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

Maryland's 10th Minority Health Disparities Annual Conference "Health Reform to Health Equity on Maryland's Eastern Shore Summit"

Regional Summit Proceedings
October 11, 2013
10:00 a.m. to 4:00 p.m.

Chesapeake College
Todd Performing Arts Center
Wye Mills, Maryland

Co- Sponsors

REGIONAL SUMMIT PROCEEDINGS

Maryland's 10th Annual Minority Health Disparities Conference
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PREFACE

The Maryland General Assembly passed legislation establishing the Maryland Office of Minority Health and Health Disparities (MHHD) during the 2004 Legislative Session. MHHD is in statue at the Annotated Code of Maryland in Health General; Title 20 Subtitle 10. MHHD's first conference was held on June 8, 2004 at the University of Maryland Baltimore County in Catonsville, Maryland. It was entitled "Closing The Health Care Divide: Eliminating Disparities for Racial and Ethnic Minorities." The purpose was to address the reduction of minority health disparities, in the promotion of quality health equity in Maryland. It was attended by 300 academic leaders, federal/state/local governments, minority community leaders, medical societies, public and private practitioners, elected officials, local health department staff, pharmaceutical representatives, residents, students and other stakeholders advocating Health Equity. Then Secretary of Maryland Department of Health and Mental Hygiene, Nelson J. Sabatini wrote, "There is more than enough evidence that health disparities exist. All one has to do is look at the differences between African Americans and Caucasians in infant and maternal mortality rates. The gap between African Americans and Caucasians is even more staggering when looking at HIV data. It is time to stop talking and move forward to eliminate the health disparities gap in Maryland."

Over the last ten years, the conferences have been attended by 3,774 health advocates, 150 attended the Tenth Annual Health Disparities Conference “Health Reform to Health Equity on Maryland’s Eastern Shore Summit at Chesapeake College in Wye Mills, Maryland. The Tenth Annual Conference focused on the State's efforts to implement the Affordable Care Act of 2010 (ACA). Since the passage of the ACA, the State of Maryland has progressively moved forward by creating and passing key health legislation designed to make healthcare affordable. The presenters provided the audience information on topic areas such as the State’s market place health connectors, local health improvement plans, cross juridictional collaboration efforts; health enterprise zone initiative, health inequities, healthcare reform, health policy and much more. MHHD will continue to play a primary role in implementing various legislative mandates by advancing the Office's mission to advocate for policies and programs that reduce the health disparities gap and improve the health of minorities and all Marylanders.

ACKNOWLEDGMENTS

MHHD thanks Chesapeake College for hosting the Regional Summit, particularly Leanne Allen. Thanks to the staff of MHHD and others from DHMH for planning and coordinating the conference. Every year, MHHD partners with the University of Maryland to present the conference with the assistance of Stephen Thomas, PhD, professor of the university's Health Services Administration and director of the Maryland Center for Health Equity for his support. MHHD appreciates the support of the Maryland Community Health Resources Commission and its chair, John S. Hurson, Esq.

MHHD thanks Dana Trevas of Shea & Trevas Inc. for providing meeting coverage and developing the Regional Summit proceedings.

Maryland's 10th Annual Minority Health Disparities Conference
"Health Reform to Health Equity on Maryland's Eastern Shore Summit"

WELCOME & OPENING REMARKS

Carlessia A. Hussein, RN, DrPH*, Director, Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene*

Dr. Hussein extended greetings on behalf of the Maryland Secretary of the Department of Health and Mental Hygiene (DHMH), Joshua M. Sharfstein, MD, who was unable to attend the meeting because he was busy improving the new Maryland health insurance exchange, the Maryland Health Connection.

The Eastern Shore is a special place, said Dr. Hussein, whose population faces challenges to getting health care thanks to the rural nature of the area, lack of public transportation, and lack of insurance coverage. Together, these factors contribute to large health disparities among the residents of the Eastern Shore, so the Office of Minority Health and Health Disparities (MHHD) dedicated its annual health disparities conference to the needs of the region. In the years to come, MHHD will determine whether to continue to focus conferences on specific regions of the state.

Despite the challenging times—the effects of sequestration (Federally mandated budget cuts), the shutdown of the Federal government since October 1, and a looming budget crisis—Maryland is moving forward, said Dr. Hussein. She charged the participants to find ways to use the information presented at this conference, share their own information with others, and come up with ideas and recommendations. Dr. Hussein hoped the conference would spur activities or alliances that last beyond the day. For example, MHHD has a virtual data collection and analysis unit, headed by David Mann, MD, PhD; Dr. Hussein proposed the Eastern Shore participants consider collaborating around virtual data for the Eastern Shore.

Dr. Hussein summarized the agenda and referred participants to the MHHD handouts, including "Selected Minority Health Insurance Data and Minority Health Disparity Data" and a list of resources. (The biographies of all the speakers, as well as the slide presentations from the conference, are available online at www.dhmh.maryland.gov/mhhd.) She introduced Dr. Mann for an overview of the data provided.

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

Dr. Mann summarized some data about the counties along the Eastern Shore, noting that most have a high percentage of uninsured adults under age 65 who are also racial/ethnic minorities (averaging about 34% across the 10 Eastern Shore counties). Health care reform will be important for minority populations on the shore, said Dr. Mann. Other data

in the handout demonstrate the disparities between Black and White residents of the Eastern Shore by showing the differences between the two groups in emergency department (ED) visits for asthma, diabetes, and high blood pressure.

***The Honorable Shirley Nathan-Pulliam**, House of Delegates, District 10, Maryland General Assembly*

Delegate Nathan-Pulliam welcomed the participants on behalf of the Governor, Lieutenant Governor, and the Maryland General Assembly. She clarified that although the terms "health disparity" and "health equity" are used interchangeably, health disparities are the conditions that exist now, while health equity is where we hope to be. She also conveyed greetings from Secretary Sharfstein, who is working night and day to fix glitches in the new health insurance exchange system so that Maryland can be one of the top states that moves smoothly through the enrollment process into implementation of the Patient Protection and Affordable Care Act (ACA).

Delegate Nathan-Pulliam congratulated Dr. Hussein and her colleagues for their work running the MHHD. They have worked diligently to become one of the best offices in the country addressing health disparities and health equity, she said. Delegate Nathan-Pulliam urged the participants to keep in mind the statistics presented by Dr. Mann underscoring the disparities among minorities on the Eastern Shore, because the ultimate goal is good health for the whole state.

