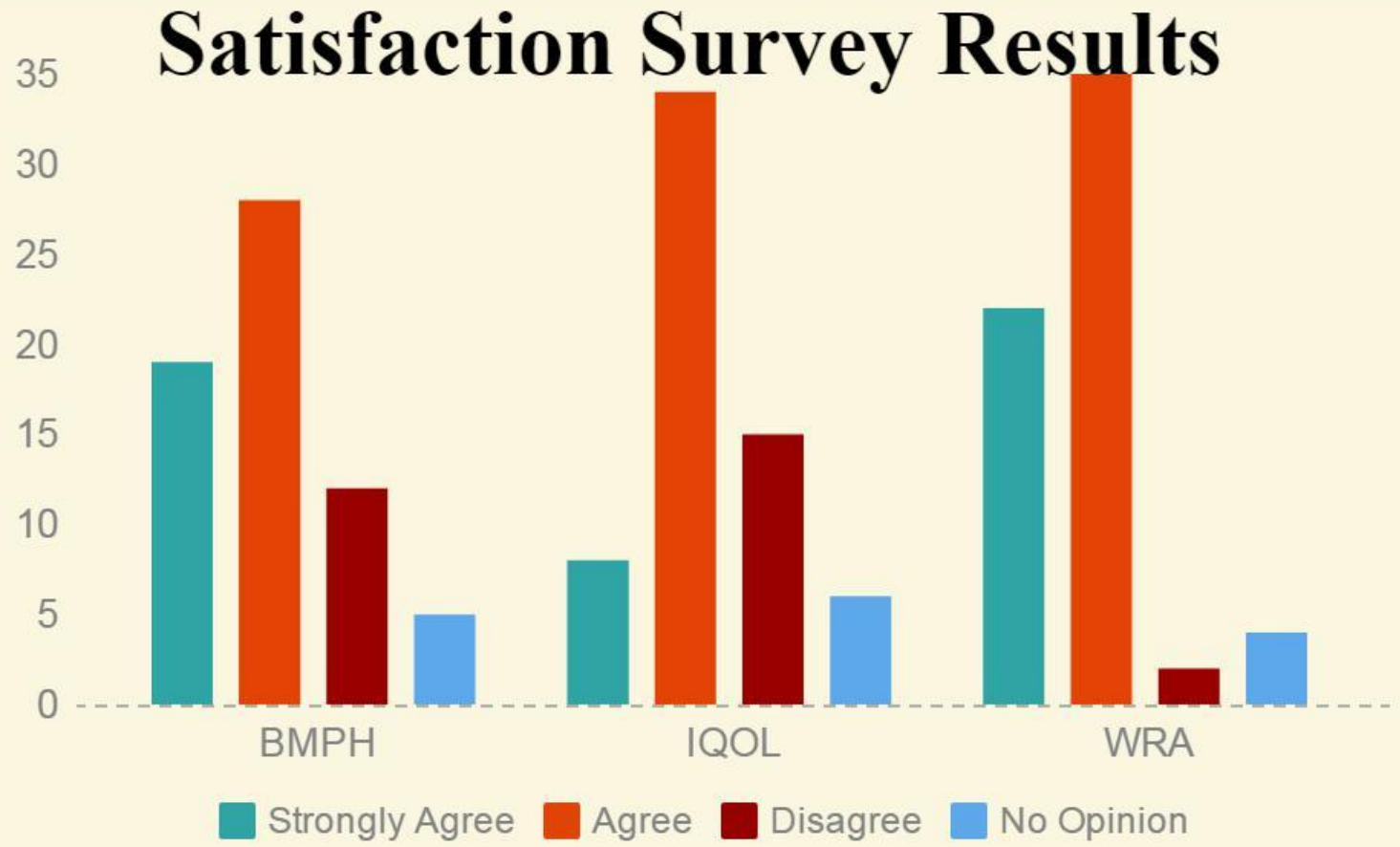
Data and Demographics

ED Utilization Data

Total number of ED visits that were avoided in one year by patients post-MICH enrollment

136.2

Data and Demographics

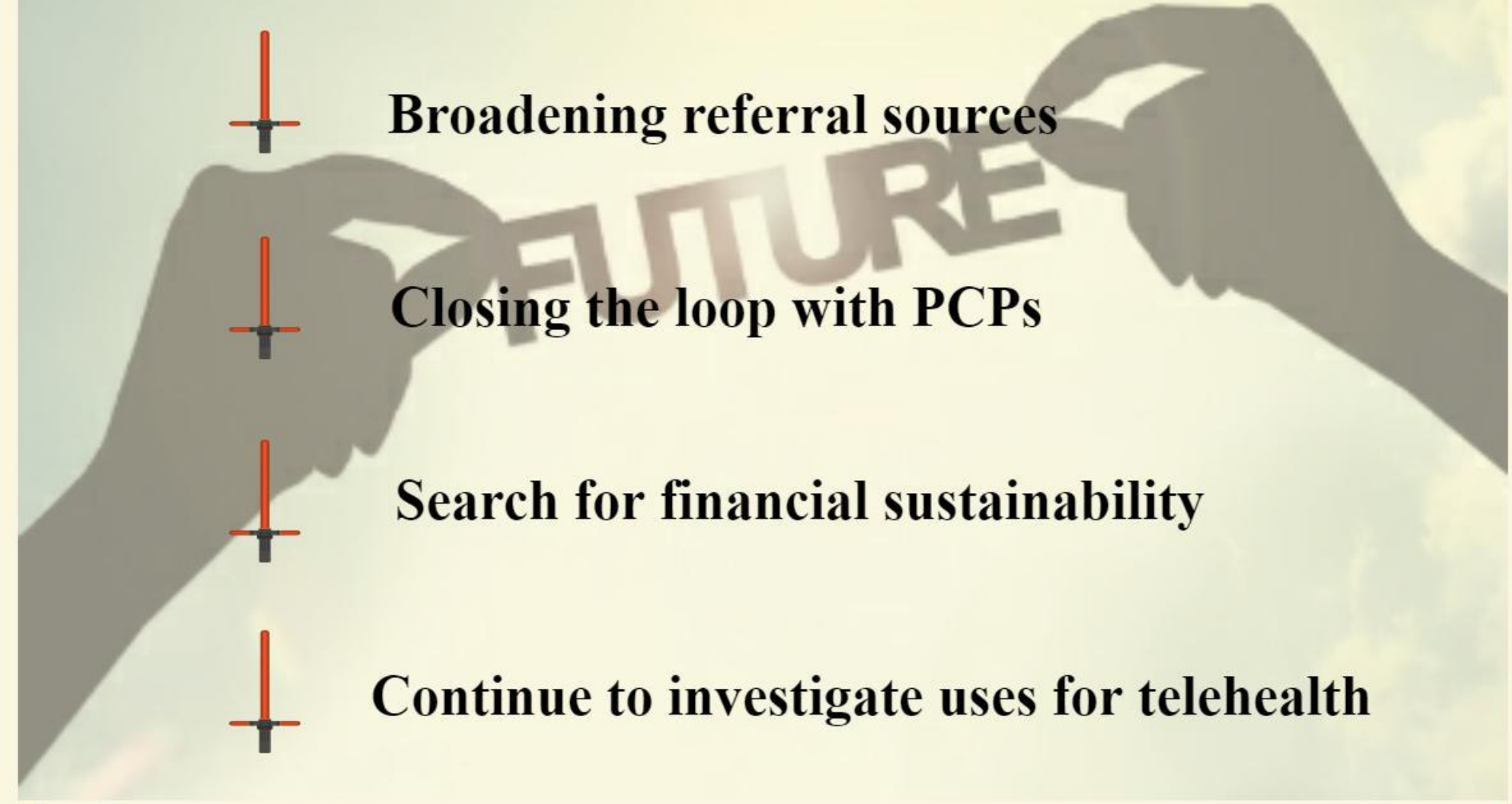


BMPH - Better able to manage your personal health

IQOL- Improved Quality of Life

WRA - Were referrals appropriate/useful

What Does the Future Hold?



- Broadening referral sources
- Closing the loop with PCPs
- Search for financial sustainability
- Continue to investigate uses for telehealth

Questions?

Maryland Office of Minority Health and Health Disparities
13th Annual Health Equity Conference
December 13, 2016

Achieving Health Equity through Community Engagement and Innovative Health Care Delivery

AFTERNOON CONCURRENT BREAKOUT SESSION D

Spotlight on Maryland's Response to Critical Health Epidemics

Moderator:

Carmi Washington-Flood, Chief, Faith Based and Community Partnerships, Prevention and Health Promotion Administration, Maryland Department of Health and Mental Hygiene

Panelists:

Boatemaa Ntiri-Reid, JD, MPH, Fellow, Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, Health and Human Services

Alexandra Reitz, Senior Specialist, Education & Community Outreach Programs, The JACQUES Initiative, Institute of Human Virology of the University of Maryland, School of Medicine

Erin E. Haas, MPH, Local Programs Manager, Overdose Prevention, Behavioral Health Administration, Maryland Department of Health and Mental Hygiene

Increasing Access to Hepatitis C Screening and Treatment in Maryland

December 13, 2016

13th Annual Health Equity Conference
Office of Minority Health and Health Disparities
Maryland Department of Health & Mental Hygiene

Boatemaa Ntiri-Reid, JD, MPH, Project Director
Infectious Disease Prevention and Health Services Bureau
Prevention and Health Promotion Administration
(Former)

Mission and Vision

MISSION

- The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION

- The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

Rationale for integrating HCV into primary care

- Expand the availability of HCV care
- New therapies that are easier to administer
- Effective, well tolerated treatments
- Comprehensive care options
- Impact of HCV on Maryland

HCV in Maryland

The Numbers…

↑23%

↑27%

50%

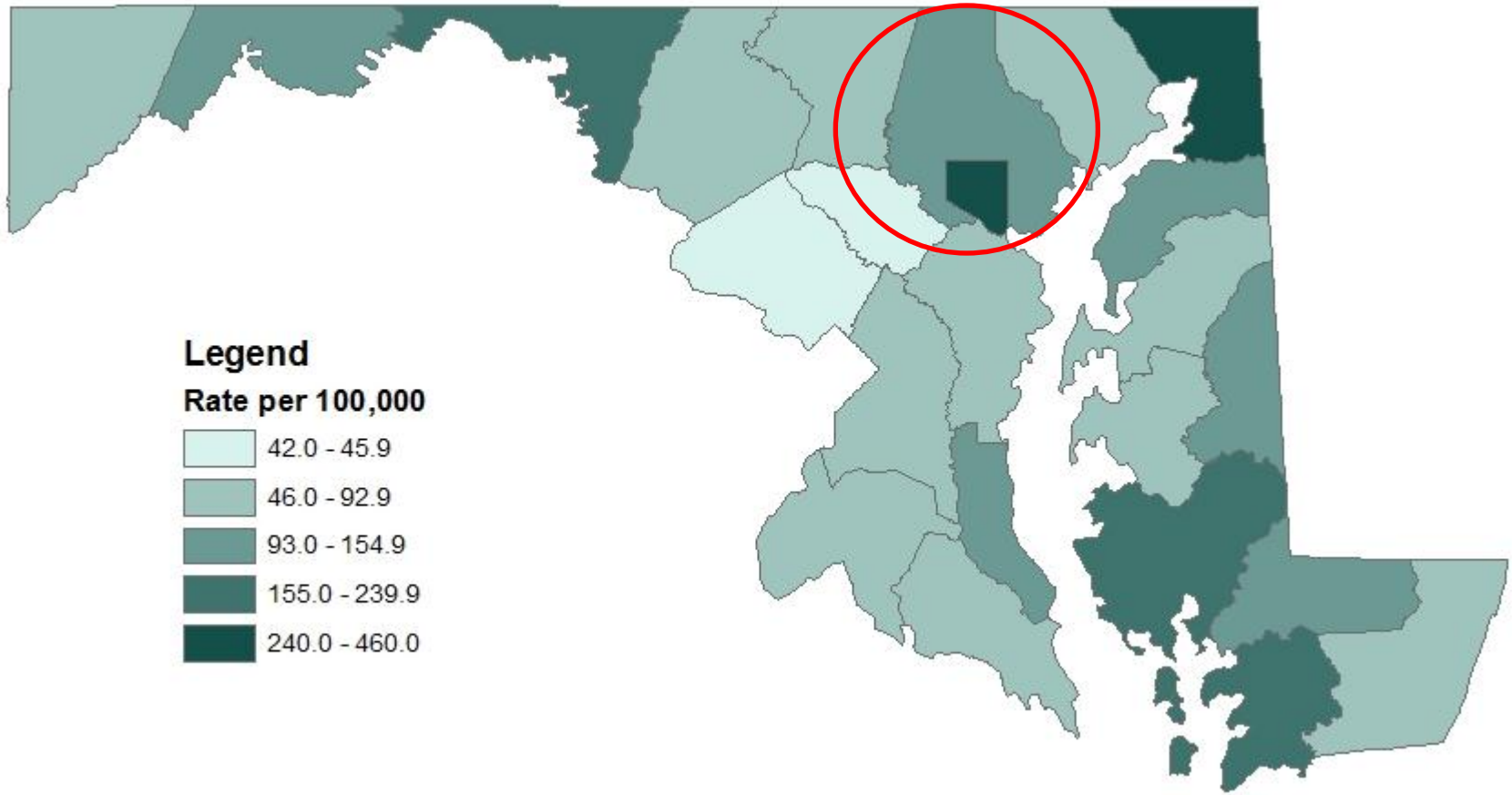
In 2015, there were 7,573 reported cases of chronic hepatitis C, compared to 6,181 in 2010.

