A Further Look at Health Disparities: Lessons Learned from the Health Enterprise Zones

Building Success of Evidence-Based Community Programs
September 7, 2016

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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.
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)
Maryland Health Improvement & Disparities Reduction Act of 2012

- Health Enterprise Zones
- Hospitals report efforts to reduce Disparities
- Standard measures on racial and ethnicity in quality and outcomes to track health insurance carriers’ and hospitals’ efforts to combat disparities.
- State institutions of higher education that train health care professionals are required to report to the Governor and General Assembly on their actions aimed at reducing health disparities.
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
Eligibility Criteria and Data

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

• Call for Proposals, developed October 2012, generated 19 applications from 16 jurisdictions

• Five HEZs were designated in January 2013 from rural, urban, and suburban areas. Three are led by coalitions of hospitals/health systems and two are led by local health departments
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
Health Enterprise Zones

Legislative Expectations (from the Statute)

20–1402.

(A) 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. (Page 5)
<table>
<thead>
<tr>
<th>Ambulatory Care Measures</th>
<th>Whites (Non-Hispanic)</th>
<th>Blacks (Non-Hispanic)</th>
<th>B/W Ratio</th>
<th>R ank</th>
<th>B-W Differ</th>
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<th>Black % excess</th>
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<td>Pediatric asthma admissions per 100,000 population, ages 2-17</td>
<td>95.98</td>
<td>294.09</td>
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<td>262.86</td>
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<tr>
<td><strong>Diabetes</strong></td>
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<td>Admissions for diabetes with short-term complications per 100,000 population, ages 6-17</td>
<td>20.56</td>
<td>22.25</td>
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<td>291.09</td>
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<td>46.72</td>
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<td>Lower extremity amputations among patients with diabetes per 100,000 population, age 18 and over</td>
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<td>8</td>
<td>37.02</td>
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HEZ Programmatic Elements

• Operational Model:
  - Coordinating Organization Manages Program
  - Hospitals, Clinics, CBOs, FQHCs
  - Application must target investments to the community
  - Must involve target audience and local assets
  - Metrics must measure change in specific outcomes

• State Health Department and Community Health Resources Commission jointly provide technical assistance:
  - Prevention and Health Promotion program support: Chronic Disease
  - MHHD office provides cultural competency training
  - Virtual Data Unit: Clinical data, CRISP data, data analysis
  - Health Systems Infrastructure Administration: Loan Repayment and Income Tax Credit
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
HEZ Logic Model

Strategy 1: Increase care capacity (defined as available clinical care visit appointment slots).
(People without primary care now get that care)
Measurement: added providers, added FTE of providers, added new visit slots, (capacity);
proportion of new capacity that is being used, visits/hour for new providers (productivity)
Reach: Small

Goal: Reduce Potentially Avoidable Utilization (PAU)
Measurement: ED visit rates, hospital admission rates, readmission “rates” (outcomes)

(People who get care stay healthier at home)
Measurement: added workers and FTE of workers, available caseload (capacity);
Proportion of available caseload that is filled, encounters per worker (productivity);
Quality metrics for workers if such exist.
Reach: Small to Medium

Strategy 2: Increase care quality (defined as NQF or similar metrics).
(People in primary care get better care)
Measurement: NQF or equivalent metrics
A) Provider guideline adherence metrics (quality)
B) Patient disease control metrics (outcomes)
Reach: Medium

Domains and Timing:
Year 1: Hire providers/workers (cap)
Year 2: Fill capacity (productivity)
Year 3: Assure quality
Year 4: Demonstrate outcomes

Strategy 4: Community-wide enabling interventions.
This includes healthy food access, safe exercise, and any other intervention where users cannot be counted.
Reach: Large, but impact may be small
All-Cause Unplanned Readmission Rates, 2012-2014.

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<th>Year</th>
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<td>317.4</td>
<td>268.4</td>
<td>588.4</td>
<td>391.2</td>
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The Annapolis Community Health Partnership
ACHP
Intervention Strategy and Goals

• Collaboration between Anne Arundel Medical Center and the Housing Authority of the City of Annapolis to insert a community health resource in public housing to serve the building’s residents and the surrounding community in two ways:
  – Primary care medical services at reduced cost to the residents of the building and surrounding community
  – Navigational services for all at no cost: care coordination, coaching, education, advice, and support

• Primary Goal: Provide culturally and linguistically appropriate primary care services to the Morris Blum residents and surrounding community.

