MDDCSAM - SB 172 FAV - Community Health Resources

Uploaded by: Adams, MD, Joseph

Position: FAV

SB 172 Maryland Health Equity Resource Act
Senate Budget & Taxation Committee. January 27, 2021

SUPPORT

The Maryland-DC Society of Addiction Medicine (MDDCSAM) is a chapter of the American Society of Addiction Medicine and represents physicians and associated healthcare professionals from different disciplines with expertise in the treatment of addiction; including internal medicine, family medicine, emergency medicine, pain management, psychiatry, nursing, social work, and counseling. MDDCSAM enthusiastically supports passage of the Maryland Health Equity Resource Act.

The people of Maryland experience significant disparities in health resources based on race, ethnicity, income level, and geographic location. For example, residents of predominantly Black, lower income neighborhoods have, on average, 15-20-year shorter lifespans than those living in predominantly White, upper income neighborhoods.[1]

HB 463 provides a proven, cost-effective remedy for these health disparities. It builds on the successful model of Health Enterprise Zones, which operated from 2013-2016. The HEZ program generated a $93 million net reduction in health care costs from an investment of $16 million in state funding.[2] Scientific studies of Health Enterprise Zones conducted by Johns Hopkins University showed the following benefits:

- 18,562 fewer inpatient hospital stays, saving $168.4 million[3]
- Created almost 300 new jobs[4]
- Majority of neighborhood health care providers reported that the program improved their ability to serve local patients, especially financial incentives such as tax credits[4]

This proposed health equity resource program would be funded by a one cent on the dollar increase in the alcohol beverage tax. This is the same mechanism as funded the successful Health Enterprise Zone program. Such a tax increase would also likely generate other public health benefits, such as reduced underage drinking, reduced driving after drinking by adolescents, and reduced binge drinking by adults.[5]

(cont'd . . .)

(. . . cont'd)

In view of the community health benefits that would be generated from this program, whose financial benefits would far outweigh the expense in tax dollars, the Maryland DC Society of Addiction Medicine strongly supports passage of HB 463/SB 172.

[1]Baltimore City Health Department 2017 Neighborhood Health Profile Reports
https://health.baltimorecity.gov/neighborhood-health-profile-reports
2018 Report "Uneven Opportunities: How conditions for wellness vary across the metropolitan Washington Region." Page 38. https://www.mwcog.org/documents/2020/10/26/uneven-opportunities-how-conditions-for-wellness-vary-across-the-metropolitan-washington-region-health-health-data/

[2] Bullard AJ, et al. *Achieving Health Equity: Health Impact of Maryland's Health Enterprise Zones*. Johns Hopkins Center for Health Disparities Solutions, Sept. 10, 2020.

[3] Gaskin DJ, et al. The Maryland Health Enterprise Zone Initiative Reduced Hospital Cost and Utilization in Underserved Communities. *Health Affairs*, vol. 37, no. 10 (2018): 1546–1554.

[4]Gaskin DJ. *Impact of Community-Based Intervention on Hospital Utilization –the Maryland Health Enterprise Zone Initiative.* Johns Hopkins Bloomberg School of Public Health. Feb. 23, 2018.

[5] Porter KP, et al. Public Health Policy in Maryland: Lessons from Recent Alcohol and Cigarette Tax Policies. *The Abell Report***.** Volume 31, Number 2, Feb. 2018.

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SB 172 - PGCEX - Support.pdf
Uploaded by: Alsobrooks, Angela
Position: FAV

THE PRINCE GEORGE'S COUNTY GOVERNMENT

OFFICE OF THE COUNTY EXECUTIVE

BILL:	**Senate Bill 172 - Maryland Health Equity Resource Act**
SPONSOR:	**Senator Hayes, *et al*.**
HEARING DATE:	**January 27, 2021**
COMMITTEE:	**Budget and Taxation**
CONTACT:	**Intergovernmental Affairs Office, 301-780-8411**
POSITION:	**SUPPORT**

The Office of the Prince George's County Executive **SUPPORTS Senate Bill 172 - Maryland Health Equity Resource Act** which will create and fund Health Equity Resource Communities across the State, qualifying such are for tax credits, grants, and health care provider loans repayment assistance to incentivize health care providers to set up or extend services in poor and rural communities.

It is unconscionable that there are such large disparities in the kind of health care which Marylanders receive depending on where they live and their socio-economic status. The Health Equity Resource Communities are modeled on a very successful pilot program, Health Enterprise Zones, which improved health care outcomes in five communities between 2012 and 2016. One of the areas was Capital Heights in Prince George's County. Capital Heights, where a Health Enterprise Zone produced a net cost savings to the community of $10.59 million by significantly reducing inpatient stays. And, across the State, the program produced a net savings of $93.39 million. Unfortunately, the program was not continued despite its clear effectiveness. That is why we must ensure the passage of **SB 172**, to commit ourselves to a program that works, and begin to undo wrongs that we have lived with for far too long.

For these reasons, the Office of the Prince George's County Executive **SUPPORTS Senate Bill 172** and asks for a **FAVORABLE** report.

MATOD - SB 172 FAV - Health Equity Resource Act.pd
Uploaded by: Ashkin, Howard
Position: FAV

c/o IBR/REACH Health Services
2104 Maryland Avenue
Baltimore, MD 21218

(410) 752-6080

www.matod.org

Senate Budget & Tax Committee
January 27, 2021

Senate Bill 172
Maryland Health Equity Resource Act
Support

MATOD supports Senate Bill 172 – Maryland Health Equity Resource Act. This legislation would create and fund Health Equity Resource Communities to help reduce health disparities throughout Maryland. The Communities will provide grants, tax incentives, and health care provider loan repayment assistance to areas in the state with poor health outcomes that contribute to health inequities.

The area of substance use disorders has data showing health disparities along with all other areas of health. Trends in opioid overdose deaths show the number of people of color has been steadily increasing over the last couple of years during periods when the number of deaths among white people has decreased.

The bill would also provide additional funding for community-based prevention, treatment, and recovery support programs to address substance use and mental health disorders. The funding for these efforts would come from a 1% increase in the state alcohol beverage sales tax. Raising the alcohol tax has been proven to reduce underage drinking, binge drinking, driving under the influence, and sexually transmitted infections.

We believe a modest increase in this tax that has not been raised in 10 years could have overwhelming public health benefits. MATOD understands the COVID-19 pandemic has had a devastating impact on most parts of our economy. The one industry that is thriving is retail alcohol stores. The benefits of passing SB 172 are nothing short of life-saving. We ask for a favorable report.

MATOD members include community and hospital based Opioid Treatment Programs, local Health Departments, local Addiction and Behavioral Health Authorities and Maryland organizations that support evidence-based Medication Assisted Treatment. MATOD members include thousands of highly trained and dedicated addiction counselors, clinical social workers, physicians, nurse practitioners, physician assistants, nurses, peer recovery specialists and dedicated staff who work every day to save and transform lives.

Testimony - Healthcare Bill SB 172.pdf
Uploaded by: Ashley-Williams, Wandra
Position: FAV

January 25, 2021

BILL:	**SB0172**
TITLE:	**Maryland Health Equity Resource Act**
POSITION:	**SUPPORT**
HEARING DATE:	**1/27/2021**
COMMITTEE:	**Budget and Taxation**
SPONSOR:	**Senator Antonio Hayes**

All Marylanders deserve access to high-quality, affordable health care. Health inequities based on race, ethnicity, disability and place of residence persist throughout the state, as shown in maternal and infant mortality rates and other measures. In underserved areas of the state, people with chronic conditions such as hypertension, heart disease, asthma, diabetes, and substance and mental health disorders have worse health outcomes and are less able to get the care and treatment they need. The COVID-19 pandemic has further exposed these health inequities and highlighted the need to address them and otherwise improve health outcomes in our state.

Health Equity Resource Communities would be underserved communities around the state that compete for grants and other financial incentives to address poor health outcomes that contribute to inequities by race, ethnicity, disability, and geographic location. Supporting health and reducing preventable hospital admissions will result in lower overall health care costs, including lower insurance premiums for everyone. This initiative is based on a 2012-2016 pilot that successfully increased access to health resources, improved residents' health, reduced hospital admissions, and created cost savings.

The Communities should be funded by a penny per dollar increase in the alcohol beverage sales tax. The 2011 alcohol beverage sales tax increase led to significant reductions in underage drinking, binge drinking, driving under the influence, and sexually transmitted infections. Maryland has not raised its alcohol beverage sales tax since 2011 and its rate has fallen behind that of Washington D.C. Raising the state's alcohol beverage sales tax will generate necessary funds and reduce drinking, including by underage Marylanders and heavy drinkers, which in turn will save lives and reduce health care costs.

For these reasons and more, Climate XChange urges a FAVORABLE REPORT on SB 172.

Respectfully submitted,
Wandra Ashley-Williams
Maryland Regional Director
Climate XChange - Maryland
410-914-8011

Cball_2021- SB 172 Health Equity Statement_Final
Uploaded by: Ball, Calvin
Position: FAV

HOWARD COUNTY OFFICE OF COUNTY EXECUTIVE
3430 Courthouse Drive ▪ Ellicott City, Maryland 21043 ▪ 410-313-2013 Voice/Relay

Calvin Ball
Howard County Executive
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January 27, 2021

Senator Guy Guzzone, Chair
Senate Budget and Taxation Committee
3 West, Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

RE: Testimony in SUPPORT of SB 172 – Health Equity Resource Act

Dear Chair Guzzone,

I am pleased to announce my support for legislation to create Health Equity Resource Communities across the state. There have been long-standing health disparities in communities across our state, which has now been exacerbated by the COVID-19 pandemic. The type of health care received should never be based on geographic location or socioeconomic status.

The Health Equity Resource Communities will work to reduce health disparities and improve health and life outcomes in communities that need critical support. The Health Enterprise Zones pilot program helped improved the healthcare outcomes and quality of life of Marylanders between 2012 and 2016. This 2021 policy proposal would create a dedicated funding stream to mitigate healthcare access gaps and ensure health improvements can be leveraged across the state and for years to come.

I believe that one of the best ways to reduce health inequities and improve health outcomes is by building on the successes of the 2012-2016 Health Enterprise Zones which as the Equity Task Force found were very successful in the five zones created under that program. SB 172 replicates and builds on this success by authorizing the Secretary of Health to establish Health Equity Resource Communities across the state which, like the old HEZ's, would fund community developed plans to put resources and medical and public health plans into disadvantaged areas of the State.

I look forward to working with my fellow County Executives, members of the Howard County Delegation, their colleagues in the General Assembly and community leaders across the state to support this initiative. I commend the hard work that has gone in to establish the Health Equity Resource Communities Maryland desperately needs to address the long-standing health inequities in our state.

I urge your support of SB 172 and the creation of equitable, affordable health outcomes and opportunity for all.

Sincerely,

Calvin Ball
Howard County Executive

Anne Arundel County_FAV_SB172.pdf
Uploaded by: Baron, Peter
Position: FAV

ANNE ARUNDEL COUNTY
MARYLAND
County Executive Steuart Pittman

January 27, 2021

Senate Bill 172

Maryland Health Equity Resource Act

Committee: Budget and Taxation

Position: FAVORABLE

The Anne Arundel County Administration **SUPPORTS** Senate Bill 172 - Maryland Health Equity Resource Act. This Bill would require the Secretary of Health to designate certain areas as Health Equity Resource Communities, with the purpose of reducing health disparities, improving health outcomes, and reducing health care costs and hospital admissions and readmissions.

COVID-19 has only heightened the health disparities that already existed in our communities, and as we continue to fight this pandemic, it is critical that we ensure health resources are going to the areas that have the most need. This legislation would play a critical step in eliminating inequities in our health care system and our communities.

The recent report from the Senate President's Advisory Workgroup on Equity and Inclusion calls for action in this area during the 2021 Maryland General Assembly Session, and highlights the success of the 2012-2016 Health Enterprise Zones, which this legislation is modeled after. Senate Bill 172 would expand this success by establishing Health Equity Resource Communities across the state, which would fund community developed plans to put resources and medical and public health plans into disadvantaged areas of the state.

Anne Arundel County has recently revamped the Healthy Anne Arundel Coalition (HAAC). The priorities for HAAC, chosen by community members, seek to reduce health disparities, improve access to care, and improve health outcomes. We strongly support SB172 which will help the county achieve these goals.

Accordingly, Anne Arundel County respectfully requests a **FAVORABLE** report on Senate Bill 172.

Peter Baron, Government Affairs Officer Phone: 443.685.5198 Email: Peter.Baron@aacounty.org

1- Luminis Health- SB 172- Maryland Health Equity

Uploaded by: Bayless, Victoria

Position: FAV

Luminis Health℠

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TESTIMONY OF TORI BAYLESS, CEO OF LUMINIS HEALTH

BEFORE THE SENATE BUDGET AND TAXATION COMMITTEE

IN SUPPORT OF SB 172, THE MARYLAND HEALTH EQUITY RESOURCE ACT

JANUARY 27, 2021

Mr. Chairman and Members of the Committee, we would like to thank you for this opportunity to testify in favor of this very important health equity legislation sponsored by Senator Antonio Hayes. Luminis Health, together with the Maryland Hospital Association's 60 member hospitals and health systems, strongly supports this legislation and the measures that it includes to address the health inequalities and disparities that persist across the state of Maryland and the country.

Luminis Health, a newly integrated health system formed in 2019, serves residents of Anne Arundel County, Prince George's County and Maryland's Eastern Shore. Comprised of Anne Arundel Medical Center (AAMC), Doctors Community Medical Center (DCMC), J. Kent McNew Family Medical Center, and Luminis Health Clinical Enterprise (LHCE), the health system includes 635 licensed beds, more than 6,400 employees, 1,800 medical staff and 1,300 volunteers. The new health system includes more entry points for coordinated care across the region, improved access to care close to home, enhanced quality and improved health outcomes. LHCE is comprised of a 450 member multi-specialty practice, ambulatory sites and clinics, physician practices and clinical service lines.

Addressing disparities and providing equitable high-quality care to all of the patients we serve is central to our mission, vision, and values. Despite our continuous work and the progress that we have made in our efforts, disparities of care continue across the counties we serve and there is more work to be done. We feel that this legislation will provide the necessary support for the commitment we have made to address the health inequities and will help to drive change across the entire state.

Central to this legislation is the opportunity for underserved areas disproportionately impacted by poor outcomes to become designated as Health Equity Resource Communities (HERC). This proposed program is modeled after the successful Health Enterprise Zone (HEZ) Initiative that was funded in Maryland from 2013 to 2016. It would allow communities the opportunity to obtain grants, tax incentives and health care provider loan repayment assistance to increase access to high-quality care

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and ultimately reduce health inequities. This funding is crucial to supporting and developing community-based initiatives desperately needed to address care disparities across the state.

AAMC received funding from the HEZ Initiative to support a partnership with the Housing Authority of the City of Annapolis (HACA) in developing the Morris Blum Community Clinic, outlined in greater detail below. The reductions in ED readmissions and improved utilization of healthcare resources brought about by the HEZ Initiative were clear indicators of the need to engage community health workers to improve care coordination and reduce costs. The broader, sustainable initiative established by this legislation will foreseeably grow the successes of the HEZ Initiative. At Luminis Health, we see this an opportunity to support the growth of our efforts across our newly integrated system to meet the needs of patients in Arundel County, Prince George's County and Maryland's Eastern Shore.

Importance of this Legislation

The quality of the care that Luminis Health provides to our patients is the ultimate measure of success and our guiding force. It is at the heart of our work and central to the strategy of the system. We track the quality levels of care at every patient interaction across the system through specific measures. Quality measures assess aspects of health care structure (such as types and availability of services), outcomes (such as infection rates, mortality and length of stay), or processes (such as giving antibiotics before and after certain surgery). Quality measures are also applied to the performance of our staff and providers.

We are transparent with our patients and our partners to allow informed decision making about where they access care and to hold ourselves accountable. The data is persistently reviewed by our staff and the trends we observe are used to drive our operations and to implement innovations designed to enhance patient safety and quality of care across our growing health system. Our quality data is stratified by gender, age, race and ethnicity to identify disparities. Additionally, our teams review an Inequity of Care Complaint Report where patients can report instances where they experienced perceived inequities at any of our facilities.

Analysis of our quality data has revealed disparities amongst different populations within the communities that we serve. The most apparent disparities occur in C- Section Rates, Readmission Rates,

Average Length of Stay, and Patient Satisfaction. As a system, we track these metrics on a consistent basis and have implemented a number of strategic initiatives to address them directly.

While we have made progress, the disparities of care that we observe nationally and within our community have been exacerbated during the COVID-19 pandemic. We have observed evidence that racial and ethnic minorities are bearing a disproportionate burden of illness and death related to this virus. The pandemic has adversely impacted African Americans and Hispanic residents and created a larger inequity, health and financial gaps. Older populations have also been negatively impacted by fast spread, disease complications, and increased mortality rates.

As a system, we rapidly developed a dedicated strategy to address the effects of the pandemic in our community. The Luminis Health community outreach team – comprised of health educators, public health nurses, case managers, nurse practitioners, and interns –collaborate with community partners in designated high risk and rising risk neighborhoods. The team goes door-to-door in neighborhoods and provides verbal instruction on COVID-19 prevention strategies, and provides the household with bags that include cloth masks, bilingual educational flyers from evidence-based public health programs, information on how to access CareConnectNow (a free telehealth program at Luminis Health), COVID-19 test locations – and now vaccination sites – and hygiene products such as hand soap, hand sanitizer, and detergent pods. Targeted prevention outreach is also completed in conjunction with faith based and social service community partners, at food giveaways and local businesses. Interpreters assist in Spanish-speaking neighborhoods and businesses. Since the onset of the pandemic, we have aided more than 50,000 residents across Anne Arundel and Prince George's counties.

As the pandemic continues and disparities persist in our community, Luminis Health remains dedicated and invested in expanding our Diversity, Equity, and Inclusion efforts. A clear and direct Diversity, Equity, and Inclusion strategy is the only way to address disparities of care and improve the quality of care for all patients.

Luminis Health's Diversity, Equity, and Inclusion (DEI) Strategy

Anne Arundel Medical Center—the American Hospital Association's (AHA) 2019 Carolyn Boone Lewis Equity of Care Award winner—first committed to reducing health inequities when, led by the Board of Trustees, the organization signed on to the AHA's ***#123forEquity*** Campaign in 2012. From

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there, AAMC's governing board formed the Health Equity Task Force (HETF) for the purpose of placing even greater emphasis on addressing disparities. This 22-person group included individuals from the health system, academia, county health and social service departments, clergy, and local business owners and entrepreneurs. Together, the HETF drew from their varied perspectives and experiences to devise initiatives and opportunities for ensuring the delivery of equitable care to all of AAMC's patients.

In October of 2017, AAMC implemented the Diversity, Equity, and Inclusion Leadership (DEIL) Scorecard (attachment included) as a metric-tool to ensure we demonstrate workforce diversity efforts. Goals are set by the DEIL Council and address our applicants, candidates, and existing workforce.

Executive leadership identified diversity, equity, and inclusion as a priority in strategic planning, leading to the incorporation of DEI workforce initiatives into the annual operating plans. The governing board approves two metrics in each area of Quality, Community, Workforce, Growth and Finance to be top-priority as part of an organizational dashboard called the "True North" (TN) dashboard. The TN metrics impacts leaders' incentive compensation. Diversity amongst leadership was selected as a TN workforce metric, and the new-hire selection processes was refined to require consideration of a diverse candidate in every leadership position.

The organization enhanced the selection process for the candidate slates to meet diversity goals and for hiring authorities to meet goals for new hires and the promotion of high-performing diverse talent. In FY20, 94% of all 34 open leadership positions included a diverse candidate finalist, and 11 of the 32 hired were new diverse talent.

Within the community, we use a data-driven approach to identify and address the most pressing inequities. One of the most-noted initiatives has been the partnership with the Housing Authority of the City of Annapolis (HACA) in developing the Morris Blum Community Clinic. This predominately African American low-income senior housing development was home to several "super-utilizers." While analyzing readmission data, the apartment building was identified as a "hot spot" with a disproportionately high number of 911 calls, Emergency Room visits and hospitalizations and hospital readmissions. To bring better care to this population, AAMC embedded a non-traditional primary care clinic within the resident center that coupled culturally competent primary care services with access to care coordination for behavioral and social services.

Since implementation, this population saw a 17% reduction in hospital admissions and 25% drop in readmissions over 4 fiscal years. The volumes of 911 calls fell by 32 percent during this same period.Our work with HACA and other community partners earned us the AHA NOVA award in 2018 (attachment included) and our leadership published the attached *Health Affairs* article highlighting this work.

In tandem with its effort to rectify disparities in care, the HETF was committed to creating a culture of inclusion among its employees that would naturally and positively impact interactions with patients. Several years ago, a group of nurses and employees started a Cultural Diversity and Workplace Advocacy Collaborative as a way to showcase and celebrate the organization's diversity through programs and 'lunch-and-learns'.

One model that has helped set the organization's direction is "Coming To The Table (CTTT)," a national nonprofit organization that provides leadership, resources, and a supportive environment to address and work through issues related to racism and discrimination. At AAMC—the first healthcare organization to implement an official chapter of the national "Coming To The Table"—meetings take place monthly and draw anywhere from 12 to 90 participants who discuss a specific issue and what those issues mean to them personally in an honest, safe space.

With the formation of Luminis Health through the merger of Anne Arundel Medical Center and Doctors Community Medical Center, we have expanded our DEI strategy across the entire system. The efforts stated above are being extended to DCMC and across the entire system, and we have developed a new task force. The Health Equity and Anti-Racism Task (HEART) Force, reporting to the Luminis Health Board of Trustees, was established in fall 2020 to render recommendations related to diversity, equity, antiracism, and inclusion that may be translated into strategic initiatives, policy updates, and/or additions to the system's True North Goals.

The purpose of the HEART Force is to bring together a diverse group of colleagues from Luminis Health, public health partners, and other community stakeholder groups to help develop an enduring plan with recommendations and goals towards building a more equitable and just health system. The HEART Force will build on the progressive work already taking place and be an extension of the great recommendations from the first Health Equity Task Force.

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Impact of our Efforts

We have seen encouraging results from our DEI efforts over the last several years – including improvements in many of the key qualities metrics where disparities were evident. In addition, the organization has grown to understand the importance of our DEI strategy and truly embraced the efforts in daily work. It has become engrained in the fibers our culture at Luminis Health.

Since the implementation of the DEIL Scorecard, substantial progress has been made within these various pools. Leadership diversity has increased from 14% to 26%, and full-time new hires are currently 54% diverse, with a 40% system-wide diversity. For individuals beginning their careers at Luminis Health, we are industry leaders in that diverse individuals outweigh non-diverse individuals.

At an executive leadership level, women comprise 55% of the 11-member Luminis Health C-Suite, and 36% are representative of marginalized populations, including people of color and the LGBTQ community. The system CEO and two of the three Luminis Health presidents are women and one is a person of color. Half (48%) of the members of Luminis Health Boards of Trustees are women -- having increased from 33% in 2011. Similarly, the Boards now include 35% people of color, up from 22% in 2011.

Disparities observed in key qualities metrics have improved in a number of areas. Most notable are the promising results in reducing the disparity in C-section rates. In analyzing the quality measures at AAMC, the Women and Children's department identified high rates of Cesarean birth. C-Sections present higher immediate and long-term risks to mothers compared to vaginal deliveries. The data also revealed that the C-section rates were higher for women in minority populations.

To reduce C-section rates to all patients at AAMC, the team developed a multi-pronged approach. Education and engagement for patients, obstetricians and midwives, and anesthesiologists were central to these efforts. Key initiatives introduced were provider score cards, new protocols for labor management, processes to audit patient cases, an Electronic Fetal Monitoring Certification course, and a Doula program. Since 2016, the NTSV C-section rates have dropped from 28% to 23%. The goal for this fiscal year is to reduce rates to <20%.

To specifically address the disparities in C-section rates for women of color, the team developed the Women's & Children's Counter Racism Taskforce. The primary objective of the taskforce is to

explore and lead on-going programming to address personal biases, systemic patterns of behavior, and omissions that compromise our efforts to advance equity in the care of women and children across Luminis Health. They work to inform and partner with service line institutional work groups to address biases that impact how care is delivered system wide. The goal for FY21 is to reduce the disparity in C-section rates between White and Black mothers to < 5%.

Analyses of quality metrics and outcomes data provide the ability to address disparities and barriers to culturally customized care. Our teams have been able to focus on specific diseases and illnesses that disproportionately effects minority groups. For example, Sickle Cell Anemia disproportionately affects the Black population. We see this in our own community and it is imperative for our providers to understand the nuances of this disorder and how to most effectively treat patients affected by it. Through the analysis of our patient grievances data, we identified a high volume of patients concerned with inappropriate pain management and a lack of understanding by providers. To address this inequity in care, we developed a series of forums to educate providers, including a Sickle Cell Conference (attachment included). In these sessions, we shared trends and specific patient stories with our providers. We then arm them with strategies to avoid common mistakes in treatment and to mitigate their own implicit biases.

The Potential for Greater Impact

The results of our efforts have been promising and encouraging, but there is still a long journey ahead in addressing the care disparities in our community. The pandemic has adversely impacted minority populations and created a larger gap of health inequity. Nationally, health disparities continue to grow and we see large mortality differences for minority groups.

Luminis Health remains committed to executing on our DEI strategy. We expect to continue to see positive trends from our current efforts, but we also acknowledge the need to adapt and grow our strategy. Two notable future efforts include:

- Development of the HEART Force – Over the next several months, the HEART Force will be working to develop a series of recommended initiatives and actions for Luminis Health. These recommendations will address ongoing efforts and immediate opportunities to: enhance the Luminis Health position in diverse communities; help eliminate health disparities at Luminis

Health; support the eradication of racism as it relates to the workforce, communities served, and the Luminis Health patient experience; and identify the role of Luminis Health in addressing racial injustices and inequities in healthcare that adversely impact people of color and those of vulnerable and/or marginalized communities. The recommendations will be included in our Vision 2030 Strategic Plan and guide the direction of the system.

- Addressing Disparities in the Latino Community – The Latino population in both Prince George's and Anne Arundel Counties is growing more than all ethnicities and currently accounts for 8.4% of the Anne Arundel County population and 17.4% of Prince George's County. This rapidly growing population faces significant health disparities, many of which have been worsened during the COVID-19 pandemic. Luminis Health is committed to addressing these concerns and holistically adapting and expanding our practices to provide the Latino population with an improved patient experience. In July 2020, Luminis Health initiated a project crafted to address patient care, communication, community relationships, financial resources, and engagement.

  Over the last few months, we have made strides in addressing the key areas of patient communication (interpretation and translation), care design and delivery, community partnerships, financial resources, and patient education. We are committed to improving Latino patients' care and outcomes.

Thank you again for the opportunity to testify in favor of The Maryland Health Equity Resource Act. This legislation will provide the support necessary to address health inequities in communities across the entire state of Maryland. We strongly urge you to give a favorable report to SB 172.

Attachments:

1. DEIL Scorecard AAMC FY20
2. Health Equity Report FY19
3. AHA 2019 Carolyn Boone Lewis Equity Award Report
4. Maryland Hospital Association CCQI – DEI Strategy Presentation
5. NOVA Awards 2018 Report
6. Health Affairs - Primary Care Where Everybody Knows Your Name
7. Sickle Cell Conference Presentation

2- Health Affairs - Primary Care Where Everybody K

Uploaded by: Bayless, Victoria

Position: FAV

Care relationships: Kari Alperovitz-Bichell (right) discusses patient outreach with medical assistant Lakyra Herndon. Alperovitz-Bichell, known as Dr. Kari to her patients, serves as anchor physician at Anne Arundel Medical Center's community clinic located within the Morris H. Blum Senior Apartments, in Annapolis, Maryland.

DOI: 10.1377/hlthaff.2018.05318

A SERIES ON
HEALTH SYSTEM TRANSFORMATION

Primary Care Where Everybody Knows Your Name

In Maryland communities such as Annapolis, Health Enterprise Zones have spurred investment and experimentation in care delivery.

BY BARA L. VAIDA

Down at the bottom of a hill, next to a creek that flows toward the Chesapeake Bay, lies a red-brick apartment building with 154 units for low-income senior citizens and disabled residents of Annapolis, the capital of Maryland. The building, located at 701 Glenwood Street, is called the Morris H. Blum Senior Apartments, after an Annapolis civil rights leader and radio station owner. It has also been a site of a statewide effort to transform primary care to meet the needs of the most vulnerable and chronically ill.

On its first floor, the building houses a nontraditional primary care clinic that provides not only the classic checkup with a physician but also access to care coordination, behavioral and social services, and self-care education classes.

"We are primary care with a flair," says Sharon Cameron, manager of community clinics at Anne Arundel Medical Center (AAMC), which opened the Morris Blum practice in 2013 in collaboration with the City of Annapolis, the Anne Arundel County health department, and the state. AAMC's nonprofit hospital is the third-busiest in the state. It also runs a multispecialist physicians' group, an imaging center, a substance abuse treatment center, and outpatient clinics.[1,2]

At Morris Blum, the clinic has walk-in appointments, a bilingual staff, a care coordinator who will help patients figure out their insurance and how to get to a specialist, and a pharmacist who tailors medications for patients. Patients are welcome to hang out in the waiting area, even if they don't have an appointment.

"We wanted the clinic to be the health care equivalent of *Cheers*, where everyone knows you and greets you by name, even if you're late for an appointment or dropping by unexpectedly," says Patricia Czapp, the former chair of clinical integration at AAMC and a cofounder of the clinic. "This departs from the traditional practice, where patients might be turned away if they're a little late or are often expected to navigate the health system alone, without assistance."

Maryland has been a leader in supporting integrated models of care delivery to address the social, environmental, and behavioral factors that have an outsize impact on health. In 2012 the state, under Gov. Martin O'Malley, funded a four-year, $16 million pilot program called the Health Enterprise Zone (HEZ) Initiative.[3] The initiative—inspired by the urban enterprise zones

Photograph by Jason Dixon

intended to increase economic development in low-income communities—provided a mix of tax credits and grants to five underserved zones in the state, including the ZIP code where Morris Blum is located, to encourage health providers and community leaders to work together to improve health outcomes and save money.

Though Maryland's current governor, Larry Hogan, didn't renew the HEZs, their work helped many Marylanders have better access to health care, improve their health outcomes, and save money, according to an October 2018 study by Darrell J. Gaskin, the William C. and Nancy F. Richardson Professor in Health Policy in the Department of Health Policy and Management and director of the Hopkins Center for Health Disparities Solutions, both at the Johns Hopkins Bloomberg School of Public Health, and coauthors that was published in *Health Affairs*.[4]

Between 2013 and 2016 communities with an HEZ reduced inpatient admissions at Maryland hospitals and saved the state's health system about $93.4 million, said the study authors.[4] Residents in the zones reported that they had become more aware of their health and were exercising more and monitoring their diets. Providers said that the HEZs helped patients manage their chronic conditions.

The HEZs also taught state health leaders about the need to engage community health workers to improve care coordination and reduce costs. Leaders in the program made extensive use of community health and social workers to build relationships with high-need patients, who are among the most frequent users of the health system.

"I see the HEZs as having been successful in helping a lot of people directly, but also successful in opening the discussion about community-based initiatives and inspiring the state to look at other kinds of projects" like these, says Joshua Sharfstein, who was Maryland's secretary of health and mental hygiene when the HEZ program was launched.

Indeed, the HEZs have informed how Maryland has structured its latest foray into care delivery reform.

Beginning this year, Maryland primary care doctors have the option to join in the state's all-payer Total Cost of Care Model for Medicare beneficiaries, dubbed the global budget. Providers who participate in the model can make more money if their Medicare patients are healthier. The global budget, which already caps the amount of money hospitals can receive for Medicare patients, has been in place in Maryland since 2014. Maryland has had a waiver from the Centers for Medicare and Medicaid Services since the mid-1970s that enables it to set rates for hospital services.[5]

To help primary care doctors meet the goals of the global budget, practices will have access to Care Transformation Organizations that employ community-based workers to help address the social determinants of health for the most complex and vulnerable Medicare patients.

Building Relationships

"The big lessons we learned from [the HEZs] is that they pointed clearly to the value of having more boots-on-the-ground involvement with people in the places they work, play, and pray," says Howard Haft, executive director of the Maryland Primary Care Program in the state's Department of Health. "And the work that we do outside of the four walls of the physician's office or hospital is even more important in many cases with individuals with heavy disease burdens than the work we do within" those walls.

The number-one ingredient in addressing the care of high-need patients is building a relationship with them. If the experience of the Morris Blum clinic is any indication, the transition to a global budget for primary care practices is likely to be challenging and time consuming.

"The learning involved was hard," says Mitchell Schwartz, chief medical officer and president of Physician Enterprise at AAMC, which took over funding of the Morris Blum clinic since the HEZ program ended in fiscal year 2017. "You need to be very sensitive about the perspectives that you bring" to delivering care to a population where not everyone can read or write or where English isn't everyone's primary language.

It took awhile for AAMC staff members to build relationships with the residents of Morris Blum and neighboring community. Initially, many people didn't want to go to the clinic in their building, preferring to go to a doctor elsewhere or the emergency department (ED) for care. Eventually AAMC's work paid off in reductions to hospital admissions and 911 calls. The medical center experienced a 17 percent decline in hospital admissions and 25 percent drop in readmissions among residents of the building between fiscal years 2013 and 2017. The number of 911 calls fell 32 percent in the same period.[6] (AAMC's fiscal year runs from July 1 through June 30, while the HEZ program was funded on a calendar-year basis in the period 2013–16.)[7]

ED visits also declined but then rose again as the HEZ funding came to an end. Between fiscal years 2013 and 2017 ED visits increased by 3 percent, according to AAMC. Hospital officials declined to comment on why they had increased.

But AAMC wasn't alone. Almost all of the HEZs experienced an increase in ED visits during the initiative. The study by Gaskin and his coauthors found that the overall initiative was associated with an increase of 40,488 ED visits in the period 2013–16, which cost insurers and patients $59.9 million. However, the cost of those visits was offset by the much larger reduction in hospital stays, which enabled the program to save money.[4]

Why ED visits increased isn't clear. One explanation may be the state's shift after 2010 to encouraging hospitals to allow patients to receive observation services such as x-rays, lab tests, and medication in the ED, according to the study.[4] Patients in the HEZs who then went to the ED for those services could be sent home, instead of being admitted. However, the study's authors said it also wasn't clear why the observation shift would have disproportionately affected the HEZs.

"What we think was happening [before the HEZs] is that patients might have been admitted to the hospital [from the ED] because there wasn't social support or the ability to use community-based services [at home]," Gaskin says. "We think the HEZs provided them with the resources they" needed, and patients then could go home.

As Maryland embarks on the next step in transforming care, it would be wise to consider how the Anne Arundel HEZ addressed social determinants of health and reduced hospital admissions.

'A Bona Fide Hot Spot'

The story begins in 2011. Patricia Czapp noticed that "701 Glenwood St., Annapolis," was frequently given as the home address of patients visiting the ED at Anne Arundel Medical Center. During a six-month period seventy-three Morris Blum residents visited the hospital's ED 175 times, and 38 of those visits led to admissions. Nine residents accounted for 41 percent of the 175 ED visits. Over a one-year period residents called 911 for medical reasons 220 times.[8(pp3–4)]

Morris Blum was a "hot spot"—a place whose residents, for a variety of reasons (including both mental health and socioeconomic challenges), end up in a hospital ED multiple times in a year. Five percent of patients accounted for about half of US health care spending in 2014, according to data from the Medical Expenditure Panel Survey,[9] and these patients are known as superutilizers of health care.

"When I saw that address come up over and over, [some of us at the hospital] decided to get in the car and drive over there to see what it was," says Czapp, who left AAMC in 2018 and is now a medical director at AbsoluteCARE, a primary care practice with four locations that focuses on patients with complex care needs.

What they found was a building at the edge of a tiny neighborhood, hidden behind the Maryland State House and Hotel Annapolis. The neighborhood was once the cultural and economic heart of the city's African American community and dubbed itself the "Harlem of Annapolis." About forty years ago it had barbershops, beauty salons, clothing shops, restaurants, a drugstore, a grocery store, and a beloved doctor named Aris T. Allen, according to Alderwoman Shaneka Henson.

"It's a rich African American history there," says Henson, who is a member of the Annapolis City Council. "There were many African American business owners and residents. You could get everything you needed in those blocks."

But with urban renewal the businesses disappeared, leaving behind boarded-up storefronts. The neighborhood became a mix of public housing, redeveloped low-income housing units, and tiny homes, surrounded by government office buildings, a parking lot, and pricey bars and restaurants. There are few businesses that cater to people in the neighborhood, and there is no bus stop at Morris Blum. In 2011 the closest medical care available was located at a free clinic, about a half-mile walk uphill.

Where a person lives has a significant impact on health. In 2011 the Centers for Disease Control and Prevention published a study finding that Americans living in poor neighborhoods with few parks or other outdoor spaces and low access to nutritious food and medical services had higher rates of premature death from heart disease, strokes, and cancer, compared with people living in affluent communities with access to medical care.[10]

Maryland has one of the highest median incomes in the country—$78,916 in 2017[11]—but the state lags behind the country in some key health indicators. In 2017 it was twenty-sixth in terms of obesity prevalence[12] and twenty-ninth in terms of diabetes prevalence.[13] In 2016 it was twenty-first in terms of deaths from heart disease.[14] In 2018 it came in thirty-first in terms of health system disparity.[15] Between 2006 and 2010 adult non-Hispanic black or African American Marylanders were 23 percent more likely to die from heart disease and 26 percent more likely to die from a stroke, compared to non-Hispanic white adults in the state.[16]

Czapp, who grew up with no health insurance in rural Michigan, has a special interest in helping people in poverty. Inspired by Jeffrey Brenner, a physician in Camden, New Jersey, who pioneered the idea of placing medical personnel in hot spots, Czapp started talking with her colleagues about putting a clinic inside Morris Blum. Serendipitously, Maryland was launching the HEZs.

"I think it came to me as a natural 'duh' because the HEZ [call for proposals] came out at just the right time," Czapp says. "We were all thinking aloud about a shovel-ready project that would fit the HEZ initiative. The problem we identified was that people in the area needed a regular source of relationship-based primary care, provided by a stable staff, and the existing free clinic down the street couldn't achieve the needed outcomes for many reasons—primarily because of its haphazard volunteer physician model."

AAMC reached out to the Housing Authority of the City of Annapolis, which operates Morris Blum; the Anne Arundel County Department of Health; the City of Annapolis; and Medical Mall Health Services, which provides health transition services. Together the organizations applied to the state to put a clinic in the senior living facility.

"The building is a bona fide 'hot spot' whose 184 elderly and disabled residents currently experience crisis-driven, episodic, and fragmented heath care," AAMC said in its 2012 application to the state.[8(p18)] The medical center requested about $1 million over four years to build the clinic, pay the salaries of clinician staff members, and fund the wraparound social services involved in addressing patients' complex care needs. AAMC anticipated that the grant would be for only four years and that it would continue to fund the clinic's work after the HEZ program ended, the documents say.[8]

"In the state of Maryland, [admissions] and readmissions are costs to the system, so investing in making people healthy and keeping them out of the hospital is better aligned in this state than others," says AAMC's Schwartz.

According to AAMC, the system ultimately received $800,000 from the HEZ program over the course of the grant—$200,000 each year. That was enough to jump-start the creation of the clinic, with AAMC covering the rest of the costs. The Housing Authority also didn't charge AAMC rent for the clinic space in the building, according to AAMC documents.

Overcoming Patients' Initial Reluctance

With the grant in hand, AAMC officials worked to build trust among building residents. As construction of the clinic began in a space that had once held the building's administrative offices, two AAMC nurses who lived in the neighborhood and knew some of the Morris Blum residents joined community meetings in the cafeteria. They did blood pressure screening for residents and explained what the clinic would mean.

Charles Carroll, a community pastor and a former service coordinator for the Housing Authority of the City of Annap-

olis, went door to door, talking to each resident about how they would now be able to walk downstairs for help instead of calling 911.

Sandra Chapman, a Morris Blum resident and a leader of the building's residents council who is also chair of the board of the Housing Authority, talked up the clinic to her neighbors and invited them to participate in its design. AAMC held lectures on health topics such as diabetes and kidney care to help build awareness of the clinic and increase health literacy among residents.

However, many residents weren't eager to embrace the idea of a clinic in their building and near their community meeting space.

"They didn't want outsiders coming into the building," Carroll says. "They kept asking me, 'How are we going to keep people from going upstairs on the elevator?' We had to do a lot to reassure them that they would be safe."

Chapman says that residents also resisted the idea of seeing an unknown health practitioner.

"Older people tend to be very set in their ways and who they get care from," she says. "They were like, 'Well, I'm not changing my doctor.'"

Locating a clinic within an affordable housing building for seniors has been tried with mixed success. In Berkeley, California, for example, LifeLong Medical Care, a health and social services provider, worked to create a health center for seniors in a new affordable housing senior living facility. But residents initially didn't want to use the clinic because they didn't want to change physicians, according to a case study published in 2011 by LeadingAge, an advocacy, education, and research nonprofit that focuses on issues of aging services.[17]

"What we have found is that most colocated [primary care] clinics don't work with the elderly" because the Medicare patients don't want to change doctors, says Robyn I. Stone, senior vice president of research at LeadingAge and codirector of the LeadingAge LTSS [Long-Term Services and Supports] Center at the University of Massachusetts Boston.