***The Honorable Adelaide C. Eckardt,** House of Delegates, District 37B, Maryland General Assembly*

Delegate Eckardt welcomed the participants and noted that she took office nearly 20 years ago with the main goal of improving access to health care for all. Her home of Dorchester County has worked hard to move forward, but good health care requires a thriving economy, a good education system, and the ability to reach all citizens. With Maryland taking a lead in health care reform, Delegate Eckardt was optimistic. Efforts to address access for children and their parents through various programs and the current Medicaid expansion are an important step. The new Health Enterprise Zones (HEZs) and more affordable insurance options through the ACA offer even more promise.

To achieve health equity, however, requires all the stakeholders working together, said Delegate Eckardt, not just the legislature and the Governor's office. She called for far more engagement from the business community and other partners, including health care providers, to ensure access to and delivery of care across the lifespan for Maryland's residents.

***The Honorable Norman H. Conway**, House of Delegates, District 38B, Maryland General Assembly*

Delegate Conway said he is pleased that Maryland is making the effort to spend its money in ways that benefit its citizens as it implements a revolution in health care. He

described how the General Assembly members negotiated successfully to address the state's persistent structural deficits. He expressed concern about the lack of discussion and negotiation among members of the U.S. Congress that led to the sequestration and the shutdown, which may hit Maryland hard, because it is home to many Federal employees and Federal institutions.

When Maryland began talking about health care reform several years ago, there were 800,000 uninsured people in the state, many of whom were treated in the ED. Their costs were covered in part by the premiums of insured people. It is important to help everyone, at every level, said Delegate Conway, because the state is committed to caring for all its residents. Efforts must be made to help residents do what they can for their own health and well-being. Delegate Conway said he is pleased that Maryland took the bull by the horns early to put health care reforms in place, because now the state is ahead of the game. He said the problems of registering for the online exchange should be considered a normal response to any large program designed to meet the needs of millions. He thanked the participants for coming together to better understand what must be done and how they can help make Maryland's health care system work better.

THIRD ANNUAL SHIRLEY NATHAN-PULLIAM HEALTH EQUITY AWARDS AND LECTURE SERIES

***Stephen Thomas, PhD**, Professor, Health Services Administration and Director, Maryland Center for Health Equity, School of Public Health, University of Maryland*

Dr. Thomas thanked Delegate Nathan-Pulliam for her vision and leadership in passing the Maryland Health Improvement and Disparities Reduction Act of 2012. The legislature needs people like Delegate Nathan-Pulliam working on the front lines, he said. To recognize the efforts of others, the Shirley Nathan-Pulliam Health Equity Awards were established 2 years ago. This year, two honorees are named.

The first is J. Nadine Gracia, MD, MSCE, deputy assistant secretary for the Office of Minority Health in the U.S. Department of Health and Human Services (HHS). Under Dr. Gracia's leadership, the Office of Minority Health oversees the implementation of the HHS Action Plan to Reduce Racial and Ethnic Disparities and the National Partnership for Action to End Health Disparities. Dr. Gracia's influence can be seen in the context of the HHS plan, which explains that health disparities are not just a statistic but a difference in care that is caused by something—namely, racial and ethnic discrimination and prejudice. The state of Maryland acknowledged that important fact by creating the MHHD to close the gap. Dr. Gracia was unable to attend the conference because the shutdown prohibits her from acting in a capacity representing the Federal government. Dr. Thomas presented the 2013 the Shirley Nathan-Pulliam Health Equity Award to Dr. Gracia in absentia for her steadfast commitment to eliminating health disparities and achieving health equity for all.

Dr. Thomas noted that in pushing for health equity, the presenters at the conference may be "speaking to the choir," but, he added, "we need some choir practice." The second

2013 recipient of the Shirley Nathan-Pulliam Health Equity Award goes to Thomas A. LaVeist, PhD, William C. and Nancy F. Richardson Professor in Health Policy and director of the Hopkins Center for Health Disparities Solutions at the Johns Hopkins University Bloomberg School of Public Health. Dr. Thomas called Dr. LaVeist "a choir director" who would help cut through the fog of misinformation to close gaps of health disparities and move toward health equity. Dr. Thomas presented the 2013 Shirley Nathan-Pulliam Health Equity Leadership Award to Dr. LaVeist.

KEYNOTE ADDRESS

***Thomas A. LaVeist**, PhD, William C. and Nancy F. Richardson Professor in Health Policy and Director, Hopkins Center for Health Disparities Solutions, Johns Hopkins University Bloomberg School of Public Health*

Dr. LaVeist said he was honored to receive an award named after his friend and colleague, a co-warrior in the fight to understand and fix health disparities. He was heartened to see participants at the conference representing various sectors, because a multidisciplinary approach is needed to deal with health disparities. We cannot fix disparities with medicine or public health programs, said Dr. LaVeist, but rather by fixing what causes the disparities. We have organized our society in a way that produces health disparities, he noted.

The term "health disparities" is relatively new, said Dr. LaVeist. Not long ago, many thought that the differences were just a fact of life as a racial/ethnic minority. He asked the participants to imagine a society without health disparities.

The Nature of Health Disparities

To illustrate the nature of health disparities, Dr. LaVeist referred to the sinking of the Titanic. The likelihood of surviving that disaster was directly related to both sex and class. A woman with a first-class ticket was most likely of all to survive; a man (with any type of ticket) was the least likely. Space on lifeboats was scarce, and when resources are scarce, "who you are determines your access to those resources," said Dr. LaVeist.

While some may believe that such stark class distinctions no longer exist, said Dr. LaVeist, a modern crisis tells a different story. A photo of US Airways flight 1549 after an emergency landing in the Hudson River in 2009 shows first-class passengers seated comfortably in a lifeboat, while the coach passengers stood along the wings of the slowly sinking aircraft.

Dr. LaVeist explained that persistent inequity of access is the result of a series of policy decisions made not by legislatures but by those who implement the laws. Regulators, lobbyists, and professionals in the field decide how to enact or interpret laws, watering them down or strengthening them as they do so. In the case of the airplane landing in the river, regulators could have required large planes to have more lifeboats, US Airways could have made a policy of buying only planes with more lifeboats, and the manufacturer could have chosen to include more lifeboats in all of its planes. Much of the

policy that affects us happens in the corporate boardroom, said Dr. LaVeist, so we must be more sophisticated in our understanding of where and how policy is made outside of our legislative bodies.