From 2005 – 2014, the HCV-related mortality rate increased 27% in Maryland.

Of Maryland's 24 jurisdictions, two account for almost 50% of reported chronic cases.

Sources: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2014 on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999-2014, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html.. Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015.

Chronic HCV by Jurisdiction- 2015



Source: Maryland's NEDSS. Cases of Selected Notifiable Conditions Reported in Maryland in 2015.

Vulnerable & Impacted Communities

- Baby boomers
- African American men
- Men who have sex with men
- People who inject drugs

Maryland Community-Based Programs to Test and Cure Hepatitis C

CDC-RFA-PS14-1413

Goal

Reduce HCV-related morbidity and mortality in Baltimore City and Baltimore County, Maryland by strengthening healthcare capacity to diagnose and cure HCV infection through a coalition of local HCV providers and key stakeholders

Strategies

Core Strategy 1:	**Increase the capacity of primary care providers to deliver HCV treatment and case management** through the provision of provider training and ongoing telemedicine consultation
Core Strategy 2:	**Increase HCV testing by primary care providers** through provider and patient education
Core Strategy 3:	**Increase linkage-to-care services available through the local health department** to ensure HCV-infected persons are supported in adhering to their treatment regimen
Core Strategy 4:	**Increase HCV surveillance infrastructure and data sharing** to refine population-level estimates of HCV infection and health outcome
Core Strategy 5:	**Increase utilization of EMR** to enhance HCV services, evaluate service outcomes, and inform quality improvement
Core Strategy 6:	Explore policy initiatives to **improve client access to HCV testing**, **care**, **and treatment**

The Maryland Coalition: Public Health Partners

- Maryland Department of Health and Mental Hygiene (Grantee)
  - Infectious Disease Prevention and Health Services Bureau
  - Healthcare Financing (Medicaid)
  - Infectious Disease Epidemiology and Outbreak Response Bureau
- Baltimore City Health Department
- Baltimore County Health Department
- Maryland Department of Public Safety and Correctional Services

The Maryland Coalition: Clinical Partners

- Johns Hopkins University, Division of Infectious Diseases
- Baltimore City Health Department, STD Clinics
- Chase Brexton Health Services
- Health Care for the Homeless
- Jai Medical Center
- Total Health Care
- University of Maryland School of Medicine

Provider Capacity and Infrastructure Development

Care Team

- Treating providers:
  - MD/DO, NP, PA
- Support:
  - **Pharmacists**
  - Nurses
  - Social workers/case managers
  - **MA and other front line staff**
  - Data/IT
  - **Management/administrators**

Training and Education

- Sharing the Cure
  - Comprehensive
- All staff trainings
  - As needed
- All Partners meetings
  - Bi-annual

Organizational Capacity and Infrastructure

- Care Team
  - Lead coordinator
  - Training and education
  - Participation and communication
- Policies and Protocols
  - Screening
  - Care delivery
  - Case management
  - Prior authorization
  - Specialty referrals
- Monitoring and evaluation
  - Usable EHR supports/enhancements
  - Evaluation and quality improvement

Challenges

- Obtaining “buy in”
- Training and continuing education
- Competing priorities and funding limitations
- High volume, fast paced environments
- Continued problems with data
- Treatment barriers
- Attrition

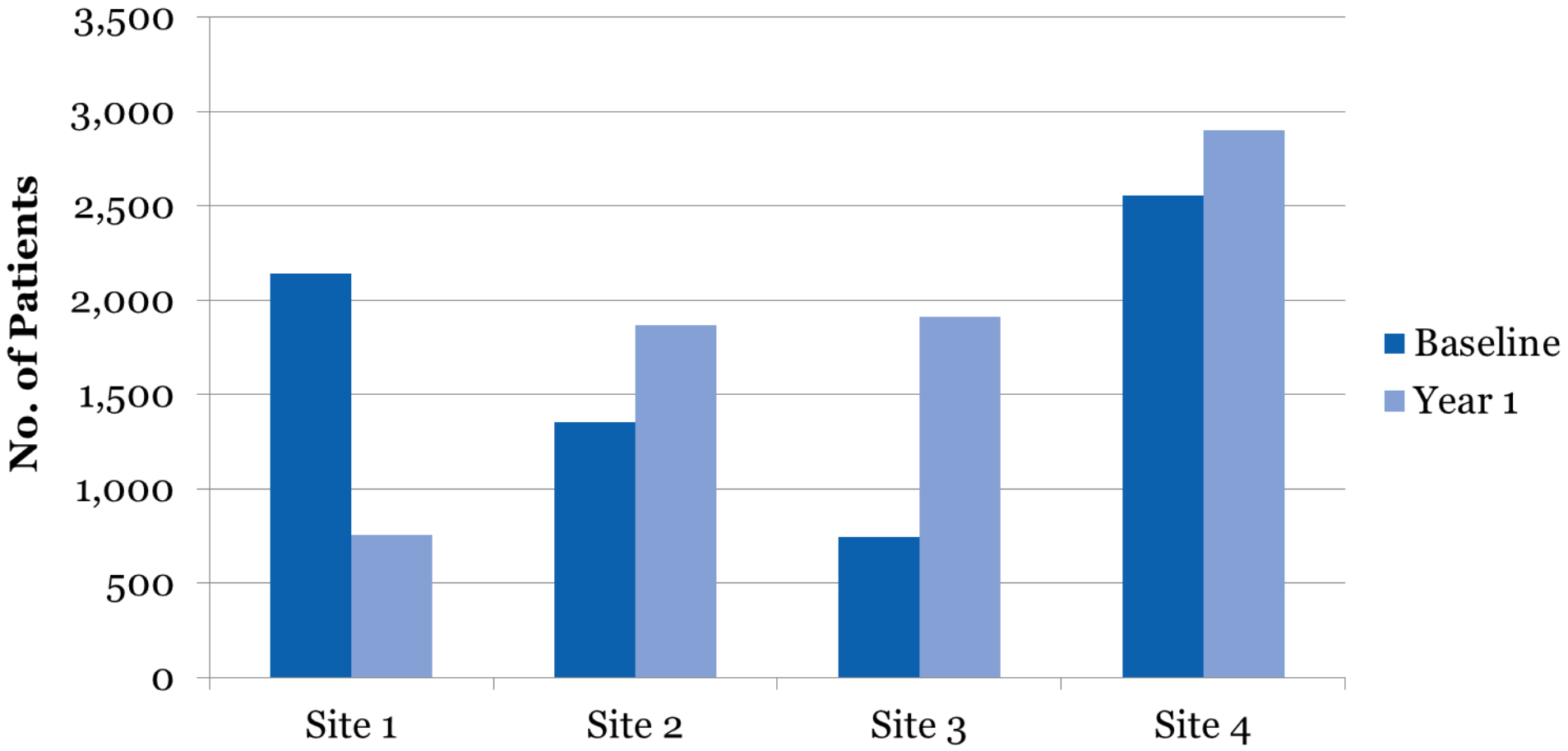
Outcomes to Date

Patient Demographics

Cumulative patients seen by participating providers, Y1 & Y2 (N=1,061)

Characteristics	N (%)
Born 1945-1965 (Baby Boomers)	764 (72.0)
Male	759 (71.5)
Black/African American	831 (78.3)
Medicaid enrollee	627 (59.1)

Screening by Site

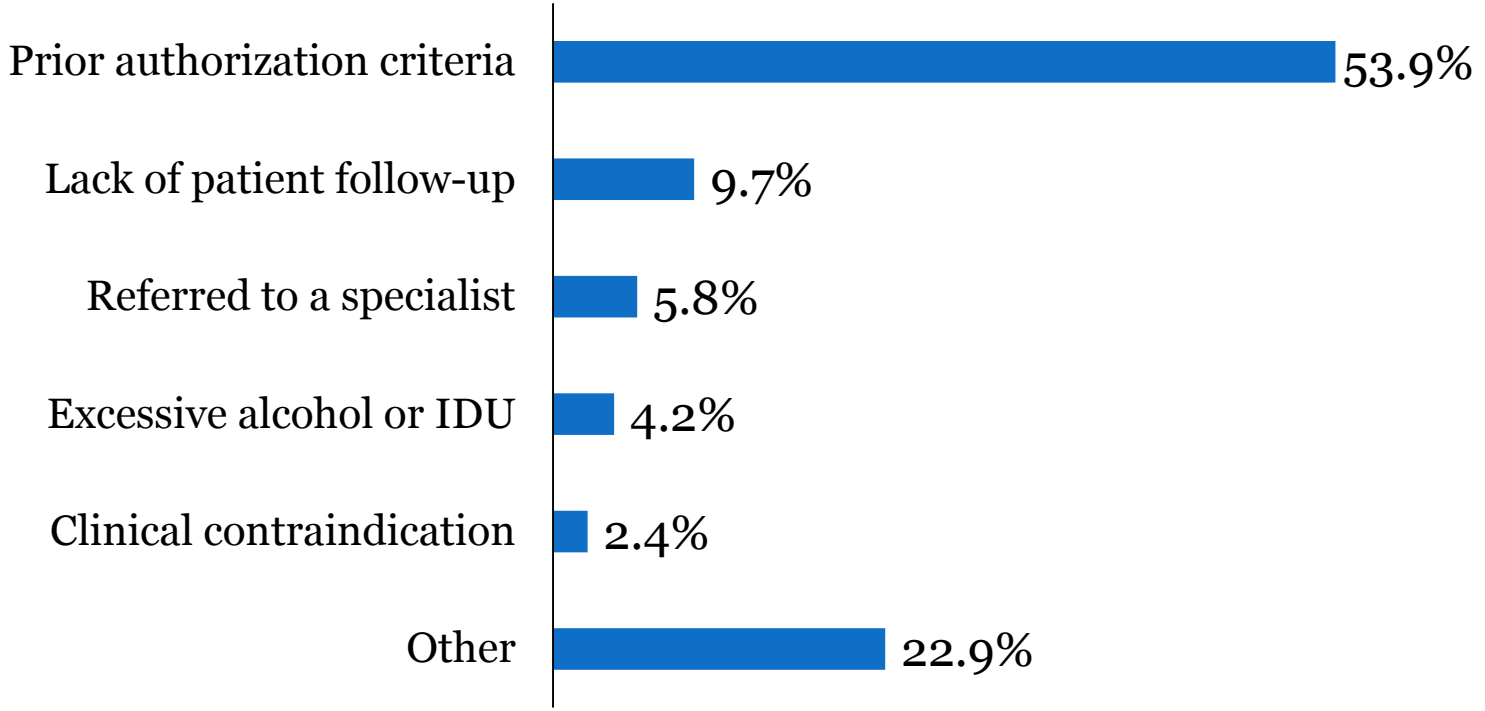


Patient-Level Data: Tx Workup

Among those HCV RNA+ (N=968)	N (%)
Worked up for treatment, with fibrosis staging results	724 (74.8)
Treatment initiation decision reported (N=658)	**N (%)**
Yes	278 (42.2)
No	380 (57.8)

Treatment Deferred

Treatment initiation decision reported: No (N=380)



Thank You

- Department of Health and Mental Hygiene
  - Jeffrey Hitt, Principal Investigator
  - Lucy Wilson, Medical Advisor
  - Hope Cassidy-Stewart, Senior Project Evaluator
  - Mary Kleinman, Epidemiologist/Evaluator
- Centers for Disease Control and Prevention
- Johns Hopkins University, Division of Infectious Diseases and the Viral Hepatitis Center
- All of our Maryland Community-based Programs to Test and Cure Hepatitis C partners!

