

Maryland Department of Health and Mental Hygiene Health Equity Awards

Maryland's Five Health Enterprise Zones have been awarded the 2016 Department of Health and Mental Hygiene Health Equity Award. The DHMH Health Equity Award: Advancing Social Justice through Health Equity, which recognizes programs and organizations that have successfully implemented efforts to promote justice by addressing health equity and social determinants of health in Maryland's most disadvantaged communities. This award considers cost, effectiveness, resilience, and impact on the State's public health.

The HEZs have created communities in which integrated health care systems, led by community coalitions, are pioneering health care and prevention efforts in a patient and family-centered manner and with a health equity approach. These systems work in tandem with a variety of stakeholders to improve health and decrease costs, expand access, empower communities, and reduce health disparities. The HEZ model aligns systems and incentives to broaden the scope of care within Maryland's most underserved communities to address social determinants of health.

Maryland's Health Enterprise Zones

Annapolis Community Health Partnership (ACHP): The Annapolis Community Health Partnership, based at Anne Arundel Medical Center, established a new primary care medical home in collaboration with the Housing Authority of the City of Annapolis and a number of other community partners within the Morris H. Blum Senior Apartments facility. The health center has expanded primary care and wrap around public health and social services for the elderly and disabled residents of Morris Blum and for low-income adults in the surrounding community who were experiencing crisis-driven, episodic, and fragmented care.

ACHP has employed a number of strategies and has reduced medical 911 calls, ED visits, admissions and readmissions among individuals living at the Morris Blum residence. Care coordination services and tools such as an electronic medical record, patient registries and onsite lab services help improve patient outcomes. A new initiative identifies patients in the ED who are uninsured and need follow-up, and links these "medically homeless" patients to the Morris Blum clinic. A collaborating mental health provider helps integrate behavioral health with annual depression and behavioral health screens and access to specialty behavioral health care within 48 hours. Annual domestic violence screenings have been embedded into the EMR and diabetes self-management classes, smoking cessation workshops, blood pressure screenings, medication reconciliation, nutrition classes, and walking groups support patient self-management. ACHP emphasizes training and relationship and team building at all levels to help meet their goals.

Caroline and Dorchester's Competent Care Connections (CCC) Health Enterprise Zone: The Caroline/Dorchester HEZ, based at the Dorchester County Health Department, has collaborated with organizations across the two Counties to integrate the efforts of seven partners that provide direct services in seven of the eastern shore's most underserved zip codes. These communities experienced significantly limited access to primary care, higher Medicaid and WIC enrollment rates and among the worst chronic disease outcomes in the State. The HEZ has worked to expand the primary care and behavioral health workforce, improve outcomes, and reduce diabetes, hypertension, and behavioral health-related risk factors. Key strategies have included recruiting providers, opening a community

mental health clinic, and expanding care coordination, school based wellness, and mobile behavioral health crisis services, among others.

The CCC HEZ utilized HEZ tax credits and loan repayments programs to significantly expand primary care and behavioral health capacity in their Zone. Care coordination services are provided through Choptank Community Health System, Inc. and are targeted at high utilizers of hospital care who are linked to a Community Health Outreach Worker (CHOW) to help find needed services. A new HEZ electronic health record enables HEZ partners to identify high utilizers, share information about patients, and track the use of clinical services, community resources and referrals. A school-based asthma management program is being implemented in the HEZ and community-wide enabling supports, such as programs that promote food access, weight management and physical activity, have been enhanced. Expanded peer recovery support, Mobile Crisis Team services, School Based Wellness Centers and a new community mental health clinic in Federalsburg have increased access to mental and behavioral health services in the HEZ. CHOWs provide health screenings, education and outreach to link individuals to HEZ programs and services and ongoing training for HEZ staff and partners is provided to address primary care, behavioral health, cultural competency and health literacy.

Greater Lexington Park Health Enterprise Zone: The Greater Lexington Park HEZ (GLP HEZ), based at MedStar St. Mary’s Hospital, has worked to expand and integrate primary care, behavioral health and community health resources to reduce unnecessary ED usage and improve health outcomes across three zip codes where Medicaid panels were closed in most practices and uninsured and underinsured residents were forced to seek both primary and crisis care in the ED. Key strategies have included opening a new primary care practice, expanding care coordination and mobile primary care services, integrating behavioral health services, and developing a mobile medical route, specialty transportation service, and dental van.