Eventually more patients from inside and outside the building did come. The clinic used strategies that can be adapted by others, including an extensive list of relationship-building efforts, that aren't traditionally considered part of primary care services. These include offering same-day appointments; health education events, such as cooking classes and how to quit smoking; referrals for mental health care; home visits to patients; help navigating the insurance and health care system; personalized health plans for patients; help accessing food, clothing, transportation, and housing; and medication therapy management. The clinic allows patients to just hang out in the waiting room if they want someone to talk to, Czapp says.

The number-one ingredient in addressing the care of high-need patients is building a relationship with them.

Furthermore, the clinic decided to accept all forms of insurance, including Medicare, Medicaid, and commercial insurance. And for uninsured people, it provides services on a sliding scale based on income.

"It is important to know that this is not a free clinic," says AAMC's Cameron.

Certainly the clinic has helped residents like Brenda Williams. The sixty-four-year-old great-grandmother of five has chronic thyroid disease, arthritis, and scoliosis. A licensed food manager, she loves to cook and has been struggling with keeping her weight down to prevent herself from developing diabetes.

In 2018, Williams says, she got an evening call from Kari Alperovitz-Bichell, Morris Blum's anchor physician.

"It was 9 p.m., and I thought the worst—because I never in my whole life got a call from a doctor at 9 p.m.," Williams says. Earlier in the day, she had had a blood test related to her thyroid condition.

"Dr. Kari wanted to tell me that my thyroid was fine but my blood sugar wasn't, and that if I didn't lose some weight, I was going to be a diabetic," Williams says. She vowed to Alperovitz-Bichell that she would lose the weight "because I don't want to be taking insulin twice a day."

Williams adds that the doctor's call to her, just hours after she had had the blood test, "made me feel like I got extra good care" and want to lose the weight: "Dr. Kari is a sweetheart. She is like a mom."

Pastor Carroll, who is also a clinic patient, echoes Williams's feelings.

"Dr. Kari has been the first doctor that asked me, 'How are you doing?,'" he says. "She just makes you want to come back."

The clinic also taught patients that many nonemergency needs could be met on site instead of having to go to the ED for care. For instance, Czapp had a patient named "Mr. P," who was a frequent visitor at AAMC's ED. If he had back pain, he would go to the ED to ask for magnetic resonance imaging (MRI). If he had a headache, he would go to the ED to request a brain scan. In talking to "Mr. P," Czapp says that it became clear he was socially isolated. The ED staff knew his name, paid attention to him, and asked him how he was feeling, providing a social connection that "Mr. P" needed, she says.

"So rather than lecture him about the lack of medical necessity for an MRI, I accompanied him to his apartment, where we reviewed the condition of his bed and mattress, and I suggested alternative ways to use pillows to support his back. And then he just beamed at me," she says. "His back didn't hurt anymore. If we hadn't been there, 'Mr. P' would have dialed 911."

During the HEZ program the clinic employed a physician, medical assistant, nurse case manager, and bilingual office assistant. The nurse case manager, who was from the neighborhood, was the key person who reached out to county agencies and social workers to help address patients' social-determinants needs. She also coordinated care for patients, helped them get insurance if necessary, helped patients fill out forms, and made sure that they got transportation to another doctor if needed, according to Czapp.

The staff members took the approach that some patients may have poor health literacy and don't know how to work with a doctor or anyone else in the health care sector, Cameron says. Sometimes patients don't understand what

they are supposed to do in a waiting room or how to use health insurance, Alperovitz-Bichell says.

"People will show up at the right time but on the wrong day, or the right day but the wrong time, …so we have to meet the needs of the patient" with flexibility, Cameron says.

After funding from the HEZ program ended in June 2017, the clinic reduced its staff but was able to sustain its work in other ways. Instead of having a full-time case manager, the clinic now has the support of a social services coordinator and behavioral health navigator through a service funded by AAMC called One Call Care Management. One Call employs social workers, who help Morris Blum clinicians and other physicians working in AAMC's hospital system address patients with complex needs, Cameron says.

"One Call will send a [social worker] here," Alperovitz-Bichell says. This is because "patients don't have a phone, or their phone gets turned off constantly. Having a social worker call them back doesn't work so well, so they send someone here."

The clinic also has the support of a doctor of pharmacy, Monique Mounce, who has taken on part of the case management role. Mounce is an assistant professor in the Department of Clinical and Administrative Sciences at Notre Dame of Maryland University's School of Pharmacy, and through a collaboration between AAMC and Notre Dame, she provides services at Morris Blum and another AAMC community clinic.

Mounce and several of her pharmacy students spend eight to nine hours a week at Morris Blum providing personalized medication therapy and health education support. Not only does Mounce talk with a patient about their medication, but she will also fill their prescription in ways that help the patient adhere to required dosages. She will even fill a pillbox for a patient, sometimes in creative ways.

After four years the investment in the Morris Blum clinic by the state and AAMC showed significant savings.

For example, with a patient who can't read, she will put a sun or a moon on a pillbox, so the patient knows to take the medication during the day or night. For a patient with mental health challenges, she obtained a pillbox with a timer, so that the patient took the medication at the right time of day. For people who don't have transportation, she arranges for a pharmacy to deliver their medications. If a medication is too expensive for a patient, she works to find affordable options.

"You have to be a certain kind of person that is patient and nonjudgmental and enjoy seeing the patients," Mounce says. "I go to the cafeteria where [the residents] are playing cards and make sure things are OK. They come to us, sometimes seven or eight times a day, just to talk and tell us what they ate. That is part of the relationship, and we appreciate it."

The Morris Blum clinicians also get help from AAMC's electronic health record (EHR) system. The clinic's records are connected to the medical center, so they know if a patient has been to the hospital.

"It really, really helps, because [with] people who don't have a lot of health literacy and don't understand what is going on[, the EHR]…helps me figure out what is going on," Alperovitz-Bichell says.

After four years the investment in the Morris Blum clinic by the state and AAMC showed significant savings. With its investment of $800,000, Maryland's health system saved $13.1 million that would have otherwise been spent on hospital care at AAMC or another hospital serving residents in the HEZ ZIP code, according to the study by Gaskin and coauthors.[4] The Anne Arundel HEZ had the best return on investment, it found.

For Morris Blum resident Sandra Chapman, that return on investment has meant quieter days and nights.

"When I moved into the building, ambulances came four or five times a week," says the sixty-eight-year-old grandmother, whose apartment window is at the back of the building where emergency vehicles arrive. "It took me a while to get used to hearing [the noise] all the time. But now they come way less. I can think of a few weeks where there were none. That is amazing." ■

This article is part of a series on transforming health systems published with support from The Robert Wood Johnson Foundation. **Bara L. Vaida** (bara.vaida@gmail.com) is an independent journalist in Washington, D.C.

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3- DEIL Scorecard AAMC FY20.pdf

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DIVERSITY. EQUITY. AND INCLUSION LEADERSHIP COUNCIL: JUNE 2020

DEIL Scorecard FY Comparison Summary Report

SCORECARD SUMMARY Year-End FY' 18- Year-End FY'20	Q4, FY'18	V.S	Q4, FY'19	V.S	Q4, FY'20

METRIC	BASELINE STARTING THIS WORK	% DIVERSITY 3/1/18	TOTAL 6/30/18	% DIVERSITY 6/30/18	TOTAL 6/30/19	% DIVERSITY 6/30/19	TOTAL 6/30/20	% DIVERSITY 6/30/20	BEST STANDARD BENCHMARK GOAL RANGE	FY'20 AAMC GOAL	% CHANGE	GOAL ASSESSMENT	GOAL v. GOAL RANGE	
WORKFORCE	4,729	33%	4,860	35%	5,005	38%	5,255	40%	40-50	40%	7%	Goal Met	Goal Within Best Standards Range	
LEADERSHIP WORKFORCE (MANAGEMENT- Supervisor (+))	NA	NA	320	19%	350	25%	372	26%	37-47	27%	7%	Below Goal 1%	Goal Below Range	
Exec. LEADERSHIP WORKFORCE (LEADERS- Director (+))	195	14%	107	14%	115	20%	119	17%	35-45	25%	3%	Below Goal 8%	Goal Below Range	
TOTAL APPLICANTS	13,720	50%	17,823	59%	20,252	63%	7,208	57%	50-60	59%	7%	Below Goal 2%	Goal Within Best Standards Range, Actuals within Range	COVID IMPACT
UNIQUE APPLICANTS	3,800	52%	5,601	59%	5,790	62%	2,199	58%	50-60	59%	6%	Below Goal 1%	Goal Within Best Standards Range, Actuals within Range	COVID IMPACT
TOTAL CANDIDATES	352	43%	626	53%	1,921	58%	306	48%	50-60	55%	5%	Below Goal 7%	Goal Within Range	COVID IMPACT
NEW HIRES	128	40%	394	41%	363	53%	302	52%	45-55	45%	12%	Exceeds Goal	Goal Within Best Standards Range	
FT NEW HIRES	89	42%	237	47%	218	59%	185	54%	45-50	48%	12%	Exceeds Goal	Goal Within Best Standards Range	
NEW HIRES LEADERSHIP (Sup +)	NA	0%	25	23%	12	64%	5	60%	35-47	35%	37%	Exceeds Goal	Goal Within Best Standards Range	
NEW HIRES NURSING (NURSE POSITIONS ONLY)	24	19%	86	32%	48	25%	94	38%	38-49	38%	19%	Goal Met	Goal Within Best Standards Range	

DEI SCORECARD SUMMARY REPORT ASSESSMENT

SCORECARD SUMMARY Year-End FY' 18- Year-End FY'20	Q4, FY'18 V.S Q4, FY'20

METRIC	BASELINE STARTING THIS WORK	% DIVERSITY 3/1/18	TOTAL 6/30/18	% DIVERSITY 6/30/18	TOTAL 6/30/19	% DIVERSITY 6/30/19	TOTAL 6/30/20	% DIVERSITY 6/30/20	BEST STANDARD BENCHMARK GOAL RANGE	FY'20 AAMC GOAL	% CHANGE	GOAL ASSESSMENT	GOAL V. GOAL RANGE
WORKFORCE	4,729	33%	4,860	35%	5,005	38%	5,255	40%	40-50	40%	7%	Goal Met	Goal Within Best Standards Range
LEADERSHIP WORKFORCE (MANAGEMENT- Supervisor (+))	NA	NA	320	19%	350	25%	372	26%	37-47	27%	7%	Below Goal 1%	Goal Below Range
Exec. LEADERSHIP WORKFORCE (LEADERS- Director (+))	195	14%	107	14%	115	20%	119	17%	35-45	25%	3%	Below Goal 8%	Goal Below Range
TOTAL APPLICANTS	13,720	50%	17,823	59%	20,252	63%	7,208	57%	50-60	59%	7%	Below Goal 2%	Goal Within Best Standards Range, Actuals within Range
UNIQUE APPLICANTS	3,800	52%	5,601	59%	5,790	62%	2,199	58%	50-60	59%	6%	Below Goal 1%	Goal Within Best Standards Range, Actuals within Range
TOTAL CANDIDATES	352	43%	626	53%	1,921	58%	306	48%	50-60	55%	5%	Below Goal 7%	Goal Within Range
NEW HIRES	128	40%	394	41%	363	53%	302	52%	45-55	45%	12%	Exceeds Goal	Goal Within Best Standards Range
FT NEW HIRES	89	42%	237	47%	218	59%	185	54%	45-50	48%	12%	Exceeds Goal	Goal Within Best Standards Range
NEW HIRES LEADERSHIP (Sup +)	NA	0%	25	23%	12	64%	5	60%	35-47	35%	37%	Exceeds Goal	Goal Within Best Standards Range
NEW HIRES NURSING (NURSE POSITIONS ONLY)	24	19%	86	32%	48	25%	94	38%	38-49	38%	19%	Goal Met	Goal Within Best Standards Range

PRIMARY OBSERVATIONS:

1. We experienced some progress during the impact of COVID-19, we may recognize that as an accomplishment as we are aware that unconscious bias is most high during times of crisis.
    a. Recruitment goals remain within the best practice goal range even when the goal is not met.
2. While workforce increased, diversity concurrently increased implying that we are supporting our commitment to ensure equity in opportunities.
3. Nursing Diversity and Leadership Diversity were both priority goals for HR and the organization; the New Hire growth in both areas would suggest that raising the area of focus to a broader goal contributes to greater progress.
4. The rate of progress in New Hire Leadership Diversity is not mirrored by the rate of progress in Leadership Workforce Diversity further implicating the importance of diverse talent retention.
5. Workforce Diversity increases in progress, yet the opportunity to advance goals towards the best practice goal range still exists.
6. The significant decrease in the amount of Applicants during the COVID-19 hiring freeze could suggest that the community is in tune with our recruitment activity.

4- AHA 2019 Carolyn Boone Lewis Equity.pdf

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Position: FAV

AHA Recognizes Anne Arundel Medical Center With 2019 Carolyn Boone Lewis Equity of Care Award

WASHINGTON (June 4, 2019) – The American Hospital Association's (AHA) Institute for Diversity and Health Equity today announced that **Anne Arundel Medical Center**, Annapolis, Md., will receive the 2019 Carolyn Boone Lewis Equity of Care (EOC) Award. The award recognizes hospitals and health systems for their efforts to reduce health care inequities, and advance diversity and inclusion. In addition, **Atrium Health**, Charlotte, N.C.; **Northwell Health**, New Hyde Park, N.Y.; **Rush University Medical Center**, Chicago, Ill.; and **Sutter Health**, Sacramento, Calif., will be recognized as honorees. The award will be presented July 25 at the AHA's Leadership Summit in San Diego.

The Equity of Care award has been renamed the Carolyn Boone Lewis Equity of Care Award, in honor of the first African-American and the first hospital trustee to chair the AHA Board; a trustee of a safety net hospital, she was a tireless advocate for equity of care.

"Hospitals and health systems that participate in the Carolyn Boone Lewis Equity of Care Award process demonstrate a commitment to improving health for all people. Their work is not only a moral imperative but it's also the way in which hospitals will be positioned to succeed under population health and value-based care," said **AHA President and CEO Rick Pollack**. "We thank Anne Arundel Medical Center and the Carolyn Boone Lewis Equity of Care honorees for their innovative work to improve outcomes and advance health equity in the communities they serve."

The Carolyn Boone Lewis Equity of Care award is awarded annually and was created to recognize outstanding efforts among hospitals and health care systems to advance equity of care to all patients,

and to spread lessons learned and progress toward achieving health equity.

“Across the country, racial, ethnic and cultural inequities are everyday realities for far too many individuals, limiting their highest potential for health and hospitals and health systems are committed to closing the gaps,” said **Duane Reynolds, IFDHE president and CEO and AHA vice president. “**A focus on eliminating disparities is one way in which hospitals and health systems make a commitment to just and equitable care for their patients and communities.”

Anne Arundel Medical Center, the 2019 Carolyn Boone Lewis EOC Award winner, is being recognized for their efforts to provide equitable care and reduce health inequities. The Anne Arundel team created a health equity report that captured patient data to identify inequities and demographics. Led by clinicians, this data has resulted in the development of targeted action plans to improve patient outcomes across the health system. The team also focused on creating a more diverse and inclusive culture by having open, candid conversations about cultural differences and discussing ways to mitigate unconscious bias. These discussions led to diversity, equity and inclusion as a top priority in the organization’s 2019 operating plan, and the team’s strategic efforts have enhanced the organization’s candidate selection process.

Internally, the governing board has increased gender, age and race/ethnic diversity by 27 percent from 13 percent.

To address inequities, Anne Arundel partnered with a local senior apartment complex and opened a non-traditional primary care clinic within the resident center, providing care coordination for behavioral and social services. Since implementation, there has been a 17 percent reduction in hospital admissions and a 25 percent drop in readmissions over a four-year period.

Highlights of the Carolyn Boone Lewis Equity of Care Award Honorees

Atrium Health – Charlotte, N.C.

At Atrium Health, the team created a Demographic Data Wall, an analytics platform that identifies inequities by race, ethnicity, gender and location. The scorecard arranges data such as unplanned readmissions and diabetes, and supports the delivery of culturally and linguistically appropriate services across the system. Atrium also developed a formal community health strategy that includes community leaders across its multi-sector service regions, focused on pediatric and adult obesity, mental health prevention and treatment, tobacco prevention and cessation, access to care, and social and economic impact.

Northwell Health – New Hyde Park, N.Y.

Northwell Health's workforce is diverse with 50 percent of its staff from underrepresented groups. In addition, women represent 72 percent of Northwell's workforce with 44 percent serving in executive roles. The team is also committed to internal and external education on the importance of collecting race, ethnic and language (REaL) data to improve patient outcomes and community care. With philanthropic support from JPMorgan, Northwell established a health care workforce development program that recruits and trains GED or high school graduates who are unemployed or under-employed and connects them with entry-level health care and social service positions.

Rush University Medical Center – Chicago, Ill.

In addition to capturing REaL data, Rush University Medical Center is implementing social determinants of health (SDoH) screenings across the system and community settings to identify risk factors including food insecurity, housing, instability and transportation. Rush is mitigating these SDoH through strategic partnerships that provide home food delivery services to older adults and community health for those in need of primary care. Through its LGBTQ Leadership Council, Rush has provided over 12 training sessions to students, staff and faculty on gender-affirming care. Rush is committed to increasing access to culturally competent LGBTQ services that includes hiring efforts for providers specializing in gender-affirmation services.

Sutter Health – Sacramento, Calif.

Nearly 56 percent of Sutter Health's patients are racially or ethnically diverse and 10 percent do not speak English. Sutter's collection of REaL data helps the team develop trainings that provide high-quality, culturally competent care to patients in their preferred language. Sutter has made steady progress in increasing diversity among its workforce with nearly 50 percent of its employees being ethnically diverse, and 20 percent of executive positons are ethnically diverse representing a 7 percent increase from 2014.

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About the AHA

The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to the improvement of health in their communities. The AHA is the national advocate for its

5- Health Equity Report- FY19_AAMC-Luminis.pdf

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Health Equity Report

Fiscal Year 2019

Data from Fiscal Year 2018

Anne Arundel Medical Center

LIVING HEALTHIER **TOGETHER.**

Table of Contents

Executive Summary

Following the Institute of Medicine's ***Unequal Treatment: Confronting Racial and Ethnic Disparities*** report in 2002, several agencies and organizations created initiatives to combat healthcare disparities. The Agency for Healthcare Research and Quality annually publishes the *National Healthcare Quality and Disparities Report*, which tracks the nation's performance on healthcare access, quality, and disparities. While some measures have improved nationally over time, others have fared worse, encouraging the American Hospital Association, with four other partner organizations, to launch a national call to action to eliminate health disparities. Anne Arundel Medical Center joined this effort and established the Board Health Equity Task Force (HETF) in fiscal year 2016 in order to analyze and address health disparities within the system. The inaugural *Health Equity Report* (Fiscal Year 2018) was a result of the work done by the HETF in fiscal years 2016-17 and a start of the HETF's efforts to address disparities within the system. After assessing 35 areas, 4 disparities were identified: (1) **C-Section Rates;** (2) **Readmission Rates;** (3) **Length of Stay;** and (4) **AAMG Patient Satisfaction[1].** Each was assigned a champion to lead work in helping to reduce disparities. Updates on progress will be reported throughout the document.

Within this second annual *Health Equity Report*, the 35 areas were again assessed, and the same four areas persisted as top priorities for the organization. In this report, we highlight the progress made during the past year. We have also learned more of the complexity involved in influencing the many socioeconomic and external factors involved in changing these results in the long-term. We anticipate that as efforts continue and are refined, results will show reductions in disparities. In the summary table, only white and black/ African American rates are provided although there are several instances throughout the document that report other racial/ethnic categories. The summary table is limited to white and black/ African American rates because of the low number of respondents in other categories. We recognize that there are disparities in these other minority groups that warrant further data collection and targeted initiatives.

Table 1: Results Comparison

	2017		2018	
	White	Black	White	Black
NTSV C-Section Rate	22.0%	34.0%	22.3%	25.4%
30-Day Readmission Rate	8.22%	10.87%	8.16%	11.28%
Length of Stay	4.09	4.80	3.84	4.33
AAMG Patient Sat.: Office Follow up with Test Results	78.6%	68.0%	79.2%	70.1%

[1] For office follow-up with test results

Introduction

In 2002, the Institute of Medicine produced the landmark report, ***Unequal Treatment: Confronting Racial and Ethnic Disparities***, which outlined the multi-faceted and complex set of issues evident in the persistent disparities of care in the United States. Since that time, the Agency for Healthcare Research and Quality has annually published the *National Healthcare Quality and Disparities Report* (QDR), which tracks the nation's performance on health care access, quality, and disparities. The report has increased awareness and visibility to the stark reality that disparities are pervasive across the health care industry. Research shows that disparities in health care can lead to increased medical errors, prolonged length of stays, avoidable hospitalizations and readmissions, and over- and under-utilization of procedures.

Specific to disparities in care, data in the QDR indicate that improvements are not closing the overall disparities gap: some measures regarding disparities have improved over time, while others have gotten worse. With this context, in 2012, the American Hospital Association (AHA), in collaboration with four partner organizations, launched a national call to action to eliminate health disparities. The goals of this seminal event were three-fold[2]:

1. Increase the collection of race, ethnicity, and language (REaL) preference data to facilitate its increased use.
2. Increase cultural competency training for clinicians and support staff.
3. Increase diversity in governance and management.

Anne Arundel Medical Center (AAMC) first committed to these efforts when, led by the Board of Trustees, the organization signed on to the AHA's #123forEquity Campaign. AAMC is one of more than 1,400 organizations who have joined this pursuit of clinical and cultural excellence by pledging to deliver equitable care and eliminate health disparities. AAMC's governing board formed the Health Equity Task Force in 2016 for the purpose of placing *even greater* emphasis on addressing disparities. The first annual report served as the next step for AAMC in highlighting several disparities and helping to prioritize them. The Health Equity Report committee identified 10 major recommendations in 5 categories: (1) Data Collection and Analysis; (2) Education and Training; (3) Communication and Awareness; (4) Engagement of Stakeholders; (5) Leadership Commitment [see Table 2]. The first recommendation, tying patient demographic data to patient outcomes, is the core of this AAHS Health Equity Report. Various quality measures were stratified by different patient demographic data to assess what disparities existed.

[2] http://www.hpoe.org/Reports-HPOE/eliminating_health_care_disparities.pdf

Table 2: AAMC Health Equity Prioritization

Priority and Actions		To-Date Actions
Data Collection and Analysis	1. Tie patient demographic data to patient outcomes	Health Equity Report and action plans
Education and Training	1. Provide training to all executives, directors, managers and supervisors on how to manage a diverse workforce, including LGBTQ 2. Develop enhanced cultural competency education for all staff and clinicians 3. Provide training to all executives, directors, managers and supervisors on "Unconscious Bias" 4. Provide training on "Workplace Bullying"; Conduct follow-up survey and focus groups targeted at RNs	Educational Classes
Communication and Awareness	1. Approach culture in a broad and inclusive basis of race, ethnicity, religion, economic status 2. ONGOING: Provide language translation/access support	Educational Classes Business Resource Groups
Engagement of Stakeholders	1. Include patient family advisors; include the patient's voice in identifying health and social issues	Patient & Family Advisors and their representation in all groups
Leadership Commitment	1. Create an ombudsman position within Human Resources 2. Implement hiring practices to support leadership diversity	True North workforce metric Diversity and Inclusion Manager

Source: *AAMG FY18 Internal Data*

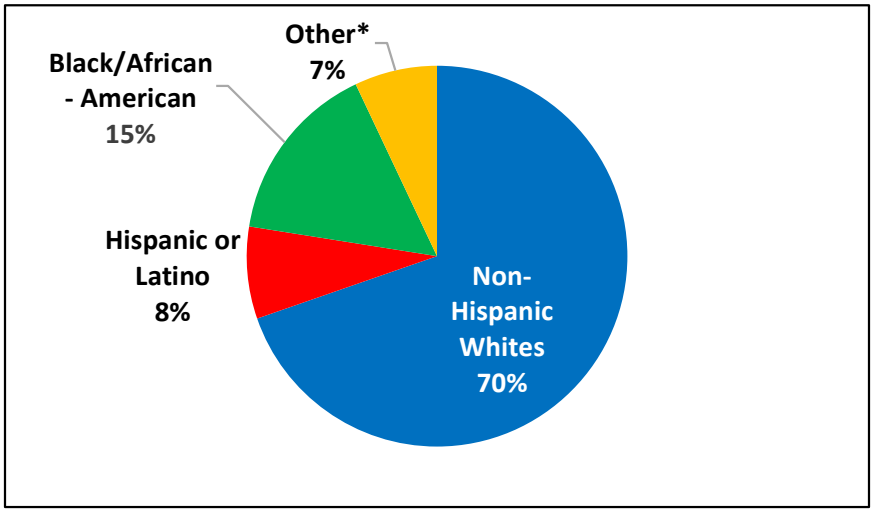
The work that followed hoped to uncover differences and determine which factors (socioeconomic and demographic factors, both patient-related and system-related) may be at play. Several follow-up and next steps were developed and mentioned in the report. These included:

1. Re-design of REaL data capture processes and re-training of staff on these processes.
2. Continued stratification of data, including the analysis of potential contributing factors.
3. Development of targeted, collaborative action plans aimed at addressing root causes.

The most recent census estimates that the county is increasing in its diversity. Since 2000, the Hispanic population has grown over 205%, up to 8% in 2016 from about 2.5% in 2000. At the same time, the non-Hispanic white population has seen a decrease from about 80% in 2000 to 70.3% in 2016. The black/ African American population and Other[3] population has also seen an increase in population size, though substantially smaller growth than the Hispanic population. Figure 1 displays the most recent demographic data from the U.S. Census Bureau.

[3] Other includes: American Indian and Alaskan Native, Asian, Native Hawaiian or other Pacific Islander, some other race, two or more races

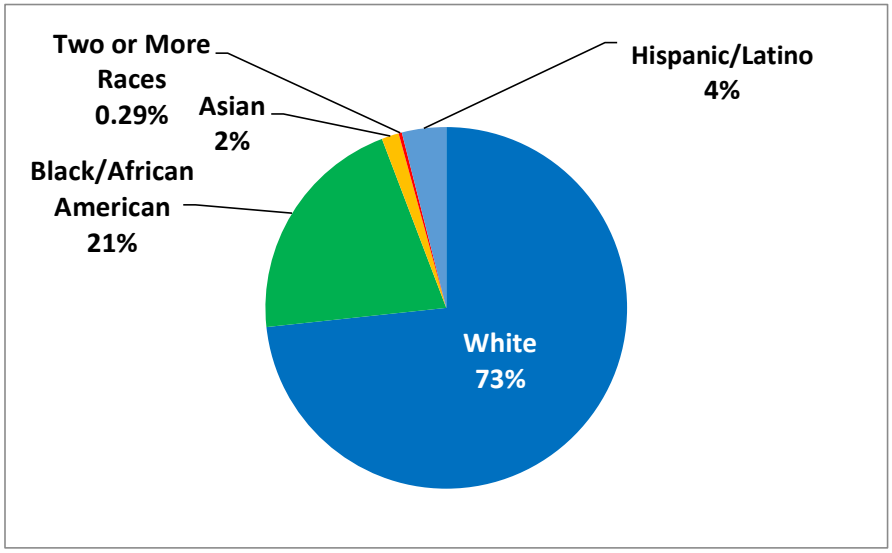
Figure 1: Anne Arundel County Demographics, 2016



Source: *U.S. Census Bureau, American Community Survey 2016*

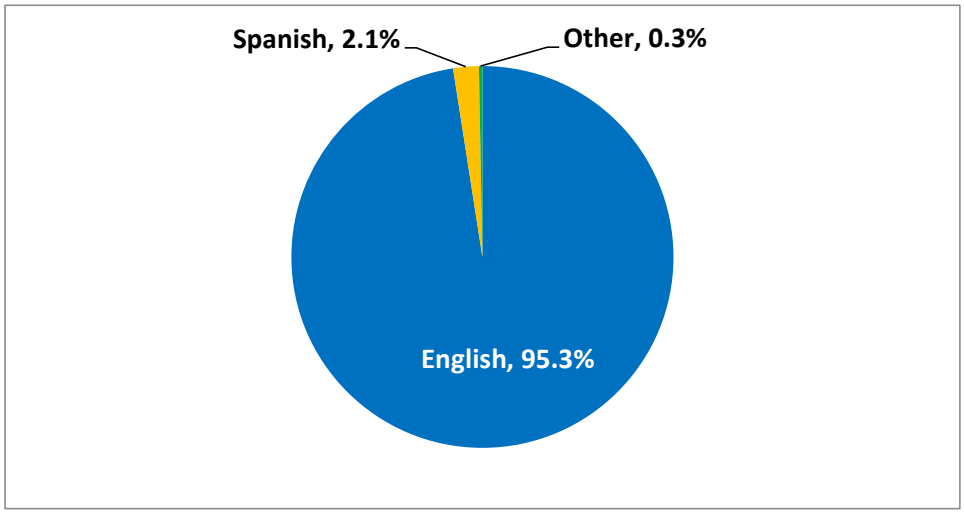
Of patients serviced at Anne Arundel Medical Center in fiscal year 2018, 94% had race, ethnicity, and/or language preferences documented within their Electronic Health Record. Training a wide range of staff responsible for the registration of patient information to include REaL data demographics has resulted in an increase of demographic documentation. AAMC recently began collecting sexual orientation gender identity (SOGI) data, with over 2000 patients SOGI documented three months after implementation. Continued efforts will focus on SOGI data collection in addition to REaL data collection. Inpatient demographics and language preference are displayed in the following figures (2-3).

Figure 2: FY18 AAMC Inpatient Demographic Data, Race/Ethnicity, July 2017-June 2018



Source: *AAMC FY18 Internal Data*

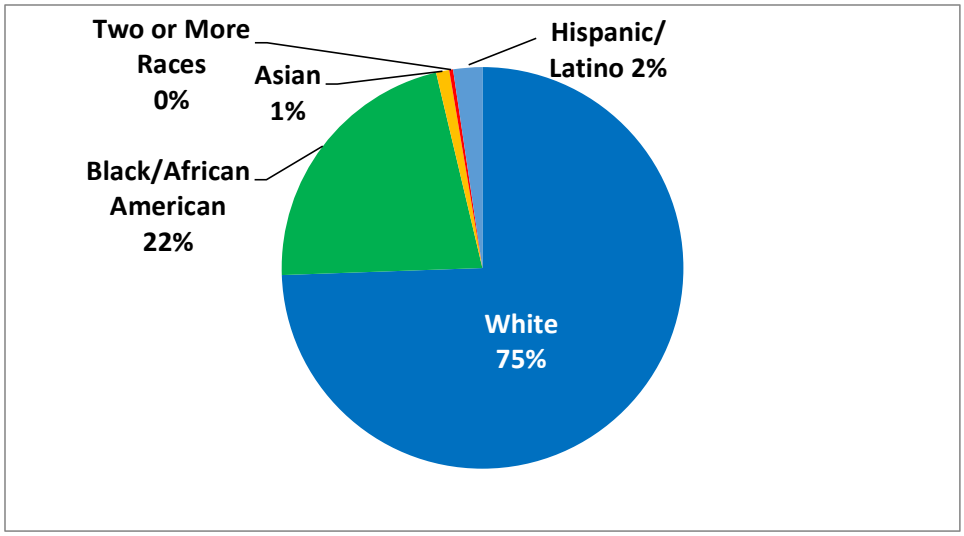
Figure 3: FY18 AAMC Inpatient Demographic Data: Patient Language, July 2017-June 2018



Source: *AAMC FY18 Internal Data*

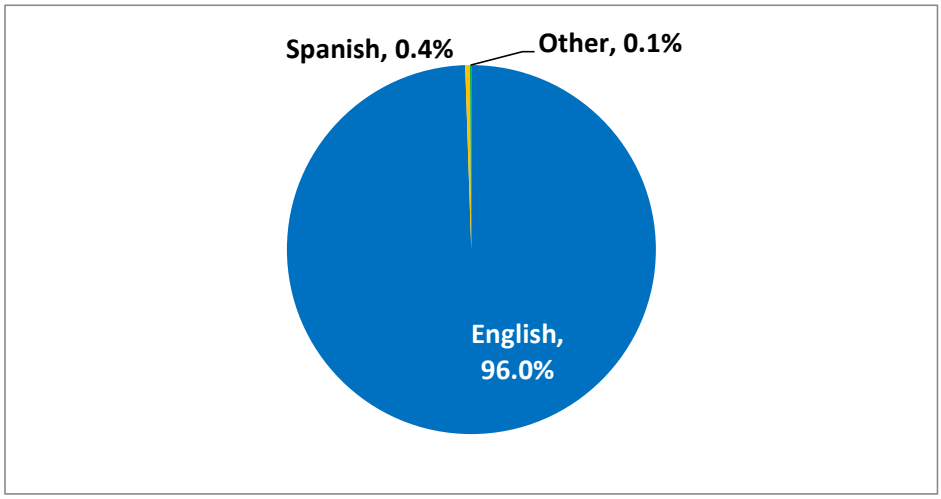
For patients that were serviced at our outpatient settings in fiscal year 2018, 93.0% of respondents completed REaL demographic data. There was little difference from the inpatient data collection, though Spanish speaking patients self-reported or attended outpatient settings less than the inpatient setting. The demographic and language data can be found in Figures 4-5.

Figure 4: FY18 AAMC Outpatient Demographic Data: Patient Race / Ethnicity, July 2017-June 2018



Source: *AAMG FY18 Internal Data*

Figure 5: FY18 AAMC Outpatient Demographic Data: Patient Language, July 2017-June 2018



Source: *AAMG FY18 Internal Data*

In reviewing the latest data, the patient population has changed only slightly from the inaugural *Health Equity Report*. The identified leaders of the four areas with identified disparities continue to develop action plans for improvement. In addition to this work, AAMC remains committed to fostering honest dialogue and open conversation about our patients, our care practices, and our disparities. The previously mentioned initiatives help set the tone for the development of a culture of equity throughout the organization. Support from leadership remains a crucial aspect to our commitment to this valuable work and helps us define our future plans. The awareness of disparities and commitment to resolving them will drive improvements inside our organization and has the potential to lead to positive cultural impact both within the hospital and the community at large.

Results Overview

As identified in the first annual report, differences by patient demographics that required further investigation were recognized in four major areas. These areas had a leader identified who was tasked with action plan development. These include:

1. **C-Section Rates**
2. **Readmission Rates**
3. **Length of Stay**
4. **AAMG Patient Satisfaction** with office follow-up with test results

Based upon initial analysis, follow-up work was conducted with a broad group of stakeholders to further understand the differences, the causes and subsequent improvement efforts to eliminate the disparities. Clinical and administrative responsibility involved creating systems and processes allowing everyone to maximize their skills, expertise, and effort. This report provides an update in each of the identified areas.

C-SECTION RATES

Initial C-section results revealed a disparity between white patients and black / African American patients. Fiscal year comparison from 2017 to 2018 is listed below.

Table 2: NTSV Births and C-Section Rates

NTSV* C-Sections ***Mother's Race***	FY17 NTSV Births	FY17 Total C-Sections	FY17 Total C-Section Rate	FY17 NTSV C-Section Rate	FY18 NTSV Births	FY18 Total C-Sections	FY18 Total C-Section Rate	FY18 NTSV C-Section Rate
White	1,261	**1,075**	32.2%	22.4%	1,182	1,060	31.3%	23.4%
Black or African American	401	**498**	41.8%	34.7%	364	418	39.5%	33.0%
Hispanic	158	**145**	26.7%	22.2%	141	149	28.9%	19.1%
Asian	72	**67**	36.8%	33.3%	74	60	32.6%	20.3%

Source: *AAMG FY18 Internal Data*

***NTSV** refers to nulliparous (first-time mothers) and term (greater or equal to 37 weeks) women carrying a singleton and vertex-presenting (head down) fetus. NTSV births are often referred to as "low risk". Also it is important to note that the information excludes races of other, Native American, as well as those who declined to answer; the sum of the NTSV columns will not total our NTSV total

Following the initial analysis referenced above, AAMC determined to take a closer look at provider-specific performance as well as patient-specific diagnoses' such as uterine fibroids/leiomyomata, a personal history of prior myomectomy (uterine surgery for fibroids) and hypertension, to determine the contribution of these factors in NTSV c-section rate disparities. NTSV C-Sections carry higher risks of negative outcomes for both mothers and babies, and nationally, non-Hispanic black women have disproportionately higher rates of NTSV C-Sections and much higher complications and maternal death rates. Reducing NTSV C-sections (and unnecessary C-Sections) can help reduce complications, costs, and improve care.

The Women's & Children's leadership team established several initiatives to reduce the disparities among minority women. A number of efforts were focused on improving patient education. After recognizing there was a higher number of C-Sections occurring in populations from Bowie, Maryland, prenatal courses were launched. The emphasis in the education was to give a better understanding of prenatal risks and pregnancy "to-do's". In addition, the Birth Class curriculum was updated with extensive clinical recommendations for promotion of vaginal deliveries, including management of early labor at home. We anticipate a slow and steady transition from higher rates of NTSV C-Sections to a culture that encourages NTSV vaginal deliveries. As AAMC continues to move several aspects of education to a technological platform, an educational "Benefits of Vaginal Birth" video was created in fiscal year 2018 and is being added to the Anne Arundel Medical Center's Birth and Baby Website, and the Spanish version is in the final stages of production. Both are set to be ready for viewing by mid fiscal year 2019.

A major advance in patient education and engagement is the partnering with Babyscripts (an online/app platform that is incorporated with MyChart). The patient will be able to access the application through AAMC's MyChart as soon as their pregnancy is determined. Babyscripts will provide mothers information pertinent to their stage of pregnancy and will allow staff to push reminders and notifications. In addition, it allows the mother to participate in the tracking of important information, like weight gain, throughout the pregnancy. In the future, the application may be paired with Bluetooth blood pressure monitors that can be used during the pregnancy, allowing for real-time information to be sent to the providers.

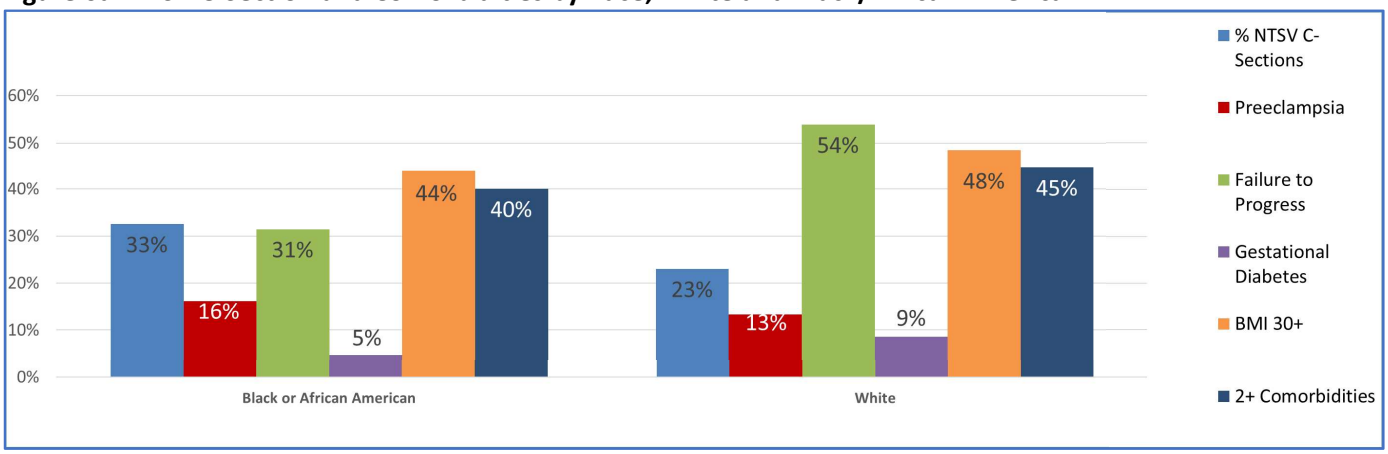
"Movement in Labor" was a concept emphasized in fiscal year 2018. All clinical staff were educated to the benefits of birthing mothers using peanut balls[4] when laboring. Appropriate use of peanut balls has been associated with an increase in the rate of vaginal birth. Peanut balls are now considered a standard part of care during the birthing process at AAMC, with an average of 40% of mothers now using peanut balls. This is a 13% increase from the beginning of fiscal year 2019. From our internal research, we also found that peanut ball use in NTSV patients correlated to lower rates of C-Section. The use of peanut

[4] Peanut balls are a specific birthing ball shaped so that they can be placed between the legs of a woman in labor. Several randomized, controlled studies found that peanut balls reduced length of labor while increasing rate for vaginal birth

balls is now considered a standard of practice, and rates are expected to continue increasing across all physician practices.