Prevention and Health Promotion Administration

http://phpa.dhmh.maryland.gov

DEPARTMENT OF
HEALTH AND MENTAL HYGIENE

CHANGING
Maryland
for the Better

Overdose Education and Naloxone Distribution in Maryland

Erin Haas, MPH
Department of Health and Mental Hygiene
December 13, 2016

Overdose Count Rising in Maryland

Figure 1. Total Number of Drug- and Alcohol-Related Intoxication Deaths Occurring in Maryland, 2007-2015.

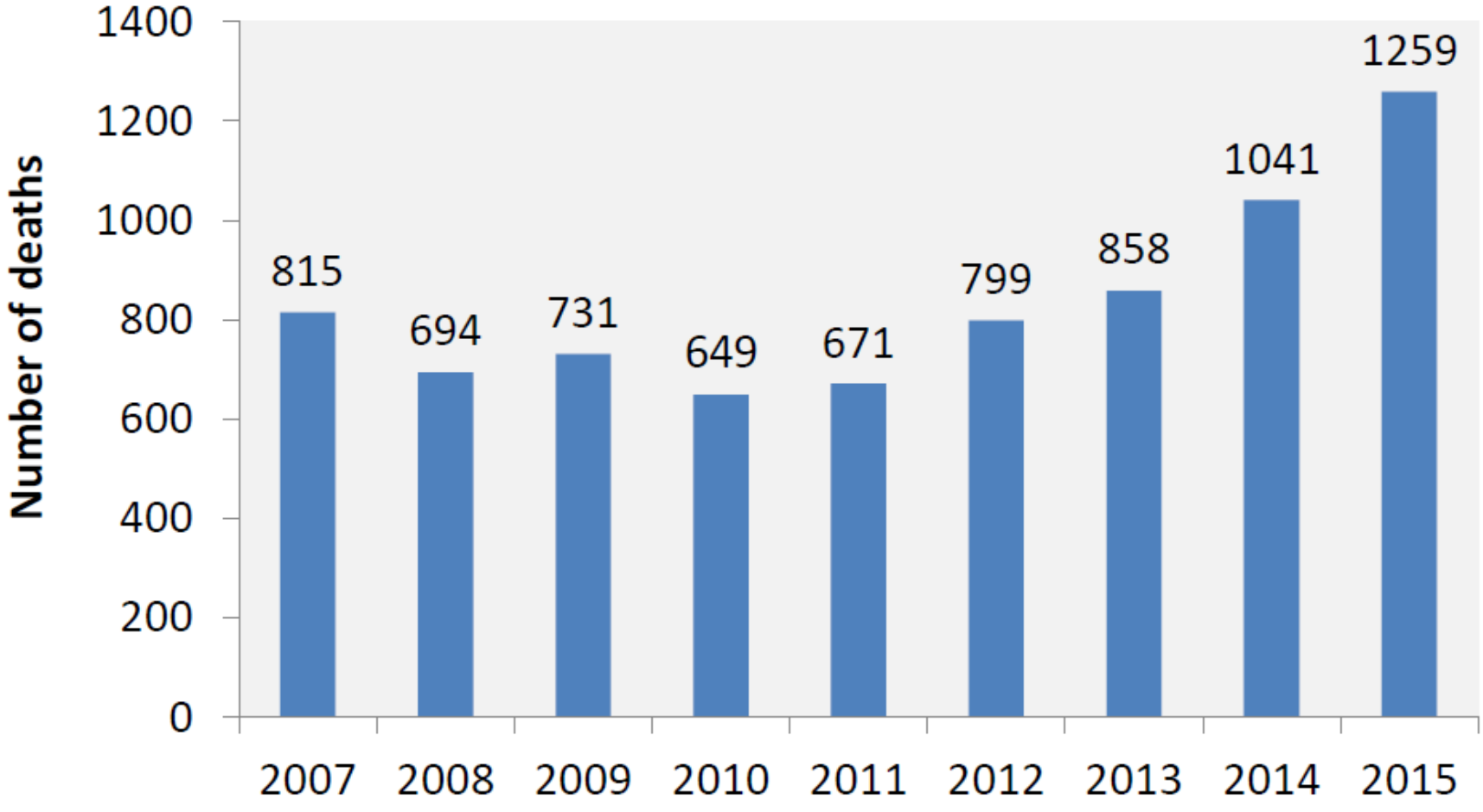


Figure 4. Total Number of Drug- and Alcohol-Related Intoxication Deaths by Place of Occurrence, Maryland, 2007-2015.

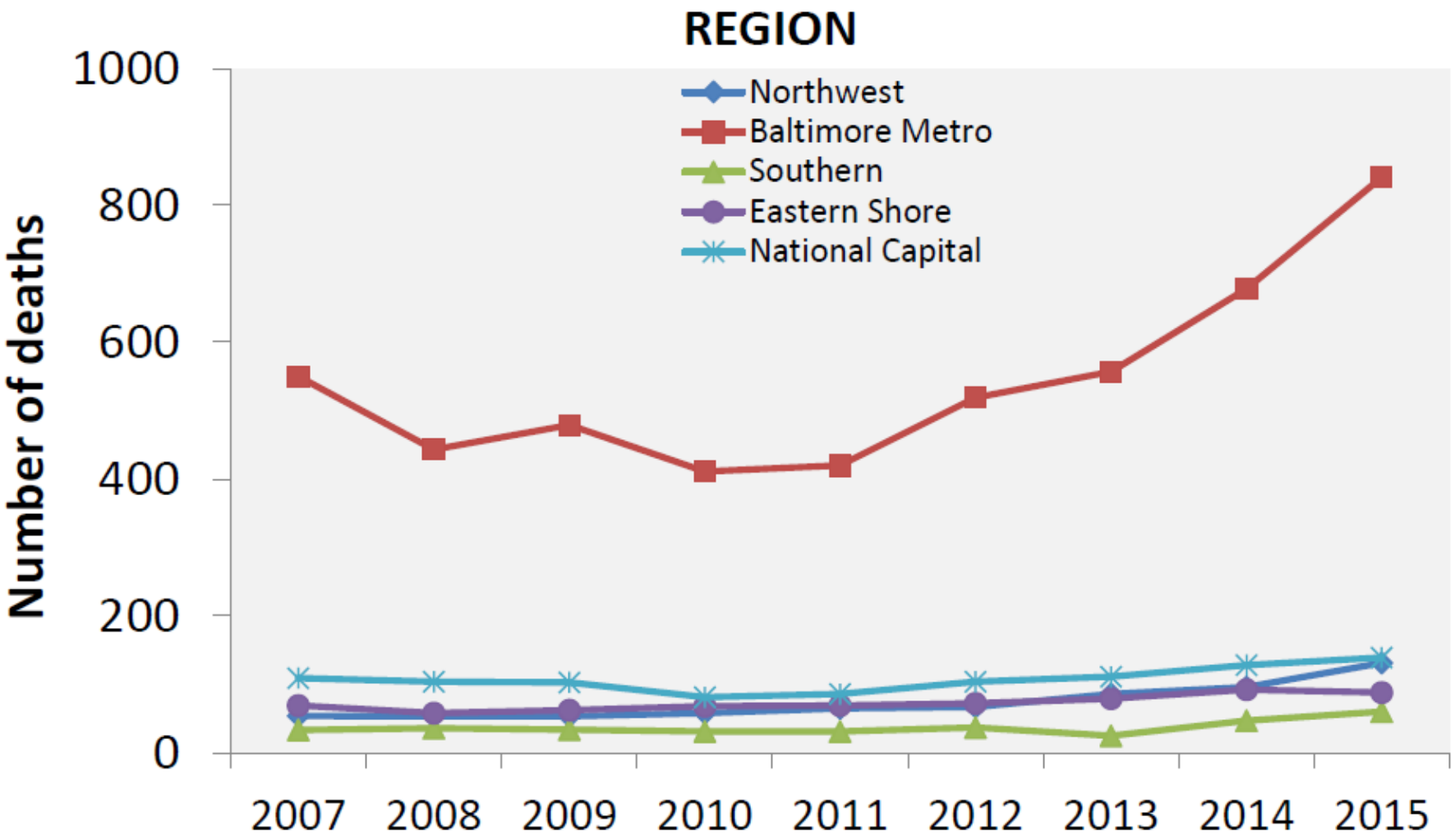
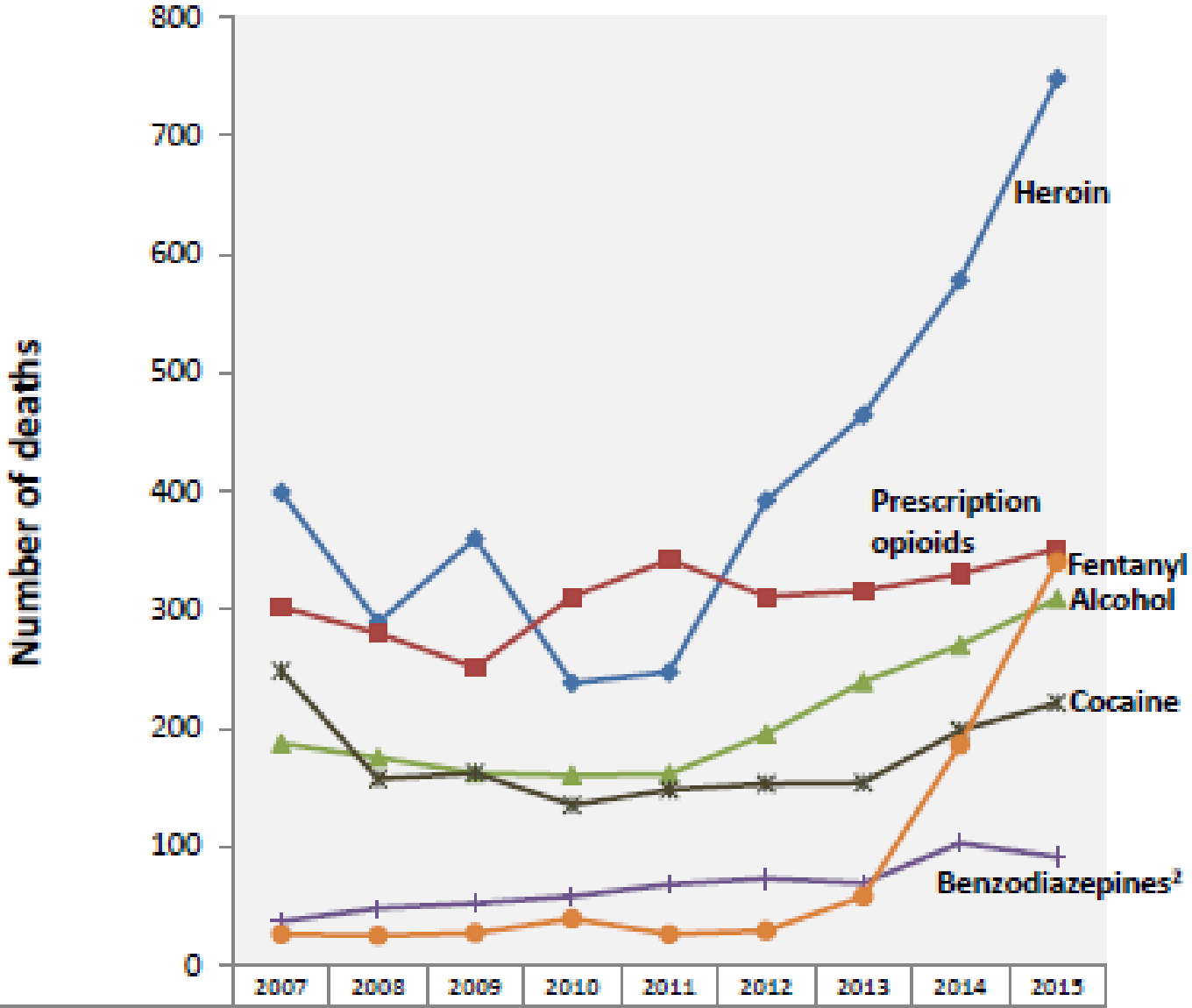
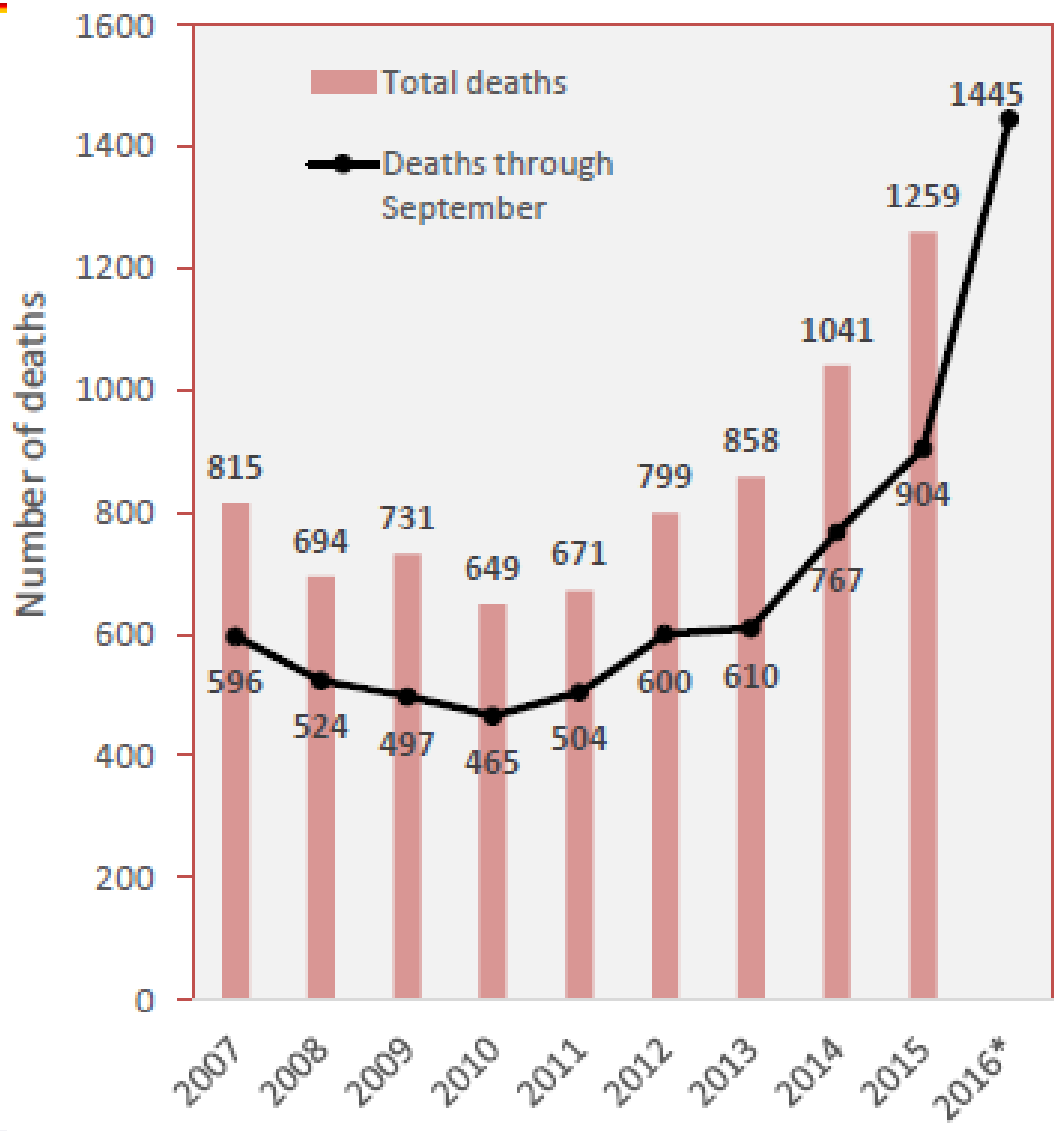