Understanding the Causes of Health Disparities

To bolster his point, Dr. LaVeist showed a chart depicting the infant mortality rate by race/ethnicity of the mother over four decades, beginning in the 1970s. The same pattern persists over time: Black women, even those with high education and economic status, have higher rates of infant mortality than even the least educated, poorest White women. The problem remains because we have not addressed the factors that cause disparities, Dr. LaVeist emphasized.

Most efforts underway now to address health disparities will fail, Dr. LaVeist predicted, because we have not yet diagnosed the underlying problem we hope to treat. The three most common reasons cited for health disparities are as follows:

- Biologic or genetic differences
- Social class/poverty/socioeconomic status
- Unequal access to care

Inequities in Access

Dr. LaVeist said socioeconomic status is related to health disparities, but it is not the sole cause, and better access to care will not eliminate disparities. To prove his point, he conducted a study evaluating the medical records of 10,000 patients with cardiovascular disease in three hospitals. All of the patients were candidates for cardiac catheterization for further diagnosis, all had health insurance, and all visited hospitals that had cardiac catheterization facilities. The results were discouraging on two fronts. First, only 88% of the White patients were referred for cardiac catheterization, representing a quality or performance problem (because all were candidates). Second, only 60% of Black patients were referred for the procedure, demonstrating a clear racial/ethnic disparity. A similar analysis of candidates for bypass surgery in a Veterans Administration hospital, where all the physicians are employed (removing the possibility of incentives affecting referral patterns), found similar results.

Biologic/Genetic Differences

To identify biologic or genetic differences as the cause of disparities, said Dr. LaVeist, we would have to believe that one gene is responsible for all the myriad health conditions for which we can see disparities (cancer, heart disease, diabetes, depression, HIV, etc.) and also all the cultural differences that distinguish Black Americans from others. He called the notion "ridiculous" but said it creeps into the mind in subtle and insidious ways.

Dr. LaVeist described the approval of the drug BiDil to treat congestive heart failure. Researchers found that a combination of two inexpensive, generic drugs produced very good results in treating the condition. The U.S. Food and Drug Administration (FDA) required evidence about the combination drug in clinical practice. In lieu of a full clinical

trial, the researchers analyzed old data and found that the combination drug was "more effective" among Blacks then Whites.

Dr. LaVeist pointed out that the drug was not, in fact, found to be more effective in Blacks but rather effective in a higher percentage of Blacks. Yet the FDA accepted the finding and approved BiDil specifically for Black patients with heart disease. The indication was approved 2 years after the Human Genome Project showed that race is not a real genetic distinction. Dr. LaVeist challenged participants to determine whether such high-profile people as Colin Powell, Barack Obama, and Tiger Woods, who are all of mixed race, would be appropriate candidates for BiDil.

Socioeconomic Status

Finally, health disparities by race/ethnicity persist even in people of similar education and income. While those with more education tend to have better health outcomes, such indicators of social class are not enough to explain disparities, as demonstrated by the persistence of higher infant mortality rates among Black women.

Persistent Segregation and Racism

Dr. LaVeist pointed out that we are still segregated in many communities by race/ethnicity, which facilitates different access to the resources needed to protect life and minimize exposure to health risks. For example, the poorest neighborhoods are filled with corner stores selling cheap alcohol and cigarettes but have few grocery stores or full-service restaurants. Dr. LaVeist said that across Baltimore, the only place on can buy large (64-ounce) bottles of malt liquor—the "elixir of poverty"—is in poor, Black neighborhoods.

Dr. LaVeist described a journal submission he reviewed that compared racial differences in firearm use among Black and White adolescent males in Maryland. The data on Blacks came from East Baltimore, where young men primarily used pistols (often in homicides); the data on Whites came from rural Alleghany County, where young men primarily used rifles for hunting. Instead of comparing Blacks and Whites in the same community, the author of the paper chose people in very different settings. Dr. LaVeist pointed out that the paper did not represent a legitimate comparison of gun use by race, but his comments fell on deaf ears, he said.

Similarly, Dr. LaVeist reviewed a study at Johns Hopkins University comparing hospital outcomes among Blacks and Whites. The White patients primarily arrived at the hospital through the outpatient department, having been referred by a health care provider. The Black patients arrived primarily through the ED. Dr. LaVeist questioned whether the poorer outcome among Blacks might be the result of whatever crisis brought them to the ED or the fact that a person in the ED typically receives less care than one in an outpatient department. That is, the study claimed to look at racial/ethnic differences but was not adequately designed to address them. Again, Dr. LaVeist's observation was not addressed in the published results. These studies represent the subtle ways that segregation influences our thinking, said Dr. LaVeist.

Disparities Are Caused by a Combination of Factors

To better understand the nature of health disparities, Dr. LaVeist evaluated integrated communities where residents have the same access to resources and the same exposure to health risks. Looking at national health survey data for specific communities that appeared to be racially integrated with similar income and education levels across residents, Dr. LaVeist and colleagues evaluated data on blood pressure and hypertension as primary outcomes. If the data did not show the typical racial/ethnic health disparities, it would support a hypothesis that such disparities are a reflection of community differences, not differences in biology, access to care, or socioeconomic status. In fact, Dr. LaVeist and colleagues found that Blacks had a higher risk of high blood pressure—but the gap between Blacks and Whites was much smaller than that seen in national statistics. Further more, there were no statistically different rates of obesity or diabetes by race/ethnicity.

Dr. LaVeist concluded that health disparities are caused by a combination of race/ethnicity and environment that increases the risk for worse health outcomes. To understand health disparities, he said, we need to consider four major disparities together:

- Health
- Wealth
- Educational attainment
- Criminal justice involvement/incarceration

These four disparities are inextricably linked. Education is a clear predictor of health, and less healthy kids receive a worse education then healthy kids. Less education is associated with criminal behavior, and incarcerated people have lower literacy levels. Less wealth can put one on the path to prison, and a strong way to prevent wealth is to incarcerate someone in his early 20s, when he is most likely to lay the foundation for future employment.