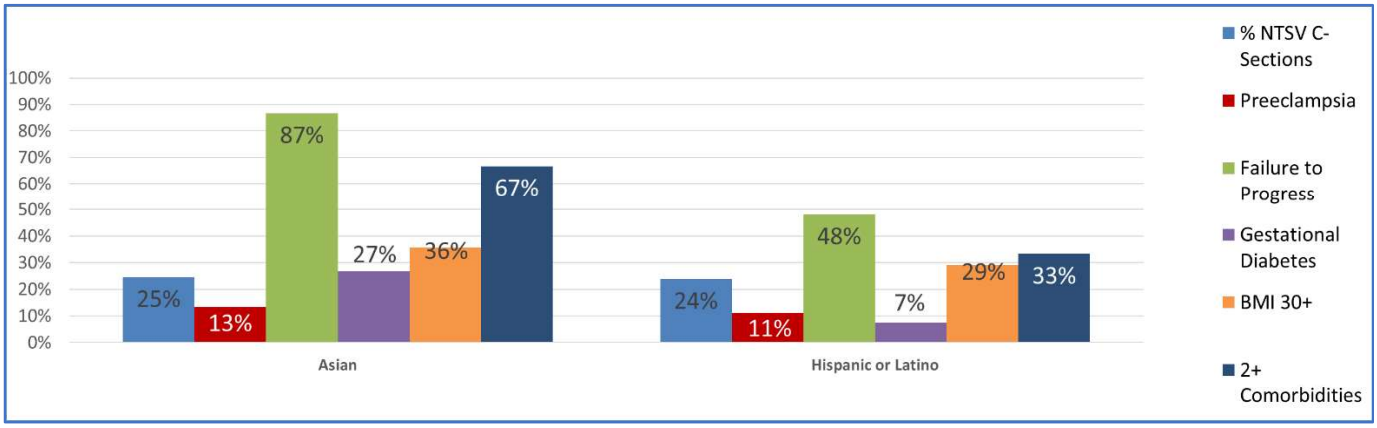
Within fiscal year 2018, many other initiatives were undertaken by the Women's & Children's Service Line to help reduce not only the disparity in NTSV C-Sections but the general C-Section rate. Several practices agreed to eliminate elective inductions. Data collection throughout Women's & Children's has allowed for a thorough analysis of the comorbidities in the patient population being served. With thorough understanding of patients' comorbidities, upcoming interventions and educational materials can be better prepared (figure 6 a,b).

Figure 6a: NTSV C-Section and Comorbidities by Race, White and Black/African American



Source: *AAMG FY18 Internal Data*

Figure 6b: NTSV C-Section and Comorbidities by Race, Asian and Hispanic or Latino



Source: *AAMG FY18 Internal Data*

There will be a continuation of this work into the fiscal year 2019. Specifically, these will include several provider education sessions around overcoming implicit bias, meetings to address team development, "cup of coffee" campaign to help foster peer coaching, and a labor management protocol that will begin in March of 2019. Next year's report will hope to show additional improvements in reducing the disparity.

READMISSION RATES

AAMC examined the 30-Day Readmission Rate and Length of Stay metrics (mentioned later) as measures of efficiency. Both revealed a disparity between white and black or African American patients. Despite volume decreases for white and black patients, readmission rates stayed relatively constant for whites and increased slightly for blacks. Asian patients, conversely, saw an increase in total visits but had a significant decrease in their readmission rates.

Table 2: Readmission Rate, Inpatient*

30-Day Readmission Rate	FY17	FY18
Race		
White		
# of Eligible Discharges	18,664	17,412
# of Readmissions	1,435	1,324
Readmission Rate	8.22%	8.15%
Black or African American		
# of Eligible Discharges	5,366	4,977
# of Readmissions	548	524
Readmission Rate	10.89%	11.28%
Hispanic		
# of Eligible Discharges	1,037	948
# of Readmissions	56	46
Readmission Rate	5.58%	5.01%
Asian		
# of Eligible Discharges	347	356
# of Readmissions	23	16
Readmission Rate	6.95%	4.71%

Source: *AAMC FY17,18 Internal Data*

* excludes pediatric patients

Understanding the disparity in readmissions requires further analysis of the inpatient population: socioeconomic status, insured status, disease type and burden, gender, access to transportation, and other factors. Though the Anne Arundel County Community Health Needs Assessment addressed that transportation remains an issue for our county, further analysis is needed for hospital-specific transportation issues.

In fiscal year 2018, black/ African American patients continue to be referred to post-discharge case management resources through The Coordinating Center, Queen Anne's County Mobile Integrated Community Health, and Prince George's County Mobile Integrated Healthcare. Participation in The Coordinating Center has demonstrated reduced readmission rates in all populations; in the seven

months of data collection, the black/ African American acceptance rate[5] was 36% compared to 30% rate for whites. But in addition, there were almost three times as many whites referred as black/ African Americans. We continue to encourage partnerships that will increase access and acceptance into these post-discharge case management resources.

[5] Here, acceptance rate refers to accepting services provided by the Coordinating Center. Additional analysis is needed to understand the combined referral network and efforts underway for fiscal year 2019 hope to better address this program.

LENGTH OF STAY

A disparity in the length of stay amongst white and black patients both in the medical inpatient adult population and in Clatanoff Pavilion (NICU, Mother Baby, Women's Surgical, and Labor & Delivery) was recognized during fiscal year 2017. In fiscal year 2018, various efforts to decrease the length of stay led to a decrease by almost equal rates among populations however, a disparity persists amongst white and black/ African American patients. English speakers saw a reduction in length of stay but Spanish patients did not. The number of Spanish speaking patients is much smaller than the other populations that it could be negatively affected by patient outliers. We continue to support Spanish speaking patients with 24-hour language interpretation. Spanish speakers saw a 15% increase in their length of stay from fiscal years 2017 to 2018.

Table 3: AAMC Length of Stay

Length of Stay* (in days)	**Inpatient Units**			
Race	**Total Patient Encounters**		**Average L.O.S.**	
	2017	**2018**	**2017**	**2018**
White	14,116	13,499	4.09	3.84
Black or African American	3,895	3,783	4.80	4.33
Language				
English	18,762	17,989	4.24	3.97
Spanish	223	192	3.80	4.35
Length of Stay^ (in days)				
Race	**Clatanoff Pavilion**			
White	4,171	4,005	2.26	2.25
Black or African American	1,404	1,215	2.64	2.69
Language				
English	5,551	5,340	2.38	2.37
Spanish	356	315	2.25	2.38

Source: *AAMG FY18 Internal Data*

*Excludes: Clatanoff Pavilion

^Only: Clatanoff Pavilion

The model of care on the medical inpatient units have been changed to include a new partnering with physicians, care managers, and the primary nurse during rounding. In addition, positions and processes were redesigned and extensive provider and staff training was provided. Reporting and accountability for outcomes was increased through additional tracking measures. Following an initial reduction in length of stay, we began to notice variance from the trend, indicating that there were additional factors that could be contributing to length of stay. Work is currently focusing on identifying gaps in care and solving for them; updates and more focused initiatives and approaches are expected through the year.

As done in the medical floors, the ICU was remodeled to a different standard of work. The ICU did notice improvement after adapting the process. Following exercises to understand current state, a

multidisciplinary rounding workflow was established to incorporate all patient care stakeholders, patients, and families in goal-oriented standard process for care treatment and planning. The multidisciplinary team changed workflow so that patient care rounds are completed three times a day, enabling increased collaboration between physicians, nurses, and patients. In this new workflow, all patient care stakeholders were required to attend the first rounds of each day, followed by having identified stakeholders in the remaining daily round times. First (morning) rounds focused on standard work set by the ICU team incorporating daily goals for care and plan management, as well as reporting structure for the team. Additional rounds focused on follow-up for daily goal completion and patient care planning. This has led to a decrease in average length of stay from 173.2 hours to 93.3 hours in 6 months' time.

We have achieved a lower length of stay in the ICU but note that the disparity persists. The next-stage of work will include expanding these efforts to identify specific differences in populations by specifically reviewing the social determinants of health. We are in development of the concept of a continuity clinic which will be run by the GME residents and fellows. This will help provide access and ensure continuity of care post discharge for some patients. Appropriate patients will benefit from easier access to services.

AAMG PATIENT SATISFACTION

The Institute for Healthcare Improvement (IHI) concisely describes what it means to be patient-centered: "Care that is truly patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles." AAMC's patient satisfaction scores provide excellent insight into how patients perceive the organization as well as the areas needing improvement. The scores listed in the table below indicate the percent of patients rating the questions asked by Press Ganey as a 9 or 10 on a scale of 1-10. The percentile ranks compare our system's results with all those scored by Press Ganey.

Patient satisfaction scores for the ambulatory settings were analyzed. Overall patient satisfaction scores showed variance in percentile ranks between white and black/ African American patients, though scores and changes between fiscal year 2017 and 2018 were similar. As observed in both fiscal year 2017 and 2018, one metric regarding the physician office following up with test results shows a significant difference in both percentage and percentile rank: Office Follow-Up with Test Results. Action items developed to address this disparity are discussed below.

Table 4: FY18 Patient Satisfaction*

Patient Satisfaction: Overall ***Race***	N 17 (Responses)	Score 17	Percentile Rank 17	N 18 (Responses)	Score 18	Percentile Rank 18
White	10,967	88.8%	78th	26,994	89.8%	63rd
Black/African American	1,805	85.6%	43rd	4,721	86.9%	46th

Source: Press Ganey

*AAMG Practices, not including the Community Clinics

Table 5: FY18 Individual Survey Questions from Patient Satisfaction*

Provider Spent Enough Time with You ***Race***	N 17 (Responses)	Score 17	Percentile Rank 17	N 18 (Responses)	Score 18	Percentile Rank 18
White	11,178	94.2%	63rd	26,942	94.7%	53rd
Black/African American	1,838	92.4%	43rd	4,713	92.6%	35th
Office Follow-Up with Test Results ***Race***	**N 17 (Responses)**	**Score 17**	**Percentile Rank 17**	**N 18 (Responses)**	**Score 18**	**Percentile Rank 18**
White	5,762	78.6%	71st	12,730	79.2%	64th
Black/African American	939	68.0%	23rd	2,161	70.1%	35th

Source: Press Ganey

*AAMG Practices, not including the Community Clinics

The Patient Satisfaction group developed action plans to address this data. Several initiatives were launched at the end of fiscal year 2018, and some others followed at the very beginning of fiscal year 2019. The patient satisfaction team found that the most significant disparities in office follow-up were in primary care offices or in orthopedics. As a result of this, there were some communication action plans developed for the Health Care Enterprises (HCE) team. HCE individual practices and management teams received diversity and inclusion training that included cultural competency training and orthopedics staff received customer service training from the Performance and Career development team. These initial efforts were to encourage a proactive conversation about opportunities for improvement and increasing diversity understanding, awareness, and acknowledgement throughout HCE.

Following primary initiatives, additional efforts were implemented throughout HCE. A retraining plan for HCE staff in REaL data collection (via HealthStream) was launched in addition with a seminar for face-to-face training in REaL data collection. Diversity and inclusion training continued in the HCE individual practices and an external customer service assessment of orthopedics was produced to assess improvements. More recently, an Orthopedics Diversity and Inclusion workgroup was created to encourage continued improvement. Physician and provider plans are being developed for diversity and inclusion training within HCE as well as a plan for SOGI training.

One can see that there is improvement in the percent of all patients scoring answers to these questions with a 9 or 10. However, a disparity still exists and work to continue to educate staff and providers persists.

Additional Quality Measures

Additional quality measures were analyzed and stratified according to the IOM's aims for quality: safe, timely, effective, efficient, and patient-centered. Several other measures from last year were identified for review and analyzed for possible variance from previous scores. There were no disparities in these data sets. The data below were specific points we highlight in this report, and were based on their overlap with IOM aims for quality. It should be noted that several categories (e.g. OP18-b & ED1-b) show disparities between racial groups. As is the case in previous categories, the number of distinct patients within these racial groups (Asian, Hispanic) is too small to make definitive conclusions about the disparities noted and should not be taken at face value. Data presentations to the Board Quality and Safety Committee and among other hospital boards, reflect the attention to differences and care taken around action plans prepared to target different racial groups, even if not identifying them as a disparity.

Timeliness

In establishing workflows and process improvement plans, it is important that timeliness is no more of a barrier for one population than another. Two specific timeliness measures AAMC evaluates are Emergency Department wait times and AAMG Days to Appointment.

Emergency Department

When compared to the previous year, volumes of all emergency department visits decreased but maintained similar rates for percentage of visits. Both OP-18b and ED-1b values for adult emergency department visits increased significantly, while pediatric ED wait times stayed relative similar.
When considering patient adherence to recommendations, access to care and access to transportation can often pose challenges when trying to schedule and attend follow-up appointments.

Table 6a: AAMC ED Wait Times, FY18 Adult

Wait Times (in minutes)	FY17 Emergency Department				FY18 Emergency Department			
	N (distinct patients, 79,873)	% of Visits	OP-18b	ED-1b	N (distinct patients, 80,088)	% of Visits	OP-18b	ED-1b
Race								
White	57,010	71%	194	412	56,297	70%	194	412
Black/African American	17,414	22%	183	416	17,494	22%	183	417
Hispanic	3,991	5%	206	487	3,987	5%	187	416
Asian	1,136	1.4%	210	441	1,148	1.4%	187	382
Language								
English	75,375	94%	190	413	77,850	97%	190	413
Spanish	2,024	3%	190	423	2,026	3%	191	418
Ethnicity								
Not Hispanic or Latino	69,105	87%	202	460	69,701	87%	190	412
Hispanic or Latino	3,991	5%	206	487	3,988	5%	187	416

Source: AAMC FY18 Internal Data

OP-18b: *ED Arrival to ED Departure*

ED-1b: *ED Arrival to Inpatient Bed*

Table 6b: AAMC ED Wait Times, FY18 Pediatric

Wait Times (in minutes)	FY17 Emergency Department				FY18 Emergency Department			
	N (Visits, 19,535)	% of Visits	OP-18b	ED-1b	N (Visits, 19,144)	% of Visits	OP-18b	ED-1b
Race								
White	13,498	69%	166	245	13,002	68%	166	239
Black/African American	5,130	26%	158	275	4,950	26%	157	233
Asian	379	2%	156	224	407	2%	158	196
Language								
English	18,303	94%	163	239	17,447	91%	163	239
Spanish	1,867	10%	163	259	1,772	9%	162	240
Ethnicity								
Not Hispanic or Latino	68,158	94%	187	418	15,823	83%	163	237
Hispanic or Latino	4,117	6%	190	412	2,969	16%	163	239

Source: *AAMG FY18 Internal Data*

AAMG Office Times

AAMG Days to Appointment were compared from fiscal year 2017 to fiscal year 2018, which indicated that Spanish-speaking patients had shorter average days from scheduling to appointment.

Further efforts to better understand this disparity we should track the average number of days from when the order is placed within the system (normally at a patient appointment) to the day the order/encounter happens. This can be difficult as certain recurring appointments (6-month or 12-month follow-up) at certain providers can possibly skew data based on demographics per practice per time interval to follow-up appointment. Additionally, any appointments scheduled in fiscal year 2018 that have not yet occurred at time of writing will not be reflected in these numbers. Quickly identifying factors that prevent earlier appointments (such as transportation issues) can lead to additional initiatives to better address various patient groups in our region.

Table 7: AAMG Days to Appointment, FY17 & FY18

AAMG Days to Appointment Race	N (Patient Encounters) 2017	 2018	% of Patient Visits 2017	 2018	Average Days from Schedule to Appointment* 2017	 2018
White	420,737	439,008	63.8%	59.9%	24.9	24.3
Black/African American	93,385	101,188	14.2%	13.8%	22.9	22.2
Language						
English	523,972	563,167	79.4%	76.8%	21.7	23.9
Spanish	9,296	9,819	1.4%	1.3%	18.3	17.8
Ethnicity						
Not Hispanic or Latino	468,968	508,476	71.1%	69.4%	21.8	24.0
Hispanic or Latino	20,446	20,961	3.1%	2.9%	20.5	19.9

Source: *AAMG FY18 Internal Data*

**measured from the amount of time it took between scheduling the appointment to being seen in office*

Patient-Centered Care

Patient-Centric care is typically measured using satisfaction rates. In considering ED disparities (particularly in wait times as seen above), demographics were also used to compare patient satisfaction rates between groups. On average, black/ African American responders had lower scores than white counterparts in a Press Ganey patient satisfaction survey. When further broken down, overall trending was favorable in the first few months of fiscal year 2019. This indicates that throughput initiatives and other efforts were able to positively influence patient satisfaction in the emergency department. Physician champions and leaders have stated their willingness to discuss patient satisfaction in their teams, address patients with honesty towards the wait-times, and show compassion and caring as they help them through any other questions.

Safety

Total Joint Arthroplasty (TJA) is a highly successful and common procedure at AAMC, however, disparities in utilization between black/ African American and white patients are known to exist within the system. In a recently posted article within *The Journal of Arthroplasty*, Dr. Paul King of the AAMC Center for Joint Replacement and others retrospectively analyzed data from TJA surgeries in order to evaluate the disparity at a single high-volume institution and try to add to national understanding. Additionally, with black/ African American patients known to have higher rates of diabetes and obesity within our service area; not only are these known risk factors for TJA but then also make our black/ African American patients higher risk candidates for TJA procedures. Data analysis, as we mention throughout this report, is only one component of the battle to reduce disparities. Creating action plans and implementing them in the system is a required part of this broader strategy. After analyzing more than 7,300 AAMC Joint replacements from 2013-17, we found a racial distribution comparable to the county demographics (84% white, 14% black/ African American). In looking at some differences in patient populations, it was noticed that white patients were more likely to have CAD or A-fib but that African American / black patients had higher rates of obesity, diabetes, and hypertension. Additionally, black/ African American patients' average income was lower per household (~$90K vs $96K).

Results indicated that black/ African American patients had a longer length of stay (2.27 vs 2.08) and were more likely to experience complications requiring an additional operation. There were several socioeconomic factors that could contribute to higher incidence rates for reoperation (access, transportation, housing). Additionally, a multiple logistic regression showed that black/ African American patients were 2.6 times more likely to discharge to a skilled nursing facility (SNF). This could indicate less support in the home environment by exposing patients to possible complications like infections. As a result of the review of this data, multidisciplinary team meetings in the Center for Joint Replacement have begun. In addition, partnerships with primary care providers through the collaborative care network have been developed. By better educating all parts of the care continuum to the complications possible to higher risk patients, we hope that primary care physicians will help better prepare and help select patients appropriate for surgery. Lastly, work is occurring so that all higher risk patients will go through our pre-anesthesia testing center where recommendations might be made to reduce a patient's risk factor for surgery.

Additional Updates

While collecting patient REaL data and developing the *Health Equity Report* is the first and most important step in knowing our patient population (Figure 1, first row), AAMC is also actively involved in other critical areas focused on furthering diversity and inclusion, cultural competency, and disparities elimination. This report is intended to connect patient demographic data to patient outcomes and was not intended to discuss the additional education and training, communication, or leadership commitments taking place in the organization. Though not part of the *Health Equity Report*, these areas are an important part in trying to achieve a more diverse and equitable workforce and population. Below is a summation of these initiatives, placed here in an effort to inform readers about how the data aids the other priorities.

Table 2: AAMC Health Equity Prioritization

Priority and Actions		To-Date Actions
Data Collection and Analysis	2. Tie patient demographic data to patient outcomes	Health Equity Report and action plans
Education and Training	5. Provide training to all executives, directors, managers and supervisors on how to manage a diverse workforce, including LGBTQ 6. Develop enhanced cultural competency education for all staff and clinicians 7. Provide training to all executives, directors, managers and supervisors on "Unconscious Bias" 8. Provide training on "Workplace Bullying"; Conduct follow-up survey and focus groups targeted at RNs	Educational Classes
Communication and Awareness	3. Approach culture in a broad and inclusive basis of race, ethnicity, religion, economic status 4. ONGOING: Provide language translation/access support	Educational Classes Business Resource Groups
Engagement of Stakeholders	2. Include patient family advisors; include the patient's voice in identifying health and social issues	Patient & Family Advisors and their representation in all groups
Leadership Commitment	3. Create an ombudsman position within Human Resources 4. Implement hiring practices to support leadership diversity	True North workforce metric Diversity and Inclusion Manager

Leadership engagement in this work is demonstrated in additional ways as noted below. Please note that several initiatives began in the planning phase during fiscal year 2018 but were not officially launched until fiscal year 2019. For those that we can discuss at time of writing, we have included them for a better understanding of current and future state initiatives for the system.

LEADERSHIP COMMITMENT

1. **True North Metric on Diversity in Leadership**: In fiscal year 2019 we introduced the Diversity Equity and Inclusion Scorecard that has revealed an 8% increase in workforce diversity and 10%

increase in new hire diversity. The True North Metric definition of leadership has been expanded to include the positions Supervisor and above and is currently above goal for candidates interviewed for leadership positions.

2. **DEIL Scorecard**: In October of 2017 we implemented the DEIL Scorecard as a metric-tool to demonstrate workforce diversity efforts. Goals are set by the DEIL Council and address our applicants, candidates, and existing workforce. In the 18 months since implementation, substantial progress has been made within these various pools. Leadership diversity has increased from 14% to 21%, and full-time new hires are currently 57% diverse, with a 37% system-wide diversity. For individuals submitting applications for careers at Anne Arundel Medical Center, we are industry leaders in that diverse individual applications outweigh non-diverse individuals. Diverse applicants make up 61% of the applicant pool, and selected candidates are about 56% diverse. The DEIL Council tracks these methods with a scorecard to observe for continuous improvement in targets and goals.

3. **Community Health Needs Assessment (CHNA)**: Triennially, AAMC develops a CHNA and implementation plan, identifying our community's most important health needs and our plan to meet them. The most recent CHNA was completed jointly with the other hospital in our county and various community organizations. The work is supported by leadership and the results from the CHNA are used to shape strategic goals and initiatives.

EMPLOYEE ENGAGEMENT

1. **Business Resource Groups**: AAMC hosts 3 major business resource groups designed to support our diversity and inclusion goals. Business Resource Groups aim to create diverse inclusive environments that reflect a changing workforce and evolving communities. The groups are designed to create a welcoming environment for underrepresented new employees and are aimed at identifying synergy for business priorities and helping to remove barriers that impact the success of underrepresented populations.

    - The LGBTQIA Business Resource Group serves AAMC by positively influencing the environment, ensuring professional development for all LGBTQIA, and by assisting the organization in achieving its diversity and inclusion plan. In 2018, AAMC participated in the Health Equity Index Survey, administered by the Human Rights Campaign, and was named a "Top Performer."

        - In fiscal year 2019 the group coordinated our participation in the Health Equity Index Survey where our score increased 50 points earning AAMC an overall score of 80 making us a Role Model in the space of LGBTQIA diversity. The group also launched gender identity training for clinical staff responsible for

data collection and hosted a special information lunch n' learn during AAMC's Diversity and Inclusion Festival Week.

- The African American Business Resource Group was launched in fiscal year 2019 after unanimous approval from the DEIL Council. The group has designed a strategy to address workforce disparities by implementing programs and initiatives that include minority mentoring, professional development workshops, and life skills supports and educational opportunities for diverse applicants, candidates, and employees. The group will submit a full plan with program and target date deadlines for fiscal year 2020.

- The GenerationNOW Younger Professional and Emerging Leaders Business Resource Group were also launched in fiscal year 2019 after unanimous approval from the DEIL Council. The group has identified key priorities to be a voice for emerging demographics to enhance the patient and employee experience at AAMC. The group plans to focus on professional development, new employee onboarding, and recruitment efforts for members of emerging generations. The group will submit a full plan with program and target date deadlines for fiscal year 2020.

2. **Champions of Inclusion Network of Ambassadors Committee**: was formally launched in fiscal year 2019. With a top down, bottom up, middle out approach, to diversity and inclusion at AAMC, COIN is aimed at supporting bottom-up effort and empowering staff employees to champion awareness programs and architect programs to foster inclusion within their work teams. Designed to assist in developing action-oriented steps for each department and COiN supports our goals to introduce and integrate accountability measures around supporting diversity and inclusion throughout the system.

3. **Coming to the Table**: AAMC has a first-in-the-nation hospital-sponsored chapter of Coming to the Table that meets monthly. This program supports open, honest dialogue to heal wounds of discrimination due to race, ethnicity, sexuality and other cultural identifiers. In fiscal year 2019 the program trained additional CTTT facilitators so that we are able to host various sessions simultaneously in different locations and at different shifts throughout the system. In fiscal year 2020 the program aims to have 5 new facilitators and introduce 2 additional series.

STAFF EDUCATION

1. **Education and Training:** Education recently completed includes training on unconscious bias, workplace bullying, and enhanced cultural competency. Education recently completed includes training on unconscious bias, workplace bullying and incivility, grand round trainings on the varying dimensions of diversity, gender identity, disability employment awareness lunch n' learns, and enhanced cultural competency. Additional training efforts include the introduction

of DIVERSITY MATTERS Virtual Resource Center and incorporating Harvard University's Project Implicit IAT.

2. **New Employee Onboarding:** Introduce new employees to AAMC's philosophy and expectations regarding diversity equity and inclusion.

3. **Physician Onboarding**: Provide education about our diversity and inclusion strategy and increase cultural competency and knowledge of diversity as a service provider.

4. **Leadership Essentials**: Provide organizational leaders with the tools to lead without disrupting inclusion with key learning objectives to; provide staff and team members with the opportunity to foster inclusion, recognize their own bias, and be equipped with tools and techniques to lead and make leadership decisions not rooted in bias, be prepared to intentionally implement efforts to support diversity and inclusion at AAMC.

5. **Inclusion Series**: A nontraditional approach towards diversity and cultural competence training. The program uses interactive diversity theater to engage leaders and staff into open dialog about varying cultures and mitigating the impact of unconscious bias. The program theatrically acts out scenes from employee and patient experiences and demonstrates varying cultural perspective. By allowing reflection moments and self-assessment opportunities the key learning objectives are to bring awareness to unconscious bias and provide tools and techniques for mitigating unconscious bias. This helps develop greater cultural competency.

6. **Inclusion Groups:** The development and aims of our various inclusion groups are to support our diversity and inclusion goal to foster a workplace environment of inclusion. All the groups with their individual priorities and goals collectively work towards achieving this overarching goal.

7. **Inclusion Includes Y.O.U**.: as the umbrella for our diversity equity and inclusion strategy the initiative plays host and brand identifier to an abundance of projects and efforts aimed at increasing diversity, fostering inclusion, eliminating barriers to culturally customized care, ensuring equity in opportunity, and increasing supplier diversity. The initiative sponsors a monthly awareness campaign designed to bring attention and education around the diversity focus of certain months.
    a. In fiscal year 2019 we hosted 9 diversity campaigns with both awareness and educational programming including; February- Black History Month with an opportunity to remember, recognize, and learn about the medical breakthroughs in minority health and the African American pioneers in healthcare; March- Women's HERstory Month; May- Asian Pacific Islander Campaign; September- Hispanic Heritage recognition and training, October- Disability Employment Awareness recognition and training sessions.

8. **Cultural Workplace Diversity Initiative**: The aim of the Cultural Diversity Initiative and Workplace Advocacy Committee is to promote acceptance of peoples' differences while identifying and embracing their similarities. This work provides education and activities designed to enhance awareness and acceptance of the diverse cultures within AAMC and surrounding communities. The initiative creates collaboration with departments regarding clinical staff education and professional development as well as community outreach and engagement.
    a. In fiscal year 2019 the group supported initiatives to recognize the Rev. Dr. Martin Luther King holiday with a partnership with local area elementary, middle, and high schools to encourage students to enter AAMC's MLK Essay contest. The partnership engaged more than 60 youth and honored 7 children and young adults and their families. The committee hosts a weeklong festival during the month of June to help raise awareness and provide information and education about the cultures of the different communities and countries represented by the AAMC workforce.

PATIENT AND FAMILY ADVISORY COUNCIL (PFAC)

1. **Health Equity Patient-Family Advisory Sub-Committee**: This group of patient-family advisors evaluates programs at AAMC through a health equity lens. They are encouraged to be present at workgroups and task forces throughout the system.

SUPPLIER DIVERSITY

1. **Supplier Diversity**: Supplier diversity reflects purchasing products and services from diverse suppliers, such as those that are from minority-owned, female-owned, and veteran-owned businesses. In fiscal year 2018, AAMC collected baseline information on the current breakdown of supplier diversity and created an action plan to implement in fiscal year 2019. In efforts to expand supplier diversity, AAMC has incorporated several key components in promoting supplier diversity within the purchasing policies, thereby enforcing the goals of the action plans. Fiscal year 2018 spend on qualified, diverse, certified vendors was $3,349,401, equating to 1.07% of total supply spend. Targets were set to increase the percentage of spend in fiscal year 2019 to 1.25% or $3,930,459. This target remians fluid, and we will expect that, as we progress, we will adjust to reflect our business.

Conclusion

As we consider the future initiatives of our health system and better understand how we can help our patients, this report becomes an outline and guideline for continued discussion among leaders in developing system-wide initiatives. We will continue to evaluate progress on our identified disparities and monitor data to ensure we identify any new disparities that may appear.

Many socioeconomic and demographic factors, both patient-related and system-related, may be at play, and we hope that our efforts identify, address, and attempt to mitigate disparities as a result of these factors.

Follow-up and next steps include:

1. Continuation of REaL data capture and increased efforts of SOGI data capture.
2. Implementation of action plans aimed at root causes with periodic updates to boards and executive leaders, as necessary.

During all stages of these action plans, AAMC is committed to fostering honest dialogue and open conversation about our patients, our care practices, and our disparities. Data and analytics will continue to play a vital role in meeting the goals by tracking goals to identify areas of opportunity in our existing plans as well as supporting next-level analysis.

The ongoing initiatives help set the tone for the culture of equity taking shape throughout the organization. Support from leadership remains crucial to ensuring this valuable work carries momentum into the future and our awareness of disparities and commitment to solving them will drive improvements inside our organization and the community we serve.

6- MHA CCQI- DEI Strategy Presentation.pdf

Uploaded by: Bayless, Victoria
Position: FAV

Luminis Health

Maryland Hospital Association CCQI

Inclusion Includes Y.O.U.

DECEMBER 2020

Diversity Equity and Inclusion Strategy

Quality Measure

Tamiko L. Stanley, Director and Head of DEI

Luminis Health DEI Strategy

QUALITY METRICS

- Rate of Readmission
- Patient Experience
- Hospital Acquired Infection
- Mortality Rates

INSTITUTE OF MEDICINE QUALITY AIMS

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Patient-Centered Care

OTHER LUMINIS HEALTH QUALITY INDICATORS

- 35 Other Measures

Related to Morbidity

And Mortality


Diversity
Innovation
Creativity
Complex Problem Solving
Prediction Forecast
Inclusion Excellence
Enhanced Engagement
Increased Productivity
Improved Job Satisfaction
Enhanced Morale
Talent Optimization (Talent Magnet)
Increased Trustworthiness
Community Responsiveness
Equity
...every person is provided the opportunity to attain their full potential...
EXCELLENCE

INFUSE EFFORTS THROUGHOUT

TO FACILITATE GOAL ACCOMPLISHMENT

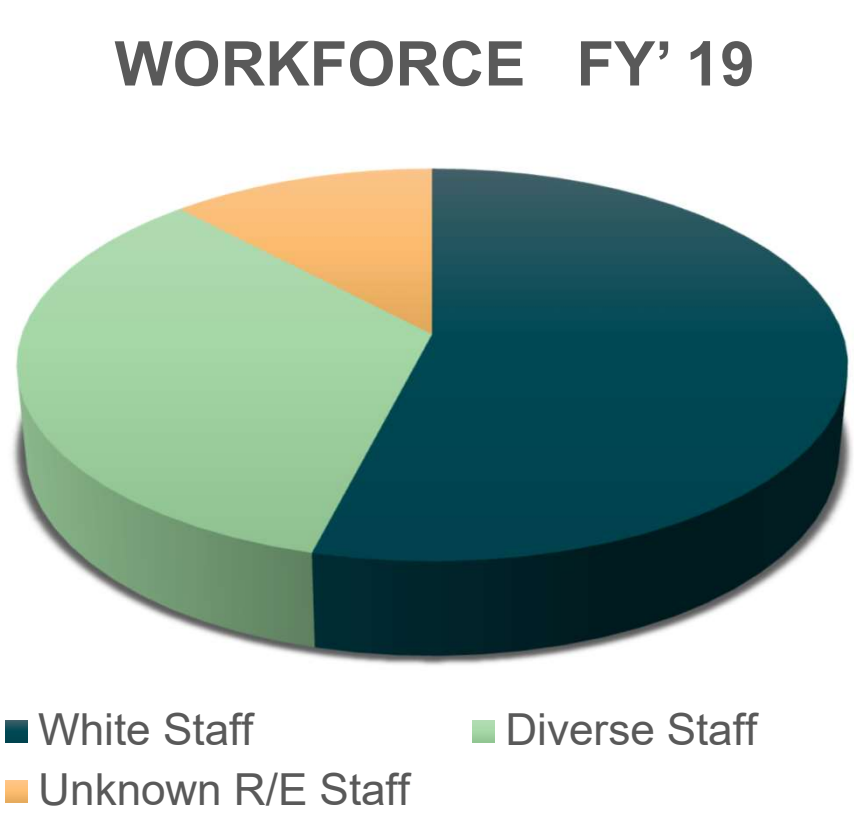
Goal: Outcomes. Quality Care. Eliminate Disparities

Taking Culturally Competent Care further to Culturally Customized Care

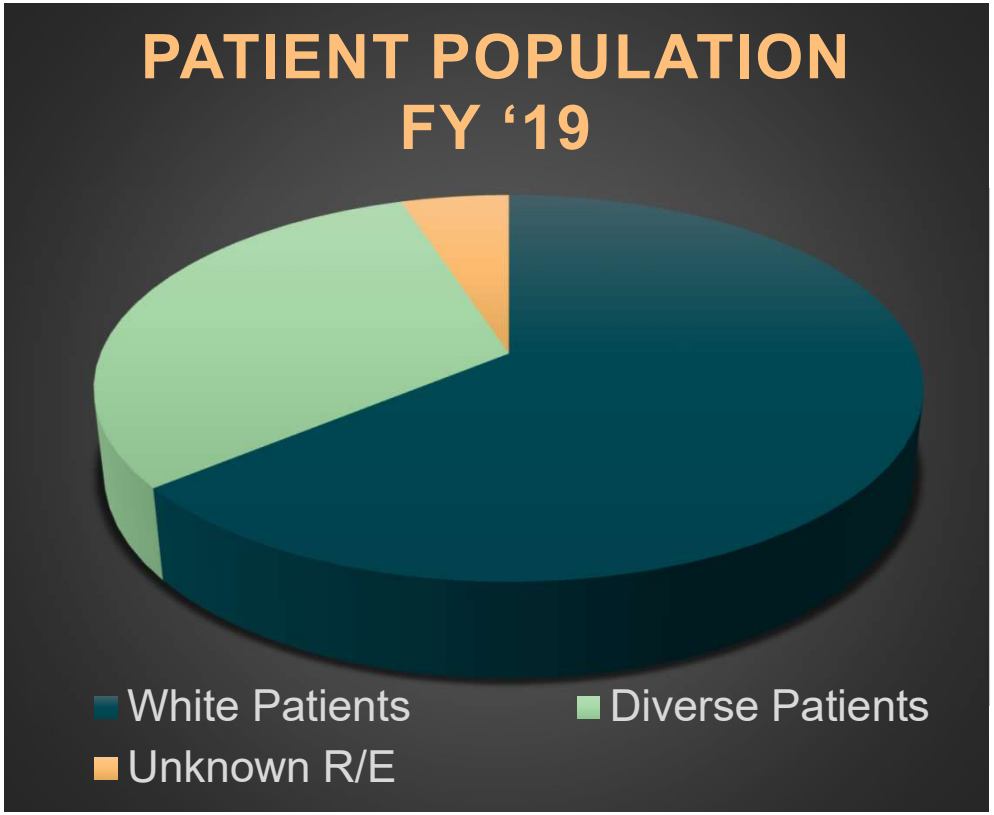
Effective Diversity Equity and Inclusion Strategy

Race – Ethnicity (AAMC)

Workforce

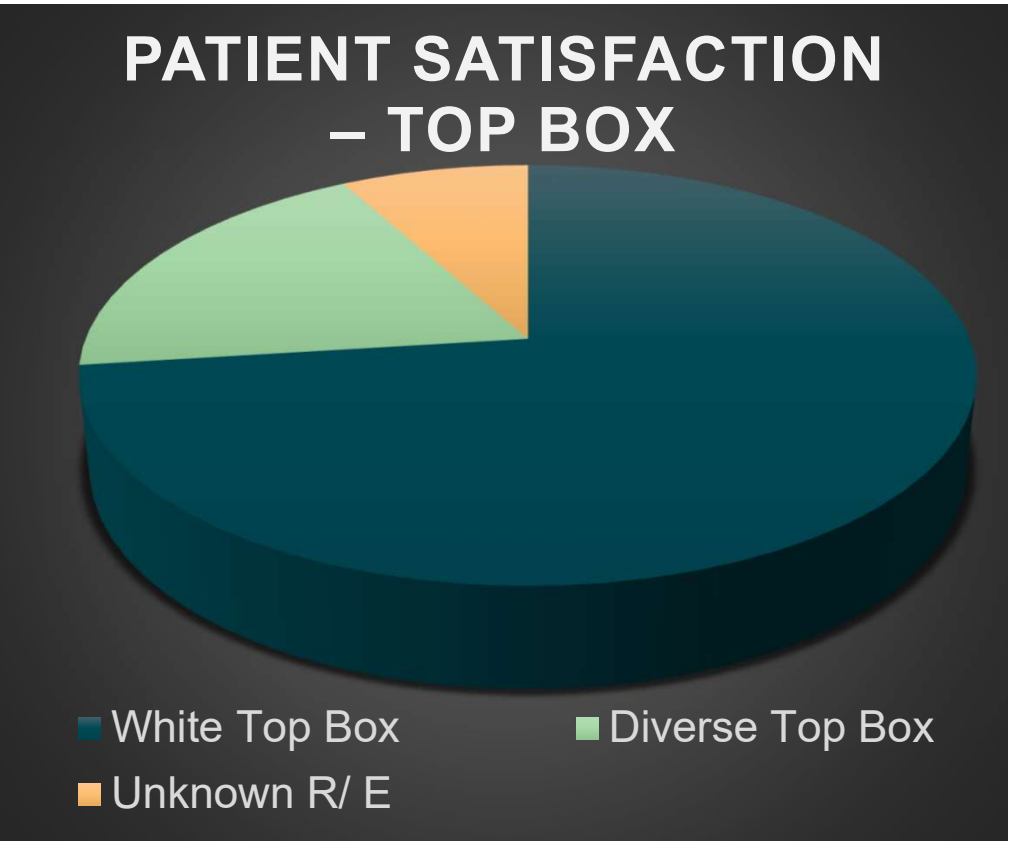


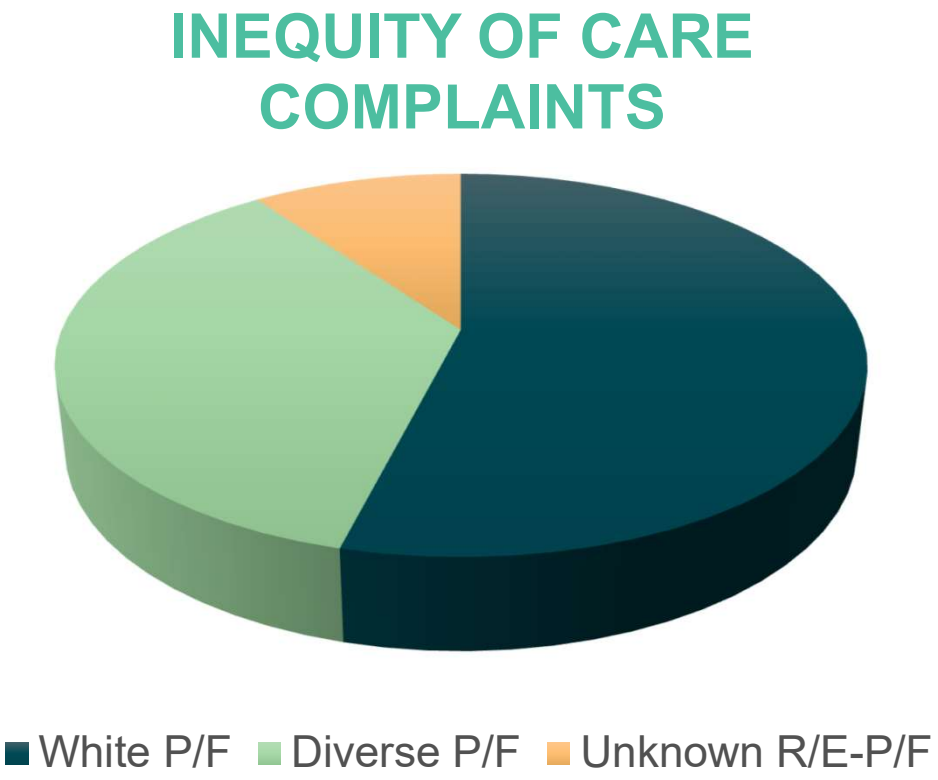
Patient Population



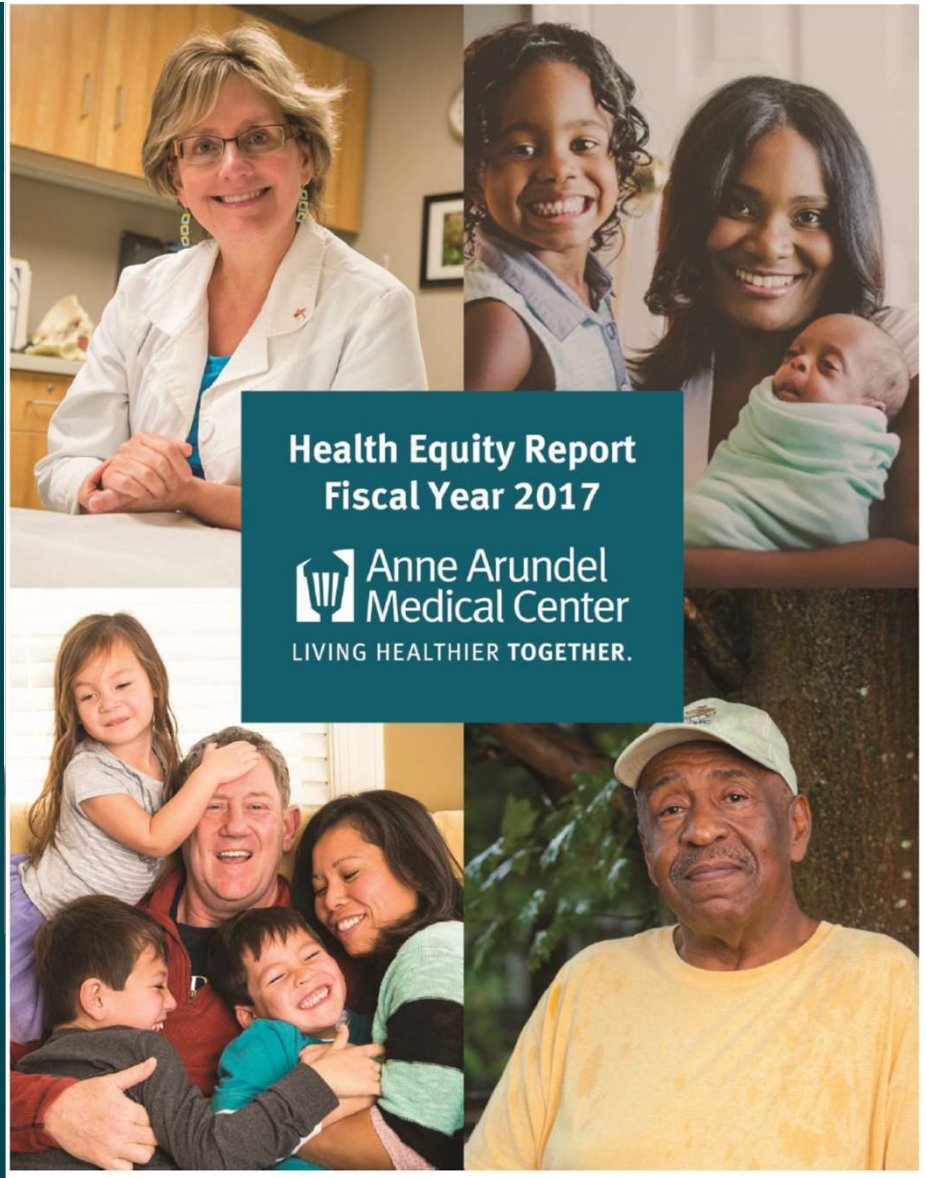
Race – Ethnicity (AAMC)