Figure 5. Total Number of Drug- and Alcohol-Related Intoxication Deaths by Selected Substances[1], Maryland, 2007-2015.

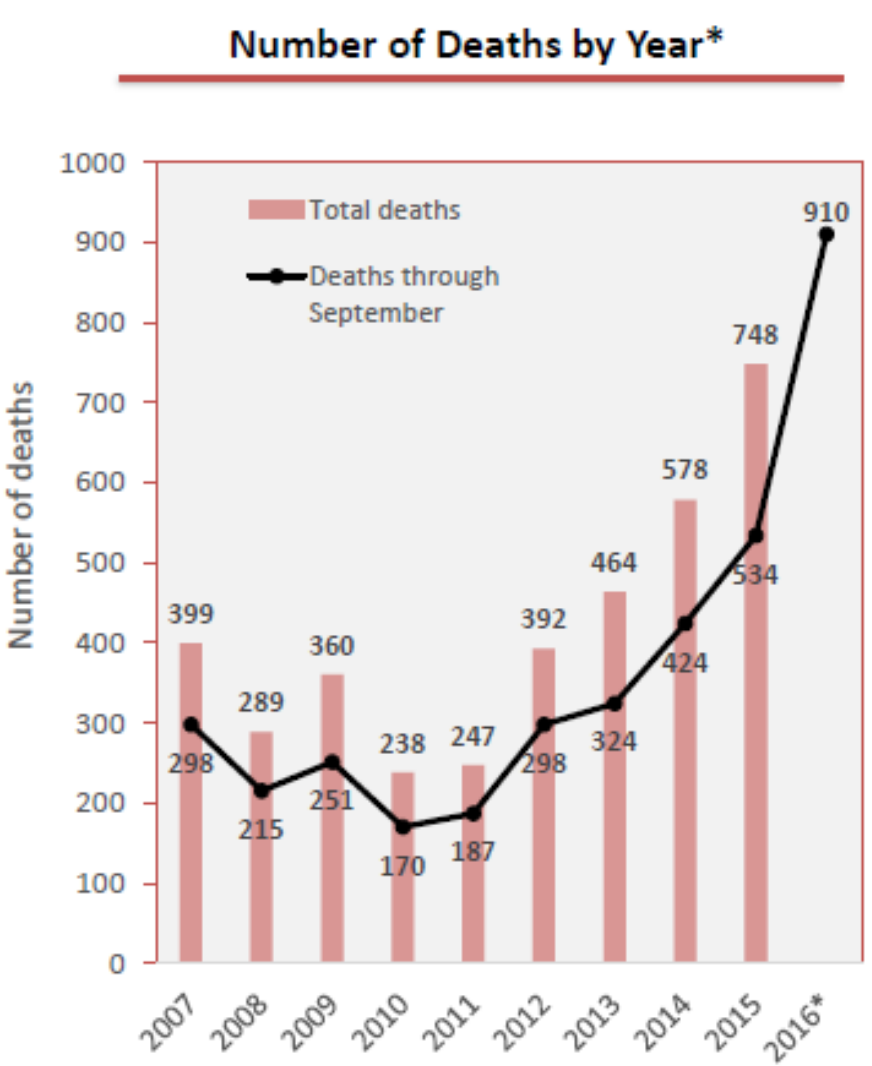


Number of Deaths by Year*



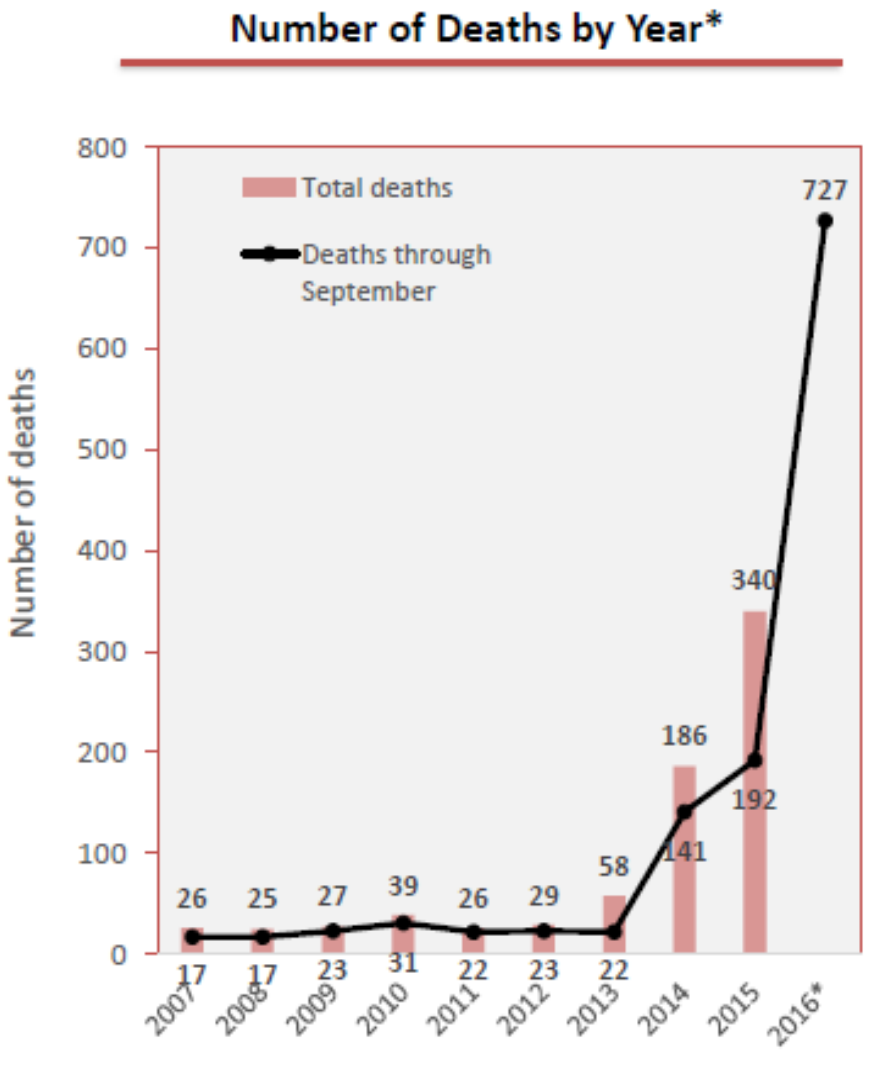
*2016 counts are preliminary

HEROIN

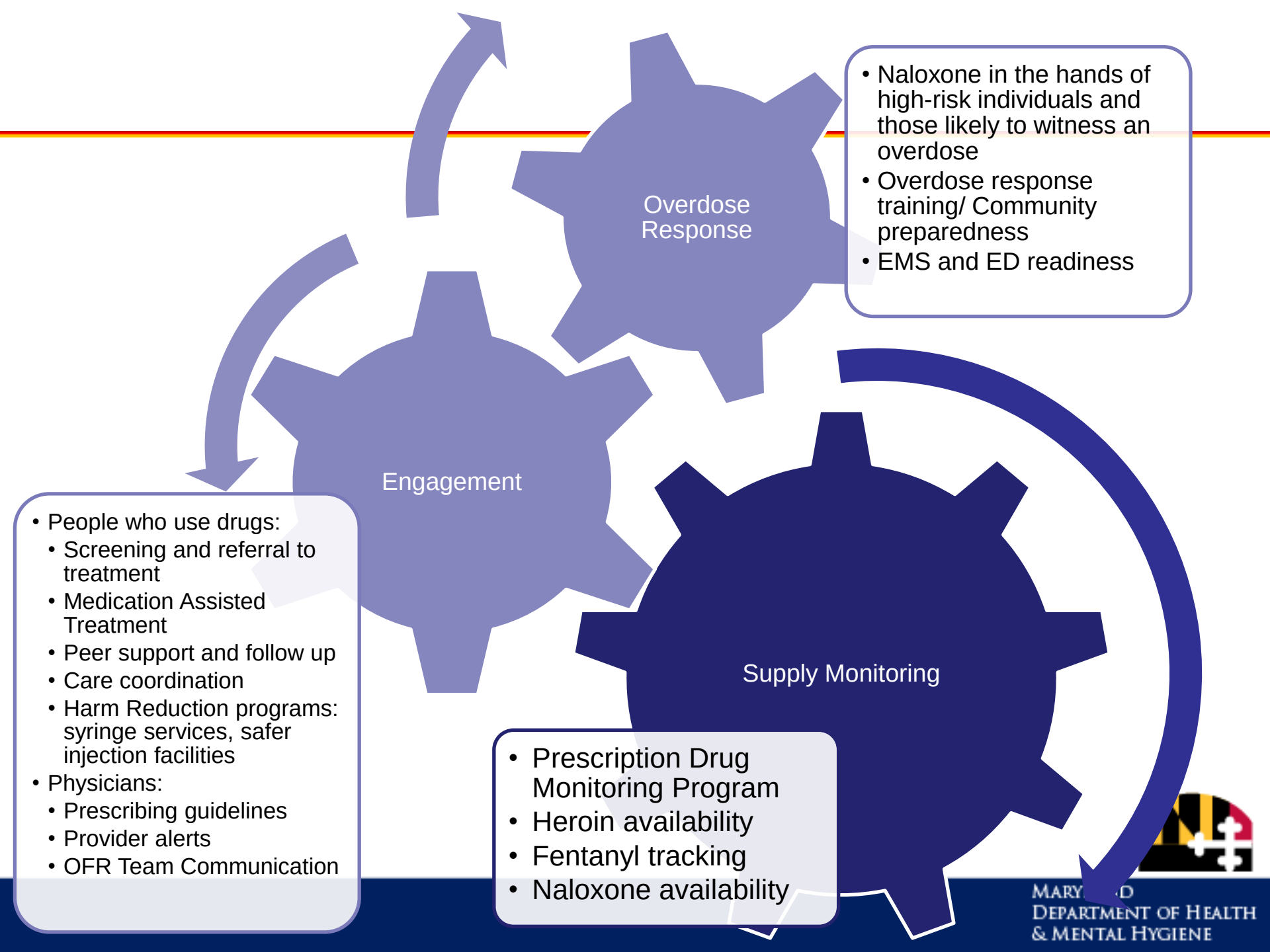


*2016 counts are preliminary

FENTANYL



*2016 counts are preliminary


Overdose Response
• Naloxone in the hands of high-risk individuals and those likely to witness an overdose
• Overdose response training/ Community preparedness
• EMS and ED readiness
Engagement
• People who use drugs:
• Screening and referral to treatment
• Medication Assisted Treatment
• Peer support and follow up
• Care coordination
• Harm Reduction programs: syringe services, safer injection facilities
• Physicians:
• Prescribing guidelines
• Provider alerts
• OFR Team Communication
Supply Monitoring
• Prescription Drug Monitoring Program
• Heroin availability
• Fentanyl tracking
• Naloxone availability