Finally, Dr. LaVeist sought to dispel the myth that there are more Black men in prison than in college. He analyzed 2006 data, which showed that 836,800 Black men were in prison, which, while "outrageously high," was still fewer than the 896,000 Black men in college. Moreover, the number of those Black men in prison who were between 20 and 29 years old (close to typical college age) was 310,000. Dr. LaVeist looked at data from other years and found that at no time were there more Black men in prison than college. He invited participants to help him dispel the myth.

In conclusion, Dr. LaVeist again asked participants to imagine what needs to happen to achieve a society without health disparities. He encouraged them to think broadly, beyond improving access to care and addressing socioeconomic disadvantages, to how we organize ourselves to become a truly equitable society.

WELCOME FROM CHESAPEAKE COLLEGE

***Barbara Viniar, EdD**, President, Chesapeake College*

Dr. Viniar welcomed the participants and noted that a recent faculty meeting reminded her how much the academic and health care sectors have in common. Both are reimagining their work in the face of significant and seemingly constant changes. Both have the will and imagination to address structural inequities. Dr. Viniar believes such inequities can be tackled through education.

Chesapeake College and other community colleges contribute to the health and well-being of their communities by preparing those on the front line of care—nurses, physical therapists, radiology and pharmacy technicians, etc. Dr. Viniar said Chesapeake College is ready to work with the health care sector to ensure that its community and students are well served.

SESSION 1: MARYLAND HEALTH CONNECTION (MARKETPLACE) ON THE EASTERN SHORE

***Moderator: Carlessia A. Hussein, RN, DrPH**, Director, Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene*

***Katherine C. Gunby**, Program Director, Lower Shore Health Insurance Assistance Program, Worcester County Health Department*

Ms. Gunby explained that the Maryland Health Benefit Exchange awarded grants to six agencies in six regions of the state to help people shop for health insurance plans using the Maryland Health Connection. The Lower Shore Health Insurance Assistance Program (LSHIAP) helps people in Somerset, Wicomico, and Worcester counties get affordable, high-quality health insurance, an endeavor that fits well with the mission of the Worcester County Health Department, where the organization is located.

The Worcester County Health Department works closely with neighboring counties. It was selected to lead the effort for the region because it has a stake in the community and works daily to guide vulnerable populations to available resources. Ms. Gunby said the department had the time, resources, and initiative to take the lead with support and backing from others. Ms. Gunby emphasized that people may come to the LSHIAP seeking help with health insurance, but they often need access to other resources as well.

Approximately 23,000 people in the lower Eastern Shore are uninsured. Of those, 86% qualify for tax credits when purchasing insurance through the exchange or are eligible for Medicaid as a result of Medicaid expansion. The uninsured vary a lot in their education, income, and fields of employment, so they are difficult to identify and target, Ms. Gunby pointed out. Educating people about insurance is even more challenging. Only about 14% of those who have insurance understand basic terms, such as premiums, copays, deductibles, and coinsurance.

On the Eastern Shore, reaching the uninsured is further complicated by the area's rural, spread-out nature and the number of small, isolated communities where many self-

employed people work (e.g., in farming and fishing). Smith Island, for example, can only be reached by boat, Ms. Gunby noted. The most vulnerable populations—that is, racial and ethnic minorities and low-income people—are more likely than others to suffer as a result of health disparities. They are also less likely than others to have cable television or get information through government sources.

To reach those in need, public health providers must not only develop a targeted message but also present information in a way that the most vulnerable populations can access, understand, and act on. One method is to tap into "community influencers," that is, trusted local sources of information, such as local pastors and doctors. The LSHIAP is collaborating with churches, health care providers, libraries, schools, and other community organizations to reach the uninsured and underserved.

The outreach effort is highly mobile, said Ms. Gunby. Eight navigators and seven assisters travel frequently to grocery stores, community fairs, local pharmacies, and other sites to reach out to the uninsured and underserved. Still, the LSHIAP must find other means to reach those in rural communities that lack public transportation. Last week, said Ms. Gunby, a navigator traveled to an individual's home to help the individual complete a written application for insurance and connect to other county services.

The LSHIAP is working with civic groups and local media to let people know about the availability of insurance and supplements to help pay for it. It is also using paid advertising (on television, radio, billboards, and buses). Ms. Gunby said the LSHIAP is encouraging community influencers to share information and also using the Internet and social media (see lowershorehealth.org and facebook.com/lowershorehealth) to spread the word. Because people tend to listen more to messages delivered by others who "look like them," the LSHIAP is staffed by locals who know the culture.

***Mark Romaninsky**, Program Director, Seedco, Maryland Health Connection—Upper Eastern Shore*

Seedco is a nonprofit organization working in several states to develop economic opportunities for disadvantaged and low-income families through workforce development and family supports. It is working in four states to assist with the rollout of the ACA. Mr. Romaninsky praised Maryland's state-based exchange. States such as Georgia, which opted for a Federally-run exchange, are only now starting up their operations. Georgia has 29 staff to serve 159 counties; by contrast, Seedco's upper Eastern Shore effort has 20 staff to serve 7 counties. The citizens of Georgia are not getting the same quality of outreach or services as those of Maryland, where the state has invested a lot in in health care reform.

Seedco covers the seven counties of the upper Eastern Shore (Caroline, Cecil, Dorchester, Harford, Kent, Queen Anne's, and Talbot). Using methods similar to those of the LSHIAP, Seedco provides education about opportunities available through the Maryland Health Connection and, if requested, helps people understand and walk through the insurance plan enrollment process.

Target audiences are the uninsured, low- and middle-income families, disabled people, the underemployed and unemployed, seasonal and migrant workers, and college students. Seedco seeks out community partners who are trusted, entrenched, well-known, and have established networks. For example, in Queen Anne's County, it has partnered with the Eastern Shore Area Health Education Center, and in Caroline County, it works with the Choptank Community Health System.

Assisters can provide education and outreach, enroll people in Medicaid, and, starting in January, assist with Maryland Children's Health Insurance Program enrollment. Navigators provide all the same services but have also been certified by the state to enroll people in qualified health insurance plans offered on the exchange. Navigators are unbiased; their goal is to help consumers find the plan that best meets their needs, said Mr. Romaninsky.

Seedco relies on its partners' expertise and knowledge to reach as many people as possible in the community. It helps develop outreach and education strategies and disseminate materials around enrollment. Seedco captures data to evaluate the effects of its efforts. In each county, Seedco works within local health departments and social security offices to reach consumers using those services. Libraries have proven to be good sites for public forums and for one-on-one education and enrollment. The Kent County school system recently agreed to send fliers to families of students. Seedco also reaches out to the public at job training sites, health clinics, and hospitals.