Patient and Family Experience

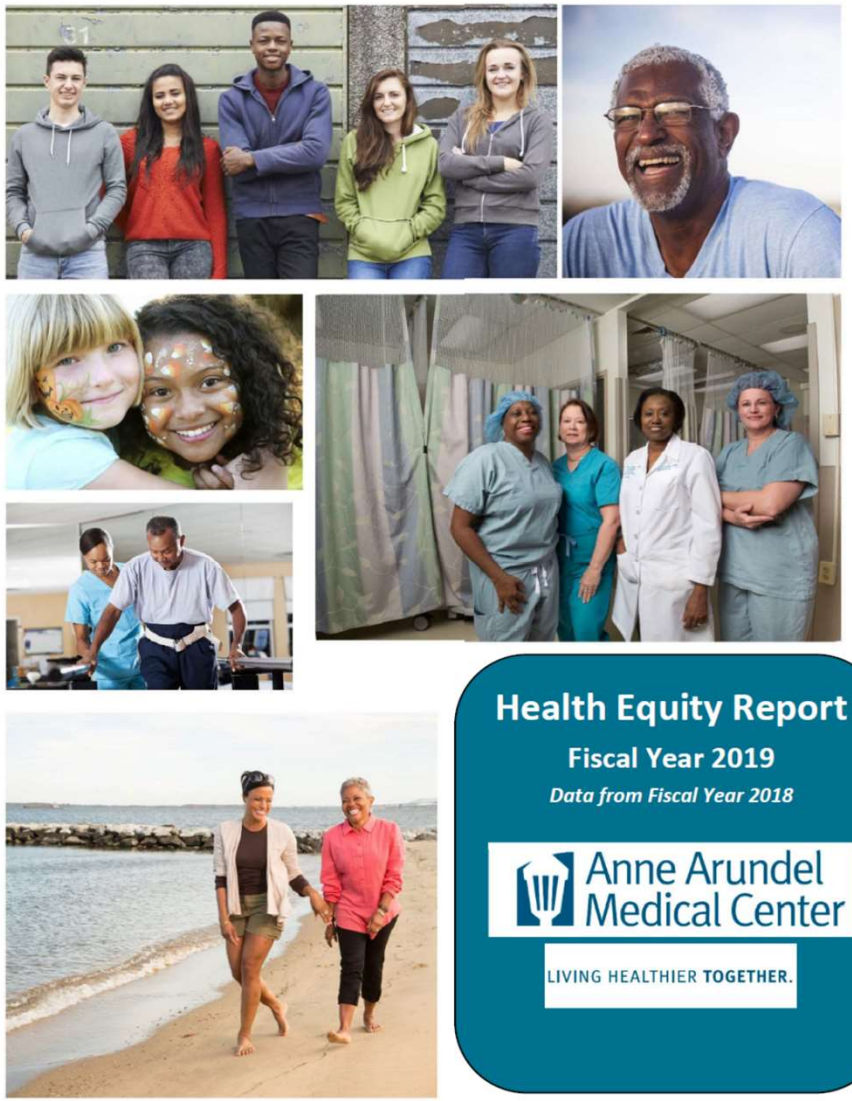




Quality Measures Stratified by: Gender, Age, Race and Ethnicity



- C- Section Rates
- Readmission Rates
- Average Length of Stay
- Patient Satisfaction



- BOARD DIVERSITY
- WORKFORCE DIVERSITY
- RETENTION AND TURNOVER-DIVERSITY
- EMPLOYEE ENGAGEMENT DIVERSITY
- PATIENT EXPERIENCE EQUITY
- WORKPLACE EQUITY
- HEALTH EQUITY GOALS

Luminis Health

DIVERSITY, EQUITY, AND INCLUSION LEADERSHIP COUNCIL: FY 21-Q1- July 1- SEPTEMBER 30, 2020

Diversity Report
Quarter1 FY '21

AREAS OF CONCERN

ALL METRIC SCORECARD (7/1/2020 to 9/30/2020)

	METRIC	TOTAL	UNKNOWN	BASE TOTAL	DIVERSITY	AFRICAN AMERICAN/ BLACK	AMERICAN/ NATIVE INDIAN & ALASKAN NATIVE	ASIAN	NATIVE HAWAIIAN/ PACIFIC ISLANDER	HISPANIC/ LATINO	OTHER/ TWO OR MORE	WHITE	TOTAL OF DIVERSITY	DECLINED / REFUSED ANSWER	LEFT BLANK INTERNAL/ UK	BASE TOTAL	DIVERSITY %	GOAL RANGE	GOAL FY 20	PREVIOUS QUARTER ACTUALS	% CHANGE
BOARD OF TRUSTEES	AAMC																				
	AAMC FOUNDATION																				
	DCMC																				
	DCMC FOUNDATION																				
	LUMINIS HEALTH																				
WORKFORCE	WORKFORCE																	40-50	40%		0%
	LEADERSHIP WORKFORCE (MANAGEMENT- Supervisor (+))																	37-47	27%		0%
	EXEC./ Sr. LEADERSHIP WORKFORCE (LEADERS- Director (+))																	35-45	25%		0%
	NURSING LEADERSHIP																	40-51	47%		0%
RECRUITMENT	TOTAL APPLICANTS																	50-60	59%		0%
	UNIQUE APPLICANTS																	50-60	59%		0%
	CANDIDATES																	50-60	55%		0%
NEW HIRES	NEW HIRES																	45-55	45%		0%
	FT NEW HIRES																	45-50	48%		0%
	NEW HIRES LEADERSHIP (Sup +)																	35-47	35%		0%
	NEW HIRES SR LEADERSHIP (Director +)																	35-47	35%		0%
	NEW HIRES NURSING (RN ONLY)																	38-49	38%		0%
RETENTION	PROMOTIONS																				
	LEADERSHIP PROMOTIONS																				
	NURSING PROMOTIONS																				
TURNOVER-RETENTION	TERMINATIONS																	30-35	30%		0%
	VOLUNTARY																	30-35	30%		0%
	INVOLUNTARY																	25-35	40%		0%
	NURSING INVOLUNTARY TERMS (RN)																				
HR DASHBOARD AND TR - ADP	INCREASE NUMBER OF DIVERSE LEADERSHIP CANDIDATES (AAMC - 80%)																				
	INCREASE NUMBER OF DIVERSE LEADERSHIP HIRES (AAMC - 51%)																				
	TOTAL % DIVERSE NURSES (RN) (AAMC -23%)																				
	DIVERSE FIRST YEAR TURNOVER (AAMC - 25%)																				
	TOTAL % OF HISPANIC EMPLOYEES (AAMC- 8%)																				
PULSE SURVEY - DEI	I FEEL MY LEADER PROMOTES AAMC'S COMMITMENT TO DIVERSITY EQUITY AND INCLUSION IN MY DEPARTMENT																				
	I FEEL AAMC PROMOTES THE COMMITMENT TO DIVERSITY EQUITY AND INCLUSION																				
INEQUITY OF CARE	PATIENT SATISFACTION																				
	INEQUITY OF CARE COMPLAINTS																				
EMPLOYEE ENGAGEMENT CONCERN	WORKPLACE INTAKE COMPLAINTS FOR INEQUITABLE TREATMENT																				
	DIVERSE WORKPLACE INTAKE COMPLAINTS																				
HEALTH EQUITY GOALS	PATIENT C-SECTION RATES																				
	30-DAY READMISSION RATES																				
	AVERAGE LENGTH OF STAY																				
	AAMG PATIENT SATISFACTION OFFICE FOLLOWUP ON TEST RESULTS																				

	METRIC
BOARD OF TRUSTEES	AAMC
	AAMC FOUNDATION
	DCMC
	DCMC FOUNDATION
	LUMINIS HEALTH
WORKFORCE	WORKFORCE
	LEADERSHIP WORKFORCE (MANAGEMENT- Supervisor (+))
	EXEC./ Sr. LEADERSHIP WORKFORCE (LEADERS- Director (+))
	NURSING LEADERSHIP
RECRUITMENT	TOTAL APPLICANTS
	UNIQUE APPLICANTS
	CANDIDATES
NEW HIRES	NEW HIRES
	FT NEW HIRES
	NEW HIRES LEADERSHIP (Sup +)
	NEW HIRES SR LEADERSHIP (Director +)
	NEW HIRES NURSING (RN ONLY)
RETENTION	PROMOTIONS
	LEADERSHIP PROMOTIONS
	NURSING PROMOTIONS
TURNOVER-RETENTION	TERMINATIONS
	VOLUNTARY
	INVOLUNTARY
	NURSING INVOLUNTARY TERMS (RN)
HR DASHBOARD AND TN - AOP	INCREASE NUMBER OF DIVERSE LEADERSHIP CANDIDATES (AAMC - 90%)
	INCREASE NUMBER OF DIVERSE LEADERSHIP HIRES (AAMC - 51%)
	TOTAL % DIVERSE NURSES (RN) (AAMC -23%)
	DIVERSE FIRST YEAR TURNOVER (AAMC - 25%)
	TOTAL % OF HISPANIC EMPLOYEES (AAMC- 6%)
PULSE SURVEY - DEI	I FEEL MY LEADER PROMOTES AAMC'S COMMITMENT TO DIVERSITY EQUITY AND INCLUSION IN MY DEPARTMENT
	I FEEL AAMC PROMOTES THE COMMITMENT TO DIVERSITY EQUITY AND INCLUSION
INEQUITY OF CARE	PATIENT SATISFACTION
	INEQUITY OF CARE COMPLAINTS
EMPLOYEE DISCRIMINATION CONCERN	WORKPLACE INTAKE COMPLAINTS FOR INEQUITABLE TREATMENT
	DIVERSE WORKPLACE INTAKE COMPLAINTS
HEALTH EQUITY GOALS	PATIENT C-SECTION RATES
	30-DAY READMISSION RATES
	AVERAGE LENGTH OF STAY
	AAMG PATIENT SATISFACTION OFFICE FOLLOWUP ON TEST RESULTS

BOARD DIVERSITY

WORKFORCE DIVERSITY

- -Leadership Diversity
- -Hospitalist Diversity
- -Nursing Diversity

RECRUITMENT DIVERSITY

- -Applicant Diversity
- -Candidate Diversity

NEW HIRE DIVERSITY

- -Leadership
- -Nursing

RETENTION and ADVANCEMENT DIVERSITY

- -Promotions

TURNOVER

- -First Year
- -Voluntary Terminations
- -Involuntary Terminations

EMPLOYEE ENGAGEMENT

- -Well-Being Pulse Survey- DEI

EMPLOYEE EXPERIENCE

- -Workplace Discrimination Complaints

PATIENT EXPERIENCE

- -Patient Satisfaction Rates
- -Inequity of Care Complaints

HEALTH EQUITY GOALS

- -Patient C-Section Rates
- -30-Day Readmissions
- -Average Length of Stay


QUALITY CARE DELIVERY- PATIENT OUTCOMES
Board and Leadership Engagement
Employee Optimization
Patient Experience
Operational Alignment and Excellence
Community Partnerships
Health Equity

Questions/

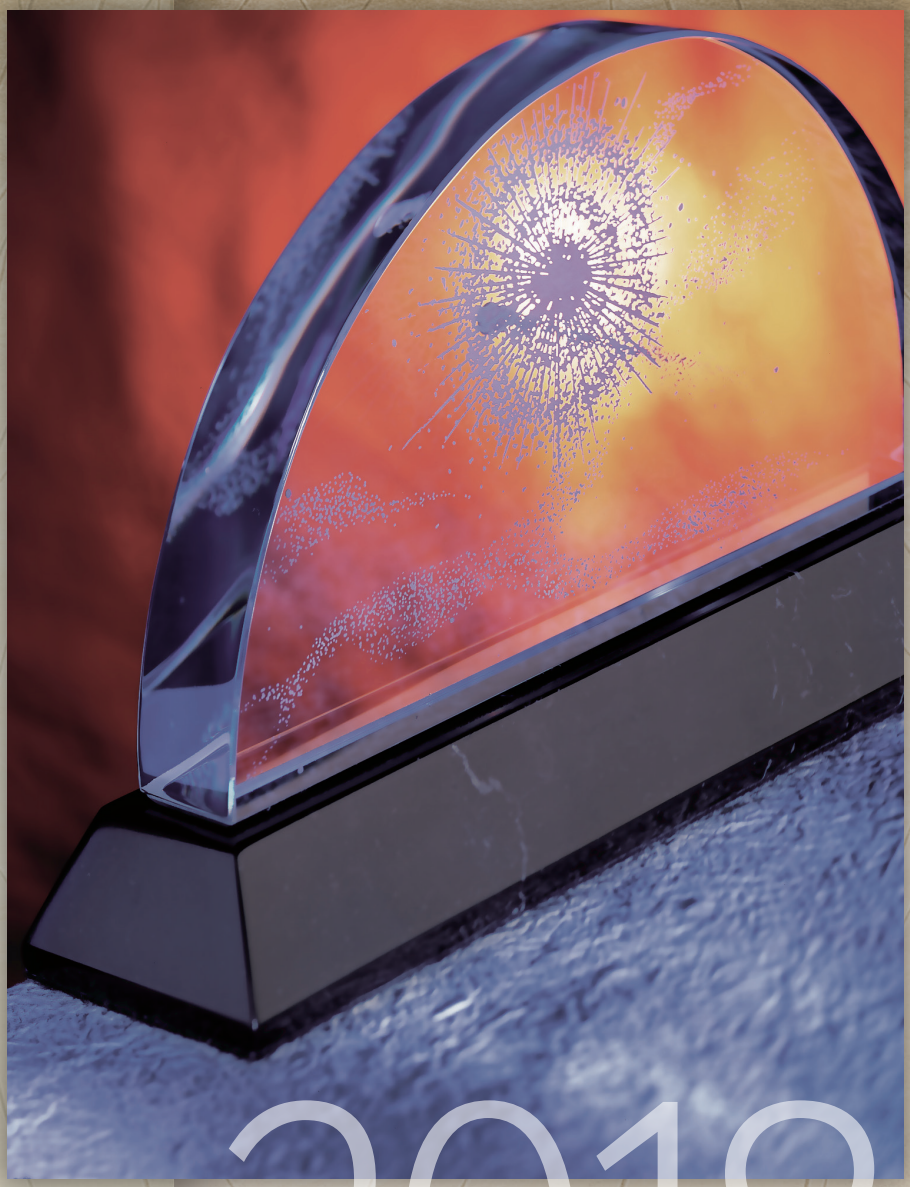
Feedback?

7- Nova Awards 2018.pdf

Uploaded by: Bayless, Victoria
Position: FAV

American Hospital Association™

Advancing Health in America



2018 AHA **NOVA** AWARD

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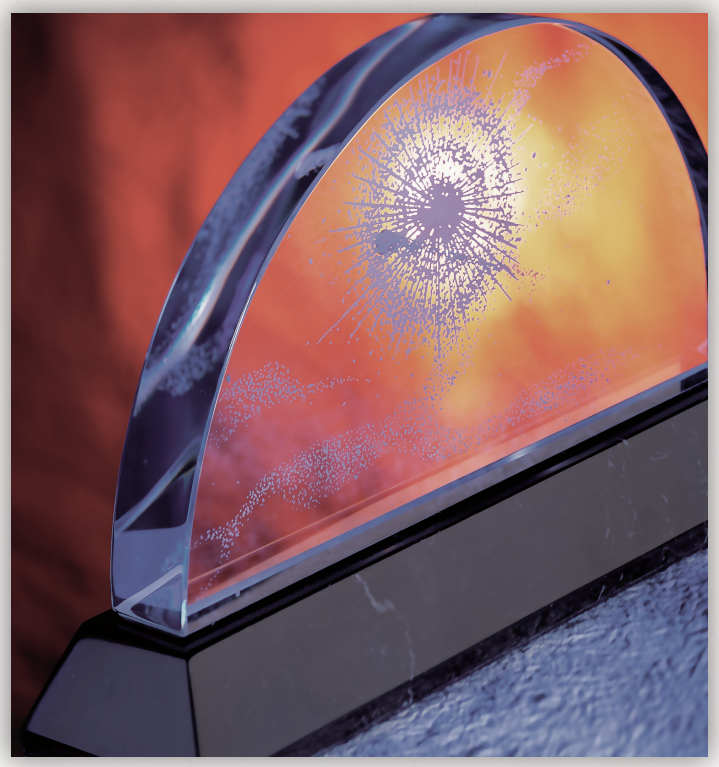

Each year, the American Hospital Association honors up to five programs led by AHA member hospitals as "bright stars of the health care field" with the AHA NOVA Award. Winners are recognized for improving community health by looking beyond patients' physical ailments, rooting out the economic and social barriers to care, and collaborating with other community stakeholders. The AHA NOVA Award is directed and staffed by the AHA's Office of the Secretary. Visit *www.aha.org/nova* for more information.

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ADVENTIST HEALTH • KAISER PERMANENTE • LEGACY HEALTH • OREGON HEALTH & SCIENCE UNIVERSITY

Portland health systems collaborate to meet behavioral health needs with psych center

Like many cities throughout the nation, Portland, Ore., suffered from a dysfunctional mental health system.

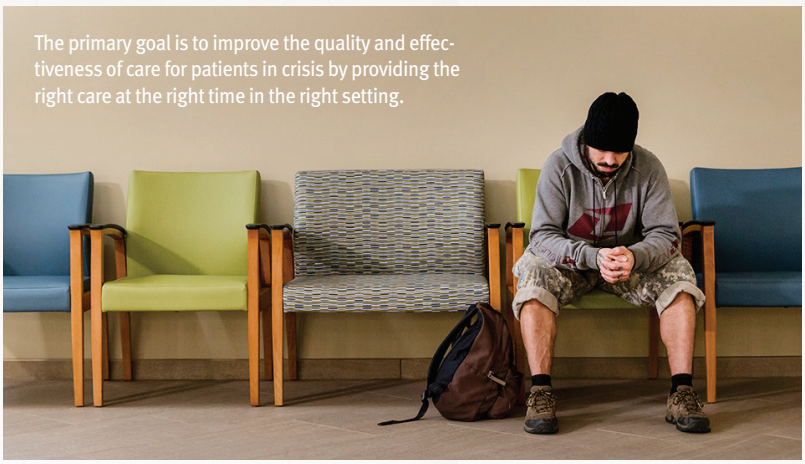
The nonprofit advocacy group Mental Health America has ranked Oregon as one of the worst states for access to care and prevalence of mental illness. Portland mental health patients in crisis frequently wound up in jail or the city's crowded emergency departments.

"We in Portland were struggling with the same issues that so many others across the country were struggling with," says Mike Newcomb, D.O., chief operating officer of Legacy Health. "Our mental health programs weren't coordinated, and existed as individual silos within hospitals in the metropolitan area."

George Keepers, M.D., chair of the Department of Psychiatry at Oregon Health & Science University, says mental health patients transported to EDs "were overloading those systems. Oftentimes, they waited for long periods of time for hospitalization, sometimes two days, in very small, cramped facilities with inadequate initial treatment, due to the limitations of regular EDs. There was a need for a larger hospital unit to take over these tasks."

That need was addressed head-on with the February 2017 opening of the Unity Center for Behavioral Health, a collaborative venture of Legacy Health, OHSU, Adventist Health and Kaiser Permanente. It is Portland's first comprehensive behavioral health care center and the first psychiatric center in the country formed by four competing health systems.

"That is a huge shift," Newcomb says. "The thought was to go to some of our competitors in the community and see if they'd be interested in combining our inpatient mental health facilities. I got immediate responses of 'yes, we're interested, let's see what we can do.' Kaiser Northwest didn't have an inpatient mental health facility, so they were very interested."



The primary goal is to improve the quality and effectiveness of care for patients in crisis by providing the right care at the right time in the right setting.

The proposal was not easy to implement, Keepers recalls. "The development of a joint operating agreement required a long period of development and negotiation. And then the planning process itself took a long time because of the involvement of so much of the community."

Unity Center was established in a building owned by Legacy Health where more than 80,000 square feet of space became available. The center includes a psychiatric emergency room for adults and a 107-bed inpatient facility for adults and adolescents.

OHSU provides the psychiatric medical staff, residents and fellows.

All four health systems share in the costs of operating Unity Center, which also receives philanthropic support through grants and contributions.

Collaborative partners in the program include area police and emergency services, health and justice departments, accountable care organizations and community-based, mental health programs.

The primary goal is to improve the quality and effectiveness of care for patients in crisis by providing the right care at the right time in the right setting. Other key goals include reducing the amount of time area hospital EDs are on divert due to large volumes of behavioral health patients, reducing the number of short-term (less than 48 hours) behavioral health inpatient stays and improving outcomes for behavioral health patients through enhanced access to community-based services.

Early results showed that Unity Center was discharging 77 percent of patients, on average, after 20 hours of stabilization, mental health crisis intervention and discharge planning. Only 23 percent of the patients who enter Unity Center are admitted as inpatients, thereby eliminating unnecessary hospitalizations. Of those who are hospitalized, more than 89 percent attend their scheduled follow-up visit with a community-based provider within seven days, compared with the Oregon state goal of 80 percent.

Since Unity Center opened, Legacy Health has seen a 70 percent drop in ED divert hours, while Adventist Health has experienced a 37 percent reduction.

ANNE ARUNDEL MEDICAL CENTER

Maryland hospital establishes primary care practice in public housing apartment building

Anne Arundel Medical Center in Annapolis, Md., discovered a "hot spot" during a 2012 examination of readmission data: the Morris Blum Senior Apartment Building operated by the city's public housing authority.

Located just blocks away from the Maryland State House and upscale neighborhoods, Morris Blum and the surrounding vicinity are home to a medically underserved population. To bring better care to this population, AAMC worked with the housing authority to develop the Annapolis Community Health Partnership.

"It's well-aligned with our mission, our vision and our values," says Victoria Bayless, president and CEO of AAMC. "Our strategic plan for this decade, called Living Healthier Together, describes a system of care that goes outside the walls of the traditional hospital and health system, and that focuses on the patients and their families. It is driven by evidence and data, and it is accomplished through partnerships in the community, in a financially responsible way."

Bayless says AAMC determined that residents of the Morris Blum building had not been accessing health care in the best way, even though many were eligible for both Medicare and Medicaid.

The program's goals are to prevent, screen for, diagnose and treat disease, in order to reduce preventable complications of hypertension, mental illness, substance abuse, diabetes, lung disease, heart disease and cancer.

Patricia Czapp, M.D., AAMC's chair of clinical integration, says the hospital didn't want to "plunk a traditional primary care practice down in public housing. In fact, we knew that many of these folks had access to primary care, but it didn't seem to work for them. They kept coming to the emergency department and the hospital, sometimes for medical reasons and sometimes for nonmedical reasons."

Residents of the Morris Blum Senior Apartment Building had not been accessing health care in the best way.

In light of that, the program adheres to a nontraditional primary care practice model. Patients are welcomed, even when they show up late or without an appointment, and their needs are always addressed.

They are greeted by staff members who are recruited from the local community. Staff members are trained in national CLAS (Culturally and Linguistically Appropriate Services) standards, as well as how to maintain a calm, nonjudgmental, welcoming attitude.

Since implementation of the Annapolis Community Health Partnership, residents of Morris Blum and the surrounding community have generated fewer ED visits, avoidable hospitalizations and medical 911 calls, along with a 25 percent decline in hospital readmissions between fiscal years 2013 and 2017.

Quality measures also have shown improvements in diabetes control, hypertension control, BMI screening/follow up, colorectal cancer screening and mammography.

"In this population, with challenges involving physical activity and nutrition, we expected a lot of poorly controlled diabetics and we certainly found them," Czapp says. "Thirty-six percent of ours were poorly controlled. We were able to get that down to 28 percent in a year. We were able to engage folks in a medical regimen that made sense to them, and tie that to nutrition and physical activity, because you need all three to treat diabetes effectively. They made differences in their lifestyle that were enduring."

The program represents an "investment in the community's health," Bayless says. "If you look at the clinic on a profit-and-loss basis, we lose money on it. But if you look at broader population health and what we're trying to achieve in terms of reduced utilization of hospitals and EDs, and bring the most appropriate level of care to the right setting, we know we're doing the right thing."

HSHS ST. JOHN'S HOSPITAL • MEMORIAL MEDICAL CENTER

Community health worker program earns trust to address health challenges and other needs

The Enos Park neighborhood in Springfield, Ill., drew the attention of HSHS St. John's Hospital and Memorial Medical Center when they forged a collaborative community health needs assessment in 2015.

"Access to care was identified as one of the most significant issues in our community, and Memorial and HSHS St. John's Hospital decided to take a deep dive into one geographic neighborhood to identify and address issues that prevent residents from getting the care they need to live healthy lives," says Ed Curtis, Memorial's president and CEO.

That resolve led to the creation of the Enos Park Access to Care Collaborative, a three-year program launched in 2015. The Enos Park neighborhood ranked high in unmanaged chronic conditions such as diabetes, heart disease, mental health and pediatric asthma. Nearly half of the roughly 2,300 residents were below the federal poverty level.

Yet, Memorial stands on the southwest corner of Enos Park, and St. John's overlooks the southeast corner of the neighborhood. Close by is the Southern Illinois University School of Medicine's Center for Family Medicine, a federally qualified health center.

"If we can't do something for our own neighbors, what can we do across town or in another city?" asks Tracey Smith, director of the program.

The primary goals of the program are to improve access to health care through the efforts of community health workers, and increase access to pediatric mental health services through screening, intervention and education.

Other goals include reducing emergency department visits for non-emergent health issues and improving self-sufficiency for program participants.

"We conducted focus groups in the neighborhood," says Kim Luz, director of community outreach for HSHS St. John's and the HSHS Central Illinois Division. "We worked with the Enos Park Neighborhood Improvement Association to address identified needs."

Summer clubs for children aged nine to 14 include a bicycle club led by neighborhood police officers.

Focus group participants said the neighborhood needed a trusted individual who could help identify health care needs and guide residents through the health care system in areas such as accessing insurance and a primary care physician.

"We established the community health worker program to go in the neighborhood and meet people in their homes, to identify not only health care needs, but also basic needs that weren't being met," Luz says.

Smith says "education or degrees are not the most important aspects of someone who is a good community health worker. The key is to find someone whose heart is in the right place."

The program reached 1,095 residents in Years 1 and 2, including 300 clients enrolled in the community health worker program. All of those 300 clients selected a primary care home through the program. Clients needing mental health services completed 172 appointments, and there was a 22 percent reduction in unnecessary ED visits.

Overall, 38 percent of Enos Park residents had obtained greater access to care in the second year of the program.

But not all the improvements directly involve health care. For example, the Springfield Police Department reported a 22 percent reduction in Enos Park police calls in Years 1 and 2 of the program, and an 11 percent reduction in crime rates.

The program also developed summer clubs for children aged 9 to 14, including a bicycle club led by neighborhood police officers.

"The outcomes demonstrate that if you provide access to the right type of health care in the right place at the right time, it's going to contribute to wellness and a better living standard," says Charles Lucore, M.D., president and CEO of HSHS St. John's.

MEDICAL CITY HEALTHCARE

Collaboration with school districts, restaurants and employers encourages healthy snacking

Snack time often is poor nutrition time for kids. High-fat snacks contribute to childhood obesity, which can lead to lifelong health problems.

Medical City Children's Hospital in Dallas, part of Medical City Healthcare, took a novel approach to this problem when it created the Kids Teaching Kids program in 2010. The initiative includes high school culinary students creating healthy snack recipe books for elementary school kids throughout North Texas.

"Our program is about nutrition education," says Ryan Eason, Kids Teaching Kids program director and Medical City Healthcare community relations manager. "We noticed that many children with obesity get many of their calories through snacking. We worked with high school culinary students and got them to come up with healthier snacks that elementary school kids can make themselves."

Erol Akdamar, president of Medical City Healthcare, says Kids Teaching Kids is "an innovative program designed to help children develop lifelong healthy eating habits. As an organization, we are committed to the care and improvement of human life — and this program personifies that mission."

The recipe books feature snacks made with "all kinds of fruits and vegetables," Eason says. "We want to get kids to not only eat more fruits and vegetables, but try more fruits and vegetables."

Eason cites banana sushi, "which a student named Alan created years ago. You take a piece of banana and roll it in Greek yogurt, and roll that in Rice Krispies cereal."

Medical City Healthcare, which is part of HCA Healthcare, collaborates with partners such as school districts, private companies, the Greater Dallas Restaurant Association and Texas Pro-Start, a program that prepares students for careers in the restaurant and food service industry.

Kids talk to local student chefs about nutrition and healthy eating.

One of the cornerstones of the program is the 21-Day Challenge. Elementary school kids are given recipe books featuring healthy snacks and challenged to make their own healthy snacks for 21 straight days.

"That's where learning happens," Eason says.

Nearly 36,000 elementary school kids signed up for the 21-Day Challenge from April 2016 to April 2017, and 9,527 completed the challenge. Those who completed the challenge demonstrated these improvements during their snack times:

- 19.8 percent reduction in chips consumption.
- 21.4 percent reduction in cookie consumption.
- 5.3 percent reduction in soda consumption.
- 14.6 percent increase in fruit and vegetable consumption.
- 61.3 percent of kids who tried a new fruit or vegetable.

A total of 143,000 kids have participated in the 21-Day Challenge since its inception. It will be offered in 14 North Texas area school districts in the coming school year, Eason says. "Those districts contain 500 elementary schools and about 300,000 kids."

Another facet of Kids Teaching Kids is a Kids Fit Menu that's offered in participating restaurants. Each meal includes at least two servings of fruits and vegetables.

"Here in the Dallas-Fort Worth area, in four years, there have been over 285,000 orders of these meals at our participating restaurant partners," Eason says.

Akdamar says Medical City Healthcare takes great pride in the Kids Teaching Kids initiatives. "Driven with passion and strong leadership, it has taken hold in the market and continues to grow. The program may expand to other HCA markets in the future — to encourage healthier communities across the country."

ST. LOUIS CHILDREN'S HOSPITAL

Healthy Kids Express sends van to schools to teach kids how to manage their asthma

One of the biggest health challenges facing America's urban communities is pediatric asthma, and St. Louis is no exception.

"It's the No. 1 diagnosis in the St. Louis public school district," says Lisa Henry, a pediatric nurse practitioner. "It's the No. 1 reason for missing school."

Henry works with the Healthy Kids Express Asthma Program operated by St. Louis Children's Hospital. Designed to help kids better manage their asthma, the program periodically sends a 40-foot mobile health unit to 14 underserved schools in five school districts.

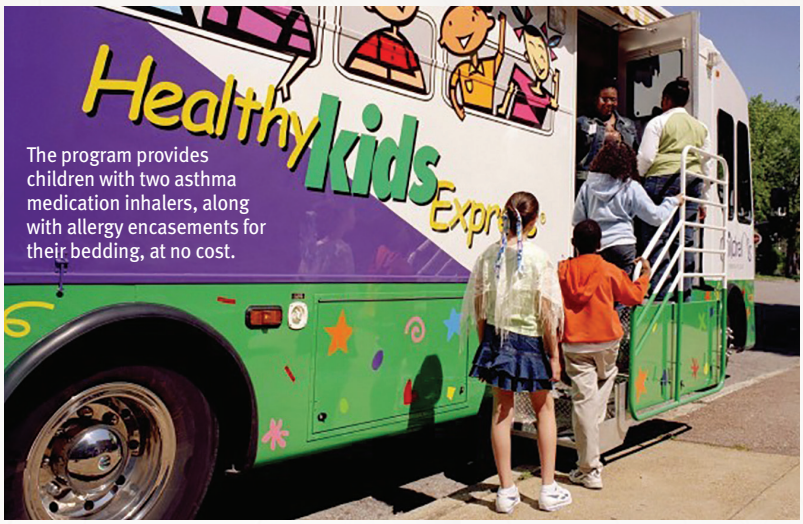
Healthy Kids Express, which was launched in 2009, helps children manage their asthma by increasing their knowledge of signs and symptoms of the disease, improving their ability to use medications correctly and following an asthma action plan.

Goals include increasing physician visits, improving school attendance and decreasing emergency department visits and hospitalizations due to asthma.

"We already had really good relationships with the schools," Henry says. "We had gone there with other programs, doing health screenings in areas such as vision and hearing. So we were able to leverage those good relationships to start the asthma program."

A multidisciplinary team creates goals and develops services that address social determinants of health, including access and health disparities. Washington University allergists and immunologists provide medical guidance for the program, which shares information with important partners such as the child's doctor, school and pharmacist.

When the program first began, students were seen inside their school buildings. "One of the challenges was finding space within the schools to see the children," Henry recalls. "And we wouldn't always have the best privacy in which to see these children."



The program provides children with two asthma medication inhalers, along with allergy encasements for their bedding, at no cost.

With funding from the St. Louis Children's Hospital Foundation, the program acquired a mobile health unit in which to see the children, thereby solving the problem of finding an appropriate space.

"The schools have agreed to let us come and park outside their school," Henry says. "The children we see on the van have been consented for our program. They're already diagnosed with asthma. We help them manage their asthma. We help them with education and supplies. We're able to do lung function testing on the van."

Henry says parents are welcome to come to school and join their kids on the van, but the parents' presence is not required. "If the parents can't take off work, we're able to see their children on the van by themselves."

The main avenue of communication with parents is over the phone. In addition, Henry says, "We make sure we're always in communication with primary care providers, so we're on the same page."

The program provides children with two aerochambers to use with their inhaled medications, along with allergy encasements for their bedding, at no cost.

Asthma coaches assist with a subset of patients considered high-risk, including those with uncontrolled asthma who may be fatality-prone. Families are paired with a social worker as an additional level of support when needed.

In 2016, students who had been enrolled in the program for at least two years demonstrated a 13 percent reduction in school absenteeism from the previous year. The program also has helped lower pediatric ED visits and inpatient admissions due to asthma.

"I've seen kids who at the beginning of the program couldn't do what they wanted to do, and by the end of the program they were able to play in the band or play on the football field," Henry says. "I've had parents thank me for being able to sleep all night for the first time since their 6-year-old child was born. I feel so lucky to be able to do this."


Health Forum

8- Sickle Cell Conference Inequity of Care 10.28.2

Uploaded by: Bayless, Victoria

Position: FAV

Inclusion Includes Y.O.U.

Anita Smith, Manager – Patient Advocacy, Interpretation Services, Spiritual Care

Melissa Anderson, Patient Relations Coordinator, African American BRG

DOCTORS COMMUNITY HOSPITAL

Anne Arundel Medical Center

Diversity Definition

- Define Diversity as an organization

DIVERSITY = Diversity + Equity + Inclusion

Diversity Equity and Inclusion together as a collective concept at AAMC

I2Y FRAMEWORK

Built on SIX GOAL PILLARS – we aim to:

1) Ensure Equity In Opportunity
2) Increase Workforce Diversity
3) Enhance Workplace Culture to Foster Inclusion
4) Eliminate Disparity and Barriers to Culturally Customized Care
5) Increase Supplier Diversity and Minority-Owned Business Enterprise (MBE) Participation
6) Ultimately become an Inclusive Employer of Choice and Diverse Leader in Healthcare

Understanding Disparities

Health Equity In Short:

Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential [World Health Organization]

DISPARITIES ARE THE OUTCOMES YIELDED FROM INEQUITABLE CARE

INEQUITABLE CARE IS THE MANIFESTATION OF MANY ELEMENTS WITH BIAS AS A LEADING CAUSE

Societal Disparities

- People of color face significant disparities in access to and in utilization of care
- Despite coverage gains (ACA) Hispanics, Blacks (African Americans), and American Indians and Alaska Natives remain significantly most likely to be uninsured
- Blacks (AA) and American Indians and Alaska Natives fare worse than Whites on the majority of examined measures of health status and outcomes
- Blacks (AA) received worse care than Whites for about 40% of health equity measures in recent studies

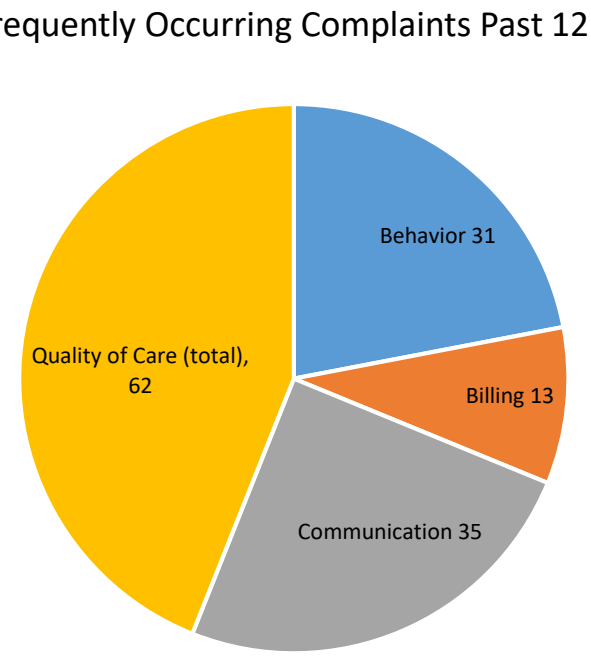
What Does It Look Like at AAMC

- At AAMC we continuously trend patient complaints & grievances
  - Quality of Care complaints
    - Inequity of care complaints

- Like industry trends AAMC inequity of care incidents/ complaints trended upward during times of crisis
  - Many disparities were exposed

Quality of Care

- Complaint Numbers: Average of 247/ month
  - FY20 2,965 Total Complaints
  - Nearly 45% of all complaints relate to quality of care forFY'20

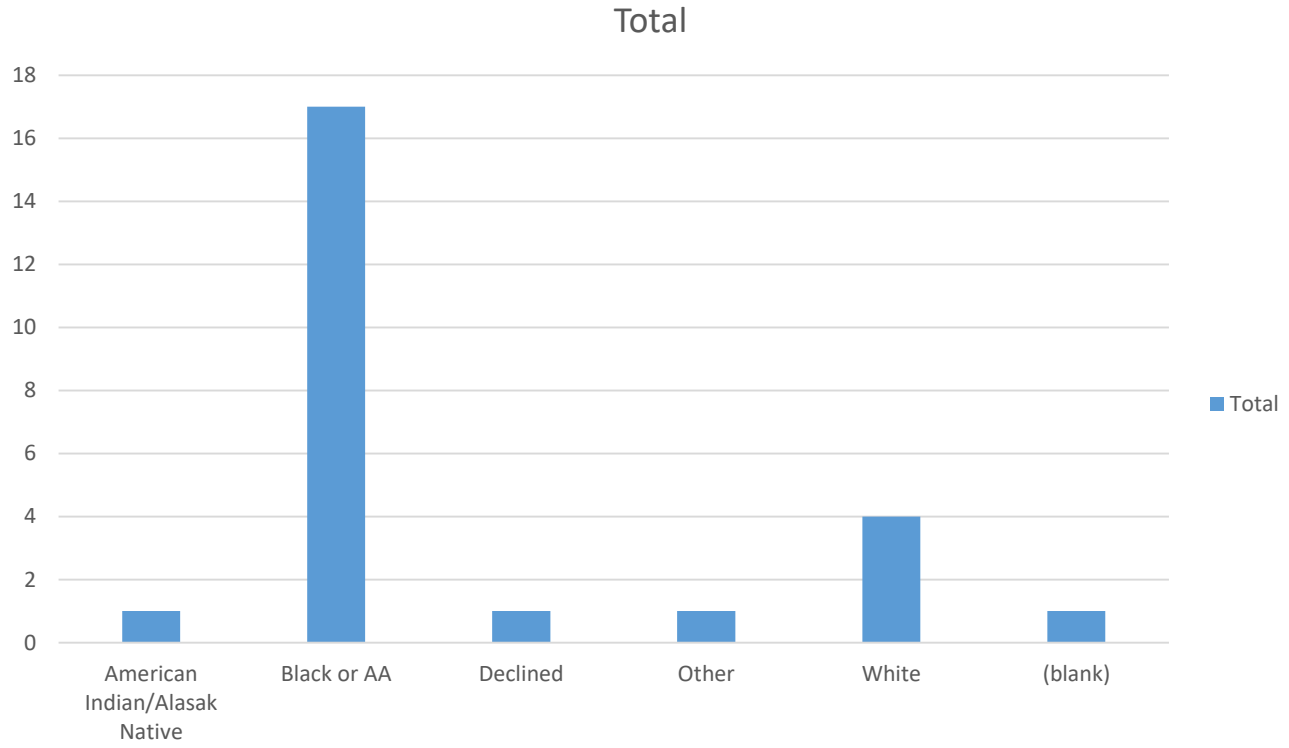


What Does It Look Like at AAMC

- Blacks (African Americans) and Hispanics are more likely to feel mistreated at AAMC more than any other patient demographic
- Black (African Americans) and Hispanic patient/ families are more likely to express that they feel less welcomed and report poor staff behavior towards them
- Blacks (African Americans) had more complaints associated with pain management than any other group

Grievances : Disparity of Care

- On avg. 90 – 100 Grievances/Year
- From Jan 2020 – July 2020
- 1/4 of Grievances are from AA patients/families



Sickle Cell Patient/Family Complaints

- 100% concerned with pain management
- 80% reported by Families
- 25% Readmitted within 48hours
- Feelings of being labeled as “drug seeker”

The AAMC Patient Voice

- Patient 1:
  - Sickle Cell patient with reoccurring admissions and also works as a nurse. Patient states that she knows her body and what's needed and that its difficult to understand how her care regimen can change from one admission to another.
  - When she was finally was in bed at 10:am, the pt. asked for pain meds but waited 4 hours. When the meds came, patient says that she had to argue with the Dr. to increase the IV dilaudid from 2-8
- Patient 2:
  - Patient's sister called and shared that the Provider was dismissive and labeled her a drug seeker.
  - She explained how they have a family of sickle cell patients and have lost a relative due to the disease. She emphasizes that her sister has "struggled with sickle cell since childhood and knows her body".