Naloxone

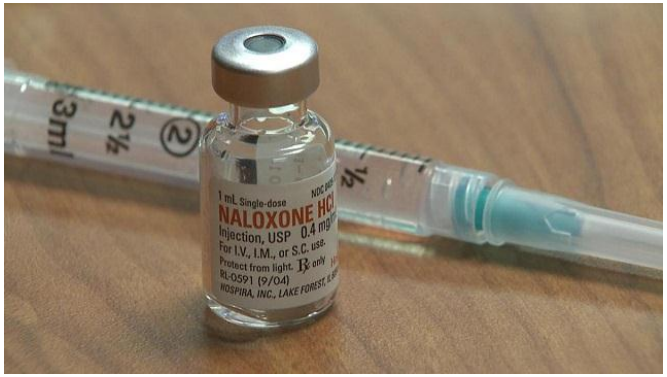
- Opioid antagonist, effectively removing opioids from receptors and reducing the opioid's effects on the brain and the body
- Takes effect in 2-5 minutes, last 30-90 minutes
- Low risk of side effects

Naloxone can be prescribed to any patient at risk of an overdose or that believes themselves able to respond to an opioid overdose.

Naloxone Formulations

Intranasal

Intramuscular



Harm Reduction Approach

- Goal: minimize the negative effects of drug use for people who use drugs, their families, and their communities
- Harm reduction approaches:
  - Are rooted in a commitment to public health & human rights
  - Combat stigma
  - Empower people who use drugs to keep themselves as safe as possible
  - Meet people where they are
  - Aim to attain any positive change

(Harm Reduction Coalition, Harm Reduction International)

Context of Overdose Education and Naloxone Distribution

- Available in emergency departments, hospitals, to EMS providers since the 1960's
- Can be prescribed to someone at risk of overdose
  - Distributed to at-risk public for the past 20 years through harm reduction programs
  - Typically accompanied by a training
- More recent laws allow for its prescription to those that may witness an overdose ("third party")
  - Prompted expansion of overdose education and naloxone distribution programs
  - Both IM and IN formulations covered by Maryland Medicaid
- Pharmacy-based distribution has precedent for greatly expanding OEND program reach

Evidence Base for OEND

	Evidence
OEND is feasible in many settings.	• Walley et al. JSAT 2013; 44:241-7 • Bennett et al. J Urban Health. 2011: 88; 1020-30 • Enteen et al. J Urban Health 2010:87: 931-41 • Doe-Simkins et al. Am J Public Health 2009: 99: 788-791 • Piper et al. Subst Use Misuse 2008: 43; 858-70
Participants demonstrate knowledge and skills after training.	• Wagner et al. Int J Drug Policy 2010: 21: 186-93 • Tobin et al. Int J Drug Policy 2009: 20; 131-6 • Green et al. Addiction 2008: 103;979-89
Naloxone does not lead to an increase in risky use, but does lead to an increase in drug treatment.	• Seal et al. J Urban Health 2005:82:303-11 • Wagner et al. Int J Drug Policy 2010: 21: 186-93 • Galea et al. Add Beh 2006: 31: 907-912
OEND contributes to reduction in overdose in communities.	• Maxwell et al. J Addict Dis 2006:25; 89-96 • Evans et al. Am J Epidemiol 2012; 174: 302-8 • Walley et al. BMJ 2013; 346: f174

How to access naloxone in Maryland:

A. Obtain a Prescription from a provider

- Obtain a prescription from your provider and have filled at a pharmacy

B. The Overdose Response Program

- Receive training and certification through the Overdose Response Program
- Use your certificate to get naloxone **without a prescription** at any participating pharmacy

Visit BHA.DHMH.MARYLAND.GOV/NALOXONE

Training Content

- Definitions for opioid, naloxone, and overdose
- How to identify an opioid overdose
- How to administer naloxone
- How to care for the person after
- The importance of contacting emergency services
- Risk reduction information
- Rights of the certificate holder and the good Samaritan law

ORP Certification

#_____

_____

PRINT FULL NAME OF CERTIFICATE HOLDER

is hereby authorized to obtain a prescription for naloxone in the certificate holder's name, and possess and administer naloxone in accordance with Health-General Article, Title 13, Subtitle 31, Annotated Code of Maryland

DATE ISSUED: _____

EXPIRATION:_____

To learn more about the Overdose Response Program, visit:
bha.dhmh.maryland.gov/NALOXONE/SitePages/Home.aspx

ISSUED BY:

[entity name]
[address]
[telephone]

Please call the Maryland Poison Center at **1-800-222-1222** after using naloxone.

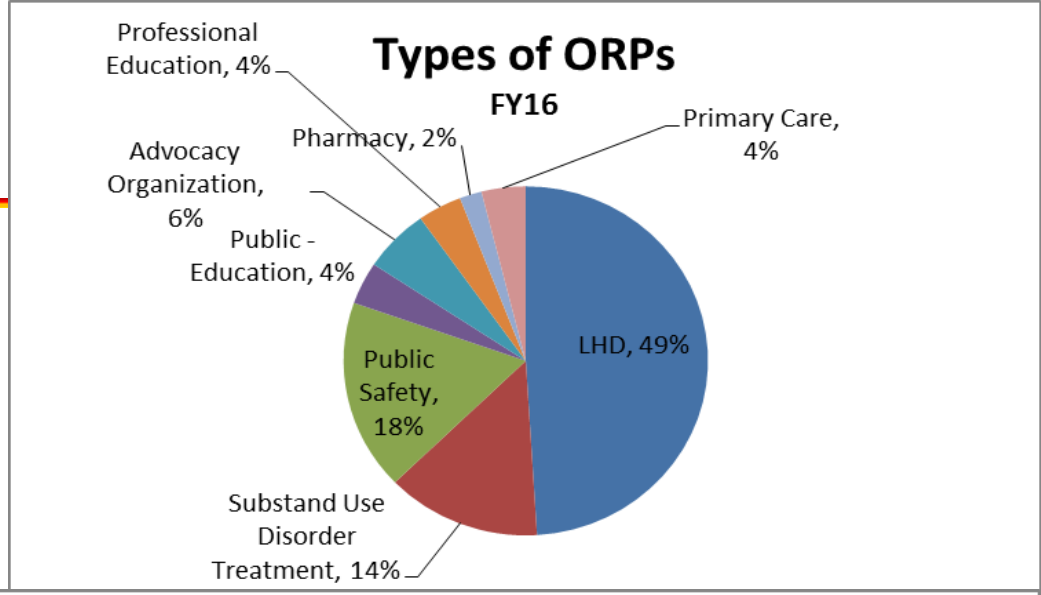
Statewide Standing Order

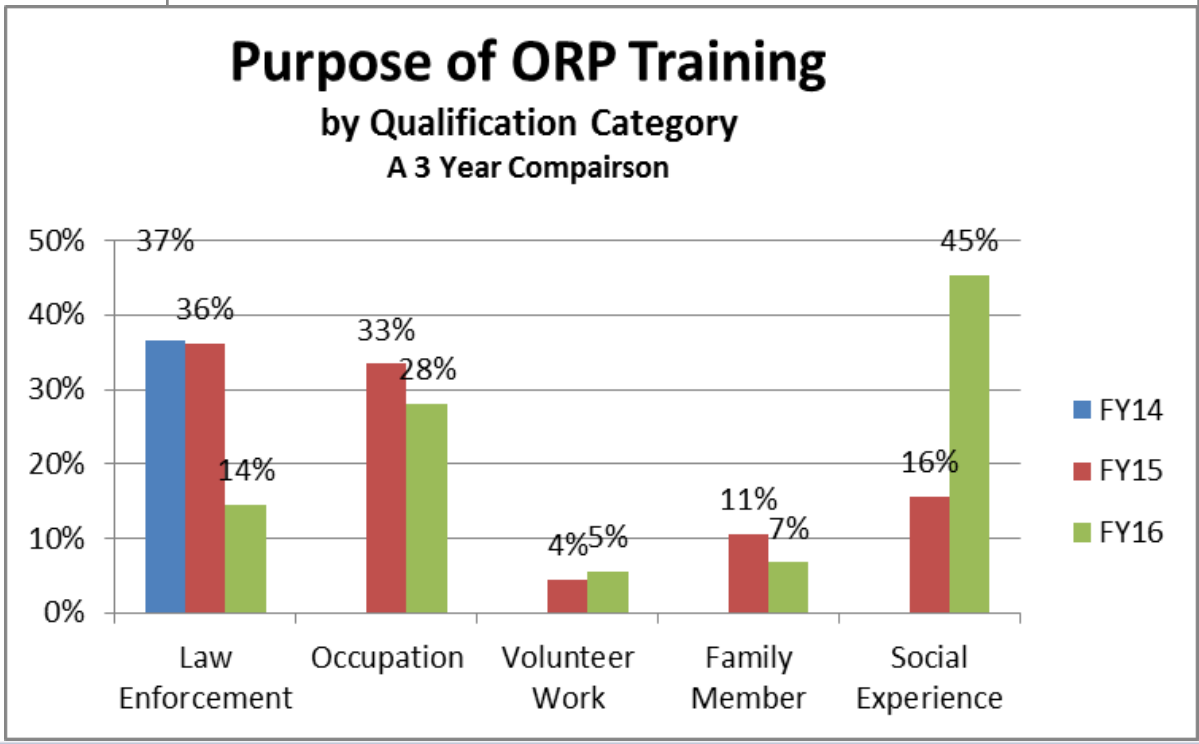
- Issued by Dr. Howard Haft to all licensed pharmacists in Maryland
- Allows naloxone to be dispensed to ORP certificate holders
- Certificate holders can choose the formulation
- Covered with $1 copay through Maryland Medical Assistance

ORP Stats

As of October 2016:

- 58 authorized entities
- 34,799 individuals trained
- 37,755 doses of naloxone distributed
- 1,181 reports of naloxone use in the community





Naloxone Priorities

Targeting individuals at risk for overdose and their friends and family…

- Outreach model
- Peer-delivered training
- Detention center training and dispensing
- Pharmacy-based distribution
- Opioid treatment programs
- Syringe services programs

…to achieve community saturation.

Rio Arriba County, New Mexico, population 40,000: Santa Fe Mountain Center gave out over 3,300 doses of naloxone with 752 reversals reported in FY16 !!!

Bet County Leaders Wish They Could Get Barney's Playground Money Back

RIO GRANDE SUN

NEWS FROM THE HEART OF THE PUEBLO COUNTRY

Volume 59, Number 42 | Española, New Mexico 87532 | Thursday, July 14, 2016 | 34 pages, 4 sections 50 cents

Fatal ODs Drop by More Than a Dozen

2014 saw an all-time high 39 overdose deaths

By Wheeler Cowperthwaite
SUN Staff Writer

The number of fatal overdoses in Rio Arriba County declined in 2015 to 23 deaths, down from 2014's all-time high of 39.