Seedco is always looking for ambassadors—people who want to get involved, are excited about the cause, and are willing to spread the word. It provides training for ambassadors so they can provide reliable information to community members at health centers, community festivals, shopping centers, and the like. Seedco also uses public service announcements (PSAs) and press releases and responds to media and community requests for information or speakers.

Mr. Romaninsky said Seedco is trying to reach businesses that do not usually offer health insurance to let them know that their employees can seek insurance using the exchange. He noted that the navigators, assisters, and ambassadors are usually welcome and rarely have to deal with political challenges about the ACA or the program. Despite the setbacks for online enrollment, said Mr. Romaninsky, the large response demonstrates that people want health care coverage. Within the first 5 days, the Maryland Health Connection had 170,000 unique visitors, and 12,000 created online accounts. Mr. Romaninsky said the system is improving.

Questions and Answers

Ms. Gunby said the toll-free number for the LSHIAP (855-445-5540) goes directly to the navigators for the lower Eastern Shore.

Mary Ashanti of the Wicomico County branch of the NAACP said her organization is already involved in getting the word out about the Maryland Health Connection. She asked how one becomes an ambassador and what training is involved. Mr. Romaninsky said ambassadors do not receive formal training (as navigators do); rather, Seedco provides an orientation about the essential elements of the Connection so that they can provide information and respond to questions. Anyone interested in becoming an ambassador or partnering in other ways should call the Seedco partner organization in their county or the Seedco hotline at 410-996-4839. Ms. Gunby said the LSHIAP relies on community influencers and organizers for outreach and events. From January through March, she noted, there may be a larger role for volunteers to hand out information door-to-door.

Bob Potter of Talbot Affordable Healthcare Outreach asked whether Seedco plays more of a coordinating role than a directive role. Mr. Romaninsky replied that Seedco does both. As an intermediary, Seedco has a contract with the state to develop approved strategies that encompass the six partner organizations who provide the navigators and assisters. Seedco oversees and coordinates the partners, who work as one unit from the state's perspective.

P. J. Townsend of Chesapeake College asked how people who want coverage are supposed to pay for it. While discounts on plans may be available, she believes they are only for those at the extreme end of the spectrum. Those working for businesses that do not offer coverage may be middle-income people who cannot afford premiums of $200 per month. Ms. Gunby pointed out that the Maryland Health Connection offers a broad range of options through 45 different plans. People earning between $16,000 and $45,000 per year likely qualify for tax credits that will lower the cost of monthly premiums; they may also qualify for other cost-sharing reductions (lowering their copayments and deductibles). Such assistance will help working and middle-income people in a way that has never been available before for health insurance, said Ms. Gunby. With so many choices, she believed that people can find a plan that fits their health needs and budget. Dr. Hussein added that there are both Federal and state subsidies, and many variables apply, including residence and income level. Each case is individualized, but the state has worked to make insurance affordable to everyone who needs it, she said.

Ann Walsh of the Maryland Office of Rural Health asked about misinformation encountered at the community level. Mr. Romaninsky described a consumer who was told he would have to pay up to $1,200 per month for insurance or face a $4,000 fine. Navigators work to correct such inaccuracies and explain that while there is a tax penalty for failing to sign up for insurance, there is no fine. Navigators educate each other about deliberate attempts to misinform the public (e.g., through false Facebook postings). Mr. Romaninsky noted that health care reform is complicated and blends together a lot of programs. In some cases, Maryland is still working out details and answers are not yet fully known. To combat misinformation, navigators rely on their training and experience.

Peggy Ferguson of the Talbot County Health Department asked how new programs will affect those currently enrolled in public health programs who may be underinsured. She

wondered whether health departments would remain viable care providers. Ms. Gunby was unable to answer the question but expressed the concern raised at her own health department about how programs will survive. She said the ACA supports screening and preventive care by making them part of the essential health benefits package for all insurance plans. At the same time, the public health system is making a transition from grant funding to insurance-funded care. Dr. Hussein said she would pose the question to the DHMH.

Bob Joyner of Salisbury University appreciated the willingness of the panel members and the MHHD staff to seek more information when they could not provide the answers. When you cannot answer a question, some people believe there is problem with the entire ACA, he said, and we have not supplied enough ways for people to get information to complex questions about the law. Mr. Joyner asked what kind of information Seedco and the LSHIAP can supply to people working part-time whose employers are considering cutting insurance benefits because the employees could get better plans on the exchange. He wondered whether such information is getting to the employees. Dr. Hussein said she would pose the question to the DHMH and Dr. Sharfstein and determine how to get such information out to navigators and others.

Mr. Romaninsky said Seedco is targeting small businesses, letting owners know what is available, and encouraging them to pass the information along. He agreed that small businesses may think the health exchange does not apply to them. Seedco is reaching out through chambers of commerce, business associations, and the like. Ms. Gunby said the LSHIAP recognizes the issue. Worcester County has a resort-based economy where many people work part-time or seasonally and/or rely on tips for income. The LSHIAP is working with organizations such as the Ocean City Hotel, Motel, Restaurant Association to provide employees of small businesses with information about their options.

Ludmilla Wikkeling-Scott of the National Association for Black Veterans (NABVETS) said some veterans who do not qualify for Tricare would benefit from learning about the health exchange. The Department of Veterans Affairs provides information on its website, which not all veterans use. She asked how NABVETS can partner with other organizations to get the word out. Ms. Gunby said she would pass NABVETS' information on to the local veterans affairs office, which works with the Worcester County Health Department. She said the LSHIAP has done joint presentations with organizations who work with homeless people or others to expand its outreach. Ms. Gunby said that in some cases, providing materials like fact sheets designed for low-literacy readers is very helpful.

An unidentified participant said that the Maryland Health Connection required users to input their zip code plus four-digit code, which most people do not know. Ms. Gunby said the state is addressing such issues. For example, the Maryland Health Connection has a new consumer update page that guides users on how to input information to avoid glitches. Laura Herrera, MD, MPH, of DHMH said users now only need to provide their five-digit zip code.