The AAMC Patient Voice

- Patient 3:
  - Niece of a patient calls to get help with getting pain meds for her aunt.
  - Niece shares, “the patient is a sickle cell patient and knows what medication works for her”
  - Left AMA

- Patient 4:
  - Brother of patient calls and shares that his brother was D/C and back in the ED 2-3 hours later
  - He is concerned because his brother is in “excruciating pain” that is not being addressed

Avoidable Mistakes

"It can only be assumed that because the patient is young and not crying out in pain, they did not think much of his initial presentation… He was discharged xxxx."

"Unfortunately, the patient went back into crisis less than 12 hours after being discharged and presented back to the hospital on … pain meds were delayed for over 3 hours, his pain became severely out of control, and his crisis worsened."

"If they had spoken to the patient or even just reviewed his medical chart it would have been discovered that the patient does not take any chronic pain meds outpatient, rather he is a natural and holistic person and has managed to remain crisis free for over 2 years until these recent episodes. Instead they treated him as a drug-seeking person, ultimately comprising his care…"

Avoidable Mistakes

“He is currently at XXX Hospital where now being treated for acute chest syndrome with signs of multi-organ failure/stress most likely from being in crisis for such a prolonged period of time. He was appropriately seen by a Hematologist, and a multi-disciplinarian team determined he needed blood transfusions and ultimately a blood exchange. ”

“He presented to your hospital twice, looking for help. He was dying, if you have any medical knowledge, you may know that acute chest syndrome, has a high mortality rate in sickle cell disease… There is a serious lack of understanding of sickle cell disease treatment at your facility, despite the areas demographics, in addition to a total miss in the area of pain management training at the hospital as can be illustrated from my brother's story.”

WAYS TO MITIGATE BIAS

- Never Assume
  - Know enough to know you need to ask the questions
  - Avoid assuming race, gender, and …
- Eliminate Biased Behavior
- Pay attention to Bias Drivers
  - They are Coded Stereotyping Communication that impact our brain by forming opinions that steer our actions

BIAS DRIVERS

- Patient Medicated Repeatedly (Again and Again)
- History of Drug Abuse
- Non Compliant
- Previous Admissions
- Drug Seeking
- Disengaged in Care
- Translation Needed
- Frequent Flyer
- History of ETOH
- Overbearing Families

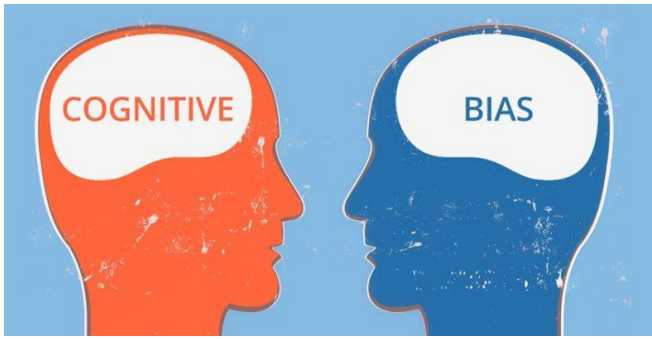
DOCTORS COMMUNITY HOSPITAL

Anne Arundel Medical Center

Self Awareness

- Individual Values
- Know Your Own Bias
  - -IAT

https://together.aahs.org/Project-Implicit-and-Understanding-Unconscious-Bias/



THANK YOU!

DIVERSITY, EQUITY, & INCLUSION

Melissa Anderson
manderson5@aahs.org
Anita Smith
asmith2@aahs.org

http://together.aahs.org/Diversity-Equity-Inclusion/

DOCTORS COMMUNITY HOSPITAL

Anne Arundel Medical Center

PJC_Support_SB 172.pdf
Uploaded by: Black, Ashley
Position: FAV

Ashley Black, Staff Attorney
Public Justice Center
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410-625-9409, ext. 224
blacka@publicjustice.org

SB 172
Maryland Health Equity Resource Act
Joint Hearing of the Senate Budget and Taxation and Finance Committees
January 27, 2021
1:00 PM

SUPPORT

The Public Justice Center (PJC) is a not-for-profit civil rights and anti-poverty legal services organization which seeks to advance social justice, economic and racial equity, and fundamental human rights in Maryland. Our Health Rights Project supports policies and practices that promote the overall health of Marylanders struggling to make ends meet, with the explicit goal of promoting strategies that work to eliminate racial and ethnic disparities in health outcomes. PJC strongly supports SB 172, which would require the Secretary of Health to designate certain areas of Maryland as Health Equity Resource Communities (HERC) and create a HERC Advisory Committee.

While all Marylanders deserve access to high quality and affordable healthcare, the reality is that people of color are less likely to receive preventative health services and more likely to receive lower quality care as compared to their white counterparts.[1] In Maryland, chronic diseases, like hypertension, heart disease and diabetes, have disproportionately impacted communities of color and low-income individuals. Similarly, infant and maternal mortality rates are higher among Black Marylanders than their white counterparts. The COVID-19 pandemic has exacerbated many of the health disparities facing low-income Marylanders and Marylanders of color. SB 172 provides an innovative, evidence-based solution to improve health outcomes and lower healthcare costs and hospital admissions.

The state cannot effectively address health inequities without feedback from underserved communities and health professionals. Meaningful partnerships between the state and underserved communities are needed to help eliminate health disparities in Maryland. SB 172 establishes the HERC Advisory Committee with clinicians, state officials and advocates with expertise in health disparities, prevention services, and clinical research to address the urgent needs of the diverse communities of Maryland. Creating an Advisory Group to guide the develop of this program would ensure that the voices of communities who face significant barriers to attaining good health are heard and valued.

[1] Martha Hostetter, et. al., *In Focus: Reducing Racial Disparities in Health Care by Confronting Racism* (2018), https://www.commonwealthfund.org/publications/newsletter-article/2018/sep/focus-reducing-racial-disparities-health-care-confronting.

The Public Justice Center is a 501(c)(3) charitable organization and as such does not endorse or oppose any political party or candidate for elected office.

For the foregoing reasons, the PJC **SUPPORTS SB 172** and urges a **FAVORABLE** report. Should you have any questions, please contact Ashley Black at (410) 625-9409, ext. 224 or blacka@publicjustice.org.

The Public Justice Center is a 501(c)(3) charitable organization and as such does not endorse or oppose any political party or candidate for elected office.

SB0172 MD NARAL SUPPORT.pdf
Uploaded by: Blalock, Isabel
Position: FAV

SB0172 – Maryland Health Equity Resource Act
Presented to the Honorable Senator Guy Guzzone and Members of the Senate Budget and Taxation Committee
January 27, 2021 1:00 p.m.

POSITION: SUPPORT

NARAL Pro-Choice Maryland urges the Senate Budget and Taxation Committee to issue **a favorable report on SB0172 – Maryland Health Equity Resource Act**, sponsored by Senator Antonio Hayes.

Our organization is an advocate for reproductive health, rights, and justice. Reproductive justice calls for an anti-racist and intersectional approach to our advocacy to ensure that rights to bodily autonomy, access to comprehensive family planning, and high-quality, affordable healthcare are upheld for all.[i] Although Maryland has some of the most progressive legislation when it comes to reproductive healthcare in the United States, racial disparities relating to access to care in the state still persist. These inequalities are apparent when considering maternal mortality rates and access to family planning resources.

The 2019 Maryland Maternal Mortality Review conducted by the Maryland Department of Health, confirmed that maternal mortality has increased since 2008 and is higher than the national average.[ii] [iii] Further, the maternal mortality rate (MMR) for Black women is 4 times higher than the MMR for white women, and is 1.2 times higher than the national average for Black women. It has also been shown that on average 65% of women have an unmet need for contraceptive services and 27% of women require public support to access contraception in Maryland, with Black and Latinx women representing 44% and 27% of those needs, respectively.[iv] These statistics demonstrate clear disparities in access to quality healthcare for these populations in Maryland.

SB0172 can help address these issues and help reduce health inequities overall by increasing access to reproductive health resources where they are needed most. This bill calls for establishing the Health Equity Resource Community Advisory Committee and Fund in order to support health care initiatives including (1) increasing health provider capacity and improving health care delivery which could mitigate unmet need for contraceptive and family planning resources;[v] (2) improving care coordination which could improve maternal health outcomes;[vi] (3) and addressing upstream determinants of health and non-medical needs of the communities at hand to improve reproductive health overall.[vii]

For these reasons, NARAL Pro-Choice Maryland **urges a favorable committee report on SB0172.** Thank you for your time and consideration.

---

[i] SisterSong. "Reproductive Justice." http://www.sistersong.net/reproductive-justice .
[ii] CDC National Center for Health Statistics. *Maternal Mortality by State, 2018*. Report. National Center for Health Statistics, CDC. 2019. https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf

[iii] Maryland Department of Health. *Maryland Maternal Mortality Review: 2019 Annual Report.* Report. April 6, 2020. https://phpa.health.maryland.gov/mch/Documents/Health-General Article, §13-1207, Annotated Code of Maryland - 2019 Annual Report – Maryland Maternal Mortality Review.pdf

[iv] Frost, Jennifer J., Mia R. Zolna, Lori F. Frohwirth, Ayana Douglass-Hall, Nakeisha Blades, Jennifer Mueller, Zoe H. Pleasure, and Shivani Kochhar. "Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016." Guttmacher Institute. August 11, 2020. https://www.guttmacher.org/report/publicly-supported-FP-services-US-2016

[v] ACOG. "Access to Contraception." January 2015. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/01/access-to-contraception

[vi] Hillemeier, Marianne M., Marisa E. Domino, Rebecca Wells, Ravi K. Goyal, Hye-Chung Kum, Dorothy Cilenti, and Anirban Basu. "Does maternity care coordination influence perinatal health care utilization? Evidence from North Carolina." *Health services research* 53, no. 4 (2018): 2368-2383.

[vii] ACOG. "Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care." ACOG. January 2018. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/01/importance-of-social-determinants-of-health-and-cultural-awareness-in-the-delivery-of-reproductive-health-care

Letter of Support CFW Health Equity Resource Act.d
Uploaded by: Boiman, Tiffany
Position: FAV

COMMISSION FOR WOMEN

January 25, 2021

The Honorable Guy Guzzone, Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401

RE: SB 172, Maryland Health Equity Resource Act- SUPPORT

Dear Chairman Guzzone and Members of the Senate Budget and Taxation Committee:

Thank you for the opportunity to submit testimony on behalf of the Montgomery County Commission for Women ("Commission"). We urge a favorable report for SB 172, Maryland Health Equity Resource Act. The Commission is comprised of 15 members from the community who are charged by law to advise the County Executive, County Council and others on issues affecting women.

Legislation to provide equitable access to health resources and resolve health disparities is particularly critical in a year like this one, where communities of color and those characterized by higher rates of poverty and socio-economic disadvantage are disproportionately bearing the health and economic impacts the pandemic has wrought, effects that are compounded by long standing, documented disparities in health care access and health outcomes experienced by people of color, in general, and impoverished demographics, in particular. Ensuring equity in health systems access and outcomes is a civil rights issue, and we owe it to our fellow Marylanders to strive to achieve healthy communities statewide irrespective of race or income.

Analysis of life expectancy in various communities in and around Baltimore revealed that in Baltimore City proper, life expectancy is approximately 20 years less than for residents of more affluent areas in the western part of the region. This analysis also revealed similar disparities in rates of chronic disease and infant mortality.

These disparities have become particularly pronounced during the pandemic, with Covid-19 death rates among Black and Latino populations exceeding that of their white counterparts. According to analysis by Johns Hopkins University, in the state of Maryland, Blacks/African Americans represented 39 percent of total Covid deaths in the state, despite composing only 30 percent of the total population, and Hispanics/Latinos represented another 11 percent of total deaths, and 10 percent of the total state population.

Among women, the Commission's primary focus, data related to maternal and infant mortality and certain types of cancer-related mortality show particularly marked disparities between white women and women of color. For example, in Maryland, Black mothers are four times as likely to die as a result of pregnancy than white mothers, and the infant mortality rate for Black, non-Hispanic infants is two and a half times the rate for White, non-Hispanic infants. According to analysis conducted in 2018 by our Commission as part of its decennial *Status of Women* report, in Montgomery County, African American mothers are 65 percent more likely to experience infant mortality than the maternal population at large.

In the midst of ongoing pandemic conditions, the need for more equitable care access and better outcome prospects have never been more urgent. Targeted policy interventions like this bill are a critical first step to sever the link between demography and destiny and ensure healthy communities are the birthright of every Marylander.

Sincerely,

Nicole Y. Drew, Esq.
President
Montgomery County Commission for Women

Tiffany Boiman, Commissioner and Policy and Legislative Co-Chair
Commissioners:

Donna Rojas – First Vice President
Diana Rubin – Second Vice President
Tiffany Boiman – Recording Secretary
Tazeen Ahmad
Isabel Argoti
Mona-Lee Belizaire
Tonia Bui
Arlinda Clark
Ijeoma Enendu
Patricia Maclay
Chai Shenoy
Patricia Swanson
Angela Whitehead Quigley
Meredith Weisel

Executive Director
Jodi Finkelstein

SB 172 MD Health Equity Resource.pdf
Uploaded by: Bresnahan, Tammy
Position: FAV

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SB 172 Maryland Health Equity Resource Act
Support
Senate Budget and Taxation and Senate Finance Committees
January 27, 2021

Good afternoon Chairs Guzzone and Kelley and members of the Senate Budget and Taxation and Senate Finance Committees. My name is Tammy Bresnahan and I am the Director of Advocacy for AARP MD. As you may know, AARP Maryland is one of the largest membership-based organizations in Maryland, encompassing over 850,000 members. I represent AARP MD and its members in support of SB 172 Maryland Health Equity Resource Act.

AARP is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

SB 172 Maryland Health Equity Resource Act will require Maryland to create and fund Health Equity Resource Communities to help reduce health inequities. The fund will provide grants, tax incentives, and health care provider loan repayment assistance in the state with poor health outcomes that contribute to health inequities. The communities will be modeled after Health Enterprise Zones Program which successfully increased access to health resources. Supporting health will help reduce preventable hospital admissions, which will result in lower overall health care costs, including lower insurance premiums for everyone. AARP supports funding the Health Equity Resource Communities through a one cent per dollar increase in the state alcohol beverage sales tax.

COVID-19 has revealed that communities of color are really suffering as it relates to health disparities. AARP MD has joined this coalition to support legislation during the 2021 legislative session that will establish Health Equity Resource Communities (HERC). The legislation will allow communities to be eligible for grants, tax incentives and health provider loan repayment assistance.

The Coronavirus pandemic (COVID-19) has exposed the vast shortcomings within our health system and the critical importance of affordable health coverage and care for all people and all families. Gaps in health and healthcare exist in Maryland and across the United States that lead to inequitable outcomes referred to as health disparity. The inequitable outcomes refer to the rate of incidence, prevalence, mortality, burden of disease, or any other adverse health condition; and is closely linked with social, economic, or environmental disadvantage for any specific population group, including a group based on education, income, location, health status, race, ethnicity, gender, sexual orientation, or age.

Disparities in life expectancy are especially apparent in predominantly Black areas. Gains in life expectancy for 50-year-old residents in majority Black counties lag almost three decades behind gains experienced by

residents of counties with less than five (5) percent Black residents, the report found. That means it took mostly Black counties until 2008 to experience the same life expectancy that counties with smaller Black populations had in 1980. (Future AARP reports will include additional analyses of trends among Hispanic, Native American and Asian American residents.) One explanation: Counties with a higher percentage of residents of color could also have a higher number of segregated neighborhoods and communities, and segregated communities can concentrate poverty, the report points out, further restricting access to quality schools, safe parks, good jobs, and banks and capital for business development. Chronic stress from systemic racism and discrimination in health care have also put predominantly Black communities at a disadvantage when it comes to life expectancy.[1] Evidence is clear that counties with more Black residents are having worse outcomes, and it's incumbent on all of us to make sure that everyone has the opportunity to live a longer and healthier life. Those extra years are another anniversary, potentially another grandchild — that's what people are missing out on.[2]

AARP through our advocacy, programs, and services, fight against discrimination, advocate for access to health care, and work to improve the lives of all people, especially those most vulnerable. As we consider this moment in time, it's clear, health equity is more important than ever. AARP will use its voice, resources, and trust in our brand to continue our fight for what is right so all people can live a life of dignity regardless of race, age, or income. This is why we support SB 172 Maryland Health Equity Resource Act.

We respectfully ask the committees to respectfully pass SB 172. If you have questions or comments please contact Tammy Bresnahan at tbresnahan@aarp.org or by calling 410-302-8451.

[1] Where you Live at 50 Could Determine How Long You Live
[2] IBID

SB0172 Health Equity.pdf
Uploaded by: Carter, Catherine
Position: FAV

Catherine Carter, Vision Advocate
ltsccampaign@gmail.com
301-693-4469
https://www.facebook.com/LetThemSeeClearly/

Testimony of Catherine Carter
SUPPORTING SB0172: Maryland Health Equity Resource Act
Wednesday, January 28, 2021

My name is Catherine Carter. I am a vision advocate who works on policy and legislative change to improve identification and access to vision care. I am also Project Manager of the Howard County "Beyond 20/20" Program is a collaborative public and private partnership that is working to bring awareness and needed eye care services to underserved/uninsured Howard County Public School System ("HCPSS") students. Distinguished members of the Committee, thank you for the opportunity to speak today in favor of ensuring Marylander have increased access to healthcare.

There are significant barriers to healthcare throughout Maryland, especially with vision care. None of 178 Maryland Federal Qualified Healthcare Centers FQHCs provide eye exams/glasses. One has purchased the equipment and is in the process of finding an optometrist. Nationwide "[w]hile dental services accounted for nearly 14% of total clinic visits in 2016, **eye care services accounted for only 0.77%**. This incongruity in health care professionals and utilization of services signals a substantial under-investment in resources for patients in need of vision care, the AOA HPI notes."

While managing the eye exam clinic, numerous parents also talked of their struggle to afford glasses, asking what resources were available to them. One single mom had an old pair of glasses that continuously broke; she couldn't afford to replace them. Marylanders on Medicare have told me of their struggle to afford glasses, resorting to the Dollar Store. Where are struggling Marylanders, who cannot afford vision care, to go if none of our Health clinics provide eye exams/glasses.

Maryland has led the nation in addressing the health disparities of its citizens. Through legislation you lowered our healthcare premiums, worked on lowering drug cost, the Maryland Consortium of Coordinated Community Supports in the Blueprint Bill to close the healthcare gap for students, and improved educational awareness in school vision and screening. You also enabled students with non-acuity vision disorders, like my son's double vision, to get access to needed vision accommodations and services, which led to a nationwide memorandum. You ensured protections for doctors who treat lyme disease through integrative medicine. These changes took vision, innovation, and a resolve to right injustices.

Passing the Maryland Health Equity Resource Act will ensure better access to the healthcare. Committee oversight can target specific gaps in our current healthcare safety nets and ensure programs address those needs, such as the lack of vision care. I ask for a favorable vote on SB0172.

Beyond 20/20 Works to Help Kids See Clearer, Giving in Depth Eye Exams
https://baltimore.cbslocal.com/2020/03/01/beyond-20-20-works-to-help-kids-see-clearer-giving-in-depth-eye-exams/

Closing the Gap in Health Care Centers' Primary Eye Care
https://www.aoa.org/news/inside-optometry/aoa-news/hpi-health-centers?sso=y

SB_172_League_Support_2021.pdf
Uploaded by: Celentano, Matthew
Position: FAV

The League of Life and Health Insurers of Maryland

15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

For information, contact:
Matthew Celentano, Executive Director

Testimony
for the Senate Budget & Taxation Committee
In **SUPPORT** of

Senate Bill 172 – Maryland Health Equity Resource Act

January 27, 2021

The League of Life and Health Insurers of Maryland Inc. supports Senate Bill 172 and urges the committee to give the bill a favorable report.

Thanks to the great work of the Maryland General Assembly, Maryland is one of America's leading states in expanding health care and improving public health, including by adding over 400,000 people to the ranks of the insured under the Affordable Care Act. But, as you know, despite this progress, health inequities continue to plague our state causing black and brown communities to suffer from substantially inferior health care outcomes. The ongoing COVID-19 global pandemic has dramatically heightened these inequities. We commend the work done on this issue by the President's Equity Task Force led by Senator Melony Griffith and we thank that task force for urging action in this area during the 2021 Maryland General Assembly Session.

The League believes that one of the best ways to reduce health inequities and improve health outcomes is by building on the successes of the 2012-2016 Health Enterprise Zones (HEZ) which as the Equity Task Force found were very successful in the five zones created under that program. SB 172 replicates and builds on this success by authorizing the Secretary of Health to establish Health Equity Resource Communities across the state which, like the old HEZ's, would fund community developed plans to put resources and medical and public health plans into disadvantaged areas of the State.

The League and its members believe that we can and should do better to address all health inequities, and SB 172 is a step in the right direction to help address problems that are not new and cannot be ignored. For these reasons, we urge the committee to give Senate Bill 172 a favorable report.

SB172_FAV_AlzheimersAssociationMD.pdf
Uploaded by: Colchamiro, Eric
Position: FAV

alzheimer's association®
1850 York Road, Suite D
Timonium, MD 21093

Testimony of the Alzheimer's Association Greater Maryland and National Capital Area Chapters
SB 172 – Maryland Health Equity Resource Act
Position: Favorable

Chair Guzzone and Vice Chair Rosapepe,
My name is Eric Colchamiro, and I am the Director of Government Relations for the Alzheimer's Association in Maryland. I am here today in strong support of SB 172.

We applaud this legislation and its focus on addressing health care disparities. Funds collected—and dispersed to communities in need—will be instrumental for a better Maryland, where your health status is not determined by your zip code. For Alzheimer's and other forms of dementia, which is associated with comorbidities such as hypertension and obesity, this can make a difference.

Alzheimer's is a disease where there are stark differences by community and by race. Black Marylanders are twice as likely to be diagnosed with dementia, and Latinos are 1.5 times more likely to be diagnosed than White Marylanders.

Our organization directly engages organizations such as African American churches—across Maryland--about the Association's resources, including our 24-7 helpline for families. We have, for the past 16 years, held the Pythias and Virginia I. Jones African American Community Forum on Memory Loss, which educates over 400 participants each year. And in 2020, we held—in addition to numerous ongoing programs—our first ever Latino Summit, which provided valuable information regarding how Alzheimer's affects the Latino community, and highlighted the many Spanish language programs and resources. But there needs to be more resources and more targeted outreach to Maryland communities in need.

Thank you for your time, and we urge a favorable report on this legislation

AACCW_SUPPORT_SB172.pdf
Uploaded by: Commission for Women, Anne Arundel County
Position: FAV

Testimony in SUPPORT of Senate Bill 172
Before the Senate Budget and Taxation Committee
Anne Arundel County Commission for Women

January 27, 2021

Mr. Chairman and Members of the Committee. We are writing today on behalf of the Anne Arundel County Commission for Women in support of Senate Bill 172 (SB 172). The Anne Arundel County Commission for Women was first created in 1975 and has since served as a resource and advocacy group for women in our county, with women's health one of our primary areas of focus. Health inequities are pervasive throughout Maryland, Anne Arundel County included, and we thank the Committee and the Maryland General Assembly for their consideration of this issue and legislation.

People should not have difficulty accessing primary and specialty health care because of where they live or who they are. Yet, health inequities primarily based on race, ethnicity, disability, and place of residence persist throughout the state. The global COVID-19 pandemic has further exacerbated and exposed these inequities.

SB 172 will help to address this problem by creating Health Equity Resource Communities. Modeled off of the successful Health Enterprise Zones that were in effect between 2012-2016, this legislation will help to focus health resources to the communities and populations that are most in need. Paid for by a one penny per dollar increase on the state's alcohol beverage sales tax, this proposal not only will help to address inequities through a dedicated funding source for the initiative, but it will also aid in reducing underage drinking and drunk driving in our state, as alcohol taxes have been proven to do.

We thank you for your consideration of this lifesaving legislation and urge a favorable report of SB 172.

BaltimoreCounty_FAV_SB0172.pdf
Uploaded by: Conner, Charles
Position: FAV

JOHN A. OLSZEWSKI, JR.
County Executive

CHARLES R. CONNER III, ESQ.
Director of Government Affairs

JOEL N. BELLER
Deputy Director of Government Affairs

BILL NO.: **SB 172**

TITLE: Maryland Health Equity Resource Act

SPONSOR: Senator Hayes

COMMITTEE: Budget and Taxation

POSITION: **SUPPORT**

DATE: January 27, 2021

Baltimore County **SUPPORTS** Senate Bill 172 – Maryland Health Equity Resource Act. This legislation would establish Health Equity Resource Communities as a means of reducing health disparities, improving health outcomes, and increasing access to primary care.

Between 2012 and 2016, the Health Enterprise Zone pilot program successfully aided disadvantaged residents by providing previously resources that were previously inaccessible. This reduced disparities in healthcare and improved the quality of life for those in the program. These zones were established through an exhaustive process which identified neighborhoods with documented economic disadvantage and poor health outcomes, and sought to rectify the issue by making targeted investments in those communities.

SB 172 would make this program permanent by requiring the Secretary of Health to designate Health Equity Resource Communities across the State of Maryland, which will achieve the same lifesaving outcomes as the former Health Enterprise Zones.

COVID-19 has highlighted horrifying disparities in the distribution of and access to healthcare, but has also given a unique opportunity to identify those communities most in need of government assistance. It is the responsibility of leaders throughout the State to root out inequitable treatment faced by its residents, and this bill would be a tremendous step towards achieving that goal.

Accordingly, Baltimore County requests a **FAVORABLE** report on SB 172. For more information, please contact Chuck Conner, Director of Government Affairs, at cconner@baltimorecountymd.gov.

sb172.pdf
Uploaded by: Conner, Sandra
Position: FAV

Baptist Ministers' Night Conference of Baltimore *and* Vicinity (BMNCBV)

5405 York Road, Baltimore, Maryland 21212, (443) 386.4739

TESTIMONY OF

REV. DR. SANDRA CONNER,
PRESIDENT BAPTIST MINISTERS'
NIGHT CONFEENCE OF BALTIMORE
& VICINITY (BMNCBV)
BEFORE THE SENATE BUDGET AND
TAXATION COMMITTEE
IN SUPPORT OF SB 172,
THE MARYLAND HEALTH EQUITY RESOURCE ACT
JANUARY 27, 2021

First, thank you for this opportunity to submit testimony for a very important health legislature that will not only benefit people of color, but all citizens of Maryland. Second**, f**aith groups from across Maryland are a key part of the HERC coalition of over 250 organizations which have endorsed this proposal.

We acknowledge the fact that Maryland has high quality health systems; however, we also realize it's time for it to make greater investments to address inequities and disparities in those areas within the state that lack vital health resources. The Health Equity Resource Communities proposal would be a great way to do this.

We welcome the plan for the HERC to generate the funds needed for this initiative by increasing the alcoholic beverages tax by one penny per dollar. The alcohol sales tax increase would also save lives by reducing underage drinking and drunk driving.

Because many of us in the faith community believe doing whatever we can to eradicate health inequities and disparities is our moral obligation, we will make enacting the Health Equity Resource Communities legislation one of our top priorities for the 2021 Maryland General Assembly session. We pray that our legislators will heed our call.

We thank you in advance for your actions towards SB172.

Best Regards,
Pastor Sandra Conner,
President Baptist Ministers' Night Conference of Baltimore & Vicinity

2021 SB 171 NAMI-FAV.pdf
Uploaded by: Cyphers, Moira
Position: FAV

January 27, 2021

Senate Bill 172 – Maryland Health Equity Resource Act - SUPPORT

Chair Guzzone, Vice Chair Rosepepe, and members of the Senate Budget & Taxation Committee,

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 45,000 families, individuals, community-based organizations and service providers. NAMI Maryland is dedicated to providing education, support and advocacy for persons with mental illnesses, their families and the wider community.

As part of our legislative priorities this session, NAMI is focused on early intervention. Part of early intervention includes better overall somatic care. All Marylanders deserve access to high-quality, affordable health care. Health inequities based on race, ethnicity, disability and place of residence persist throughout the state, as shown in maternal and infant mortality rates and other measures. In underserved areas of the state, people with chronic conditions such as hypertension, heart disease, asthma, diabetes, and substance and mental health disorders have worse health outcomes and are less able to get the care and treatment they need.

The COVID-19 pandemic has further exposed these health inequities and highlighted the need to address them and otherwise improve health outcomes in our state. Supporting health and reducing preventable hospital admissions will result in lower overall health care costs, including lower insurance premiums for everyone.

As part of this effort NAMI supports coordinated care models that integrate physical and mental health services in Health Equity Resource Communities. Physical and mental health integration have been shown to improve patient outcomes, save money and reduce mental health stigma.

Millions of Americans have both a physical and a mental health or substance use condition, yet our health care system largely fails to integrate mental health care with other medical services. This fragmented system produces poorer health outcomes and higher costs – in the form of higher insurance premiums in the private market, as well as greater state and federal budget expenditures for public programs like Medicare and Medicaid.

By bringing doctors, nurses, social workers and therapists together, integrated mental and physical health care:

- Normalizes and de-stigmatizes mental health treatment;
- Ensures that all health needs are addressed holistically, leading to proper treatment and better quality of life;
- Helps address the physical health needs of people with mental illnesses;
- Helps reduce the fragmentation between behavioral and physical health services; and
- Is critical for positive health outcomes and cost-effective care.

This legislation focuses on increasing access to health care where it's most needed – we ask that behavioral health be a critical part of this effort. For these reasons, NAMI Maryland asks for a favorable report on SB 172.

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Moira Cyphers
Compass Government Relations
MCyphers@compassadvocacy.com

SB 172 MCHI Support Testimony 27JAN21.pdf
Uploaded by: DeMarco, Vincent
Position: FAV

HEALTH CARE for All
MARYLAND CITIZENS' HEALTH INITIATIVE
2600 ST. PAUL STREET BALTIMORE, MD 21218 P: (410)235-9000 F: (410)235-8963 WWW.HEALTHCAREFORALL.COM

TESTIMONY OF VINCENT DEMARCO, PRESIDENT
MARYLAND CITIZENS' HEALTH INITIAITVE
BEFORE THE SENATE BUDGET AND TAXATION COMMITTEE
IN SUPPORT OF SB 172, THE MARYLAND HEALTH EQUITY RESOURCE ACT
JANUARY 27, 2021

Mr. Chairman and Members of the Committee, thank you for this opportunity to testify in favor of this very important health equity legislation sponsored by Senator Antonio Hayes. The Maryland Health Care For All! Coalition, on behalf of over 270 faith, community, labor, business and health care groups from across the state, strongly urges you to pass this measure which will reduce health inequities by race, ethnicity, disability, and location, and improve health outcomes and reduce underage drinking and drunk driving in our state. For a list of our coalition members and other information about this proposal, see healthcareforall.com/equityresolution.

Thanks to the great work of the Maryland General Assembly, Maryland is one of America's leading states in expanding health care and improving public health, including by adding over 400,000 people to the ranks of the insured under the Affordable Care Act. But, as you know, despite this progress, health inequities continue to plague our state causing communities of color to suffer from substantially inferior health care outcomes. The raging COVID pandemic has dramatically heightened these inequities. We commend the work done on this issue by the President's Equity Task Force led by Senator Melony Griffith and we thank that task force for urging action in this area during the 2021 Maryland General Assembly Session.

We believe that one of the best ways to reduce health inequities and improve health outcomes is by building on the successes of the 2012-2016 Health Enterprise Zones which as the Equity Task Force found were very successful in the five zones created under that program. SB 172 replicates and builds on this success by authorizing the Secretary of Health to establish Health Equity Resource Communities across the state which, like the old HEZ's, would fund community developed plans to put resources and medical and public health plans into disadvantaged areas of the State.

SB 172 also addresses a major weakness of the Health Enterprise Zone program which was its lack of a dedicated funding source. SB 172 would increase the state alcohol sales tax from 9% to 10%, a one penny per dollar increase, and dedicate this money for behavioral health needs and for funding Health Equity Resource Communities. In light of the impact of the COVID 19 pandemic on bars and restaurants, the tax increase would be delayed for two years for

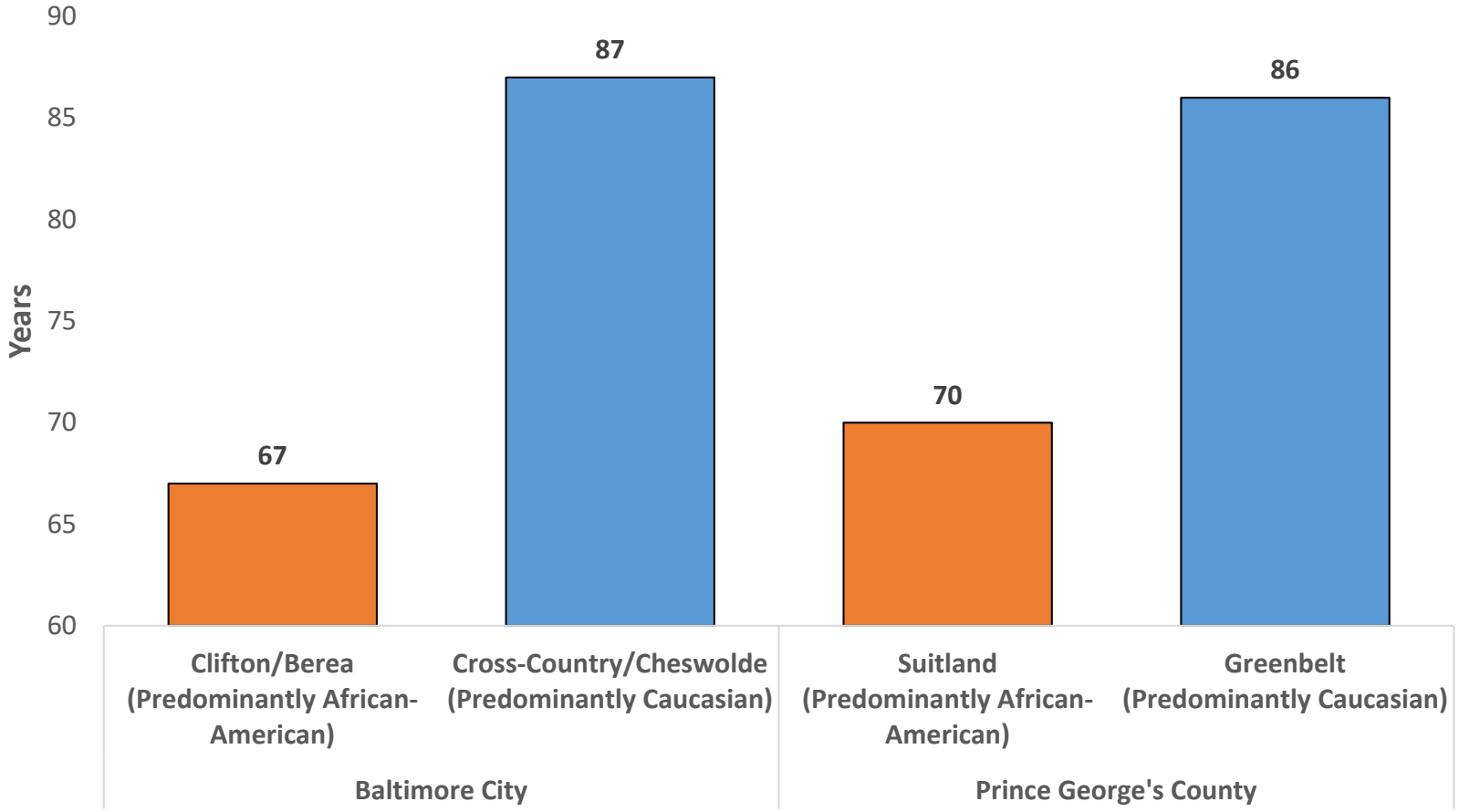
alcohol consumed in a bar or restaurant. The alcohol sales tax increase is projected to raise $14 million per year for the first two years, with $1 million per year going to statewide behavioral health programs and the rest going to fund Health Equity Resource Communities, and $22 million per year in subsequent years, with $2 million per year for statewide behavioral health and the rest going to fund Health Equity Resource Communities.

We believe that the proposed one penny per dollar increase in the state alcohol sales tax is the best way to fund the Health Equity Resource Communities. In addition to making sure the Communities have a permanent and adequate funding source, the alcohol sales tax increase would separately reduce drunk driving and underage drinking. An Abell Foundation Report found that the increase you made in the state alcohol sales tax from 6% to 9% in 2011 substantially reduced deaths and other problems caused by drunk driving, underage drinking and other abuse of alcohol. As the Report lays out, between 2011 and 2015, there was a 26 percent reduction in the percentage of students who consumed alcohol in the preceding 30 days, a 28 percent reduction in binge drinking, and a 31 percent reduction in students riding in a vehicle operated by a driver who had been drinking alcohol. See healthcareforall.com/equityresolution. Further, as the attached alcohol sales tax revenue chart shows, overall alcohol sales actually increased after the 2011 alcohol sales tax increase showing that it did not harm the alcohol industry in Maryland. Finally, the General Assembly chose 9% as the amount to which to increase the alcohol sales tax in 2011 because that was the amount of the alcohol sales tax in Washington, DC at that time. Since then, DC has increased its alcohol sales tax to 10% and used its additional one penny per dollar increase to fund health care programs, which we hope Maryland can do also.

Thank you so much to this Committee for all you have done to expand health care and public health in Maryland. We strongly urge you to build on this success by addressing the pressing issue of improving health equity by giving a favorable report to SB 172, the Maryland Health Equity Resource Act.