The number of deaths in 2015 is just under the former peak of 26, in 2012 and 2007.

While the number of overdoses may have declined, it still puts Rio Arriba County and Española far above all national and state averages.

Heroin continued its trend of being involved in a majority of overdoses. It was involved in 17 of the 24 deaths, or 70 percent. Three deaths were caused by heroin, alone.

Opiates garnered an even larger portion, being involved in 20 of the 23 deaths, or 87 percent. Heroin is an opiate.

The third most-involved drug was alcohol, contributing to 13 deaths, or 54 percent. Alcohol-only overdoses were not counted.

Prescription drugs, including the opiate methadone, were responsible for nine deaths, or 37 percent, while cocaine was involved in six, or 25 percent.

The *Rio Grande SUN* reviewed 102 autopsy reports produced by the Office of the Medical Investigator, following an Inspection of Public Records Act request, part of the *SUN's* annual review of overdose deaths in Rio Arriba County.

Office Records Custodian Rebecca Montoya said, on June 1, that there were still four or five autopsies that had not yet been completed from 2015.

The review does not include deaths that happened on either the Santa Clara Pueblo, Ohkay Owingeh pueblo, Jicarilla Apache Nation or in Santa Fe County, which includes parts of Española, Chimayó and Santa Cruz.

One death, not counted toward the 23 total, happened in Arroyo Seco, but the Office pathologist declared it as being in Rio Arriba County.

For every death (listed on pages A5 and A7), a pathologist concluded the consumption of drugs was at fault.

The review only counted unintentional overdoses, although no suicides were committed through the use of drugs this year.

The pathologists read police

See 'Police' on page A5

"We had 234 reported (fentanyl overdose) reversals by drug users between June-August (2015) and only a couple of unfortunate deaths, about which we still have little information. There were two uses of naloxone by law enforcement in the same period and no noticeable uptick in EMS responses to overdoses. Essentially, this was handled expertly by the syringe exchanges and drug users and many, many possible deaths were averted."

-Eliza Wheeler, the DOPE Project, San Francisco

Naloxone Story, SHARP, Baltimore City

"A client who received Evzio through our program saw a group of people carrying someone out of an abandoned condominium near his home. Coincidentally, it was his neighbor who was being carried to the apartment building. His friends were planning to abandon him. When the client realized it was someone overdosing, he ran to his apartment to retrieve his Evzio. After carrying the neighbor to the apartment, the client administered his Evzio and the neighbor awoke within a minute! He was agitated at the time, and was transported to the emergency department nearby. Two days later, the neighbor came to the client's apartment and thanked him for saving his life. The client took the opportunity to refer him to the treatment program where he received the Evzio. Both the client and the neighbor are now in treatment together."

Sources and Resources

- DHMH Naloxone Website: http://bha.dhmh.maryland.gov/naloxone
- Prescribetoprevent.org
- Harmreduction.org
- College of Psychiatric and Neurologic Pharmacists Naloxone Access: A Practical Guide for Pharmacists
- Scope of Pain Module: "Overdose Education and Naloxone Rescue Kits for Prescribers and Pharmacists" Boston University

Contact

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Local Programs Manager, Overdose Prevention

Maryland DHMH/ Behavioral Health Administration

Office: 410-402-8574

erin.haas@maryland.gov

Maryland Office of Minority Health and Health Disparities
13th Annual Health Equity Conference
December 13, 2016

Achieving Health Equity through Community Engagement and Innovative Health Care Delivery

Equity vs. Equality: Current Initiatives to Address the Social Determinants of Health

Moderator:

Stephanie Slowly, MSW, LCSW-C, Deputy Director, Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene

Speakers:

Debbie Ruppert, Executive Director, Office of Eligibility Services

Nisa M. Maruthur, MD, MHS, Assistant Professor of Medicine & Epidemiology, The Johns Hopkins University

Yolanda Ogbolu, PhD, CRNP-neonatal, FNAP, Assistant Professor, Director, Office of Global Health, University of Maryland School of Nursing

CHANGING
Maryland
for the Better

Building Medicaid Eligibility and Service Linkages for Justice-Involved Individuals

Shannon M. McMahon, MPA
Deputy Secretary, Health Care Financing, Department of Health and Mental Hygiene

December 13, 2016

OVERVIEW

- Maryland Medicaid Overview
- Current Landscape of Justice-Involved Population
- 1115 Waiver – Presumptive Eligibility
- Connecting Criminal Justice to Health Care (CCJH) Initiative
- Justice Reinvestment & Data
- Challenges, Opportunities, and Next Steps

Maryland
Medicaid Overview

MARYLAND MEDICAID: OVERVIEW

Maryland Medicaid's total enrollment: about 1.3 million

- One in five Marylanders receive services from Medicaid.
- Of those, roughly 1.1 million beneficiaries are currently enrolled in HealthChoice, Maryland's mandatory managed care program

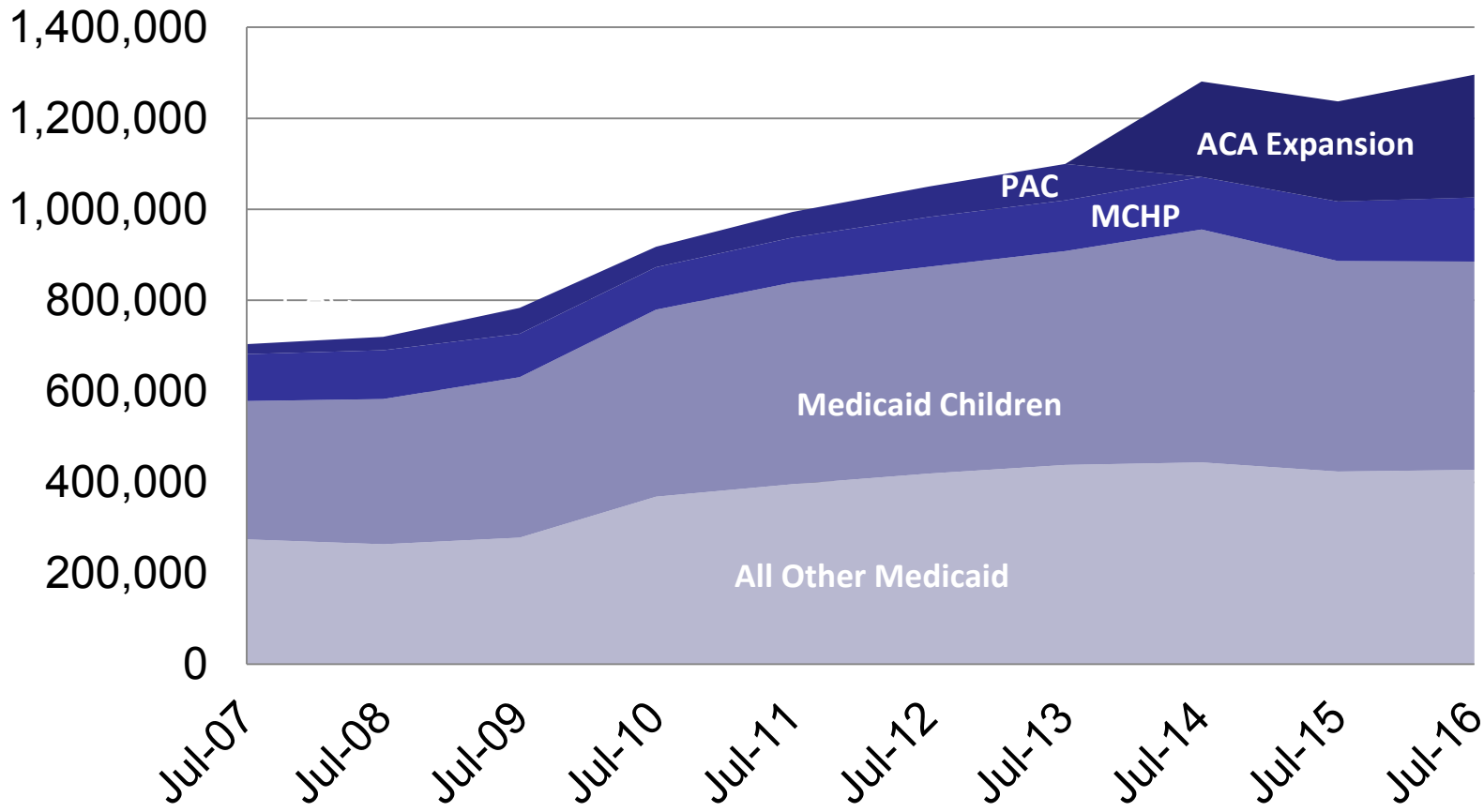
Maryland's health coverage enrollment attributed to the ACA

- 269,968 adults enrolled through Medicaid expansion.
- Over 162,000 Marylanders enrolled in QHPs during 2016 open enrollment.
    - 33% increase in enrollment from 2015 open enrollment
- 30,313 individuals enrolled in 2016 dental plans (first year offered through Maryland Health Connection).
- 90% of Marylanders using MHC were eligible for federal subsidies or Medicaid.
- 40% of uninsured Marylanders who were eligible for private insurance are now covered under MHC. About 240,000 individuals remain uninsured.*

Numbers as of July 2016

*Source: SHADAC. (May 16, 2016). *How many remain eligible for private insurance through Maryland exchange?* Available at: http://www.marylandhbe.com/how-many-remain-eligible-for-private-insurance-through-maryland-exchange/

2008 AND 2014 ENROLLMENT EXPANSIONS



MARYLAND MEDICAID: HEALTHCHOICE

***HealthChoice* = Maryland's statewide managed care program**

- Roughly 80% of beneficiaries enrolled in HealthChoice
- 8 participating MCOs
- 3 main eligibility groups: (1) families and children; (2) aged, blind, disabled; (3) childless adults
- MCOs paid a risk-adjusted, fixed PMPM
- Childless adults and parents = primary justice involved population are in HealthChoice

FFS: Certain services and care groups not covered under managed care

- Population: individuals over 65 years of age, receiving HCBS, and dually eligible for Medicaid/Medicare.
- Services: specialty mental health and substance use disorder services, dental for children and pregnant women, and LTSS.

Justice-Involved Population Landscape

MARYLAND'S JUSTICE INVOLVED POPULATION

Population supervised by US adult correctional system in 2014:*

- National: 6.85 million individuals
- Maryland: 109,000 individuals
  - About 1/4 of the state's correctional population is incarcerated (31,100 individuals)

Health conditions in Maryland facilities run by DPSCS:

- Chronic conditions: ~57% & see a provider at least every 90 days
- Hepatitis C: ~23%
- Mental illness: ~18%
- Serious mental illness (SMI): ~7.3%

DPSCS medical vendor: Wexford

- Provides medical treatment and some enrollment activities within walls

Total cost of correctional spending in Maryland (FY16): $1.4B

- General fund spending: $1.2B
- Expected rate of increase: 1.6%

*US Department of Justice. Bureau of Justice Statistics. (January 21, 2016). *Correctional Populations in the United States, 2014*.

MEDICAID SERVICE SUSPENSION STRATEGY

In Maryland, individuals enrolled in Medicaid at the time of incarceration are not disenrolled from the Medicaid program, but have their enrollment suspended or "turned off."

Maryland inmates enrolled in an MCO are moved to FFS

- Since 2008 Medicaid receives daily files from Maryland Department of Public Safety and Correctional Services (DPSCS)
- Run weekly process to find new inmates that have matching MCO eligibility
- Inmates enrolled in FFS to allow for payment of inpatient hospitalization

Medicaid uses DPSCS and local corrections data to "turn on" enrollment when released.

- Most inmates qualify for Medicaid at time of release

1115 Waiver Renewal

1115 WAIVER RENEWAL

1115 Waiver Renewal Initiative: *"Transitions for Criminal Justice Involved Individuals"*

- Initiative Aim: Presumptive Eligibility (PE) for Medicaid for individuals leaving jails and prisons
- Launch Date: July 1, 2017, if approved.
- Ultimate Goal: To provide a pathway to **full** Medicaid coverage upon release and allow individuals access to health care services through temporary eligibility determination.
- PE as a 'stop gap' for eligibility verification challenges, coordination issues, etc.