SESSION 2: HEALTH ENTERPRISE ZONES: PREVENTION, BEHAVIORAL HEALTH AND MORE

***Moderator: The Hon. John A. Hurson, Esq.**, Chairman, Maryland Community Health Resources Commission*

Mr. Hurson said Maryland began putting health care reforms in place long before the ACA came into being, and the state has accomplished a lot. The panelists for this session are experts on the front lines of a program that is nationally recognized for its innovation. The HEZs were the brainchild of Lieutenant Governor Anthony Brown and were part of the Health Improvement and Disparities Reduction Act of 2012. The effort expands health services in underserved areas by providing tax incentives to community health care providers to practice in underserved areas. The first five HEZs began operating this year. The DHMH and the Maryland Community Health Resources Commission (CHRC) jointly oversee the program, which includes rigorous performance monitoring.

***Roger L. Harrell, MHA**, Health Officer, Dorchester County*

Mr. Harrell explained that Dorchester and Caroline counties partnered to create an HEZ, Competent Care Connections, because they identified disparities in neighboring communities. The group aims to improve health equity, primarily for diabetes, hypertension, and behavioral health conditions. Behavioral health is a key component, said Mr. Harrell; many of the chronically ill suffer from behavioral health conditions, and it is time we treat the whole person, he said. The key to making the program work is well-trained community health and outreach workers, said Mr. Harrell—people you know and can relate to who will help you work through the maze of information.

Competent Care Connections expects to leverage the services of 170 community-based mental health support and outreach workers, such as those in the Healthy Ways program, which deals with obesity and weight loss, and Dry Dock, a peer recovery program for substance abusers. The program projects saving as much as $3 for every $1 spent by decreasing ED visits for diabetes, hypertension, and behavioral health conditions.

Mr. Harrell said Secretary Sharfstein helped Competent Care Connections stretch its HEZ dollars further by moving $385,000 already allotted to mental health under the DHMH budget to the HEZ for efforts such as expanding the crisis response team in Dorchester County. Dr. Sharfstein also identified existing programs, such as loan repayment and tax credits for health care providers, that could be combined with the HEZs, saving Competent Care Connections another $110,000.

Competent Care Connections involves 14 partners. Mr. Harrell said the key to success is developing strong relationships among partners and letting partners do their work.

***Ashyrra Dotson**, Program Coordinator, Associated Black Charities*

Associated Black Charities coordinates community health outreach for the Competent Care Connections HEZ, acting as a liaison between providers and people in need. The organization's goal is to reach people where they are, thus making the community healthier and increasing overall health equity. Community health workers (CHWs) are trained through the Eastern Shore Area Health Education Center; four CHWs work under the HEZ in Dorchester and Caroline counties to link community members with partners providing health care, behavioral health, and social services.

Ms. Dotson said the organization is using PSAs and other outreach approaches to let people know that CHWs are available. A number of community partners outside the HEZ, including 17 faith-based organizations, are helping get information to community members. Since the CHWs completed training in August, information has been disseminated to nearly 1,800 individuals, and 16 cases are being managed under the HEZ umbrella. The CHWs have given 27 blood pressure screenings, and 11 healthy living units (e.g., walking groups) have been established. People are getting resources and participating in programs, said Ms. Dotson. Other outreach efforts, such as health fairs and community events, are underway to raise awareness about the CHWs and to "meet people where they are."

***Leland Spencer**, MD, MPH, Health Officer, Caroline and Kent County Health Departments*

Mr. Spencer outlined the tremendous need for services, particularly behavioral health care, in Caroline County. The county ranks second in the state in number of people diagnosed with depressive disorders and is seeing dramatic increases in suicide and drug overdoses. It also has the second-highest number of uninsured residents and a severe workforce shortage, particularly in terms of mental health care providers and primary care physicians. The public health department in Caroline County is the only source of behavioral health care in the county and sees more than 1,000 patients each year. For these reasons, said Mr. Spencer, the county was eager to participate in the HEZ.

The city of Federalsburg borders Dorchester County; it has about 6,500 people, most of whom are on Medicaid, while many others are uninsured. The area has no mental health providers and limited school-based services. Thanks to the Competent Care Connection, Caroline County is seeking a site to establish a satellite office in Federalsburg to offer behavioral health services and a full-time mental health provider and to expand school-based services. The new site could also be used to provide more preventive screening and to help residents enroll in health insurance plans through the exchange.

***Carol Masden**, Director, Eastern Shore Mobile Crisis*

Ms. Masden explained that the Eastern Shore Mobile Crisis team began in response to the closing of the Upper Shore Community Mental Health Center in 2010. Various organizations in the area advocated for an alternative to take its place. The Eastern Shore Mobile Crisis team had been serving eight counties with two provider teams until the HEZ provided funding to double its services.

The team takes a broad approach, allowing individuals to determine what constitutes a crisis, such as a mental health need, an addiction issue, or an overwhelming financial concern. The team links clients to a community provider if they do not already have one. Ms. Masden said clients come from many different avenues. Anyone in need can contact the team at any time, and staff will assess the situation and dispatch the mobile crisis unit. Ms. Masden said the team has an 81% hospital diversion rate, meaning that 81% of cases (which can include, for example, people experiencing psychotic episodes or contemplating suicide) are managed without the individual using the hospital or ED.

Thanks to additional grant funds, the Eastern Shore Mobile Crisis team is rolling out behavioral health first responder training for law enforcement and emergency responders. Dorchester County is second only to Baltimore City in its use of the ED for behavioral health crises. A mobile response team not only reduces ED admissions but also keeps down the high costs of transport to and from hospitals. In the first quarter of 2013, the Eastern Shore Mobile Crisis team responded to over 400 calls, compared with about 800 for all of 2012. Ms. Masden said the team is definitely making a difference.

***Gene M. Ransom III**, Chief Executive Officer, MedChi*

Mr. Ransom explained that MedChi is the Maryland state medical society, an association of physicians that is involved in various public health and patient health care issues. MedChi is a proud supporter of Governor O'Malley's efforts to marry private practice with public health in Maryland. As part of the Competent Care Connections HEZ, MedChi focuses on recruiting physicians using loan repayment and tax credits as incentives.

Physicians who work in the HEZ can receive up to $25,000 per year for 2 years to repay their student loans. The terms of the tax credits have not been finalized, but MedChi is working with the state on the issue. Mr. Ransom said 41% of the physician practices in the Competent Care Connections HEZ would hire another physician if one were available, and the incentive programs can make it work. Also, 29% of physician practices said they would hire other types of providers (but not case managers) if they could.