HEALTH CARE for All
AARP Maryland
NCADD MARYLAND
1199SEIU United Healthcare Workers East Maryland Division
NAACP Maryland STATE CONFERENCE
The Arc Maryland
NASW National Association of Social Workers MARYLAND CHAPTER
AHF AIDS HEALTHCARE FOUNDATION
CASA WE ARE CASA SOMOS CASA
MEPPN
CENTRAL ECUMENICAL COUNCIL
MINISTERS CONFERENCE OF BALTIMORE & VICINITY
JOHNS HOPKINS UNIVERSITY & MEDICINE
MISSIONARY BAPTIST MINISTERS' CONFERENCE Washington, DC and Vicinity Est. 1985
MARYLAND COMMUNITY ACTION PARTNERSHIP A NETWORK OF COMMUNITY ACTION AGENCIES SERVING MD, DC & DE
Episcopal Diocese of Washington
Maryland Hospital Association
SOUTHERN CHRISTIAN LEADERSHIP CONFERENCE
sclc Southern Christian Leadership Conference PRINCE GEORGE REGIONAL CHAPTER
THE UNITED METHODIST CHURCH Baltimore-Washington Conference
ST. MARY'S COLLEGE of MARYLAND The National Public Honors College
STRONG FUTURE MARYLAND
MATOD Maryland Association for the Treatment of Opioid Dependence
MARYLAND NONPROFITS
CareFirst BlueCross BlueShield
50 YEARS
STRONG CITY BALTIMORE
KAISER PERMANENTE
THE EPISCOPAL DIOCESE OF MARYLAND
Quaker Voice of Maryland
MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS
CITY OF BALTIMORE
BRIDGE Maryland
mhamd MENTAL HEALTH ASSOCIATION OF MARYLAND
CHESAPEAKE CLIMATE ACTION NETWORK
The MARYLAND ACADEMY of ADVANCED PRACTICE CLINICIANS A Voice for Advanced Practice Clinicians in Maryland
UNIVERSITY of MARYLAND BALTIMORE
UNIVERSITY of MARYLAND MEDICAL CENTER
WISE WOMEN'S INVESTMENT STRONG EFFECTIVE
BAPTIST MINISTER'S NIGHT CONFERENCE OF BALTIMORE AND VICINITY
THE COLLECTIVE
AFSCME MD COUNCIL 67 We Make Maryland Happen
AFSCME 3
AHEC West
EST. 1998 JOTF
BALTIMORE JEWISH COUNCIL
alzheimer's association
Maryland Public Health Association (MdPHA.org)
MCRC MARYLAND CONSUMER RIGHTS COALITION
FIRN
UMBC
THE UNITED BAPTIST MISSIONARY CONVENTION & AUXILIARIES OF THE STATE OF MARYLAND, INC. "Fulfilling Our Mission Thru Ministries"
Common Cause Maryland Holding Power Accountable
GEDCO
CAUCUS OF AFRICAN AMERICAN LEADERS
BALTIMORE DISTRICT
CLIMATE X CHANGE
MARYLAND LEGISLATIVE COALITION
FAMILIESUSA THE VOICE FOR HEALTH CARE CONSUMERS
NAMI Maryland National Alliance on Mental Illness
ADVOCATES FOR CHILDREN AND YOUTH
AIDS ACTION BALTIMORE, INC.
Disability Rights Maryland
COMMUNITY DEVELOPMENT NETWORK OF MARYLAND
Community Action Council of Howard County HELPING PEOPLE. CHANGING LIVES.
NATIONAL CAPITAL BAPTIST CONVENTION OF WASHINGTON D.C. & VICINITY Organized 1961
be the change BMORE
W.O.A.MD Women of Action Maryland CHARLES COUNTY
GOUCHER college
Maryland Legislative Agenda for Women
MARYLAND STATE EDUCATION ASSOCIATION
THE MARYLAND COLLABORATIVE TO REDUCE COLLEGE DRINKING AND RELATED PROBLEMS
ST. JOHN'S College
Towson Communities Alliance
Allergy & Asthma NETWORK
DELAWARE-MARYLAND SYNOD
UNITARIAN UNIVERSALIST LEGISLATIVE MINISTRY of Maryland
NARAL Pro-Choice Maryland
PUBLIC JUSTICE CENTER
Jewish Federation OF HOWARD COUNTY
BALTIMORE CITY SUBSTANCE ABUSE DIRECTORATE
MCASA Maryland Coalition Against Sexual Assault
American Foundation for Suicide Prevention
MARYLAND RURAL HEALTH ASSOCIATION
MDCEP MARYLAND CENTER ON ECONOMIC POLICY

Average Life Expectancy by Neighborhood



Sources:
Baltimore City Health Department 2017 Neighborhood Health Profile Reports
https://health.baltimorecity.gov/neighborhood-health-profile-reports

2018 Report "Uneven Opportunities: How conditions for wellness vary across the metropolitan Washington Region." Page 38.
https://www.mwcog.org/documents/2020/10/26/uneven-opportunities-how-conditions-for-wellness-vary-across-the-metropolitan-washington-region-health-health-data/

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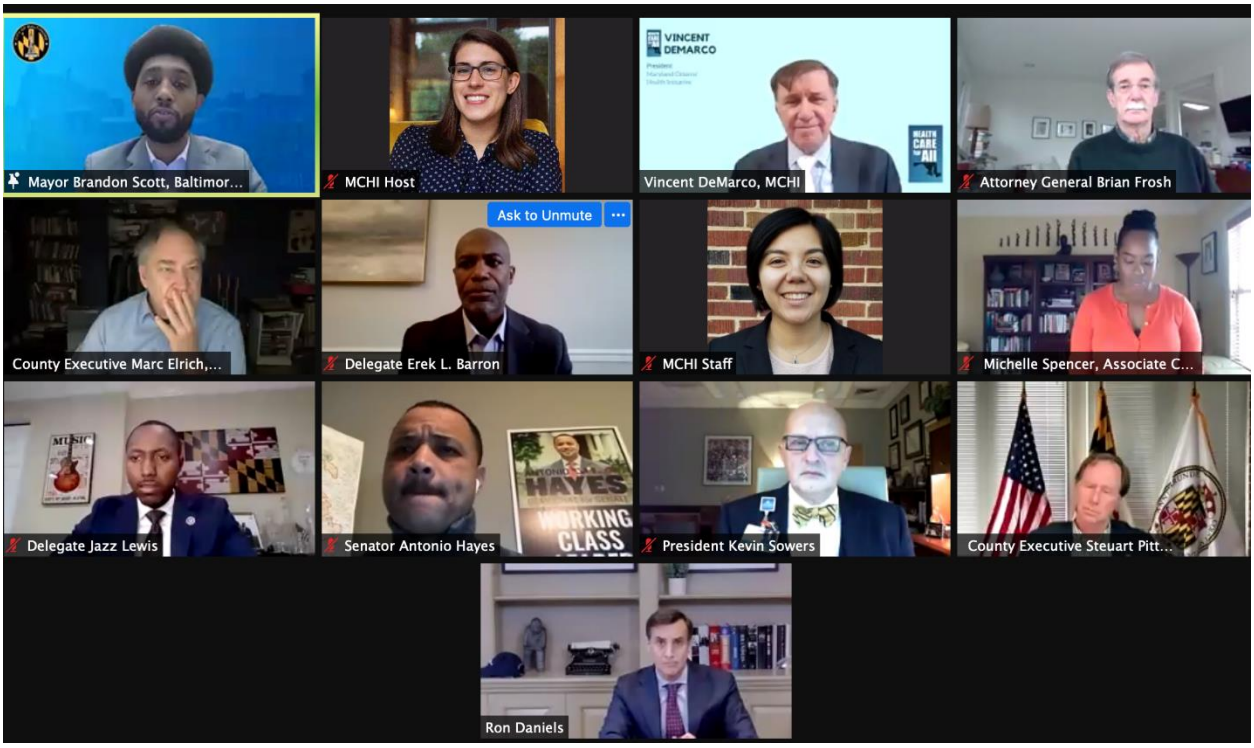
FOR IMMEDIATE RELEASE
January 8, 2021

Contact: Vincent DeMarco
410-591-9162

Johns Hopkins Institutions Endorse Major Initiative to Expand Health Care in Underserved Communities

Legislative initiative would increase sales tax on alcohol to generate significant new resources for communities with disparate health outcomes across Maryland



Johns Hopkins Institutions, which includes Johns Hopkins University, the Johns Hopkins Health System and The Johns Hopkins Hospital, **today endorsed** a Maryland legislative initiative to establish Health Equity Resource Communities (HERC) across Maryland that will receive significant new funding to address longstanding health care disparities and bring new resources to underinvested communities across the state.

Under the proposed legislation, areas with poor health outcomes can become HERC communities and be able to compete for grants, tax incentives and health care provider loan repayment assistance to increase access to high-quality care and ultimately reduce health inequities by race, ethnicity, disability, and geographic location.

Funding for the Communities, as well as new programs to address substance use and mental health disorders, will come from a one penny per dollar increase in the state alcohol beverage sales tax.

"The Health Equity Resource Communities legislation is a critically important strategy to provide new resources to Maryland communities that lack adequate access to health care. For far too long, far too many of Maryland's citizens have borne the unfair burden of racial, economic, and health disparities, especially in Black and Latinx communities," said Johns Hopkins President Ronald J. Daniels. "This is a timely, research driven measure that will help expand access to high-quality health care and that has the potential to reduce alcohol-related problems for so many in communities across our state."

"The Johns Hopkins Health System is committed to ensuring people in underserved communities can receive the health care they need," said Kevin W. Sowers, president of the Johns Hopkins Health System Corporation and executive vice president of Johns Hopkins Medicine.

Maryland Citizens' Health Initiative has worked across the state to build support for this legislation, and more than 250 labor, faith, business, health, and community organizations have also signed on in support (**Logo Flyer**, **Full List of Members**).

"Johns Hopkins' endorsement is a major boost to our legislation, and we salute President Daniels, President Sowers and their teams for joining us in this initiative," said Sen. Antonio Hayes (Baltimore City), the lead Senate sponsor of the legislation. "Hopkins has been a leader in developing and supporting innovative approaches to improving community health care."

"We are pleased at the support this initiative is receiving from community groups across Maryland and now from Johns Hopkins, one of the world's pre-eminent public health institutions," said Del. Erek Barron (Prince George's), the lead House sponsor of the legislation. "We urge the General Assembly to embrace this legislation and begin to address disparities in health care resources."

"Marylanders are focused on making our state more equitable, and a basic principle is that everyone should have access to high-quality, affordable health care, no matter where they live," said Del. Jazz Lewis (Prince George's), a co-sponsor of the legislation. "Our bill is a smart way to funnel new resources to improve access to care in areas that have for too long suffered without it."

The Communities will be modeled after the successful 2012-2016 Health Enterprise Zones (HEZ) Program, which increased access to health resources, improved residents' health, reduced hospital admissions, and created cost savings as shown by studies conducted by researchers at Johns Hopkins including Dr. Darrell Gaskin, Michelle Spencer, and Dr. Roland Thorpe. Unlike the HEZ pilot which ended after five years, money raised for the Health Equity Resource Communities would go directly into a dedicated fund for the program to help ensure longevity.

The legislation would increase the alcohol sales tax by one penny per dollar, with some of the new revenue dedicated to the Health Equity Resource Communities initiative. An increase in the

alcohol tax itself will also promote public health and lower health care costs. Research found that the last increase in the alcohol tax in Maryland, in 2011, led to a reduction in underage drinking, binge drinking, driving under the influence, and sexually transmitted infections. Proceeds from the alcohol tax increase would also be used to strengthen programs to address substance use and mental health disorders.

"We couldn't be more excited that the Johns Hopkins Institutions have joined our efforts to create Health Equity Resource Communities," said Vincent DeMarco, president of the Maryland Citizens' Health Initiative (MCHI), the advocacy group leading the effort to enact the HERC initiative. "Their experts have looked closely at our proposal and believe it holds real promise for advancing equity in how health care is delivered in underserved communities in Maryland."

A range of state and local elected officials are also working to pass the legislation this year.

"We need to act this year to expand access to health care in underserved communities," said Maryland Attorney General Brian Frosh. "The COVID pandemic has exacerbated longstanding inequities in our state, and many people struggle to get access to the care they need. This legislation is an important step in rectifying these unacceptable disparities."

"Too many communities in Baltimore and other areas of the state lack equitable access to the kind of health care all people want and deserve. This legislation will mean far more resources will be available to promote health care in all of our communities," said Baltimore Mayor Brandon Scott. "It's a smart strategy that will help us transform health care in Maryland and address longstanding disparities in how resources have historically been allocated."

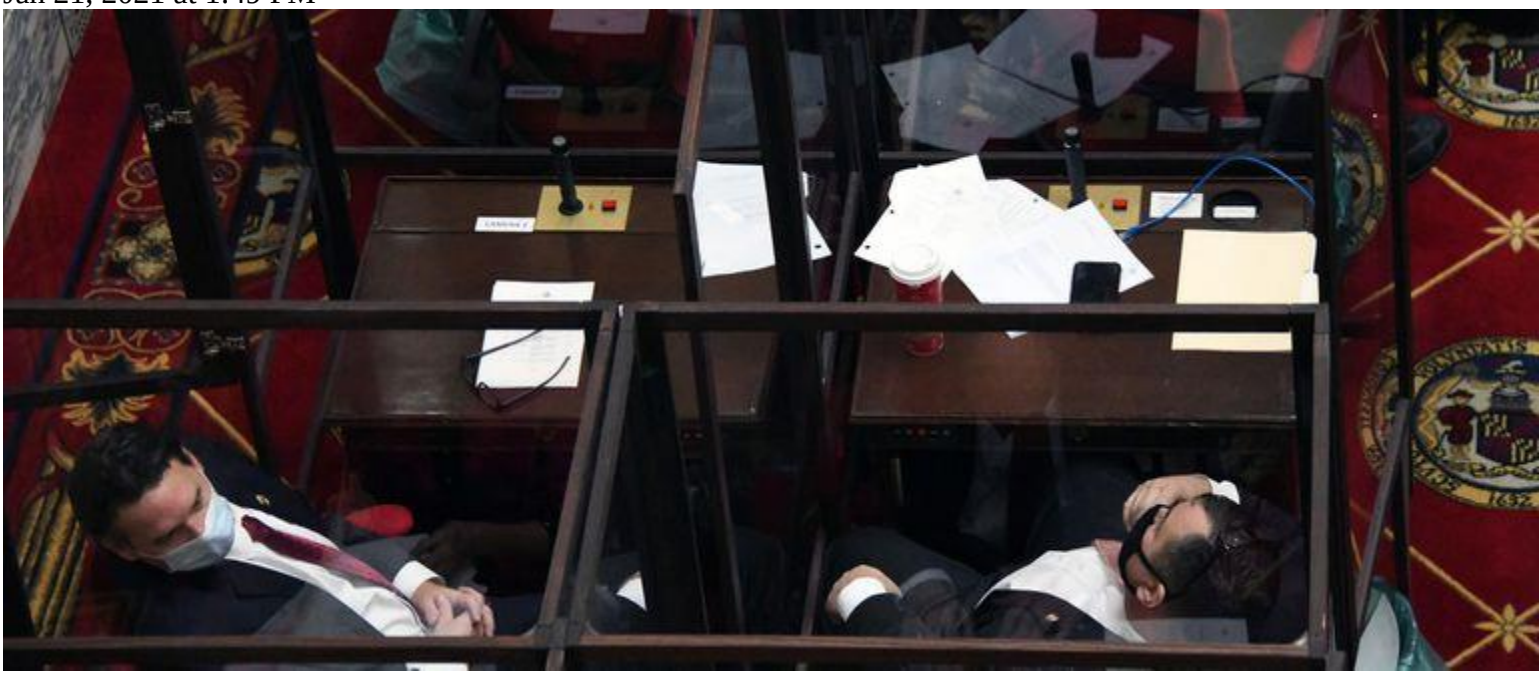
"Montgomery County is committed to improving access to health care across the state, and I urge the legislature to support this measure," said Montgomery County Executive Marc Elrich. "Adding a penny per dollar to the alcohol tax is a sensible way to generate revenue to support an expansion of health care and will help reduce alcohol-related issues that hurt our families and communities."

"As we battle to overcome the pandemic and support families in need, it's vital that we make sure more Marylanders have access to health care that is high-quality and convenient," said Anne Arundel County Executive Steuart Pittman. "The Health Equity Resource Communities is a strategic approach to getting resources into the areas that have the most need. We need to pass this legislation."

County Executives Angela Alsobrooks of Prince George's County, Calvin Ball of Howard County, and Johnny Olszweski of Baltimore County could not attend the event but issued **statements of support** for the Health Equity Resource Communities proposal.

Maryland’s House speaker crafts ambitious ‘Black Agenda’ to close equity gaps | COMMENTARY

By Baltimore Sun Editorial Board
Baltimore Sun |
Jan 21, 2021 at 1:49 PM



From left, Sens. Stephen Hershey, Jr. (R- Caroline, Cecil, Kent and Queen Anne's Counties) and J.B. Jennings (R-Baltimore County and Harford County) The Maryland General Assembly convenes at the State House with changes in the House and Senate Chamber due to the COVID-19 pandemic. House Speaker Adrienne A. Jones and Senate President Bill Ferguson will deal with issues such as economic relief during the pandemic, public education, police reform and the state song. (Kim Hairston, The Baltimore Sun) (Kim Hairston / Baltimore Sun)

After watching images of George Floyd take his last breaths as a Minneapolis police officer knelt on his neck last spring, it seemed just about everyone jumped on the social justice bandwagon. Multiracial groups took to the streets in major cities in protest. Corporations, restaurants, suburban moms and government entities declared their allegiance to the Black Lives Matter movement. The BLM acronym was suddenly ubiquitous, plastered on yard and window signs, bumper stickers and T-shirts. But those who had fought in the trenches for years were skeptical — based on past experience — that this would be followed by meaningful action to truly put African Americans on equal footing. And they had every right to be doubtful.

But Maryland lawmakers appear ready to do more than talk this General Assembly session — State House Speaker Adrienne Jones in particular. On Tuesday, she rolled out an ambitious “Black agenda” and racial equity plan aimed at closing the race gap in areas such as homeownership, health and wealth. As Maryland’s first Black person and the first women of any race to lead the House, Speaker Jones is seeking to use her powerful

position to dismantle the institutional racism that has existed since the end of slavery and kept African Americans steps behind white citizens in most areas of life by creating an unceasing cycle of poverty.

Developed with input from more than three dozen thought leaders, Speaker Jones' plan includes 30 policy recommendations along with nine pieces of legislation to help African Americans build wealth, better compete for state contracts and buy homes by erasing unfair credit criteria and down payment barriers. It would also throw more resources at addressing health gaps that result in African Americans dying on average at younger ages than white Marylanders, a disparity further highlighted by COVID-19.

Among some of her recommendations that make solid sense:

- Requiring the state to devote 50% of its spending on goods and services with small businesses and requiring businesses who want state capital funding over $1 million to prove racial diversity in their leadership ranks and mission.
- Declaring racism a public health crisis and requiring doctors, nurses and nurse practitioners to undergo healthy equity and bias training to get licensed and accredited.
- Allowing people applying for home loans to use something other than credit scores for approval, such as rent or utility payment history, so that mistakes made in youth, or because someone fell on hard financial times, don't haunt someone over the long haul.
- Bringing back health opportunity zones created under the O'Malley administration, but disbanded under the leadership of Gov. Larry Hogan and using a one penny per dollar increase in the alcohol tax to fund initiatives in these zones to reduce health disparities. (There is both a Senate and House bill on this issue).
- Conducting a disparity study to look at the amount insurers are charging per square foot of homes by county to see if appraisers are undervaluing homes in African American neighborhoods.

A work group formed by Senate President Bill Ferguson also recently released worthwhile equity recommendations, some of which dovetail with Speaker Jones' agenda, but others include fresh recommendations and address environmental justice as well.

Some Senate recommendations worth pursuing include: better tracking of why waivers are granted to companies who don't use minority subcontractors as required on state-funded projects; increasing the minority doctor ranks by expanding access to state scholarships; creating an inclusion fund through TEDCO, the state agency that funds startups, to help economically disadvantaged firms; and launching a state pilot program for mold remediation in schools and public housing.

We're glad to see both chambers trying to answer the calls for social justice that have reverberated across the country in recent months and hope lawmakers have the courage to pass the legislation necessary to put some of these ideas into practice. But we've seen good intentions fall apart before, allowing injustice to persist. That can't happen again; now is the time to begin righting the wrongs of the past.

The Baltimore Sun editorial board — made up of Opinion Editor Tricia Bishop, Deputy Editor Andrea K. McDaniels and writer Peter Jensen — offers opinions and analysis on news and issues relevant to readers. It is separate from the newsroom.

https://www.baltimoresun.com/opinion/editorial/bs-ed-0121-speaker-equity-plan-20210121-6bnzuqxirvcn5dnuwozft23bge-story.html

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Health Equity Resource Communities Initiative

WHEREAS, all Marylanders deserve access to high-quality, affordable health care;
WHEREAS, health inequities based on race, ethnicity, disability and place of residence persist throughout the state, as shown in maternal and infant mortality rates and other measures;
WHEREAS, the COVID-19 pandemic has further exposed these health inequities and highlighted the need to address them and otherwise improve health outcomes in our state;
WHEREAS, in underserved areas of the state, people with chronic conditions such as hypertension, heart disease, asthma, diabetes, and substance and mental health disorders have worse health outcomes and are less able to get the care and treatment they need;
WHEREAS, supporting health and reducing preventable hospital admissions will result in lower overall health care costs, including lower insurance premiums for everyone;
WHEREAS, the 2012-2016 Health Enterprise Zones Program successfully increased access to health resources, improved residents' health, reduced hospital admissions, and created cost savings;
WHEREAS, the 2011 alcohol beverage sales tax increase led to significant reductions in underage drinking, binge drinking, driving under the influence, and sexually transmitted infections;
WHEREAS, Maryland has not raised its alcohol beverage sales tax since 2011 and its rate has fallen behind that of Washington D.C.;
WHEREAS, raising the state's alcohol beverage sales tax will generate necessary funds and reduce drinking, including by underage Marylanders and heavy drinkers, which in turn will save lives and reduce health care costs;

THEREFORE, BE IT RESOLVED that the undersigned organization supports increasing the state alcohol beverage sales tax by one cent per dollar to save lives and reduce health care costs caused by alcohol overuse, and supports using the funds raised by the alcohol tax increase to:

1) Create Health Equity Resource Communities, modeled after the former Health Enterprise Zone Program, in locations around the state to address poor health outcomes that contribute to racial, ethnic, and geographic health inequities, and
2) Create more community-based prevention, treatment, and recovery support programs to address substance use and mental health disorders.

Organization:_____

Address: _____

Phone Number: (o)_____(c)_____Email:_____

Name of Representative of the Organization (Print Name):_____Title:_____

Signature:_____Date:_____

Please fill the form out ONLINE at: healthcareforall.com/EquityResolution
Or mail, fax, or email completed form to:
Maryland Citizens' Health Initiative, 2600 St. Paul St., Baltimore, MD 21218
Fax: 410-235-8963; Email: stephanie@healthcareforall.com

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Health Equity Resource Communities Coalition

Statewide and Regional

1. 1199SEIU United Healthcare Workers-East
2. AARP Maryland
3. Advocates for Children and Youth
4. AFSCME Council 3
5. AFSCME Council 67
6. AIDS Action Baltimore
7. AIDS Healthcare Foundation
8. Allergy & Asthma Network
9. Alzheimer's Association, Greater Maryland Chapter
10. American Foundation for Suicide Prevention, Maryland Chapter
11. The Arc Maryland, Inc.
12. Baltimore City Conference, DE-MD Synod, Evangelical Lutheran Church in America
13. Baltimore City Council
14. Baltimore City Substance Abuse Directorate
15. Baltimore District (AME Zion Church)
16. Baltimore Jewish Council
17. Baltimore Washington Conference of The United Methodist Church
18. Baltimore Yearly Meeting Religious Society of Friends
19. Baltimore Yearly Meeting - Baltimore STRIDE Program
20. Baltimore Yearly Meeting - DC STRIDE Program
21. Baltimore Yearly Meeting Young Adult Friends
22. Baltimore Yearly Meeting, Young Friends
23. Baptist Ministers' Conference of Washington, DC and Vicinity
24. Baptist Ministers' Night Conference of Baltimore & Vicinity
25. Be the Change Bmore
26. Bridge Maryland, Inc.
27. CareFirst BlueCross BlueShield
28. CASA
29. Caucus of African-American Leaders
30. Central Maryland Ecumenical Council
31. Chesapeake Climate Action Network
32. Climate XChange
33. Collective Empowerment Group, Inc.
34. Common Cause of Maryland

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35. Community Action Council of Howard County, MD, Inc.
36. Community Development Network of MD
37. Delaware-Maryland Synod, Evangelical Lutheran Church in America
38. Disability Rights Maryland
39. The Episcopal Diocese of Maryland
40. The Episcopal Diocese of Washington
41. Families USA
42. FIRN: Foreign-Born Information and Referral Network
43. Govans Ecumenical Development Corporation (GEDCO)
44. Goucher College
45. Jewish Federation of Howard County
46. Job Opportunities Task Force (JOTF)
47. Johns Hopkins University
48. Johns Hopkins Medicine
49. Kaiser Permanente
50. LatinosAgainstAlzheimer's Coalition
51. The League of Life & Health Insurers of Maryland, Inc.
52. Maryland Academy of Advanced Practice Clinicians
53. Maryland Alliance for Justice Reform
54. Maryland Area Health Education Center West (AHEC West)
55. Maryland Association for the Treatment of Opioid Dependence
56. Maryland Center on Economic Policy
57. Maryland Citizens' Health Initiative
58. Maryland Coalition Against Sexual Assault
59. Maryland Collaborative to Reduce College Drinking and Related Problems
60. Maryland Community Action Partnership
61. Maryland Consumer Rights Coalition
62. Maryland-DC Society of Addiction Medicine
63. Maryland Episcopal Public Policy Network
64. Maryland Hospital Association
65. Maryland Kenyans Organization
66. Maryland Legislative Agenda for Women (MLAW)
67. Maryland Legislative Coalition
68. Maryland Nonprofits
69. Maryland Public Health Association
70. Maryland Rural Health Association
71. Maryland State Education Association
72. Mental Health Association of Maryland
73. Mid-Atlantic Association of Community Health Centers
74. Ministers' Conference Empowerment Center, CDC

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75. Ministers' Conference of Baltimore & Vicinity
76. NAACP Maryland State Conference
77. NAMI Maryland
78. NARAL Pro-Choice Maryland
79. NASW- MD Chapter
80. National Capital Baptist Convention
81. National Council on Alcoholism and Drug Dependence NCADD-Maryland
82. Progressive Maryland
83. Public Justice Center
84. Quaker Voice of Maryland
85. Reproductive Health Equity Alliance of Maryland
86. St. John's College
87. St. Mary's College of Maryland
88. SEIU (Service Employees International Union) Maryland and DC Council
89. Southern Christian Leadership Conference (SCLC) Prince George's County Chapter
90. Strong City Baltimore
91. Strong Future Maryland
92. Towson Communities Alliance
93. Unitarian Universalist Legislative Ministry of Maryland
94. United Baptist Missionary Convention of Maryland and its Auxiliaries. Inc
95. University of Maryland, Baltimore
96. University of Maryland, Baltimore County
97. University of Maryland Medical System
98. Wise Women of Maryland
99. Women of Action Maryland

Local

100. ABC123andME
101. Adelphi Friends Meeting
102. Adullum Community Healthcare Center LLC
103. Affordable Housing Conference of Montgomery County
104. A Friendly Bread
105. Annapolis Friends Meeting
106. Ardmore Springdale Civic Association
107. Ark Church
108. Arlington Partnership for Affordable Housing (works in Montgomery County)
109. Asbury Broadneck UMC
110. Asian American Center of Frederick

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111. Awesome Respite
112. BA Auto Care
113. Baltimore Medical System
114. Baltimore Monthly Meeting of Friends, Stony Run
115. Baltimore Trauma Response Team
116. BDS Healthy Aging Networks
117. Bethany Baptist Church
118. Bethesda Friends Meeting
119. Beth Shalom AME Zion Church
120. Blueberry Gardens Healing Center
121. Bon Secours Baltimore Community Works
122. Branch Communications
123. Capital T. Solutions LLC
124. Carroll County Democratic Central Committee
125. Carroll County Democratic Club
126. Casarea Christian Community Chapel
127. Catonsville Indivisibles
128. Cedar Lane Unitarian Universalist Social Justice Ministry Team
129. Center for Therapeutic Empowerment
130. Central Civic Association
131. Chase Brexton Health Care
132. Chesapeake Health Care
133. Christian Community Church of God
134. Church of the Guardian Angel
135. Clement Cinema LLC
136. Clinton A.M.E. Zion Church
137. Community Baptist Church
138. Community Clinic, Inc. (CCI)
139. Community Ecology Institute
140. Computer Management Services
141. Congregation Or Chadash
142. Corner Rock Ministries
143. CurlyRed
144. Democratic Club of Leisure World
145. Destiny Christian Church
146. Dorchester County Health Department
147. Doterra Essential Oils
148. DoTheMostGood MoCo MD
149. Dreams come true travel
150. Eddie's Market, Charles Village

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151. Eloqui
152. Energy Concepts Co.
153. Enon Baptist Church
154. Empowering Believers Church
155. Empowering Our Children
156. Empowering Our Community
157. Energy Concepts Co.
158. Family and Medical Counseling Service, Inc.
159. First Baptist Church of Highland Park
160. First Mt. Calvary Baptist Church
161. First Unitarian Church of Baltimore
162. Fraspera LLC
163. Frederick Friends Meeting
164. Garrett County Democratic Central Committee
165. Gethsemene Baptist Church
166. Gethsemane United Methodist Church
167. Global Vision Foundation, Inc
168. Gospel Tabernacle Baptist Church
169. Graphics by Chalk
170. Greater Baden Medical Services
171. Greater Beulah Baptist Church
172. Greater Faith Baptist Church
173. Greater Harvest Baptist Church
174. Greater Victory and Deliverance Church Of Jesus Christ
175. Gunpowder Friends Meeting
176. HBCU College of Plant-Based Lifestyle Medicine
177. Health Care For the Homeless
178. HeartSmart - The Cliff R.Roop Cardiac Support and Education Foundation
179. Herron and Associates, LLC
180. High Rock Missionary Baptist Church
181. Holy Ghost Deliverance Tabernacle Church
182. Holy Trinity Episcopal Church
183. Homewood Friends Meeting (Quakers)
184. Hyattsville Mennonite Church
185. IBR/REACH Health Services
186. The IMAGE Center for People with Disabilities
187. IndivisibleHoCoMD
188. Inner Light Yoga
189. Integrative Healing
190. Isaiah Baptist Church

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191. Keep It Classy By Regina
192. Kidz Biziness
193. Kindred Hair & Skin Center
194. Kingdom Missionary Baptist Church
195. Koinonia Baptist Church
196. LeanToo Consulting LLC
197. Make Studio
198. Maryland Baptist Aged Home
199. Mary's Center
200. Mary's Kiddie Kare, LLC
201. Megaphone Project
202. Meridian Hill Baptist Church
203. Miche Booz Architect
204. Miracle Baptist Church
205. Mobile Medical Care
206. Molly Perkins Hauck, PhD., LLC,Licensed Psychologist
207. Movement Disorder Education, Exercise & Community Outreach
208. Mt. Calvary Freewill Baptist Church
209. Mount Calvary Church
210. Mt Calvary Free Will Baptist Church and Ministries, Inc.
211. Mt. Olive Baptist Church
212. Musical Eargazm
213. Muslim Community Cultural Center of Baltimore
214. My Father's House of Baltimore, Inc.
215. NAMI Howard County, MD, Inc.
216. NAMI Metropolitan Baltimore
217. NAMI Prince George's County, MD, Inc.
218. New Corner Stone Baptist Church
219. New Faith Christian Community
220. New Metropolitan Baptist Church
221. New St. Mark Baptist Church
222. Next Day Animations
223. Nu Season Nu Day Church & Ministries
224. Open Bible Baptist Church
225. Paramount Constructors, LLCCD
226. Park Moving and Storage
227. Park West Health System Inc.
228. Pastors' Conference
229. Patuxent Friends Meeting
230. Perkins Square Baptist Church

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231. Perseverance Counseling Services, LLC
232. Prince George's County (MD) Peace & Justice Coalition
233. Prince George's Healthcare Alliance, Inc.
234. Prince of Peace Baptist Church
235. The QED Foundation, Inc.
236. QED Inc.
237. Remnant Center of Excellence
238. Restoration Community Church
239. Root Studio
240. Ruth Downs little ones daycare
241. SEIU Local 400 PG
242. Shepherd's Empowerment Center
243. Sisters In Ministry, Inc.
244. Smalltimore Homes
245. S.M. Jackson Government Business Solutions, LLC
246. St. Francis of Assisi, Baltimore
247. St. Ignatius Church Baltimore
248. St. John’s Episcopal Church Asian Ministry
249. St. Martin Church of Christ, Inc.
250. Shepherd's Heart Missionary Baptist Church
251. Silas First Baptist Church
252. Solid Rock Baptist Church of Baltimore
253. teenieweenie
254. Teri’s Learning Station
255. Third Haven Friends Meeting
256. TRG Management
257. Tri-Area Civic Association
258. Trinity Baptist Church
259. Triumph Nation Church & Ministries
260. Twisted Diction
261. Unitarian Universalist Congregation of Columbia
262. Unitarian Universalists of Charlestown
263. Victory Missionary Baptist Church, Inc
264. Village Baptist Church
265. Wayland Baptist Church of Baltimore
266. Wild Thyme, LLC
267. Willow Grove Citizens' Association
268. Willow Wood Estates Civic Association
269. Wilson Park Christian Community Church
270. Winston Avenue Baptist Church

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271. Woods Memorial Presbyterian Church
272. Youth Empowered Society - YES Drop In Center
273. Zion Hill Baptist Church
274. Zion UMC Lexington Park
275. Zpvmedia

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Public Health Policy in Maryland: Lessons from Recent Alcohol and Cigarette Tax Policies

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Executive Summary

Taxing some consumer products is a public health policy strategy that has the potential to improve the public's health. Over the past decade, the Maryland General Assembly has passed legislation that increased taxes on two consumer products – alcohol and cigarettes – both of which are associated with large burdens of injury and disease. In this report, we examine two laws affecting these products: The Sales and Use Tax – Alcoholic Beverages – Tax Rates Supplementary Appropriation Act of 2011, and the Transportation and State Investment Act of 2007. We consider the public health benefits of these tax laws and analyze the revenues generated by them and how those revenues were spent.

While the alcohol excise tax had been stable for over 45 years, the 2011 law increased the sales tax rate to 9 percent. Following the alcohol sales tax increase, binge drinking by Maryland adults decreased; the 17 percent reduction seen in Maryland between 2011 and 2016 was greater than the 6 percent reduction nationally. Among Maryland high school students, between 2011 and 2015, there was a 26 percent reduction in the percentage of students who consumed alcohol in the preceding 30 days, a 28 percent reduction in binge drinking, and a 31 percent reduction in students riding in a vehicle operated by a driver who had been drinking alcohol. Published research also documented a decrease in alcohol-positive drivers and in sexually transmitted infections in Maryland following the 2011 alcohol sales tax increase.

Maryland's state tax per pack of cigarettes increased incrementally from 1961 to 2008 and has been stable for the last 10 years. Following the $1.00 per pack cigarette tax increase in 2008, smoking by Maryland adults decreased by 26 percent among current smokers between 2011 and 2016. Among Maryland high school students there was a 47 percent reduction in students who reported smoking a cigarette in the preceding 30 days, as well as a decline in frequent smoking between 2007 and 2015.

We conclude that these public health impacts, documented both by the published evidence and experts we interviewed, occurred from relatively modest tax increases. Based on this research, we provide four recommendations for maximizing public health gains through state policy:

1. Consider taxes an effective policy strategy to improve the public's health.
2. Monitor the public health impacts of tax policy.
3. Ensure transparency for bills that generate revenue.
4. Employ effective advocacy strategies when promoting public health policy initiatives.

Introduction

Each year during the 90-day legislative session, the Maryland General Assembly approves thousands of bills that the governor decides whether to sign into law. Many of these laws support public health goals, including health promotion, disease and injury prevention, healthy and safe schools, vaccine uptake, and the realization of smoke-free environments. After these laws are enacted, researchers evaluate many of them to determine how they, in fact, have affected the public's health.

Two consumer products, alcohol and tobacco, are associated with large burdens of injury and disease among Marylanders and have also been the subject of legislation that addresses those burdens through taxes. In this report, we examine how these tax increases are affecting Marylanders' health, based on published evaluations and interviews with subject matter experts. The focus of this report is on the following two laws: the Sales and Use Tax – Alcoholic Beverages – Tax Rates Supplementary Appropriation Act of 2011, which increased the sales and use tax rate for alcoholic beverages from 6 percent to 9 percent, effective July 1, 2011 [Maryland General Assembly, 2011]; and the Transportation and State Investment Act of 2007, which increased the excise tax on a pack of 11-20 cigarettes from $1.00 to $2.00, effective January 1, 2008 [Maryland General Assembly, 2007].

The proposals to raise taxes on alcohol and cigarettes were, in large part, driven by the significant public health impacts these products have on Marylanders. For example, in 2016, 582 people died from alcohol intoxication in Maryland; most involved the concurrent use of other drugs [Maryland Department of Health and Mental Hygiene, 2017]. Drinking alcohol is also associated with both short-term health effects, including unintentional injuries, violence, overdose, and risky sexual behavior, as well as long-term effects such as heart disease, stroke, liver disease, dementia, and several types of cancer [CDC, 2015d; Cook, 2016].

Smoking has been causally linked to multiple negative health conditions including several types of cancer, cardiovascular disease, diabetes, and respiratory diseases such as chronic obstructive pulmonary disease [U.S. Department of Health and Human Services, 2014]. Each year, approximately 7,500 Marylanders die from a smoking-related disease [CDC, 2017]. These conditions are costly, with estimates of $3.5 billion for 2015 and $4.5 billion projected for 2020 [Maryland Department of Health and Mental Hygiene, 2014; Maryland Department of Health and Mental Hygiene, 2016].

Organization and Methodology of this Report

This report includes three sections.

Section I begins with an overview of the public health problems that the tax increases sought to address, and outlines important contextual background information that preceded passage of the laws. This is followed by a review of the evidence about the public health impacts associated with the laws. We also include a description of impacts hypothesized by interviewees that have not been examined through empirical study.

Section II describes the revenues generated through the laws and how that revenue has been used to advance the public health goals specified by each law.

The final section presents recommendations for maximizing public health gains through state policy based on lessons learned from this review. This research does not describe in detail how these laws were passed; others have documented these efforts [Pertschuk, 2010].

We compiled this report based on a review of the proposed bills, accompanying fiscal notes, and the two codified laws – including all subsequent modifications – through the 2017 legislative session. We also conducted a literature review to document the impacts of

these laws, primarily comparing the differences in risk factors before and after each law.

For adults, these data are from the annual national Behavioral Risk Factor Surveillance System (BRFSS), a survey conducted by the Centers for Disease Control and Prevention (CDC) that queries a sample of adults in each state. It is important to note that because of a change in how the survey was administered and analyzed in 2011, the federal government cautions that small increases for health-risk indicators, such as tobacco use and binge drinking, are likely due to changes in survey methodology [CDC, 2013]. Thus, shifts in observed prevalence from 2010 to 2011 for BRFSS measures may reflect true trends in risk-factor prevalence or the new methods of measuring risk factors [CDC, 2012]. As a result, for data on adults, we compare data from 2007 with 2010, and then data from 2011 with 2016 (the most recent data available).

For youth, data are from the Youth Risk Behavior Surveillance System (YRBSS), which is a national survey of thousands of high school students conducted by the CDC. It measures the prevalence of high-risk behaviors among youth, including tobacco, alcohol, and drug use [Eaton, 2012]. Data from the YRBSS did not undergo the same methodological change as the BRFSS survey of adults; however, the data from this biennial survey are only reported through 2015, which are the latest available data. All prevalence numbers in the report have been rounded to the nearest whole number. These rounded numbers were used to calculate the percent change in prevalence over time for each specific health-risk behavior. These percent changes were also rounded to the nearest whole number.

We searched the internet to identify stakeholder organizations and potential key informants for each issue and complemented that search with recommendations for additional interviewees we gained from those original key informants. This process yielded a sample of 10 people highly knowledgeable about the two laws from advocacy organizations, academic institutions, and state government agencies who we interviewed between July and November 2017. These interviews allowed us to capture a robust and comprehensive account of the public health impacts for each case. Several interviewees requested that their names not be included in this report. We respected these requests and, therefore, do not include any interviewees' names.

We collected financial information about the laws and the revenue they generated from the Maryland Comptroller's Alcohol and Tobacco Tax Annual Reports for the years 2006 to 2016. We also reviewed the 2016 Comprehensive Annual Financial Report, as well as the 2016 Department of Legislative Services Fiscal Briefing [Franchot, 2016a; Franchot, 2016b]. We searched the comptroller's website for information about the sales and use taxes, the Health Department's website for budget information, and the Department of Budget and Management's website to access the list of Special Funds [Department of Budget and Management, 2017]. In addition, the Governor's "Maryland Budget Highlights FY2016" [Hogan, 2015] contained information we used to further understand the Cigarette Restitution Fund.