PRESUMPTIVE ELIGIBILITY FOR INMATES

Corrections and Local Health Department (LHD) staff will be trained as Presumptive Eligibility Determiners (PEDs)

- PEDs will assist individuals in completing the eligibility application through Maryland Health Connection
- If outstanding verification items or connectivity issues make the completion of a full application difficult, PEDs will proceed with the PE application and encourage the applicant to complete a full application at a later date

While eligibility is temporary, individuals eligible for PE receive full MA benefits during this temporary period

- PE enrollees are not placed in an MCO, but in Fee-For-Service, during the temporary eligibility period

ENHANCING CONNECTION TO SERVICES

Current Activities

- Medicaid is actively working to strengthen the linkages with DPSCS and detention centers;
- Medicaid in convening key stakeholders to evaluate enrollment and care coordination strategies at the front and back end of an individuals' involvement in the justice system;
- Medicaid is working with national consultants to identify gaps, challenges, priorities, and best practices to improve current initiatives.

Goals

- Improve eligibility and enrollment processes/data analytics capabilities between programs;
- Improve post-release care and converge connections.

Connecting Criminal Justice to Health Care (CCJH) Initiative

CCJH: OVERVIEW

Spring 2016, Maryland and Los Angeles County were selected to participate in CCJH, a national initiative that explores states' strategies to connect justice-involved individuals to health care.

- Supported by US Department of Justice's Bureau of Justice Assistance
- Facilitated by two technical assistance entities: the Urban Institute and Manatt Health Solutions.

Three Learning Collaboratives (LCs)

- LC1: Linking individuals to coverage – August 2
- LC2: Providing care coordination – September 21
- LC3: Identifying sustainable funding – October/November

Main goals for DHMH

- Increase coordination across all relevant health and criminal justice entities
- Improve data collection and exchange
- Leverage available workforce
- Ensure appropriate resources are available and accessible

CCJH: MARYLAND PARTNERS

CCJH: CURRENT ACTIVITIES

DHMH has begun assessing available resources and designing potential strategies to implement enrollment and care coordination activities.

- Many local health departments, detention centers, and navigators are moving forward with enrolling individuals into Medicaid.

Since the start of the initiative, all three counties have made tremendous progress in enrollment.

- Resources identified: caseworkers/enrollment assisters, IT capabilities, space
- Connections strengthened: Case managers and enrollment assisters across health department and detention centers are connecting regularly to discuss enrollment processes
- Enrollment processes implemented or close to being implemented: the 3 counties were in different stages of planning and implementation when we first began the initiative

DHMH hosts regular stakeholder calls to track efforts throughout the state.

CCJH: COUNTY ACTIVITIES

HARFORD COUNTY	WASHINGTON COUNTY	BALTIMORE COUNTY
Enrollment: Front End (switched from Back-End enrollment in September) **Staff:** 1 Health Department Staff identified **Frequency:** Every Wednesday **Data:** Detention center sends weekly reports to health department. Continued conversations around improving inmate tracking and data exchange. **Resources:** Space provided by detention center.	**Enrollment:** Back End (implemented October) **Staff:** 3 Health Department Staff identified **Frequency:** 1 Staff per week **Data:** Detention center to send health department a list of inmates to be released 1-2 weeks prior to release. **Resources:** Space provided by detention center. Laptops provided by health department. Internet access being explored.	**Enrollment:** Back-end (still in discussions) **Staff:** 5-6 Health Department staff identified **Frequency:** 2 staff every Wednesday. Will reduce to one based on diminishing demands. Targeting male and female facilities on alternating weeks. **Data:** Detention center sends weekly reports to health department. **Resources:** Space provided by detention center. Internet and laptops provided by health department.

CCJH: STATEWIDE PROCESS

DHMH is exploring ways to establish a coordinated and sustainable, statewide process that includes both enrollment and care coordination.

DHMH's Major Priority: DATA

- Medicaid continues to have conversations with private and public entities that have expertise around data for the incarceration population
- Real-time (or close to real-time) Data is key to ensure the State:
  - Reduces gaps in health coverage after individuals leave correctional facilities.
- Data will be used to determine when to:
  - Enroll inmates into Medicaid prior to release;
  - "Turn on" Medicaid post-release; and
  - Connect individuals to an MCO and/or providers post-release.

Justice Reinvestment and Data

JUSTICE REINVESTMENT

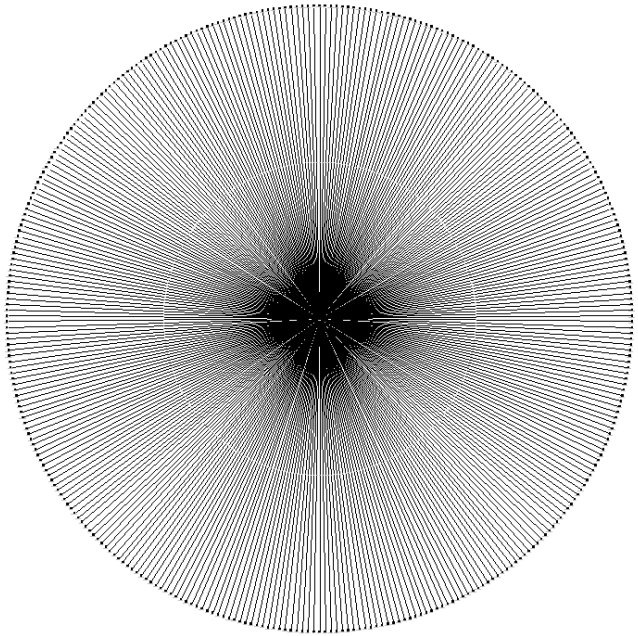
Nationwide, data-driven approach to improve public safety, reduce corrections spending, and reinvest savings in strategies that can decrease crime and reduce recidivism.

- Use data to identify and proactively break the cycle of incarceration
- Identify and provide recourses for returning citizens

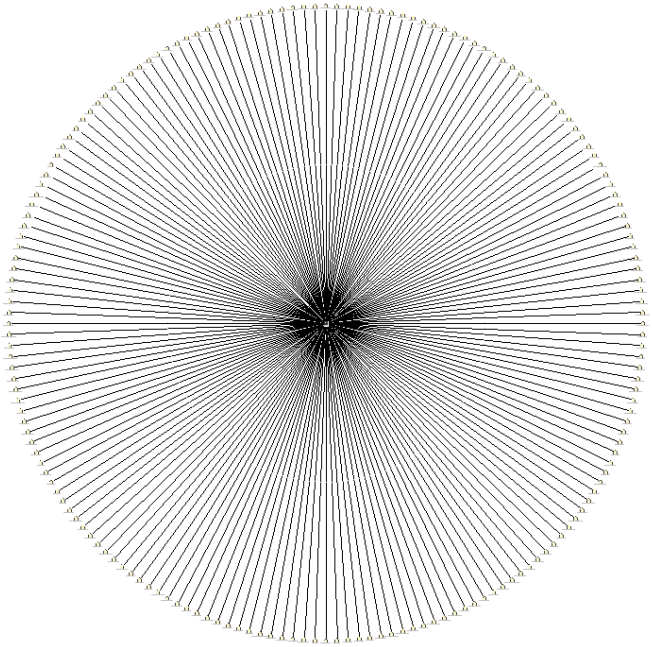
In 2016, Maryland lawmakers pass the Justice Reinvestment Act

- Gap Analysis Report on health needs/services for justice-involved
- Treatment instead of jail time for low-level drug offenders
- Lowered age from 65 to 60 for geriatric parole, must serve 15 years

POOR DATA SHARING: POOR DECISIONS



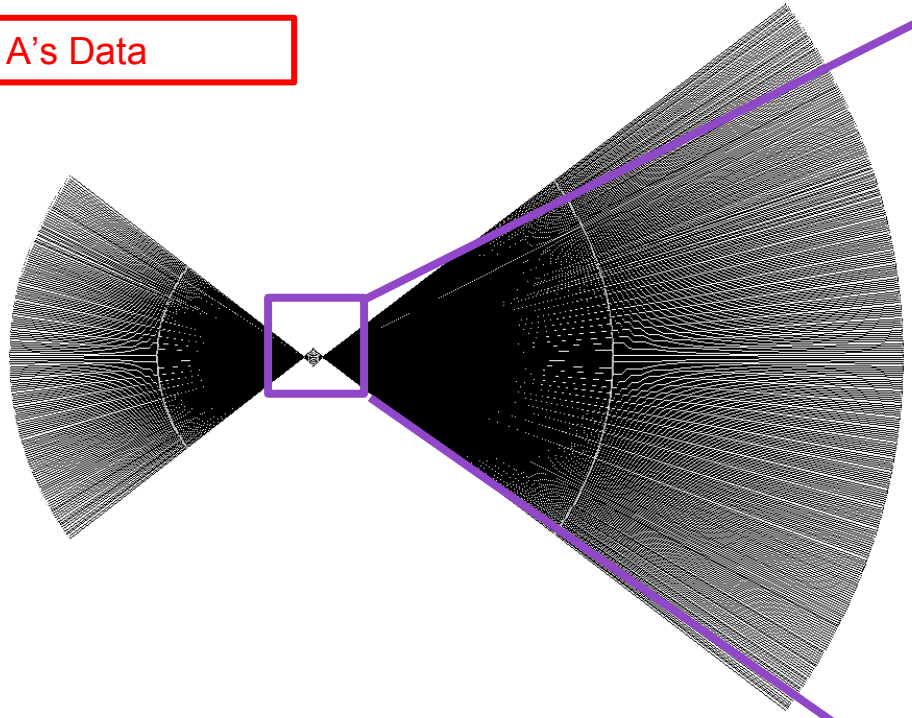
Agency A's Data



Agency B's Data

BETTER DECISIONS VIA COMPREHENSIVE DATA SETS

Agency A's Data



Agency B's Data

ID	Agency 1	Agency 2	Agency 3	Agency 4	Total
1	2	1	3		6
2			5	1	9
3				6	6
4		1	4		5
5		2	2	1	5
6		1	3	1	5
7		5			5
8		1	4		5
9	1		3		4
10		1	3		4
11		1	3		4
12	2	1	1		4
13		2	1	1	4
14		2	2		4
15	1		3		4
16			3	1	4
17	1		2	1	4
18			3	1	4
19			3	1	4
20			3	1	4

Next Steps
and Anticipated Challenges

HOW WE GOT HERE

The Math Works: Medicaid Expansion + Justice Reinvestment Act = Executive Buy-In

Enthusiastic Staff

- State agency partners: DHMH, DPSCS, Maryland Health Benefit Exchange, and the Governor's Office of Crime Control and Prevention
- Local jurisdictions: Harford, Baltimore, and Washington Counties; initiating discussions with others in 3rd and 4th Q of 2016

Federal support through Bureau of Justice Assistance (BJA)

- Component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics and National Institute of Justice
- Grant-supported funding

Data

- DHMH-Public Safety data sharing partnership since 2008

FUTURE CHALLENGES

Items Under Federal Purview

- Waiver approval from CMS
- Institutions for Mental Disease exclusion from reimbursement for SUD treatment
- Data sharing: 42 CFR Part 2

IT/ Data Infrastructure

- Internet connections, hardware and software
- Data warehousing and maintenance
- Procurement
- Streamlining multiple data systems and sources for a single enrollment process

Prison Easier than Jail…

- Jail=Quick in/quick out / Prison=Work for the same Governor and longer term

FUTURE CHALLENGES

Eligibility

- Role of Local Health Departments
- Local detention center buy-in
- Cultural sensitivity training
- Connections to care entities

Care Coordination

- MCOs – Considering autoassignment
- Addiction Authorities, Mental Health Authorities and BH Carveout
- Prison and jail health vendors: terms negotiated on local levels
- Cultural sensitivity training
- County-specific care coordination procedures

Questions?

Power to Stop Diabetes: Diabetes Prevention in East Baltimore

Nisa M. Maruthur, MD, MHS

Director of Community Partnership, The Johns Hopkins Brancati Center for the Advancement of Community Care

Maryland DHMH

Minority Health and Health Disparities

Achieving Health Equity through Community Engagement and Innovative Health Care Delivery

December 13, 2016

Take-Home Points

- Diabetes is preventable in the community.
- Successful Diabetes Prevention Programs are hard to implement, but we can do it.
- Inequity in diabetes prevention exists, but we are learning concrete ways to address this.

Health Equity: WHO

- *Equity* is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.
- *Health inequities* therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes.

How did I get here?

Diabetes affects everything and everyone.