Mr. Ransom described the keys to progress of the HEZ as follows:

- Keep working on the program and stay positive.
- Finalize the tax credit and loan repayment programs.
- Consider flexibility in the program to get physicians where they are most needed (because office and clinic visits are less expensive than ED visits).

Regarding the glitches in online enrollment, Mr. Ransom urged those involved to be persistent and work through the issues. He projected that the residents of the Eastern Shore would soon have more access to care and be better off thanks to the work that advocates and providers are doing now.

Questions and Answers

Mr. Joyner of Salisbury University asked whether the HEZs were considering petitioning for reimbursement of case managers. Mr. Ransom said Medicare now has some codes to allow for reimbursement of case management services, and through the new Medicare accountable care organizations, MedChi provided advance payment to some practices to hire case managers. The whole system now is geared around services that are reimbursed, said Mr. Ransom. If we change how people are paid, focusing on outcomes and not volume, we will see the value of case managers. Mr. Harrell added that a new waiver introduced by Secretary Sharfstein will force the issue, because it focuses on how to provide care that keeps people healthy and out of hospitals. The HEZ demonstrations may also help, he said.

In response to an unidentified participant, Mr. Ransom explained that the legislation creating the HEZs focused specifically on physicians but does include other types of providers.

SESSION 3: HEALTH REFORM: LOCAL HEALTH IMPROVEMENT ON THE EASTERN SHORE

***Moderator: Laura Herrera, MD, MPH**, Deputy Secretary of Public Health, Maryland Department of Health and Mental Hygiene*

Dr. Herrera said Maryland believes that HEZs are the way forward and recently proposed to fund three more. The DHMH is also taking into account the sustainability of the existing HEZs and how they align with ACA efforts. The Health Improvement and Disparities Reduction Act of 2012 grants the DHMH authority to address other issues, such as hospitals' reporting on how they benefit their communities. The Local Health Improvement Program focuses on communities, because that is where the work is done, said Dr. Herrera. Through local efforts, the state aims to increase life expectancy, improve access to care, and improve performance on 39 measures of health that are being tracked at the state and community level, most of which focus on health disparities.

***Leland Spencer, MD, MPH**, Health Officer, Caroline and Kent County Health Departments*

Dr. Spencer described the Mid-Shore Local Health Improvement Coalition (LHIC), which consists of five counties that share community resources, a regional hospital system, regional core service agencies, and a regional health education center. Despite the fact that the coalition includes one of the richest counties in Maryland and also one of the poorest, all five counties share the same disparities, especially among African Americans. For example, while Baltimore City has the highest rate of premature death among Blacks, the next four highest rates occur in counties in the Mid-Shore coalition.

The counties work together to set local health goals and develop strategic plans. For example, the coalition developed a strategic plan to reduce deaths from accidental

overdose by bringing together local public health providers, including addiction specialists, from all five counties. The coalition is currently focusing on ED visits by people with diabetes. Dr. Spencer noted that most people with diabetes in the region have never attended a class on how to manage their condition. The coalition plans to target those at highest risk: African Americans with diabetes in the region, who use the ED five times more than Whites and twice as much as Blacks across the state.

With support from a regional health grant, the coalition established a pilot project to engage African American churches to provide basic education about diabetes screening and care. The effort aimed to enroll at least two African American churches per county to participate in wellness centers offering a variety of programs. In 2 years, the coalition will evaluate the results and develop a strategy for the Eastern Shore.

In the recruitment phase, the coalition quickly reached its target. The participating churches use the Body & Soul healthy living and eating program. So far, 68 people have been trained as health coaches, while others have organized walking groups and other health initiatives. Some churches are incorporating a health message into their sermons. The next phase of the project involves geographic mapping to target people at risk and the establishment of the wellness centers.

***Stephanie Garrity**, Health Officer, Cecil County Health Department*

Ms. Garrity explained that most of the population of Cecil County is White, but the LHIC identified health issues similar to those of other counties. It established priorities around substance abuse, access to mental/behavioral health treatment, child abuse, and childhood obesity. The local hospital's strategic planning process identified some other health priorities (respiratory diseases, heart disease, and diabetes).

Ms. Garrity pointed out that Blacks and Whites in Cecil County have the same life expectancy rates, yet other statistics reveal large disparities by race/ethnicity, such as ED visits for asthma, diabetes, hypertension, and mental/behavioral health conditions (including substance abuse). The county recently received funding from the CHRC and Union Hospital in Cecil to address asthma, diabetes, and hypertension. With these funds, two case managers were hired to assist with discharge planning, maintain contact with patients after they are discharged, link patients to available resources, and encourage patients to see a health care provider.

To address ED visits for behavioral health, several groups joined together to expand services so that Cecil County now has a dedicated mental health response team. In addition, Cecil County hired peer recovery counselors to work in the ED and at the hospital bedside. Peer recovery counselors are individuals who are doing well in their own recovery and understand both the system and the needs of individuals.

In closing, Ms. Garrity said that Dr. LaVeist's comments helped her realized that despite the fact that Cecil County has few minorities, that is not an excuse not to consider their needs. Much work remains to be done to reduce health disparities.

***Susan C. Kelly**, Health Officer, Harford County Health Department*

Ms. Kelly pointed out that Harford County is not usually considered part of the Eastern Shore but requested to be included in the Upper Shore region under the Seedco contract. From the outset, she said, Harford County made it clear that to succeed in Harford, Seedco must be aware of the diversity, culture, and unique character of the county. Harford has everything from horse country and farms to historic areas to pockets of high crime. Public transportation is limited, so even those who have insurance may not be able to access a provider.

Because Harford has better education rates, a wealthier population, and a smaller minority population than many other Maryland counties, one might think the county has no big problems, said Ms. Kelly. Yet pockets of high risk exist, and racial/ethnic disparities persist. The LHIC's top priorities are obesity, tobacco use, and behavioral health—issues that resonate throughout the state.

Harford County has not targeted minority health but hopes that its initiatives improve the health of all its citizens. The coalition received a community transformation grant to promote a healthy lifestyle in schools and in the community to address obesity. It sponsors the annual Healthy Harford Day in conjunction with the local farmer's market, where attendees can take part in fitness classes and other activities. The county is forming a Healthy Community Planning Board, which will promote community engagement and healthier lifestyles. It recently implemented a Healthy Families initiative and a Healthy Restaurants designation program.