• Secondary Goal: Measurably reduce 911 calls, ED visits, admissions, readmissions of Morris Blum residents.
What Works

- On demand services
- Team-based care: it’s NOT all about the doctor!
- Fun health education events: it’s all about THEM!
- Relationship building-trust
- Psychosocial needs competently identified and addressed
- Home visits
- Navigational services
- Medication Therapy Management
- Health coaching
- Tobacco Cessation Counseling
What Works-continued

• Referral for Recovery Program-network of (6) behavioral health providers-ability to connect patients in need of mental health services obtain an appointment within 48 hours of referral
• Integrated EMR and supportive specialist community
• Build traditional and non traditional community partnerships to meet the non-medical needs-housing, EMS, police, food bank, etc.
• Team interview and team decision to hire candidates who want to join our team
• Welcoming, forgiving, tolerant atmosphere: NO JUDGEMENT-patients-family and staff!
• Ongoing staff training/coaching
What Works-continued

• Specialized staff training
  – CLAS standards
  – Crisis Prevention Intervention (CPI)
  – Team based training
  – Medical Assistant Training provided by our Essential Skills Team 2-3 times per year
• Annual staff retreat
• Team huddles (daily)
• Humor
Lessons Learned

• Just because you build it does not necessarily mean they will come! Trust and consistency are essential
• Inter-cultural conflicts can be overcome
• Newly insured individuals need to be oriented and navigated
• Awareness and respect of a primary care clinic sharing space in a residential apartment building—we are in their living room
• Importance of hiring staff (all levels) that have passion and the skill set to work with a marginalized population
Summary

• Right care is given at the right time in the right place, thus improving quality and cost-effectiveness of care.

• Chronic disease in marginalized populations is identified and treated earlier, thus decreasing preventable, costly complications.

• A trusted, community-based health care resource provides a better alternative to the ED.
Greater Lexington Park
Health Enterprise Zone (HEZ) Project

Lori Werrell
Program Director, GLPHEZ
MedStar St Mary’s Hospital
**Vision**

Establish accessible, integrated, culturally competent healthcare in the HEZ supported by clinical care coordination, prevention services, community outreach and education

**Core Disease States**

Diabetes, Asthma, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Behavioral/Mental Health Diseases
HEZ Demographics

• Population of approximately 34K in 3 zip codes (20653, 20634, 20667)

• Clients being assisted
  – 31% identify as Hispanic
  – 46% identify as Black or African American

Approximately 7% identify as Hispanic
Greater Lexington Park Health Enterprise Zone

• **Lexington Park:**
  – Life Expectancy: 77.6 (lower than 79.1 years eligible)
  – Medicaid Enrollment: 200.93 (higher than 109.1 per 1000 eligible)
  – WIC participation: 38.77 (higher than 18.0 per 1000 eligible)

• **Great Mills:**
  – Average % low birth rate: 7.4 (higher than 6.4 per 1000 births eligible)
    Medicaid enrollment: 128.84
    WIC participation: 20.49

**Needed to meet either life expectancy or low birth weight and Medicaid enrollment or WIC participation thresholds.**
Major Program Components

**Hospital encounter**
- Inpatient (readmission risk factors triggers Care Coordinator)
- Emergency Room (follow up by Community Health Worker)

**Care Coordinator**
- Home visits, care plans, phone support, medication reconciliation
- Working with other care coordination programs and primary care

**Community health worker**
- Removing Barriers (Their training is offered to whole community)
- Transportation (shuttle and medical specialty routes)

**Outpatient Care**
- Primary and specialist appointments, Dental
- PT, Dialysis, Cardiac Pulmonary Rehab etc

**Self management programs**
- Walk with Ease, CDSMP, NDPP, diabetes self management program, support groups, Walden Sierra programs
Success in Year 3

- Readmission rate of RN Care Coordinated patients - 7.03%
  - State data has the whole zone Readmissions rate dropping from 13% to 8% (36.9% drop)
  - Emergency Room Visits are down
  - PQI Composite scores are below state averages

- # of new clients served by CHWs – 271
- # of client encounters with CHWs – 4421

- Shuttle ridership – 7497
- Medical Specialty rides – 440

- # of patients served by Walden for behavioral Health – 656
- # of unduplicated Psychiatric patients seen by Walden – 87
- # Dental patients seen – 42
- # Primary Care patients seen - 2105
Year 4 Focus

• Sustainability
• Care Coordination/CHW program
• Transportation
• Dental
• Behavioral Health
• Health Center/Primary Care/Psychiatry
• Provider recruitment
Lessons Learned

• Don’t be afraid to change from the original plan
• Take risks
• Data – blessing and a curse
• Be patient – don’t stop trying
• Listen to the community
• Staffing
• Vehicles
Health Center Building under Construction - FINALLY
QUESTIONS?

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301-475-6195