Diabetes Prevention Program

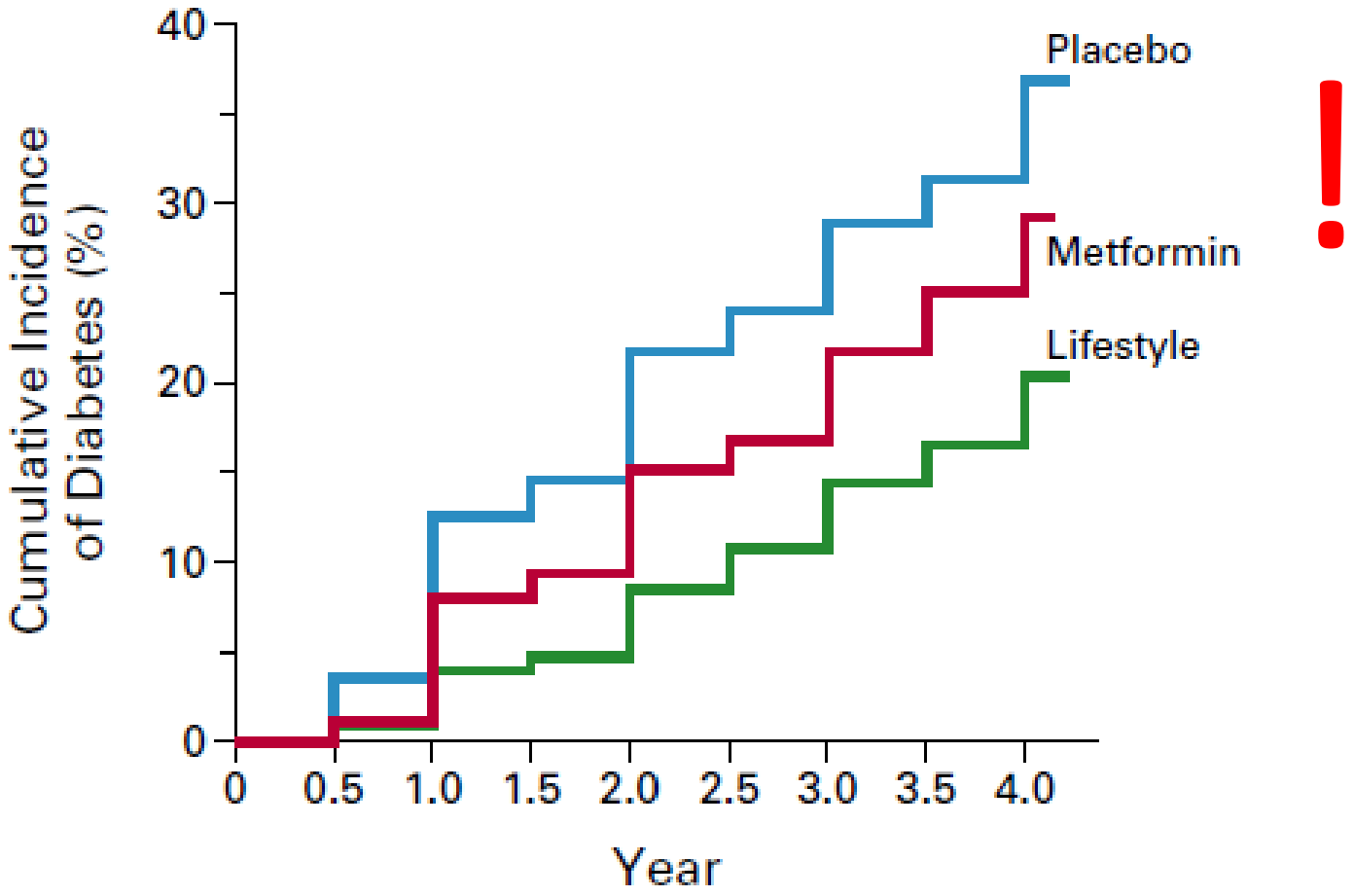
The New England
Journal of Medicine

VOLUME 346 FEBRUARY 7, 2002 NUMBER 6

REDUCTION IN THE INCIDENCE OF TYPE 2 DIABETES WITH LIFESTYLE INTERVENTION OR METFORMIN

DIABETES PREVENTION PROGRAM RESEARCH GROUP*

Diabetes is preventable!


Cumulative Incidence of Diabetes (%)
40
30
20
10
0
0
0.5
1.0
1.5
2.0
2.5
3.0
3.5
4.0
Year
Placebo
Metformin
Lifestyle
!

- Goals of Intensive Lifestyle Intervention
  - 7% weight loss
    - Reduction in calories, mainly fat
  - 150 min/wk moderate intensity exercise
- Intervention contacts
  - Dieticians/exercise physiologists
  - 1-on-1 meetings weekly → monthly
  - Motivational interviewing

Diabetes Prevention 2002-

- Efficacy trials across the globe
  - Finnish DPS, Da Quing (China), DPP, Indian DPP
- Effectiveness studies
  - E.g., YMCA
  - Tested group-based intervention

Diabetes Prevention Act of 2009

111TH CONGRESS
1ST SESSION

H. R. 4124

To amend the Public Health Service Act with respect to the prevention of diabetes, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 19, 2009

Mrs. DAVIS OF CALIFORNIA (for herself, Ms. RICHARDSON, Mr. LOEBSACK, and Ms. BORDALLO) introduced the following bill; which was referred to the Committee on Energy and Commerce

---

A BILL

To amend the Public Health Service Act with respect to the prevention of diabetes, and for other purposes.

CDC National Diabetes Prevention Program (NDPP)

- Eligibility: [Prediabetes by lab + ↑BMI] or [risk test + ↑BMI] and **no diabetes**
- Programs using an approved curriculum can be recognized by the CDC based on performance
  - Average weight loss 5% at 6 and 12 mo
  - Attendance, reporting of activity minutes
- Weekly sessions x ~6 mo → monthly sessions x 12 mo

NDPP 2009-2016

- As of 11/17/16, 1138 programs registered
  - Most are in-person (34 virtual, not recognized)
  - 85 (7.5%) programs w/ full recognition
- Maryland
  - 47 registered in Maryland
    - 2 have attained recognition
      - Kent County, Washington County
- Recognized programs will be eligible for Medicare reimbursement in 2018

March 2016 – Medicare to Reimburse for DPP

HHS.gov

U.S. Department of Health & Human Services

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View 2012 - 1991 archive

Independent experts confirm that diabetes prevention model supported by the Affordable Care Act saves money and improves health

First ever preventive service model eligible for expansion under Medicare holds promise for employers, private insurers and patients

Today, the Department of Health and Human Services announced a significant step forward in building a health care system that works better, spends dollars smarter, and keeps people healthy. Secretary Sylvia M. Burwell announced that the independent Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS) certified that expansion of the Diabetes Prevention Program, a model funded by the Affordable Care Act, would reduce net Medicare spending. The expansion was also determined to improve the quality of patient care without limiting coverage or benefits. This is the first time that a preventive service model from the CMS Innovation Center has become eligible for expansion into the Medicare program.

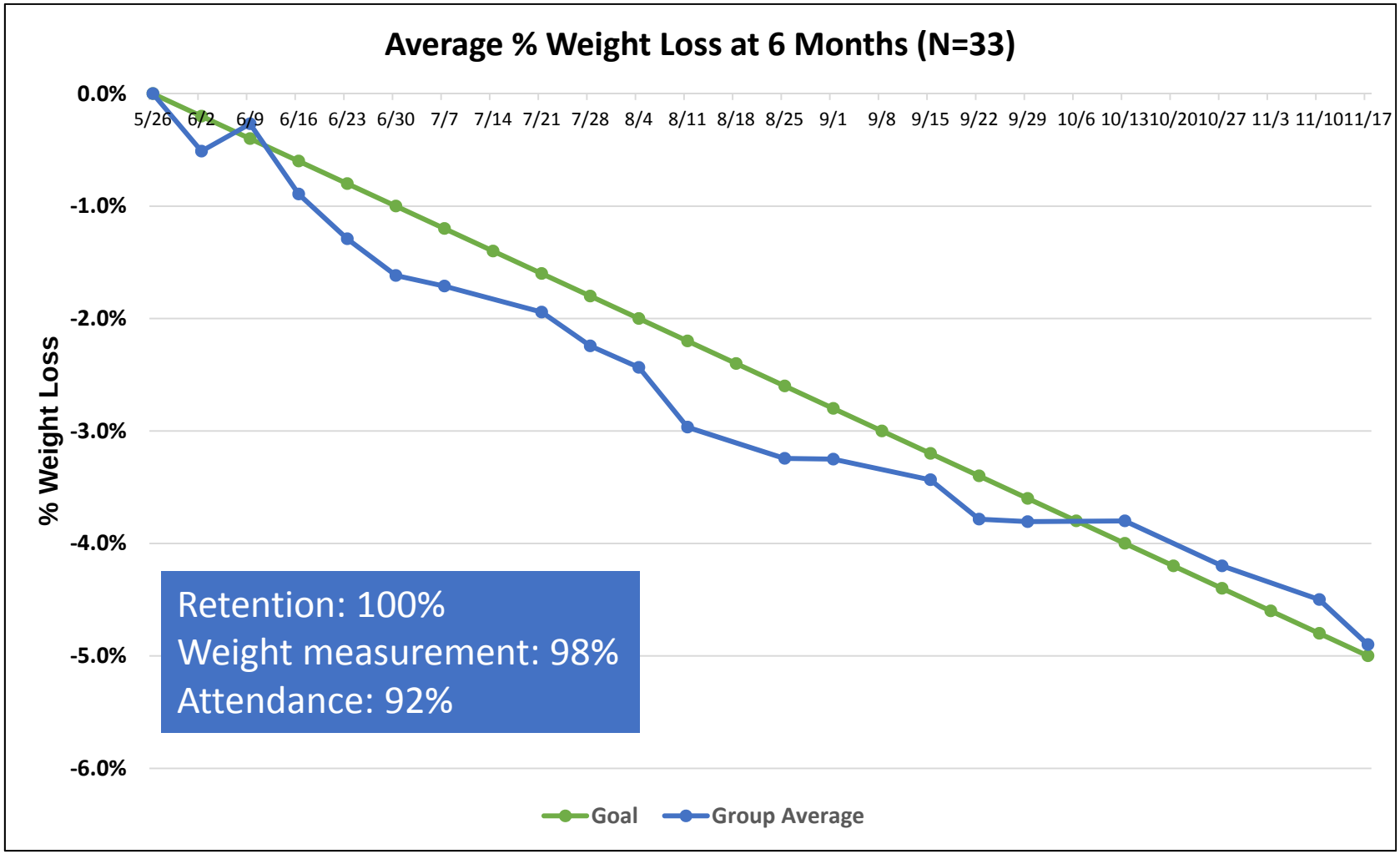
Currently, about 30 million - PDF Americans have type 2 diabetes, resulting in two deaths every five minutes in this country. Additionally, 86 million - PDF Americans have a high risk of developing diabetes, because one in every three adults has prediabetes, a condition that arises when blood glucose levels are higher than normal but not high enough for a diagnosis of diabetes. Prediabetes

Power to Stop Diabetes: Diabetes Prevention in East Baltimore

Hospital-community partnership essential

Community	**Hospital**
Churches as enduring structures	Population health as focus
Support of Pastors	Technical expertise
Health ministries	Data
Peer coaches/volunteerism	Volunteerism
	Reimbursement

Power to Stop Diabetes: Results



Addressing equity

"They're poisoning us."

- Education
  - Healthy lifestyle, diabetes prevention
- Access in community
- Evenings and weekends
- Technical expertise
- Data – training, management, analysis, interpretation
- Skills training for coaches
- Healthier diet – food demos, grocery store tours
- Increasing physical activity

Gaps that remain

- Costs of healthier lifestyle
- Access to healthy food/physical activity
- Health care system focus on treatment vs. prevention
- Jobs
- Transportation
- Caregiving
- Reimbursement
  - Medicare coming
  - Medicaid
- Nutrition – knowledge and application

Facilitators

- Centers for Disease Control
- Engaged community partners
- Brancati Center resources
- Local public health/govt.
  - State of Maryland DHMH – going national!!
  - Baltimore City Health Department

Take-Home Points

- Diabetes is preventable in the community.
- Successful Diabetes Prevention Programs are hard to implement, but we can do it.
- Inequity in diabetes prevention exists, but we are learning concrete ways to address this.

Thank you

- Baltimore City Health Department
  - Emilie Gilde
- State of Maryland DHMH
  - Kristi Pier, Sue Vaeth
- Maryland Medicaid
  - Sandy Kick
- Priority Partners MCO
- Brancati Center
  - DPP participants
  - Zion Baptist Church/Memorial Baptist Church
  - Dr. Fred Brancati
  - Dr. Jeanne Clark
  - Megan Brown
  - Kathy Michalski
  - Dr. Raquel Greer
  - Fatmata Timbo

THE BRANCATI CENTER
FOR THE ADVANCEMENT OF COMMUNITY CARE