Ms. Kelly said the county has a slight racial/ethnic disparity in rates of heart disease and cancer, linked in part to tobacco use. Using Cecil County as a model, Harford County made the sale of tobacco to minors a civil rather than criminal offense. The county health department is working closely with the county council on more legislation around health goals. The county has also launched an anti-smoking education campaign that aims to reduce tobacco use among youth and adults, particularly in minority populations.

Notable racial/ethnic disparities persist in use of the ED for several indicators, particularly for behavioral health. Ms. Kelly said 75% of people referred to a mental health provider never follow through. The county is working with primary care providers to encourage more depression screening in the office and hopes the effort will lead to a reversal in trends.

Despite the fact that many people in Harford County have insurance, the disparities in the use of the ED for medical issues raises concerns. As noted earlier, some may lack access to a provider or Federally qualified health center; there may be a shortage of providers or specialists, particularly mental health care providers, to meet the demand. The Harford County Health Department has assisters to help with insurance enrollment. Recently, it received CHRC funds to hire care coordinators who will help link clients with other available services and resources and follow up with clients as needed.

Ms. Kelly said the health department has one bilingual staff person who connects with clients not just linguistically but also culturally. The department is conducting a quality improvement project to create a welcoming environment for people with limited English proficiency. To improve relationships with clients of different races/ethnicities, the department has increased staff training, promoting the use of translation services when needed, and increased outreach to minorities.

***Deborah Goeller, RN, MSN**, Health Officer, Worcester County Health Department*

The Lower Shore LHIC includes Worcester, Wicomico, and Somerset counties, where the minority population ranges from less than 20% to nearly 50%. Each county has had its own local health planning council for more than 20 years, but the three have collaborated around various issues. Recently, they banded together as a regional LHIC as part of the state's health improvement planning process. In doing so, however, the stakeholders requested and the state agreed to allow the individual counties to retain their identities and pursue grants individually as needed.

The Lower Shore LHIC has two projects underway, both on diabetes. The first uses the Lifestyle Balance evidence-based prevention program from the Centers for Disease Control and Prevention. The program has demonstrated that weight loss as little as 5% of total body weight, combined with regular physical activity, can prevent diabetes. The coalition aims to achieve certification as a program provider, which would allow it to bill for services under the ACA. In year one, 151 people participated, and 97 completed the 16-session program. Of the participants, 35% were African American. Those who finished the program all made improvements (weight loss, more healthy eating habits, and more physical activity).

The second program focuses on ED visits related to diabetes, for which the three counties demonstrate the worst rates in Maryland. The project addresses some of the medical and social determinants of health among high ED users by linking clients to providers and services for various conditions. The effort includes case management, home visits, education, medication reconciliation, and healthy lifestyle coaching.

Worcester County hosts a number of events and programs around health disparities, including an annual diversity and health disparities summit, cultural competency training, and an annual public health conference. The county is implementing a 3-year demonstration project to address cardiovascular disease among minority adults. The demonstration project uses word of mouth and local advertising (featuring community members) to spread the message about services and programs available.

Questions and Answers

Dr. Herrera asked the panelists how they identified priorities for their communities. Ms. Kelly said Harford County held a community forum using an outside facilitator. Participants received data and took part in facilitated discussions; ultimately, the

participants voted on priorities, identifying obesity, tobacco use, and access to mental and behavioral health care as the top three.

Ms. Goeller said that her county began with little data but solicited suggestions from the community. Now that more data are available, she said, it is still important to ask people what they think, because their interpretation of the data is important. The Lower Shore LHIC gathers input from community coalitions and task forces addressing health and social issues. It also hosts community focus groups to get input from individuals. Ms. Goeller said the LHIC combined all the suggestions with the data to identify priorities.

Michelle Hammond of the Chesapeake Multicultural Resource Center asked how her church could get involved in the Mid-Shore LHIC project around diabetes education, and Dr. Spencer arranged to provide her information.

A participant asked whether the Lower Shore LHIC had any return-on-investment data on its diabetes program. Ms. Goeller responded that the program was just starting. Dr. Herrera noted that some of the state's work on community-integrated medical homes builds on the efforts of local coalitions and LHICs to meet the needs of patients who may not be involved with the health care system. The state is looking at national data so that it can promote those that demonstrate a return on investment as well as improved health outcomes for patients, she said.

CONFERENCE WRAP-UP AND EVALUATION

Carlessia A. Hussein, RN, DrPH*, Director, Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene*

Dr. Hussein summarized some of the key messages of the conference:

- Collaboration with trusted community partners is an important part of the work to address health disparities. Community partners should be engaged early in the planning process. Enthusiastic volunteers can serve as ambassadors, spreading awareness and leveraging limited resources.
- Lay health outreach workers, or CHWs, are essential to reaching people where they are.
- HEZs are taking the approach of improving the health of the whole person—mind, body, and spirit—including behavioral health issues, a topic that came up repeatedly throughout the day.
- Stakeholders should consider how to marry physician practices (some of which may be struggling to stay in business) with efforts to implement health care reform.
- Even areas with few minorities or low rates of disparities have opportunities to reduce health disparities and doing so may improve the overall health of the area.
- The issue of ED visits must be addressed, as it comes up in every effort to address health disparities.

- Culturally and linguistically appropriate outreach is critical, especially as the state becomes more diverse. (Dr. Hussein observed that more and more nurses come from outside the United States and may not be familiar with American subcultures.)

On the basis of the presentations and discussion, Dr. Hussein offered three points for further consideration:

- Regional collaboration is important, so organizations should consider joining together to address health disparities in their communities while at the same time retaining the integrity of their own programs. Each county has its own culture, needs, and workforce, but neighbors can work together to move forward.
- Data are important and available. Consideration should be given to creating a virtual data unit for the Eastern Shore so that organizations can share information and gather more data for analysis. Dr. Hussein said the MHHD would assist with creating a virtual interface if there is consensus about moving forward on data sharing.
- Focusing on reducing disparities is important and can help improve the health of the whole region, not just those directly affected by health disparities.

In closing, Dr. Hussein thanked all the participants. She reiterated that the MHHD would like to reach out to other regions of the state in the same manner but also include the Eastern Shore in future meetings.