I. Alcohol and Cigarette Tax Increases: Public Health Problem, Legislative Background, and Public Health Impacts of the Laws

The Alcohol Tax Increase

Public Health Problem Prior to the 2011 Tax Increase

The sales tax on alcohol increased in July 2011. Prior to the alcohol tax increase taking effect, the prevalence of binge drinking (on a single occasion, five or more drinks for men and four or more drinks for women) among Maryland adults was 13 percent in 2007 and 15 percent in 2010 [CDC, 2015b]. In 2011, the prevalence of binge drinking was 18 percent for Maryland adults [CDC, 2015b]. However, as previously

described, the CDC changed its methodology for analyzing adult BRFSS survey responses in 2011. Therefore, the adult survey results from 2010 and prior years cannot be compared with 2011 and subsequent years [CDC, 2012]. The higher prevalence number in 2011 is likely explained by changes in how the CDC collected and analyzed these data, as opposed to real changes in the prevalence of binge drinking.

Among Maryland high school students surveyed in 2007, 43 percent reported drinking alcohol at least once in the preceding 30 days [Eaton, 2008; CDC, 2007-2015]. In 2011, the year of the tax increase, 35 percent of Maryland high school students reported drinking alcohol in the prior 30 days [Eaton, 2012]. When asked about binge drinking alcohol (five or more drinks in a row within a couple of hours), 24 percent of Maryland high school students reported the behavior in 2007 compared to 18 percent in 2011 [Eaton, 2008; Eaton, 2012; CDC, 2007-2015]. Evidence of other risky drinking behaviors over time is seen in the percentage of Maryland students who reported riding in a car with an alcohol-positive driver (29 percent in 2007 and 26 percent in 2011) [Eaton, 2008; Eaton, 2012; CDC, 2007-2015]. In addition, 9 percent of students reported driving after drinking alcohol in 2007 compared to 8 percent in 2011 [Eaton, 2008; Eaton, 2012].

In addition to the risky behaviors documented through surveys, the impact of alcohol on the public's health is also defined in terms of costs. At an estimated $2.22 per drink and $860 per person, the total annual cost of consuming alcohol was approximately $4.9 billion in 2010 [Sacks, 2015; CDC, 2015c]. We were unable to locate post-law estimates of the cost of alcohol consumption in Maryland.

Legislative Background

Excise taxes are charged per unit (e.g., gallon) of an item while sales taxes are a percentage of the sale. An excise tax can have the effect of decreasing the quantity of the item that is sold and consequently its consumption. Maryland alcohol excise taxes have been stable for over 45 years without any adjustments for inflation, which is shown in Table 1. Federal excise taxes are additional taxes: $13.50 per gallon of distilled spirits, $1.07 per gallon of wine, and $0.58 per gallon of beer [Maryland General Assembly, 2011; Xu, 2011].

Maryland also imposes a sales tax on alcohol as well as on most other consumer products; it is added at the point of purchase and is not included in the shelf price of the product. In January 2008, the General Assembly passed a bill that increased the general sales tax from 5 percent to 6 percent [Franchot, 2016a]. A special tax increase went into effect in

Table 1. Maryland's excise tax rates on alcoholic beverages

Alcoholic beverage	Initial tax per gallon (year tax imposed)	Current tax per gallon (years tax rate in effect)
Distilled spirits	$1.10 (1933)	$1.50 (1955 – present)
Wine	$1.10 (1933); reduced to $0.20 (1935)	$0.40 (1972 – present)
Beer	$0.02 (1936)	$0.09 (1972 – present)

Source: Franchot, 2016b.

According to the state tax data document, per capita consumption of beer decreased by 11 percent between fiscal year 2010 and fiscal year 2016 (from 18 gallons in 2010 to 16 gallons in 2016).

July 2011 and raised the sales tax on alcoholic beverages to 9 percent [Maryland General Assembly, 2011].

This additional 3 percent sales tax on alcoholic beverages reflected a determination to raise the long stagnant tax. In 2011, advocates supporting the alcohol tax increase, known as the Lorraine Sheehan Alcohol Tax Coalition, proposed a dime-a-drink increase in the excise tax on beer, wine, and liquor distributors, with the proceeds to fund public health initiatives including drug and alcohol abuse prevention and treatment, mental health programming, support for people with developmental disabilities, and health care coverage. Near the end of the 2011 general assembly session, it became clear that the excise tax would not pass at the dime-a-drink level. Instead, legislative leaders proposed increasing the state sales tax—on alcoholic beverages only—from 6 percent to 9 percent. This translated to a nickel-a-drink excise tax, which was an acceptable compromise for the advocates. Legislative leaders preferred this approach because it would keep Maryland's alcohol tax at the same rate as the District of Columbia, which has the same excise tax as Maryland and a similar alcohol-specific sales tax.

As enacted, the alcohol sales tax law earmarked some of the funds for the Developmental Disabilities Administration ($15 million) and dedicated about $72 million (amount cited by an interviewee) to projects including school aid and construction in the first year, with those proceeds going to the general fund in subsequent years. Although the advocates would have preferred the money to be allocated as they had originally proposed, they agreed to the compromise for two reasons. First, they were confident that regardless of how the money was spent, it would lead to a significant drop in alcohol abuse and underage drinking. Second, they planned to work closely with the Governor and General Assembly to ensure that most of the proceeds from the alcohol sales tax increase were allocated for the purposes originally identified by the Lorraine Sheehan Coalition after the first year.

While advocates originally proposed an excise tax rather than a sales tax, there are advantages to the sales tax. The alcohol sales tax is a value-based tax on the advertised price of the alcohol and therefore adjusts with inflation and does not diminish with time [Lavoie, 2017]. Unlike the sales tax, the excise tax is a flat, volume-based tax that is part of the advertised price. Importantly, its value decreases over time due to inflation [Lavoie, 2017]. Between 1970 and 2009, inflation is estimated to have decreased the real-dollar value of the average state excise tax on beer by 70 percent [Naimi, 2016]. In addition, several interviewees noted that the sales tax is progressive in that the largest increases are on expensive cocktails at high-end bars and restaurants.

In reflecting on this legislative process, one interviewee pointed out that there was no significant public opposition following either the 2008 general sales tax increase or the 2011 alcohol-specific sales tax increase.

Public Health Impacts of the 2011 Law

The 2011 Maryland alcohol sales tax increase is associated with decreases in alcohol consumption. According to the state tax data

The relationship that is evident across these studies is clear: As the price of alcohol increases, death and injury decrease, with specific declines in alcohol-related diseases, violence, traffic crashes, and crime.

document, per capita consumption of beer decreased by 11 percent between fiscal year 2010 and fiscal year 2016 (from 18 gallons in 2010 to 16 gallons in 2016) [Franchot, 2016b].

This decline in alcohol consumption is seen especially in the adult population. Binge drinking among Maryland adults decreased from 18 percent in 2011 to 14 percent in 2015 but rose slightly to 15 percent in 2016 [Kanny, 2013; CDC, 2015b]. Thus, in Maryland, the prevalence of adult binge drinking was 17 percent lower in 2016 than it was in 2011. This decline is greater than the national trend in which there was only a 6 percent reduction in adult binge drinking between 2011 and 2016 (U.S. prevalence: 18 percent in 2011, 16 percent in 2015, and 17 percent in 2016) [CDC, 2015b].

Declines in alcohol consumption among youth are also documented after the law took effect. Comparing the YRBSS from 2011 with 2015, the percentage of Maryland high school students who had consumed alcohol at least once in the preceding 30 days decreased from 35 percent in 2011 to 26 percent in 2015, a reduction of 26 percent [Eaton 2012; Kann 2016; CDC, 2007-2015]. In comparison, there was a 17 percent reduction among students nationwide over the same time period (from 36 percent in 2011 to 30 percent in 2015) [Eaton 2012; Kann 2016]. In addition, the percentage of Maryland high school students who reported binge drinking on at least one day in the preceding 30 days decreased from 18 percent in 2011 to 13 percent in 2015 [Eaton 2012, Kann 2016; CDC, 2007-2015]. This decrease of 28 percent in binge drinking reported by Maryland youth from the YBRSS is similar to that seen in the country as a whole (the U.S. median for high school student binge drinking decreased by 27 percent, from 22 percent in 2011 to 16 percent in 2015) [Eaton, 2012; Kann, 2016; CDC, 2007-2015].

The public health benefit of this reduced consumption is evident in studies that examine the relationship between the 2011 alcohol sales tax increase and reductions in alcohol-related automobile deaths and injuries. Self-reports of Maryland high school students who rode in a vehicle driven by a driver who had been drinking alcohol decreased by 31 percent between 2011 and 2015 (26 percent in 2011 and 18 percent in 2015) [Eaton 2012; Kann 2016; CDC, 2007-2015], although the percentage who reported driving after drinking was similar for both years: 8 percent in 2011 and 7 percent in 2015 [Kann, 2016].

Further, a 2017 study evaluated motor vehicle crash reports involving Maryland drivers who tested positive for alcohol. The study compared crashes with alcohol-positive drivers for the 127 months prior to the sales tax increase with the 29 months following the law's effective date [Lavoie, 2017]. The authors documented a 6 percent reduction in alcohol-positive drivers of all ages, and a 12 percent reduction among alcohol-positive drivers ages 15-34 years after the sales tax increase took effect [Lavoie, 2017]. The authors posit that this decrease resulted from lower levels of drinking among younger drivers, who are more price-sensitive. Unlike younger drivers, crash rates among those 55 years and older increased among alcohol-positive drivers involved in crashes [Lavoie, 2017]. The findings for the younger drivers are

consistent with an evaluation of Illinois' alcohol tax increase, which measured a 26 percent decrease in fatal motor vehicle crashes for all drivers, and a 37 percent reduction among drivers under 30 years of age [Wagenaar, 2015].

One other public health benefit described by interviewees, and supported by the literature and the CDC, is a decline in risky sexual behavior explained as a consequence of reduced alcohol consumption [Chesson, 2000; CDC, 2015d]. Alcohol intoxication can lead to unprotected sex and sexually transmitted infections (STIs), and may explain a recent finding in Maryland that the mean monthly rate of gonorrhea cases decreased from 11 cases per 100,000 before the tax increase (January 2003 to June 2011) to nine cases per 100,000 after the tax increase (July 2011 to December 2012) [Staras, 2016]. This is a 24 percent reduction, or almost 1,600 cases avoided every year [Staras, 2016]. In contrast, there was a non-statistically significant increase in the incidence of chlamydia from a mean monthly rate of 35 cases per 100,000 before the tax increase (January 2003 to June 2011) to 39 cases per 100,000 after the tax increase (July 2011 to December 2012) [Staras, 2016]. The different outcomes for gonorrhea and chlamydia may be because detection of chlamydia is dependent on screening. It is often asymptomatic, while the gonorrhea rate more closely reflects its prevalence in the population. These authors conducted a similar analysis using Illinois data and found there were fewer cases of both gonorrhea and chlamydia in Illinois following an increase in alcohol taxes [Staras, 2014]. A systematic review of the literature has also established that increases in the price of alcohol have

Table 2. Summary of impact of alcohol sales tax in Maryland

Positive impacts of sales tax on alcohol consumption in Maryland			
Population	**Parameter**	**Prevalence (year)**	**Change in prevalence**
Youth[1,2,3]	Drinking in last 30 days	35% (2011) vs. 26% (2015)	26% reduction
	Drinking ≥5 drinks in a row	18% (2011) vs. 13% (2015)	28% reduction
	Riding in vehicle with alcohol-positive driver	26% (2011) vs. 18% (2015)	31% reduction
Adults[4]	Binge drinking	18% (2011) vs. 15% (2016)	17% reduction
General	Decreased alcohol-positive drivers[5]		
	Health impacts (e.g., decreased risky sexual behavior and sexually transmitted infections[6,7])		

Sources: [1]Eaton, 2012; [2]Kann, 2016; [3]CDC, 2007-2015; [4]CDC, 2015b; [5]Lavoie, 2017; [6]Staras, 2016; [7]CDC, 2015c. All prevalence numbers in the report have been rounded to the nearest whole number (0.5 and higher numbers were rounded up; 0.4 and lower numbers were rounded down). These rounded numbers were used to calculate the percentage change in prevalence over time for the health-risk behavior. The calculated percentages for prevalence change were also rounded to the nearest whole number.

a small inverse relationship with STIs [Wagenaar, 2010].

Maryland's 2011 alcohol-specific sales tax increase, like similar alcohol tax increases in other states, has had the expected public health benefit of reducing alcohol abuse, particularly among high school students. These Maryland findings are consistent with the national literature demonstrating public health benefits associated with increasing alcohol taxes, with particular gains noted among adolescents and young adult populations [Wagenaar, 2010; Xu, 2011]. The relationship that is evident across these studies is clear: As the price of alcohol increases, death and injury decrease, with specific declines in alcohol-related diseases, violence, traffic crashes, and crime [Wagenaar, 2010]. The Task Force on Community Preventive Services, a respected national body that identifies evidence-based interventions, recommends increasing alcohol taxes and projects that the resulting public health benefits will be proportional to the size of the tax increase [U.S. Task Force on Community Preventive Services, 2010]. Table 2 summarizes the impacts reviewed in this section.

Perceived Unintended Consequences and Contradictory Outcomes

Interviewees recalled that during the alcohol sales tax increase policy debate, opponents described Marylanders' ability to purchase alcohol through alternative venues such as the internet and neighboring states with lower taxes. Such a shift in purchasing could result in a false underestimation of alcohol consumption that would affect impact measures and decrease revenue for the state. Products bought over the internet by Maryland residents may not be subject to the sales tax if the retailer is located out of state. Cross-border shopping has been the subject of a few studies, one of which shows that this occurs when the tax savings compensate for the transportation costs of traveling to the jurisdiction with lower taxes [Leal, 2010]. Interviewees were unable to cite any evidence showing that these impacts hypothesized by bill opponents actually occurred, and we are unaware of any evidence that supports this concern being realized. While such evidence does not exist to assess whether Maryland is losing alcohol tax revenues to other states, Maryland's 2011 alcohol sales tax increase raises approximately $70 million in additional tax revenue for the state every year.

Finally, alcohol-related intoxication deaths have increased in Maryland over the last several years from 187 deaths in 2007 to 582 deaths in 2016 [Maryland Department of Health and Mental Hygiene, 2017]. The role of alcohol in these deaths is only one part of the story. In fact, the total number of intoxication deaths from alcohol and/or drugs occurring in Maryland has increased significantly from 815 deaths in 2007 to 2,089 deaths in 2016 [Maryland Department of Health and Mental Hygiene, 2017]. The increase in alcohol-related deaths is related to the use of opioids; approximately half of these deaths (49-54 percent) were combined with heroin or fentanyl intoxication in 2016 [Maryland Department of Health and Mental Hygiene, 2017].

The Cigarette Tax Increase

Public Health Problem Prior to the 2008 Tax Increase

Smoking causes multiple negative health conditions including several types of cancer, cardiovascular disease, diabetes, and respiratory diseases such as chronic obstructive pulmonary disease [U.S. Department of Health and Human Services, 2014]. Smoking is also a leading cause of mortality. Each year approximately 7,500 Marylanders die from a smoking-related disease [CDC, 2017].

In 2007, before the cigarette tax increase, 17 percent of Maryland adults identified as current smokers [CDC, 2015b]. Smoking was also common among Maryland youth. Data from the

Smoking is a leading cause of mortality. Each year approximately 7,500 Marylanders die from a smoking-related disease.

2007 YRBSS reported that 17 percent of Maryland high school students had smoked a cigarette at least once in the preceding 30 days while 5 percent reported smoking daily [Eaton, 2008; CDC, 2007-2015]. Among these high school smokers, 10 percent reported smoking more than 10 cigarettes per day in 2007 [Eaton, 2008; CDC, 2007-2015].

Legislative Background

Tobacco tax increases are considered the most effective policy for reducing tobacco use [Chaloupka, 2017]. The Maryland government first taxed cigarettes in 1958 at $0.03 per pack [Franchot, 2016b]. The state tax per pack of cigarettes increased incrementally from 1961 to 2002 and reached $1.00 in 2002 where it held steady until 2008 [Franchot, 2016b].

In 2007, the Maryland General Assembly passed The Transportation and State Investment Act of 2007, which increased the cigarette tax from $1.00 to $2.00 per pack of 11-20 cigarettes, effective January 1, 2008. The combined federal and state tax per pack of cigarettes is now $3.01 compared with $1.39 in 2007 [Orzechowski and Walker, 2017]. The average cost per pack of cigarettes in Maryland was $6.72 in 2016, an increase from $4.28 in 2007 [Orzechowski and Walker, 2017]. Of the total price of cigarettes in 2016, almost half (45 percent) is taxes. This is an increase from 2007 when taxes comprised 33 percent of the retail price [Orzechowski and Walker, 2017].

The main goals of the cigarette tax increase, as described by the experts we spoke with, were twofold: 1) to reduce tobacco use and related negative health conditions, especially lung cancer; and 2) to fund an expansion of health care coverage for low-income Marylanders not eligible for Medicaid; this extended coverage included tobacco cessation services. During the same time the bill was being considered, there was a separate bill to expand Medicaid to include parents up to 116 percent of the Federal Poverty Level. The Working Families and Small Business Health Care Coverage Act of 2007 preceded the federal Affordable Care Act (ACA). During a Special Legislative Session in 2007, called by the Governor to resolve the state's budget deficit, the Maryland General Assembly passed these two bills that established the cigarette tax increase ($1.00 per pack) and expanded Medicaid, with the revenue from the tax being used to support expanded health care coverage. Experts we spoke with emphasized that the Medicaid expansion would not have occurred without the cigarette tax increase, as the additional revenue from the tax increase was needed to pay for expanded health care coverage. One interviewee shared that initially many advocates wanted the proceeds from the tax to fund tobacco prevention programs. However, the most politically viable use of the proposed revenue was to fund expansion of the Maryland Medicaid program.

Public Health Impacts of the 2008 Law

There is strong evidence of an inverse association between cigarette prices and sales. Cigarette pack sales in Maryland have declined with each cigarette tax increase [Health Care for All, 2013; Health Care for All, 2017; Orzechowski and Walker, 2017]. In 2007, Maryland retailers sold 269 million cigarette packs compared to 182 million in 2015 [Maryland Department of Health and Mental Hygiene, 2016]. Also, between 2007 and 2016, per capita cigarette consumption decreased

by 38 percent, from 48 packs per person to 30 packs [Orzechowski and Walker, 2017]. Most of this decline occurred in the years immediately following the tax increase and is consistent with decreased consumption patterns following previous cigarette tax increases in Maryland that occurred between 1998 and 2012 [Health Care for All, 2013; Orzechowski and Walker, 2017]. Reductions in cigarette sales and smoking rates were key public health goals of the cigarette tax legislation.

In 2010, two years after the cigarette tax increase went into effect, 15 percent of Maryland adults were current smokers, a decrease of 12 percent compared with the 17 percent smoking prevalence in 2007 [CDC, 2015b]. As previously noted, the CDC changed the methodology for collecting and analyzing adult BRFSS data in 2011, thus limiting comparison of pre-2011 adult data with subsequent years [CDC, 2012]. Under the revised methodology, 19 percent of Maryland adults were identified as current smokers in 2011 [CDC, 2015a; CDC, 2015b]. This prevalence declined to 15 percent in 2015 and to 14 percent in 2016 [CDC, 2015b]. Comparing 2016 with 2011, there has been a 26 percent decrease in the prevalence of adult current smokers in Maryland.

The ability of the law to impact youth smoking was also a goal of the cigarette tax, in part because reducing smoking among youth is an effective strategy for preventing youth from becoming adult smokers. An estimated 90 percent of current smokers began smoking before the age of 18 years [Farber, 2016]. The impact of price on smoking is particularly strong among youth, making tax interventions an important strategy for preventing youth smoking. Several studies document declines in smoking among youth after a tobacco tax increase, noting that youth price sensitivity impacts decision-making [Chaloupka, 2011; Ross, 2001].

High school student cigarette smoking rates in Maryland declined between 2007 and 2009 and have also decreased when 2007 is compared with 2015. More specifically, the percentage of Maryland high school students who reported smoking a cigarette at least once in the preceding 30 days was 17 percent in 2007, 12 percent in 2009, and 9 percent in 2015 [CDC, 2007-2015]. This corresponds to a 29 percent decrease between 2007 and 2009, and a 47 percent decrease between 2007 and 2015. These declines are higher than the national trend, where the prevalence dropped by 3 percent between 2007 and 2009 and by 45 percent between 2007 and 2015 (U.S. prevalence: 20 percent in 2007, 19.5 percent in 2009, and 11 percent in 2015) [CDC, 2007-2015].

Comparing YRBSS Maryland high school student data from 2015 with 2007, there was a 71 percent decline in the prevalence of students who had smoked cigarettes on 20 or more days in the preceding month (Maryland prevalence: 7 percent in 2007 and 2 percent in 2015) [CDC, 2007-2015]. There was also a 60 percent decline in the prevalence of Maryland high school students who smoked cigarettes daily from 5 percent in 2007 to 2 percent in 2015 [CDC, 2007-2015]. The YRBSS data from the same time period also revealed a 10 percent increase in the prevalence of Maryland high school smokers who smoked more than 10 cigarettes a day in the preceding month (10 percent in 2007 and 11 percent in 2015) [CDC, 2007-2015].

Another public health goal of the increased tax was the potential for the cigarette tax to lead to decreases in other illegal substance use by youth. Adolescent smokers are more likely to use illegal drugs than nonsmokers, 55 percent versus 6 percent [Farber, 2016]. National data from the YRBSS revealed that youth who reported smoking cigarettes were 2.6 times more likely to drink alcohol, 3.5 times more likely to use marijuana, and 3.8 times more likely to have four or more sexual partners [Demissie,

Table 3. Summary of impact of cigarette tax in Maryland

Positive impacts of cigarette tax on smoking in Maryland			
Population	**Parameter**	**Prevalence (year)**	**Change in prevalence**
Youth[1,2,3]	Smoked cigarette in last 30 days	13% (2011) vs. 9% (2015)	31% reduction
	Smoked cigarettes for >20 days in last 30 days	4% (2011) vs. 2% (2015)	50% reduction
	Smokers who smoke >10 cigarettes a day	6% (2011) vs. 11% (2015)	83% increase
Adults[4]	All current smokers	19% (2011) vs. 14% (2016)	26% reduction
General	Fewer youth smokers can potentially decrease prevalence of adult smokers in the future.[5]		
	Health impacts (e.g., decreased smoking-related morbidity and mortality, and potentially decreased health care costs[6,7])		

Sources: [1]Eaton, 2012; [2]Kann, 2016; [3]CDC, 2007-2015; [4]CDC, 2015b; [5]Farber, 2016; [6]CDC, 2014; [7]Maryland Department of Health and Mental Hygiene, 2014. All prevalence numbers in the report have been rounded to the nearest whole number (0.5 and higher numbers were rounded up; 0.4 and lower numbers were rounded down). These rounded numbers were used to calculate the percentage change in prevalence over time for the health-risk behavior. The calculated percentages for prevalence change were also rounded to the nearest whole number.

2017]. In Maryland, according to the Youth Tobacco and Risk Behavior Survey of 2013, high school smokers are three times more likely to currently drink alcohol, five times more likely to currently use marijuana, nine times more likely to currently abuse prescription drugs, and six times more likely to ever use other illegal drugs [Maryland Department of Health and Mental Hygiene, 2014]. Specifically, 79 percent of high school cigarette smokers reported consuming alcohol, and 67 percent reported using marijuana in the prior 30 days [Maryland Department of Health and Mental Hygiene, 2014]. This is higher than for nonsmokers (24 percent reported consuming alcohol, and 13 percent reported using marijuana in the prior 30 days).

Interviewees also expected the tax would reduce exposure to secondhand smoke and benefit nonsmoking adults and children, although the individuals who mentioned this specific impact recalled that it received less attention during the policy debate than the direct health impacts to smokers themselves. Few studies have examined this impact, and we were unable to identify any data to support this association. However, an association between the District of Columbia's cigarette excise tax and declines in periodontal disease, which is highly correlated with secondhand smoke exposure, is reported in the literature [Sander, 2013; Sutton, 2012].

Interviewees also described the potential impact on low birthweight babies because of the connections between a pregnant woman's tobacco use and prenatal outcomes [Windham, 2000]. Baltimore has experienced dramatic decreases in infant mortality since

the Baltimore City Health Department launched the B-More for Healthy Babies initiative in 2009 [B'more for Healthy Babies, 2017]. Interviewees were careful not to attribute the declines to the increase in cigarette prices; however, given the relationship between cigarette taxes and smoking, and smoking and low birthweight, interviewees who mentioned this impact explained that the tobacco tax likely amplified the effects of the initiative.

Maryland's 2008 cigarette tax increase, like similar cigarette tax increases across the country, has reduced cigarette use, especially among young people, and can reduce death and disease caused by tobacco use [Chaloupka, 2017]. Table 3 summarizes the impacts reviewed in this section.

Perceived Unintended Consequences and Contradictory Outcomes

Interviewees raised potential unintended consequences in considering the impacts of the tax, many of which opponents highlighted during the policy debate. The most prominent concern was that the cigarette tax could cause youth to switch to more affordable tobacco products such as little cigars, smokeless tobacco, and e-cigarettes. In 2015, among high school students in Maryland, 10 percent had smoked cigars, cigarillos, or little cigars, and 20 percent used electronic vapor products at least once in the past 30 days [Maryland Department of Health, 2014].

At the time the cigarette tax bill was being considered, there were inconsistencies across taxes and policies for cigarettes compared to other tobacco products. Beginning in 2012, the Maryland General Assembly passed several bills that prohibit e-cigarette sales and their components to minors [Maryland General Assembly, 2012a; Maryland General Assembly, 2015], and increased the tax on little cigars and smokeless tobacco [Comptroller of Maryland, 2012]. Although the increased taxes for these tobacco products were not as large as the cigarette tax, it did bring these products more in-line with cigarette prices. Interviewees hypothesized that increasing the costs of these other products could address concerns about tobacco users switching products because of the cost. In support of this perspective, there was a reported 14 percent decline in cigar smoking in Maryland (from 14 percent in 2010 to 12 percent in 2013) by adolescents after this tax increase went into effect [Maryland Department of Health and Mental Hygiene, 2016].

A second unintended consequence interviewees raised was that the higher tax would result in a new market for smuggled cigarettes from states with lower taxes, particularly neighboring Virginia, West Virginia, Delaware, and Pennsylvania. This was a prominent argument raised by the tobacco industry. After the cigarette tax took effect, the Tax Foundation reported that the percentage of cigarettes smuggled into Maryland increased from 10 percent in 2006 to 20 percent in 2013 [Drenkard, 2015], resulting in lost tax revenue for the state. Interviewees questioned the accuracy of these data and referenced a report from Tobacco-Free Kids that concluded there is a net increase in cigarette tax revenue for Maryland and every other state that has passed a cigarette tax of 50 cents or more since 2008 [Tobacco-Free Kids, 2018]. While smuggling may have increased, Maryland's overall revenues from the cigarette tax increased following the effective date of the new tax. Regardless of the size of the smuggling problem, continued law enforcement actions to address this activity are important.

Another potential unintended consequence interviewees raised, and that was emphasized by the tobacco industry during the policy debate, was the differential impact of the tax on low-income individuals who are spending an increasing proportion of their resources on cigarettes as a result of the tax. Interviewees shared that while there was support for the potential benefits of the tax, a common

Maryland's 2008 cigarette tax increase, like similar cigarette tax increases across the country, has reduced cigarette use, especially among young people, and can potentially reduce death and disease caused by tobacco use.

concern centers around equity, [Dinno, 2009; Franks, 2007; Gospodinov, 2009], and that low-income individuals would be disproportionately impacted by the tax.

One final unintended consequence mentioned was the impact of the cigarette tax on participation in the Supplemental Nutrition Assistance Program (SNAP) among eligible low-income households. One expert mentioned this association, which is supported by a few studies. Rozema and colleagues demonstrated that the likelihood that smokers who are eligible for SNAP benefits actually enroll in SNAP increased between 10 percent and 15 percent after a cigarette tax was passed [Rozema, 2017]. The hypothesized mechanism for this association is that low-income families experience greater financial strains from the higher taxes but cannot easily stop using cigarettes because of their addictive quality. In order to cover the price increase, some may be more likely to obtain governmental assistance to help ease the new tax burden [Rozema, 2015].

II. Revenues from the Alcohol and Cigarette Tax Increases: How Much and What Has it Been Used For?

Revenue Created by the 2011 Alcohol Sales Tax Increase

Of the $1.13 billion in sales tax collected from food and beverages in fiscal year 2016, alcohol sales generated $283 million [Comptroller's office, personal communication]. One hundred percent of these alcohol sales tax and excise tax revenues go to the general fund. Further, the alcohol tax revenue is projected to increase by 3.5 percent annually [Maryland General Assembly, 2017]. Thus, the estimated revenue from the sales tax on alcohol for fiscal year 2017 is $289 million and $306 million for fiscal year 2018 [Maryland General Assembly, 2016; Maryland General Assembly, 2017].

The 2011 bill that increased the alcohol sales tax mandated certain appropriations for the following fiscal year, specifically schools and school construction, and the Developmental Disabilities Administration. For fiscal year 2012, the law required that $15 million be appropriated to the Waiting List Equity Fund for the Developmental Disabilities Administration and $47.5 million be appropriated to the Public School Construction Financing Fund [Maryland General Assembly, 2011; Maryland General Assembly, 2012b]. The Waiting List Equity Fund provides money for community services to disabled individuals [Maryland General Assembly, 2011]. The Public School Construction Financing Fund is administered by the Board of Public Works for construction projects for public schools [Maryland General Assembly, 2012b; Maryland General Assembly, 2012c].

Appropriations were not specified for subsequent fiscal years, though interviewees noted that they met with the Governor several times to discuss allocation. Perhaps as a result of these meetings, the Governor proposed in his budget for fiscal year 2013 that $64 million of the approximately $70 million raised annually from the 2011 alcohol sales tax increase be allocated for the original goals of the Lorraine Sheehan Alcohol Sales Tax Coalition, which included funding for drug and alcohol prevention, support for people with mental health and developmental disabilities, and health care needs such as funding for

Experts emphasized that the Medicaid expansion would not have occurred without the cigarette tax increase, as the additional revenue from the tax increase was needed to pay for expanded health care coverage.

health enterprise zones and home- and community-based long-term care.

Revenue Created by the 2008 Cigarette Tax Increase

The cigarette tax increase became effective on January 1, 2008, during the 2007 fiscal year. According to the Comptroller's office, the revenue from this tax was $271 million for fiscal year 2006 and $268 million for fiscal year 2007. It subsequently increased to $340 million for fiscal year 2008 and $394 million for fiscal year 2009 [Franchot, 2016b]. Revenue remained between $394 and $397 million for fiscal year 2010 through fiscal year 2012. Since fiscal year 2013, cigarette tax revenues have been declining, by about $11 million annually, to $357 million in 2015. However, between fiscal year 2015 and fiscal year 2016, revenue increased by $3 million, according to the report from the Comptroller [Franchot, 2016b]. In general, state revenues following the tax increase remain substantially higher than before the increase took effect.

A review of the legislation revealed that the law did not specifically allocate the revenue for public health purposes. This was confirmed by the experts we spoke with, and, in fact, our interviewees noted that they advocated for revenue to support tobacco prevention programs. However, a couple of experts we spoke with recalled that at the time, the Governor and state policy leaders, in response to strong advocacy efforts, agreed that the revenue would be used to support health care expansion through the Working Families and Small Business Health Care Coverage Act of 2007, which expanded Medicaid coverage to adults making less than 116 percent of the federal poverty level – about 100,000 Marylanders.

While the cigarette tax revenue goes into the general fund, funds can be earmarked for specific uses. For example, even though the law did not specifically designate the revenue for cigarette-related purposes, to at least one expert we spoke with, it is clear that the revenue is doing what it was intended to do – expanding health care coverage. An additional 100,000 Maryland adults have health care through the Working Families and Small Business Health Care Coverage Act, which, as previously noted, was paid for by the cigarette tax revenue. Thus, although advocates were disappointed that the revenue did not specifically go to tobacco cessation or prevention, a few noted that with the expanded health care coverage, adults could have access to smoking cessation programs through Medicaid.

One interviewee we spoke with noted that these efforts to raise taxes have continued in Maryland in hopes of having additional state money allocated for tobacco prevention in Maryland. The CDC has recommended levels for funding tobacco prevention and cessation programs for each state [CDC, 2014]. For Maryland, based on its population and prevalence of tobacco use, the CDC recommends spending $48 million to support interventions, mass-reach health communications, cessation programs, and surveillance. According to Tobacco-Free Kids, Maryland is falling short in meeting

recommended funding levels for tobacco prevention, cessation, and treatment. In fiscal year 2017, Maryland spent less than $11 million on tobacco prevention, even though the state received an estimated $554 million in tobacco settlement payments and taxes [Tobacco-Free Kids, 2016]. Of note, tobacco companies spent an estimated $127 million in Maryland on advertising in 2014 [Tobacco-Free Kids, 2016].

III. Recommendations

We propose the following four recommendations for advocates, researchers, funders, and concerned citizens to consider. Based on findings from the literature review and interviews with experts familiar with the policy debate surrounding these two laws and their subsequent implementation, these recommendations are intended to help maximize public health gains through state policy.

1. Consider taxes an effective policy strategy to improve the public's health.

By increasing cigarette and alcohol taxes, policymakers can realize the tremendous public health benefits associated with price increases. It is remarkable that the impacts documented by the evidence, as well as described by interviewees, occurred from relatively modest tax increases. Because of the public health benefits associated with even a modest tax increase, policymakers stand to see more impressive declines in key health indicators by pursuing a higher tax. Moreover, despite anticipated resistance to the bills, interviewees noted the lack of public backlash once the laws were passed.

2. Monitor the public health impacts of tax policy.

The two laws reviewed benefitted from the wealth of existing research documenting how each tax policy could achieve public health goals.

This research was not only critical for developing evidence-based policies for the advocacy campaigns, which were central to the debates surrounding those bills, but also illustrative for highlighting public health impacts. To fully understand the various ways laws can improve the public's health, continued support for research documenting the impacts of tobacco and alcohol taxes is needed. Additional research to further illuminate the long-term public health impacts of state tax policy, and any unintended consequences for health, as well as disproportionate impacts on certain segments of the population, is crucial to fully understanding these tax policies.

3. Ensure transparency for tax bills that generate revenue.

Information about the revenue generated from these laws is insightful. Although the revenues generated through these laws become part of the general fund, a number of experts who we spoke with were unable to provide clear details about how these funds have been spent. Assuring that funds generated through public health policies are strategically spent to advance public health goals should be standard procedure. At the very least, we recommend that language be included in legislation that requires transparency so that the public can identify how funds are being used.

4. Employ effective advocacy strategies.

Utilizing effective public health advocacy strategies to support policy change was key to the passage of these two tax laws [Pertschuk, 2010]. These efforts indicate the importance of citizen involvement when it comes to informing policy action on matters that impact the public's health. Without strong advocacy for public health policies, it is unlikely that the cigarette and alcohol tax policies highlighted in this report would have been realized. Advocating for evidence-based public health policies with deliberate, strategic, and proven strategies is critical, and should remain a priority in Maryland.

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**Public Health Policy in Maryland:
Lessons from Recent Alcohol and Cigarette Tax Policies**

by Keshia Pollack Porter, PhD, MPH, **Shannon Frattaroli**, PhD, MPH, **Harpreet Pannu**, MD, MPH

About the Abell Foundation

The Abell Foundation is dedicated to the enhancement of the quality of life in Maryland, with a particular focus on Baltimore. The Foundation places a strong emphasis on opening the doors of opportunity to the disenfranchised, believing that no community can thrive if those who live on the margins of it are not included.

Inherent in the working philosophy of the Abell Foundation is the strong belief that a community faced with complicated, seemingly intractable challenges is well-served by thought-provoking, research-based information. To that end, the Foundation publishes background studies of selected issues on the public agenda for the benefit of government officials; leaders in business, industry and academia; and the general public.

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Alcohol Taxes Save Lives

Excessive alcohol use in the United States and in Maryland is expensive. It leads to health problems, crime, violence, car crashes, preventable death, and decreased productivity. These costs fall not just on heavy drinkers but on all Marylanders, costing the state an estimated $5 billion per year in health care expenditures, productivity losses, property damage, criminal justice and other costs.[1] Current alcohol prices do not reflect these costs. Alcohol taxes in the U.S. are low and are updated so infrequently that their value has declined significantly over time. Raising these taxes increases the price of alcohol and lowers drinking, particularly heavy drinking, and reduces the consequences of alcohol use and abuse.[2]

While strict enforcement of drunk driving and underage drinking laws and public education on the dangers of excessive drinking are important, ***one of the most effective ways to reduce excessive alcohol use is simpler and less expensive: raise alcohol taxes.***

Maryland's experience bears this out. In the wake of the state's 3 percent increase in the sales tax on alcohol passed in 2011, underage drinking fell by 26 percent, underage binge drinking by 28 percent, and binge drinking among adults by 17 percent.[3] The number of alcohol-positive drivers of all ages on Maryland's roadways fell by 6 percent, including a 12 percent drop in alcohol-positive drivers between the ages of 15 and 34.[4] Risky sexual behavior is also closely associated with alcohol consumption, and in Maryland average monthly cases of gonorrhea declined by 24 percent, or almost 1600 cases per year.[5]

There are two types of alcohol taxes: excise taxes and sales taxes. Wholesalers pay excise taxes based on the type of alcohol and amount being produced. The wholesaler then passes the increase on to retailers, who pass it on to consumers. Taxes per gallon are fixed amounts that do not change with inflation. As a result, from 1991 to 2015, on average across the nation the inflation-adjusted value of these taxes fell by 30% for beer, 32% for distilled spirits, and 27% for wine.[6] In contrast, sales taxes on alcohol are a percentage of the total price, and are charged to the consumer. Unlike excise taxes, because sales taxes are tied to the price of the beverage, their value rises with inflation.

Increasing Maryland's alcohol sales tax to match that of the District of Columbia would be a win-win for the state: it would reduce underage drinking, drinking-driving and other alcohol problems, and increase state revenues. The 3 percent sales tax increase passed in 2011 increased alcohol sales tax revenues off-premises (at package stores and taverns) by 44.7 percent, or an average of 14.9 percent per one percent change in the tax. One of the main arguments for the 2011 increase was to come closer to the District of Columbia's alcohol tax rate, which currently stands at 10 percent, as opposed to Maryland's 9 percent. Increasing Maryland's sales tax on alcohol sold for off-premises consumption by 1 percent could be anticipated to raise approximately $14.3 million.[7] If the increase included all sectors (i.e. package stores and taverns as well as hotels, motels, restaurants and nightclubs), it would raise an estimated $22.3 million.

Increasing Maryland's alcohol excise tax by a nickel a drink could raise significant revenues. Had Maryland's alcohol excise taxes kept up with inflation, current taxes would be $.05 per can of beer, $.10 per glass of wine, and $.17 per serving of distilled spirits. A nickel a drink increase would come close to adjusting the beer tax for inflation, although it would fall short of adjusting it for wine and spirits. A nickel a drink increase would raise approximately $111 million in new revenues for the state.[8]

The bulk of an alcohol tax increase would be paid by excessive drinkers. In Maryland, 42% of adults did not drink in the past 30 days, while 21% drank excessively. This group, the excessive drinkers, would pay three-quarters of any alcohol tax increase in Maryland.[9]

Alcohol Taxes: Basic Facts

Binge drinking hurts all Americans, whether they drink or not. Heavy drinking causes preventable death, health problems, injuries, and violence, and reduces workplace productivity.

- Excessive drinking is the third leading cause of preventable death in the United States.[10] A total of 88,000 lives are lost to alcohol abuse each year, including an estimated 1321 deaths in Maryland.[11] Binge drinking is responsible for more than half of these deaths.[12]
- Excessive drinking can lead to cirrhosis of the liver, cancers of the head, neck, digestive tract and female breast, alcoholism, and injury.[13]
- Alcohol is involved in a third of violent crimes and two in three cases of intimate partner violence.[14]
- Lost productivity due to alcohol-related illness, death, disability and incarceration costs $161 billion each year.[15]

Current alcohol taxes do not reflect the high cost of excessive drinking. Alcohol taxes in the United States are low and decrease in value each year. Today's alcohol tax revenues do not come close to covering the cost of excessive drinking.

- The United States has some of the lowest alcohol taxes in the developed world. In many European countries taxes on liquor are three times what they are in the U.S.[16]
- In 2010 excessive drinking cost an estimated $249 billion, or $2.05 per drink.[17] Federal taxes on alcohol are about 8.5 cents per drink, and state taxes are an average of 5 cents per drink.[18]

Raising alcohol taxes reduces binge drinking and alcohol-related harms.

- Doubling federal alcohol taxes would reduce alcohol-related deaths by 35 percent, traffic fatalities by 11 percent, and sexually transmitted disease by 6 percent.[19]
- An increase in federal alcohol taxes of 25 cents a drink would reduce drinking in excess of amounts recommended by the U.S. Dietary Guidelines by 11 percent. High-risk drinkers would pay nearly five times more in taxes than low-risk drinkers.[20]
- A nickel a drink increase in federal alcohol taxes would reduce fatal traffic crashes by 7 percent and deaths due to cirrhosis by 32 percent.[21]

Increasing alcohol taxes makes the roads safer for everyone by reducing drunk driving. Drunk driving and high numbers of fatal traffic accidents are associated with heavy drinking.