The GLP HEZ expanded and integrated primary care and behavioral health services through their *Get Connected to Health* mobile clinic and a partnership with Walden Sierra, who placed a buprenorphine certified psychiatrist in the HEZ to assist with opiate addicted patients who overuse ED services. Walden also implemented the E-Prescribe system to assist with medication prescription and refill processes. Care coordination services, provided by nurse case managers and neighborhood wellness advocates, target high utilizers of hospital care through home visits, clinic appointments, phone calls and outreach and are supported by an outpatient care coordination software system linked to the hospital’s electronic medical record. The GLP HEZ has also initiated a 16-stop mobile medical route to provide rides to medical appointments, pharmacies, grocery stores and social services, a specialty transportation service to transport patients to medical appointments inside and outside the HEZ, and has equipped and staffed a mobile dental van. The GLP HEZ is constructing a new community health center in the HEZ, which is due to open in spring 2017.

Prince George’s County Health Enterprise Zone (PGCHEZ): The PGCHEZ, based at the Prince George’s Health Department, has worked to increase accessibility and availability of primary care services by establishing or expanding five primary care medical home hubs in their Capitol Heights target zip code, which are supported by a county-wide Public Health Information Network and a Community Care Coordination Team. Capitol Heights led the county in poor health outcomes and ambulatory care-sensitive hospital admissions, experienced poverty rates nearly double those of the county as a whole and Medicaid and WIC enrollment rates that exceeded State rates. This enhanced

primary care capacity is expected to improve health outcomes, increase community resources and reduce preventable hospitalizations and ED visits.

The PGCHEZ 's five primary care medical home hubs are linked to community health worker care coordination services that target at risk patients and are supported by software that tracks services received and the outcomes of clinical and non-clinical patient care pathways. The PCHEZ also initiated a Community Care Coordination Team with partners from around the county to manage the care of patients if gaps remain following community health worker intervention. Preliminary analyses indicate that clients who are high utilizers of ED and hospital inpatient services experienced a decline in the number of ED and hospital visits following participation in care coordination. The county Public Health Information Network has been established with HEZ support and is linked to Maryland's health information exchange (CRISP). It allows for laboratory, radiology, immunization, and clinical records to be delivered to HEZ providers from hospitals, clinics, and providers in Maryland and Washington, DC. Finally, the PGCHEZ has launched a comprehensive health literacy campaign and requires all staff and HEZ providers to participate in cultural competency training.

West Baltimore Primary Care Collaborative (WBPCAC): The West Baltimore HEZ, based at Bon Secours Hospital, has employed a variety of strategies to increase primary care and community health resource capacity in four zip codes in West Baltimore in order to reduce risk factors, improve health outcomes and reduce preventable ED visits, hospital admissions, readmissions and related costs among targeted high utilizers of hospital care. These neighborhoods had higher disease burden than most communities in Maryland and established the lower extremes for health disparities in Baltimore City and the State across all major chronic illnesses. Key strategies have included a two-tiered care coordination program targeting high utilizers of five partner hospitals; extensive training of HEZ residents, staff and providers; mini-grants to community partners to provide self-management and community supports; and a scholarship program to increase and diversify the local health care workforce.

The West Baltimore HEZ's efforts to build capacity have included promoting recruitment and retention by helping providers access HEZ tax credits and loan repayment support to work in the HEZ. They have also facilitated primary care medical home trainings for clinical partners, provided scholarships for HEZ residents pursuing health and social service professions, conducted community health worker, cultural competency and other trainings for HEZ providers and residents, and enhanced patient care plans through the many self-management and community supports provided by the HEZ, such as fitness classes, cooking classes, and chronic disease self-management courses. West Baltimore has deployed five community health workers to provide care coordination services for HEZ patients from five partner hospitals to reduce readmissions to the hospital or ED. The community health workers engage patients through home visits and phone calls in 30 day or 60 day interventions (depending on need) that focus on hospital-to-community transitions and development of a care plan. The care coordination team is led by a nurse care coordination manager and is supported by a web-based data platform that uses a validated screening tool to predict risk of hospital readmission and ED utilization. Preliminary analyses indicate that readmission rates among care coordination patients are decreasing.