- Three in ten Americans will be involved in an alcohol-related traffic accident during their lifetime.[22]
- Drunk drivers kill one person every 50 minutes in the United States.[23]
- A 10 percent increase in the price of beer would reduce traffic accidents by 5 to 10 percent, and traffic accidents involving youth by 7 to 17 percent.[24]

Raising alcohol taxes would reduce underage drinking. Three out of ten high school students drink, and one in eight binge drinks.[25] However, because most people under 21 do not have much disposable income, raising alcohol taxes can reduce underage drinking significantly.

- Alcohol use causes the deaths of 4,400 people under age 21 annually. The most common causes of death are motor vehicle crashes, homicides and suicides.[26]
- Teen drinking is associated with higher rates of risky sexual behaviors.[27]
- Underage drinking is very responsive to changes in the price of alcohol.[28]
- Higher alcohol taxes lead to improved graduation rates, study habits and higher grades.[29]

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Setting the Record Straight on the Health Equity Resource Communities Initiative and the Alcohol Tax

September 30, 2020

1. **An increase in the alcohol tax will hurt small businesses, especially restaurants and bars. The 2011 increase led to a reduction in sales of alcoholic beverages.**

   This initiative will have enormous positive public health benefits, including a reduction in drunken driving, underage drinking and binge drinking. And it will generate critically needed funds to improve health care in underserved communities and expand behavioral health treatment.

   The penny per dollar increase in the alcohol tax will not affect alcohol consumed in bars and restaurants for two years, which gives them ample time to recover from the current economic downturn.

   Maryland saw significant benefits from an increase in the alcohol sales tax in 2011 (see Reference 1):

   - Underage drinking fell by 26 percent, underage binge drinking by 28 percent, and binge drinking among adults by 17 percent.
   - The number of alcohol-positive drivers of all ages on Maryland's roadways fell by 6 percent, including a 12 percent drop in alcohol-positive drivers between the ages of 15 and 34.
   - Risky sexual behavior is also closely associated with alcohol consumption, and in Maryland average monthly cases of gonorrhea declined by 24 percent, or almost 1600 cases per year.

2. **People who have lost their jobs in the pandemic will have to pay more for alcoholic beverages with this tax increase and that's unfair.**

   For the next two years, the tax would not increase on alcohol consumed in restaurants or bars, so average Marylanders will not even notice the increase. Those who will be most affected are those who drink excessively. Overall, a penny per dollar is a very small increase, while the proceeds will be used to provide benefits in communities hit hard by the pandemic.

3. **In a recession is a terrible time to impose an additional tax on the hard-hit hospitality industry.**

   Research has found that the alcohol industry passes through tax increases to its customers. While consumers will pay pennies more for their alcohol, communities hardest hit by the pandemic and the recession will get much-needed health resources.

   The recession has had a minor impact on sales at package liquor stores and taverns. For the 12 months ending in June 2020, which included the main impact of the pandemic, sales tax revenue

from liquor stores and taverns declined by only 1.6 percent, according to records compiled by the Maryland Comptroller's office.

4. **Revenue generated by the 2011 increase in the alcohol tax was supposed to go to the Developmental Disabilities Administration, but only a small fraction of the revenues actually went there. While addressing health disparities is a good goal, the General Assembly will simply redirect proceeds from an alcohol tax increase to other state needs.**

   That's not true. This proposal will create a dedicated fund that cannot be used for anything except substance use treatment and support for HERCs. It can ONLY go for these purposes. The 2011 law did allocate $5 million annually to the DDA, and at least $5 million in new revenues from the alcohol tax increase did indeed go to the DDA every year since 2012. (The first year, some of the proceeds from the tax increase were allocated to a major school construction initiative.) Other revenue from the 2011 tax increase went to other aspects of public health, including support for the Health Enterprise Zone initiative. (See Reference 2.)

5. **While it's a good goal to address health disparities, it's wrong to increase the most regressive tax in the state.**

   The tax on alcoholic beverages has the largest impact on heavy drinkers. Benefits from the tax are clearly progressive, providing support to communities that have suffered from disinvestment.

   A study found that roughly 75 percent of the additional cost as a result of a tax increase is paid for by excessive drinkers. Among customers who do not drink excessively, those in the highest income bracket would pay more additional taxes per year on average than those in the lowest income bracket. (See Reference 3.) A 2015 national survey on consumption habits found that 78% of higher-income adults reported that they drink alcohol in contrast to only 45% of lower-income adults. (See Reference 4.)

6. **Alcohol is taxed twice in Maryland – the excise tax and point-of-sale tax.**

   Maryland's excise tax is among the lowest in the country. Plus, however we tax alcohol, the proceeds do not come close to paying for the damage to public health caused by alcohol, through things like drunken driving, binge drinking, emergency room and other medical care costs, and spousal abuse. Even with this tax increase, we will continue to subsidize alcohol.

   A study found that in Maryland in 2010, excessive drinking cost the state $4.96 billion, with government covering $2.1 billion (42.3%) of these costs. Binge drinking represented $3.85 billion (77.6%) of these total costs. Those figures far outpace how much money the state collects through taxes on alcoholic beverages. (See Reference 5.)

7. **Maryland's alcohol tax rate is already higher than most surrounding states, including Virginia (5.3%), Pennsylvania (6%) and West Virginia (6%).**

We cannot compare Maryland's tax rate to those states, because those states all control liquor prices, giving them an extra tool to increase revenue on alcoholic beverages. The neighboring jurisdiction that is most comparable is the District of Columbia; with this increase, we would match the District's tax rate.

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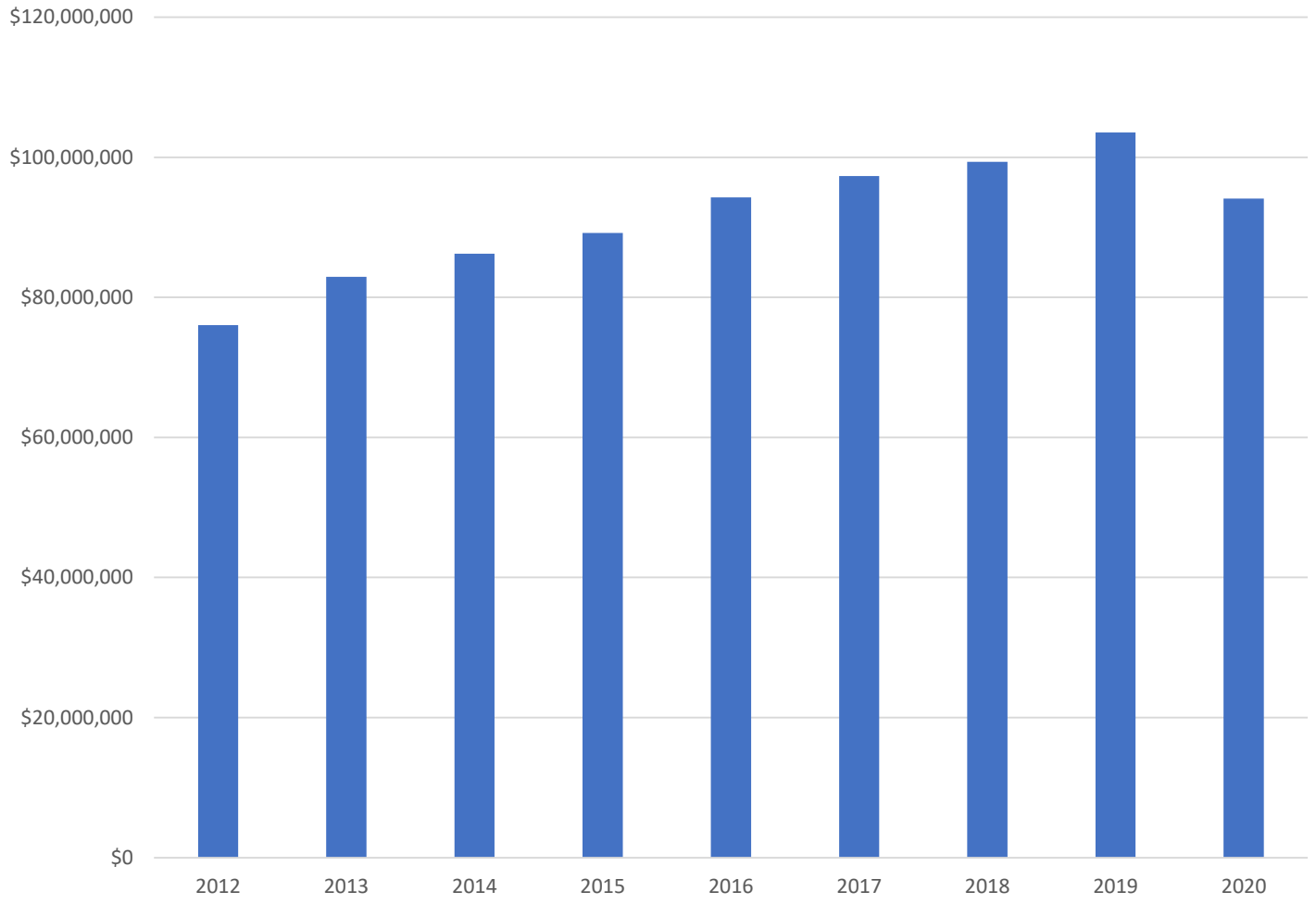
Annual Revenue from 2011 Alcohol Sales Tax Increase



Source: Maryland Office of the Comptroller

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To: **Vincent DeMarco, President**
Maryland Citizens' Health Initiative, Inc.

From: **Steve Raabe, President**
OpinionWorks LLC

Date: **September 15, 2020**

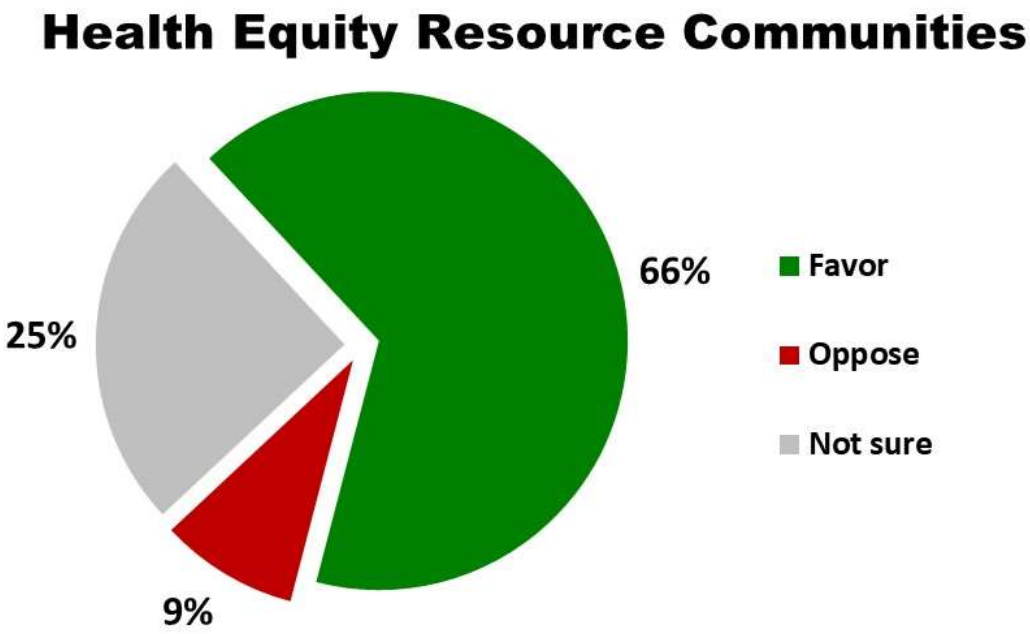
Subject: **Maryland Polling on Health Equity Resource Communities**

Our new statewide poll of Maryland voters shows overwhelming support for a proposal to create Health Equity Resource Communities (HERC). Two-thirds of voters favor the proposal, while opposition amounts to fewer than one in ten voters. Furthermore, a more than four-to-one supermajority of voters would support a 1% increase in the state's alcohol sales tax to pay for this new program.

These findings are based on our statewide poll of 838 registered votes, conducted both online and by telephone September 4-11, 2020. The poll has a potential margin of sampling error of ±3.4% at the 95% confidence level.

Widespread Support for Health Equity Resource Communities

By an overwhelming margin of 66% to 9%, Maryland voters support the creation of Health Equity Resource Communities to provide grants, tax incentives, and loans for health care providers in parts of the state with poor health outcomes. One-quarter of the state's voters said they were not sure.



There is a proposal to create Health Equity Resource Communities in Maryland to provide grants, tax incentives, and loans for health care providers in parts of the state with poor health outcomes to improve those health outcomes. Would you generally favor or oppose this proposal?

Support for this proposal crosses party lines, with Republicans supporting it with a 55% majority compared to only 16% opposed, Independents and third-party voters supporting the proposal by a margin of 63% to 7%, and Democrats by 74% to 6%.

Support by Political Party for Health Equity Resource Communities

	All Voters	Democrats	Republicans	Independents
Favor	**66%**	**74%**	**55%**	**63%**
Oppose	9%	6%	16%	7%
Margin	**+57%**	**+68%**	**+39%**	**+56%**
Not sure	25%	20%	29%	30%

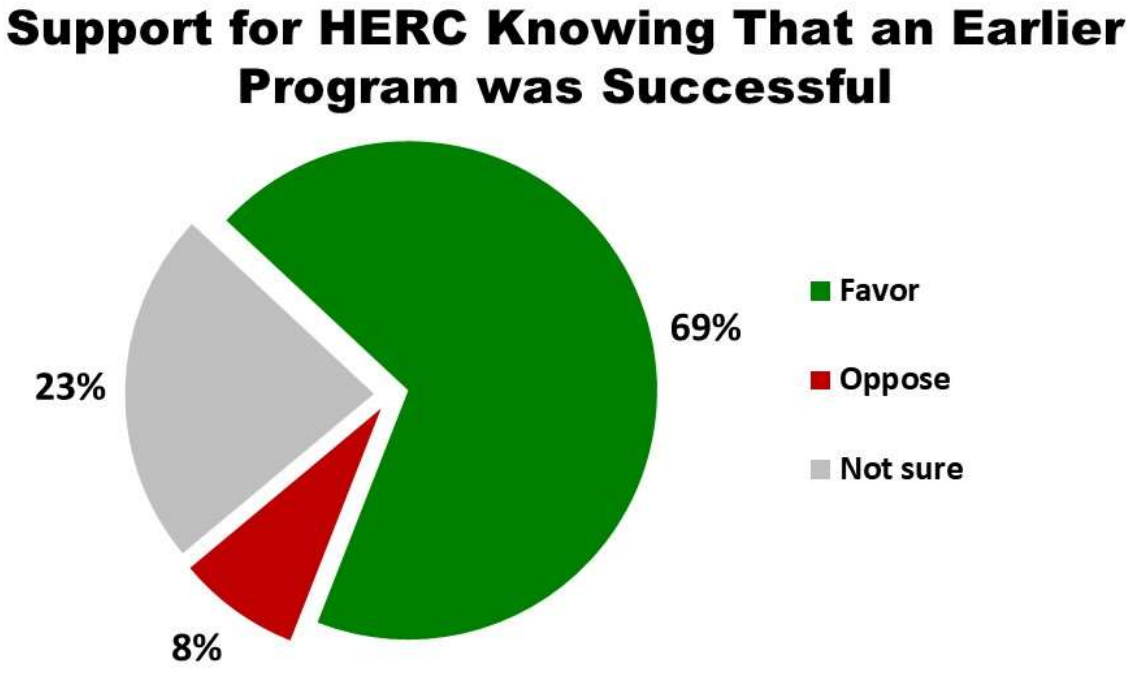
Support is never lower than the mid-60s across all parts of the state.

Support by Jurisdiction and Region for Health Equity Resource Communities

	Baltimore City	Baltimore County	Greater Baltimore[1]	Mont-gomery	Prince George's	Greater Washington[2]	Shore/ Southern MD	Western MD
Favor	**66%**	**65%**	**66%**	**74%**	**68%**	**68%**	**63%**	**64%**
Oppose	7%	12%	10%	6%	6%	8%	8%	12%
Margin	**+59%**	**+53%**	**+56%**	**+68%**	**+62%**	**+60%**	**+55%**	**+52%**
Not sure	28%	22%	24%	19%	26%	24%	30%	24%

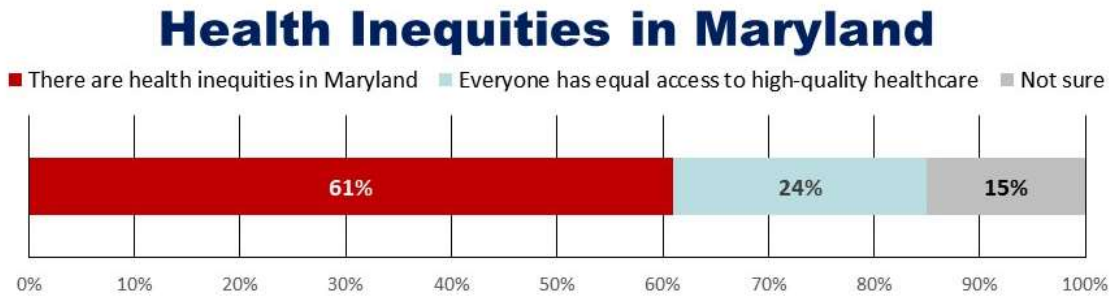
[1]Greater Baltimore includes Anne Arundel, Baltimore City, Baltimore County, Carroll, Harford, Howard.
[2]Greater Washington includes Charles, Frederick, Howard, Montgomery, Prince George's.

Informed that "this proposal is based on an earlier program that successfully increased access to healthcare, improved residents' health, reduced hospital admissions, and created cost savings, but was allowed to expire in 2016," support climbs slightly higher. Knowing this information, 69% support the proposal and only 8% oppose it, with 23% unsure.



Awareness of Health Inequities in Maryland

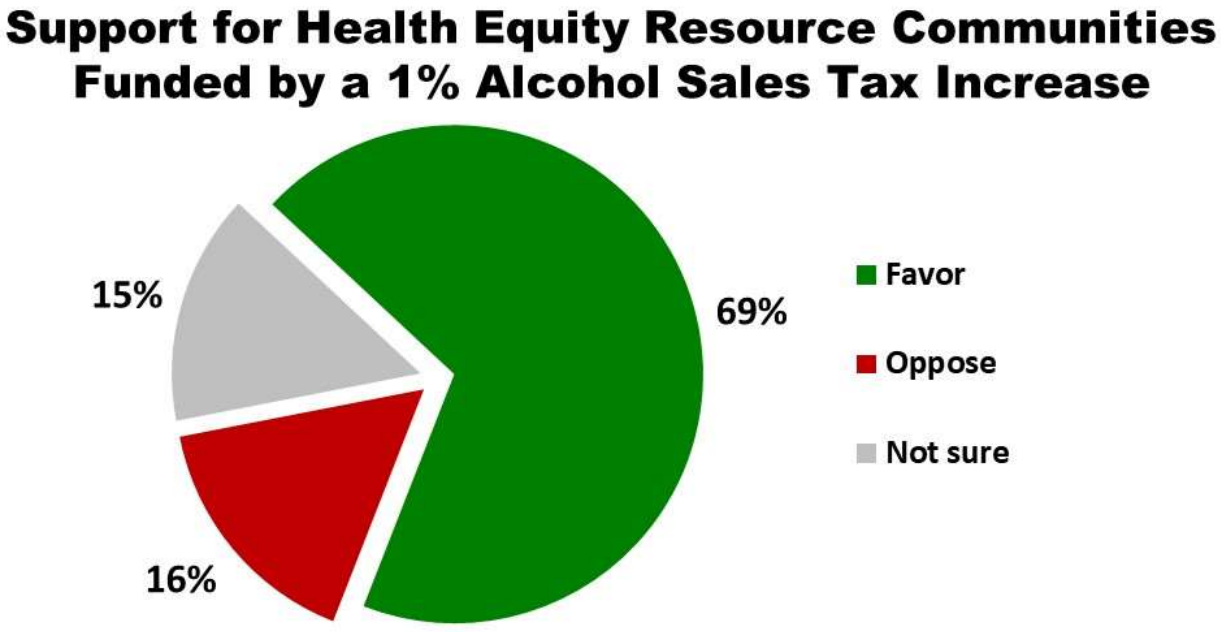
This high level of support is explained in part by the realization by most Marylanders that not everyone has equal access to high-quality healthcare across the state. More than six out of ten Marylanders (61%) acknowledge that there are "health inequities based on income, race, ethnicity, disability, or place of residence in the state." Only 24% believe "everyone in Maryland has equal access to high-quality healthcare," while 15% are not sure.



Do you think everyone in Maryland has equal access to high-quality healthcare, or are there health inequities based on income, race, ethnicity, disability, or place of residence in the state?

Support for a 1% Increase in the Alcohol Sales Tax to Pay for Health Equity Resource Communities

A more than two-thirds majority of voters would raise the state's alcohol sales tax from 9% to 10% to pay for this program. By a margin of more than four-to-one – with 69% of voters in favor and only 16% opposed – Maryland registered voters favor "a 1% increase in the alcohol sales tax in Maryland if the money was dedicated to the Health Equity Resource Communities program." Fifteen percent are unsure.



The proposed program would be funded with a 1% increase in the state's alcohol tax, raising it from 9% to 10%. A prior increase in the alcohol tax was shown to reduce drinking by underage Marylanders and heavy drinkers, which saved lives and reduced healthcare costs. Knowing this, would you favor or oppose a 1% increase in the alcohol tax in Maryland if the money was dedicated to the Health Equity Resource Communities program?

Support for a 1% increase in the alcohol sales tax to fund this program crosses all lines, with 61% of Republicans, 65% of Independents, and 75% of Democrats supporting it. Politically, this proposal is a winner all across the political spectrum.

Support by Political Party for a 1% Alcohol Sales Tax Dedicated to HERC

	All Voters	Democrats	Republicans	Independents
Favor	**69%**	**75%**	**61%**	**65%**
Oppose	16%	11%	25%	17%
Margin	**+53%**	**+64%**	**+36%**	**+48%**
Not sure	15%	14%	13%	18%

Support by Jurisdiction and Region for a 1% Alcohol Sales Tax Dedicated to HERC

	Baltimore City	Baltimore County	Greater Baltimore[1]	Mont-gomery	Prince George's	Greater Washington[2]	Shore/ Southern MD	Western MD
Favor	**70%**	**72%**	**70%**	**78%**	**65%**	**71%**	**62%**	**65%**
Oppose	17%	12%	17%	12%	15%	14%	19%	10%
Margin	**+53%**	**+60%**	**+53%**	**+66%**	**+50%**	**+57%**	**+43%**	**+55%**
Not sure	13%	15%	13%	11%	20%	15%	17%	25%

[1]Greater Baltimore includes Anne Arundel, Baltimore City, Baltimore County, Carroll, Harford, Howard.
[2]Greater Washington includes Charles, Frederick, Howard, Montgomery, Prince George's.

Political Impact of Legislators' Position on Health Equity Resource Communities

This overwhelming support for the HERC proposal translates into a potential political impact on future General Assembly races. A hypothetical legislative candidate's position on this proposal could have a significant influence over whether voters would support that candidate – even causing voters to oppose legislative candidates of their own party.

As the table on the following page indicates, on the so-called generic ballot, Democratic legislative candidates start off with a 29-point advantage based on partisan preferences across the state, if the election were held today. (Note that this Democratic advantage is 10 percentage points higher than it was in November 2017, when Democrats enjoyed a 19-point margin in the generic legislative ballot.)

Learning that a hypothetical Democrat in their district supports creating Health Equity Resource Communities while the Republican candidate opposes it, the margin for the Democrat increases to 37 points.

Surprisingly in this partisan age, the advantage for Democrats is erased and reversed if the *Republican* supports the proposal while the Democrat opposes it. In this scenario, the Republican legislative candidate wins by a six percentage points, representing an enormous 43-point swing in voter support. This proposal to address healthcare inequities is a potent political issue, and helpful to legislative candidates of both parties.

Support for Legislative Candidates Based on Their Position on HERC

	Support the Democratic Candidate	Support the Republican Candidate	Margin
Generic Ballot in State Legislative Elections	56%	27%	Democrat +29%
Democrat Supports HERC Proposal Republican Opposes It	58%	21%	Democrat +37%
Republican Supports HERC Proposal Democrat Opposes Legislation	31%	37%	Republican +6%

"In the next state legislative elections, are you more likely to vote for… (rotate): the Democratic candidates or the Republican candidates?"

(Rotate order of next two questions):
"If you learned that the Democratic candidate in your legislative district supported creating Health Equity Resource Communities while the Republican candidate opposed it, who would you be more likely to vote for (rotate): the Democratic candidate or the Republican candidate?"
"If you learned that the Republican candidate in your legislative district supported creating Health Equity Resource Communities while the Democratic candidate opposed it, who would you be more likely to vote for (rotate): the Republican candidate or the Democratic candidate?"

How This Poll was Conducted

A total of 838 interviews were conducted statewide September 4-11, 2020 among randomly selected Maryland registered voters. A cross-section of Marylander registered voters were surveyed online, and live telephone interviewers reached additional voters on both wireless and landline telephones, to ensure the poll best represented all segments of the electorate. Sampling targets were adhered to throughout the interviewing process to ensure that the sample represented the statewide electorate geographically, by political party, and for key demographic indicators such as gender, age, and race or ethnicity. Following interviewing, statistical weights were applied to ensure the sample most closely mirrored the characteristics of the statewide electorate. This poll produces a margin of sampling error no greater than ±3.4% at the 95% confidence level, meaning that at least 19 times out of 20 the actual results would differ by no more than that margin if every registered voter in the state had been interviewed.

Brief Background on OpinionWorks

OpinionWorks conducts frequent opinion studies at the state and local level across the country. Since 2007 we have been the polling organization for *The Baltimore Sun* newspaper in Maryland and have polled for numerous other media and advocates throughout the Mid-Atlantic region. We are engaged by state and local government agencies from Delaware to Oregon to assess public needs and preferences. We measure health attitudes and practices for public health departments and advocates, assess alumni engagement and prospective student expectations for colleges and universities, evaluate donor and volunteer relationships for non-profit organizations, and study human decision-making to inform behavior change efforts on environmental and health questions.

Achieveing Health Equity: Health Impact of Maryland's Health Enterprise Zones

White Paper

September 10, 2020

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Johns Hopkins Center for Health Disparities Solutions

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Executive Summary

Historically, racial/ethnic minorities and residents living in underserved areas have experienced disparate access to health care in Maryland. The same communities also have higher rates of chronic diseases such as diabetes, hypertension and heart disease. This can lead to preventable, costly hospitalizations and poor health outcomes.

During implementation of the Affordable Care Act and Medicaid expansion, the Maryland General Assembly passed legislation authorizing the Maryland Health Improvement and Disparities Reduction Act. This policy created the framework for an innovative pilot program referred to as the Health Enterprise Zones (HEZ) Initiative. The goals of the initiative were to reduce health disparities, improve health care access and health outcomes, and reduce health care costs and hospital admissions/readmissions in some of the state's most underserved communities. Health Enterprise Zones, coordinated by local public-private coalitions, were eligible for financial incentives such as tax credits and loan repayment programs. These incentives were used to attract much needed health care providers to the HEZs and to address unmet healthcare needs of the community.

In a previous analysis, the HEZ Initiative was associated with a significant reduction of inpatient hospital stays and a net savings of over $93 million for Maryland's health care system. The purpose of this white paper is to examine the associated health impacts of the initiative.

The State funded five HEZs: Annapolis/Morris Blum; Capitol Heights in Prince George's County; Caroline and Dorchester Counties; Greater Lexington Park in St. Mary's County; and West Baltimore in Baltimore City. All of the HEZs sought to reduce diabetes and cardiovascular disease related illnesses and associated risk factors. In addition, two HEZs addressed asthma (Capitol Heights and Greater Lexington Park), two HEZs addressed behavioral/mental health (Caroline-Dorchester and Greater Lexington Park) and two HEZs addressed obesity (Caroline-Dorchester and West Baltimore).

To achieve their program objectives, each HEZ had latitude in the strategy they developed to address the unique challenges to health in their community. However, all of the HEZs used financial incentives to expand the availability of primary care in their communities; whether through recruiting additional health providers or opening new health centers/clinics. In addition, each HEZ employed community health workers to address clinical and social risk factors of vulnerable patients in their community. Depending on their specific community needs, the HEZs also operated mobile care units (medical, mental, and dental), implemented nutrition and healthy lifestyle programs, provided transportation assistance and enhanced school-based health services. In total, the five HEZs provided over 300,000 visits to more than 170,000 individual patients during this pilot program.

Overall, the HEZs were able to positively impact health outcomes in their respective areas by employing a variety of creative community-based solutions. The HEZ Initiative can serve as a model for future programs aiming to address racial/ethnic health disparities, improve access to health care, and reduce health care costs in low-income and medically underserved communities.

Introduction

In general, racial/ethnic minorities are more likely to be diagnosed with and die from chronic diseases. For instance, compared with non-Hispanic whites, Black/African Americans are 40% more likely to have hypertension and 20% more likely to die from heart disease and American Indians are 50% more likely to be diagnosed with heart disease and 2.5 times more likely to die from diabetes (OMH, 2019). Disparities also exist in access to health care and treatment. For example, Hispanic/Latino Americans are twice as likely to visit the emergency department for asthma and receive mental health treatment half as often as non-Hispanic whites (OMH, 2019).

In Maryland, health disparities have also disproportionally impacted racial/ethnic minorities and plagued underserved communities for many years. Although progress has been made to reduce some disparities, higher mortality rates still exist for racial/ethnic minorities and residents of rural regions in the state (Chen, 2012). In particular, Blacks in Maryland have higher death rates for heart disease (1.2 times), stroke (1.35 times), diabetes (2.1 times) and asthma (4.5 times) as compared to Whites (Mann, 2019). Rates of emergency department visits related to these conditions are also significantly higher among Blacks than whites. (Mann, 2019). In recent months, the global COVID-19 pandemic has shed new light on social determinants of health that impact health disparities. In Maryland, Blacks and Hispanics overwhelmingly represent the higher percentage of cumulative COVID cases and COVID-related hospitalizations as compared to the total population; with Blacks and Whites representing the highest percentage of deaths (Mann, 2020).

In 2011, Lieutenant Governor Anthony G. Brown, Chair of the Maryland Health Quality and Cost Council, formed a Health Disparities Workgroup in response to the continuous health inequities in Maryland and a report from the Maryland Health Care Reform Coordinating Council. The workgroup was charged with investigating strategies to reduce and eliminate health disparities. Led by Dean E. Albert Reece of the University of Maryland School of Medicine, the workgroup was composed of a diverse group of health experts and community health leaders. The workgroup recommended three innovative strategies to improve health and health care disparities in Maryland, in particular, the formation of Health Enterprise Zones (HEZs) (Maryland Health Quality and Cost Council, 2012). These recommendations, based on principles of economic development and public health practice, formed the foundation of the Maryland Health Improvement and Disparities Reduction Act of 2012 (Senate Bill 234) which was signed into law by Governor Martin O'Malley on April 10, 2012. (Maryland Health Improvement and Disparities Reduction Act of 2012).

The legislation enabled the establishment of HEZs as a mechanism to target resources in specific areas of the State. The purpose of the HEZs were to:

- Reduce health disparities among racial/ethnic groups and geographic areas;
- Improve health care access and health outcomes in underserved communities; and
- Reduce health care costs and hospital admissions/readmissions.

HEZs were defined as contiguous geographic areas where the population experienced poor health outcomes that contribute to racial/ethnic and geographic health disparities. HEZs were

eligible for technical support and special financial incentives that were used to recruit primary care practitioners and support community-based interventions. Incentives included income and hiring tax credits, loan repayment assistance, priority participation in the Maryland Patient Centered Medical Home Program and grant funding provided by the Maryland Community Health Resources Commission (CHRC). HEZs were required to be small enough for incentives to have a significant and measurable impact. The Health Improvement and Disparities Reduction Act provided $4 million per year over a four-year period (2013-2016) to support the Maryland Health Enterprise Zones Initiative (DHMH, 2014).

In a previous analysis, the Health Enterprise Zones Initiative was associated with a reduction of 18,562 inpatient hospital stays, an increase of 40,488 emergency department visits and a net savings of $93.4 million for Maryland's health care system (Gaskin et al, 2018). The increase in emergency department visits was probably due to two phenomena. One, patients who were not seeking care because of the healthcare aware the HEZ raised in the community, these patients began seeking care. Two, patients who normally would have been admitted to the hospitals through the emergency room were now being sent home because there were follow-up resources available in the community. There was anecdotal evidence from residents and healthcare providers to support the latter explanation. The purpose of this white paper is to examine the associated health impacts of the five Health Enterprise Zones piloted in Maryland.

Overview of Maryland's Five Health Enterprise Zones

In collaboration, the Maryland Department of Health and Mental Hygiene (DHMH) and the Community Health Resources Commission administered the HEZ initiative in three stages: (1) Public Comment & Community Forums, (2) HEZ Selection Process and (3) Implementation & Evaluation. Nonprofit community-based organizations and local government agencies were eligible to apply for HEZ designation based on the following criteria (DHMH, 2012):

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 economic disadvantage by: Medicaid enrollment rate; or WIC participation rate above the median value for Maryland.
4. An HEZ must demonstrate poor health outcomes by: a lower life expectancy or higher percentage of low birth weight infants based on the median value for Maryland.

The HEZ call for proposals resulted in 19 applications from various areas across Maryland. In January 2013, the DHMH designated five Health Enterprise Zones based on the recommendations of an independent HEZ Review Committee and the CHRC. The five HEZs, depicted below, represent rural, suburban and urban communities from across the state.

Figure 1: Map of Maryland's Health Enterprise Zones, January 2013
(Source: Dwyer, 2017)

During the four-year implementation and evaluation period (2013-2016), each HEZ focused on improving the health care needs of their respective community. Although there was variation in approaches, each HEZ targeted specific clinical conditions/diseases with the common goal of reducing health disparities, increasing health care access and improving health outcomes. The health impacts of each HEZ are described below and Table 1 provides a summary of HEZ characteristics. This table provides the county where the HEZ was located, the zip codes that comprised the HEZ, the HEZ's population, the lead organization coordinating the HEZ, the HEZ budget, and the chronic health conditions the HEZ addressed.

Annapolis Community Health Partnership (ACHP) HEZ

The ACHP utilized HEZ funds to establish a new primary care health center in the Morris H. Blum senior citizen public housing facility. The primary goal of the HEZ was to screen and treat patients for cardiovascular risk factors, including diabetes, hypertension, obesity and smoking. In addition, the ACHP HEZ aimed to reduce preventable emergency room visits and hospital admissions among this community of high utilizers. Services were available to the Morris Blum residents and low-income adults in the surrounding community at reduced or no cost.

The Morris Blum Clinic opened in October 2013 and began providing services with one physician, one registered nurse/case manager and two medical office assistants (Hussein, 2014). After three years in operation, the clinic provided 7,089 patient visits to 4,191 individuals who resided in the Morris Blum facility and surrounding community, including 1,037 patients with diabetes (MDHMH, 2017). The clinic also received Level 3 recognition by the National Committee for Quality Assurance as a Patient Centered Medical Home. As compared to the total HEZ population, the Morris Blum Clinic served higher proportions of Black/African American and Hispanic/Latino patients.

The ACHP employed a number of strategies to improve patient outcomes in the HEZ including: care coordination services, utilization of an integrated electronic health record, patient registries, onsite lab services, chronic disease management programs and trainings in bias awareness, trauma informed care and cultural competency for all staff. To prevent additional emergency room visits or readmissions, the clinic linked patients recently discharged from the hospital into follow up care. In addition to annual depression and behavioral health screenings, the clinic also partnered with community mental health providers to offer timely behavioral health care, when needed. Other activities conducted by the ACHP HEZ included home visits, annual domestic violence screenings, medication reconciliation, and a variety of nutrition classes and walking groups to support patient self-management.

As a result of these efforts, the following patient outcomes were accomplished by September 30, 2016:

- 480 individuals provided smoking cessation workshop
- 426 patients provided care coordination services
- 1,113 participants in blood pressure screening
- 62 participants in the diabetes self-management program
- 410 participants in healthy lifestyle activities
- 1,106 participants in community health events

Metrics reported for the ACHP HEZ and Morris Blum Clinic in 2018 show continued growth in chronic disease management and improved health outcomes. The clinic exceeded baseline performance and improvement goals in all four measures: poorly controlled A1C, hypertension control, measurement of BMI and follow-up of abnormal BMI, and screening/cessation intervention for tobacco use (Cameron, 2018).

Overall, the ACHP HEZ was able to increase and maintain medical service capacity, provide health care to thousands of patients, and offer a number of interventions to address cardiovascular risk factors, diabetes, hypertension, obesity and smoking in the Annapolis community. Navigational services and community partnerships to address non-medical needs such as housing and food insecurity were also important components of the ACHP strategy.

Competent Care Connections (CCC) HEZ

The CCC HEZ utilized funds to expand primary care and behavioral health services in rural Caroline and Dorchester Counties; targeting workforce development and increasing community health resources. The primary goal of the HEZ was to reduce risk factors and improve outcomes related to diabetes, hypertension, asthma and behavioral health.

The CCC HEZ expanded the primary care and community health workforce by adding over 30 jobs (30.1 FTEs) to the area including primary care providers, community health outreach workers (CHOWs), care coordinators and peer recovery support specialists for mental health and substance use; all whom received training in cultural competency, trauma informed care and health literacy (MDHMH, 2017). The HEZ partnered with community organizations such as the Choptank Community Health System and Associated Black Charities CHW Team to provide care coordination services, develop a HEZ electronic health record, and offer an assortment of health education and wellness programs. In particular, the CCC HEZ supported an intensive obesity treatment program (Maryland Healthy Weighs) for low-income patients, offered telehealth services, and established the Dorchester School Based Wellness Center which implemented an evidence-based asthma management program and provided mental health care and counseling services (Mercier, 2018 & Gaskin et al., 2018).

The CCC HEZ also created a new Mobile Crisis Team (MCT) that delivered mental health/behavioral health crisis intervention, assessment, and referral services to community members in need. As of September 30, 2016, the MCT had served 636 individuals and had reduced the response time to mental health crises in Caroline and Dorchester Counties from over one hour to just 19 minutes. The MCT generated potential savings of nearly $1.2 million by facilitating 545 emergency department diversions and 1,525 initial and follow-up dispatches (MDHMH, 2017). In addition, the CCC HEZ opened the Federalsburg clinic, a community-based, outpatient mental health clinic for adults, which had served 430 patients in 10 months.

As a result of these efforts, the following patient outcomes were accomplished by September 30, 2016 (MDHMH, 2017):

- 27,087 visits provided throughout the CCC HEZ to 6,098 unduplicated patients and clients (Mercier, 2018)
- 464 participants in peer recovery support
- 534 participants in weight management program
    - In 121 patients who completed Maryland Healthy Weighs for more than 8 weeks, the average BMI was reduced by 13%, resulting in an estimated savings of $11,000 in annual medical costs for each patient (Mercier, 2018).
    - In a subset of patients who completed at least eight weeks of the program from April-September 2016, all (100%) of the diabetic patients had a reduction or elimination of diabetic medications and 67% of hypertensive patients had a reduction or elimination of high blood pressure medications. (MDHMH, 2017)
- 409 patients provided care coordination services
- 940 students provided somatic health services
- 521 students provided mental health services

- Over 3,200 individuals provided education or health screenings by CHOWs
- Additional 28 hours/per week of Nurse Practitioner coverage at Dorchester School Based Wellness Center

Overall, the CCC HEZ increased access to primary care services and behavioral health resources in some of the most underserved communities in Caroline and Dorchester counties. This resulted in improvements in chronic diseases (diabetes, hypertension and asthma), behavioral health outcomes and reduced medical costs. Most CCC HEZ participants were White (52.6%), but as compared to the total HEZ population, the CCC HEZ served a higher proportion of Black/African American patients (40.2% vs. 29.0%).

Greater Lexington Park (GLP) HEZ

The GLP HEZ utilized funds to expand access to primary care, behavioral health and dental services in a community of St. Mary's County that chronically lacked primary care providers. A primary goal of the HEZ was to improve outcomes related to hypertension, asthma, diabetes, congestive heart failure and chronic obstructive pulmonary disease (COPD).

The GLP HEZ expanded access to health services by adding over 16 jobs (16.2 FTEs) to the Greater Lexington Park community including primary care physicians, a physician assistant, a nurse practitioner and a buprenorphine-certified physiatrist. The GLP HEZ also facilitated the opening of a new primary care office at MedStar St. Mary's Hospital (MSMH) until the construction for the HEZ supported community health center, East Run Medical Center, was completed in the spring of 2017. The medical center includes a medical clinic, behavioral health and dental services.

In addition to recruiting new providers, the GLP HEZ also developed a clinical care coordination program, implemented an electronic prescription system, utilized community health workers, integrated care coordination software system with MSMH's electronic medical record, and provided a selection of evidence-based health programming, including the Hair, Heart and Health Program. To address transportation barriers experienced by community members, the GLP HEZ established a 16-stop mobile medical route to be used for rides to medical appointments and other human services. The HEZ also equipped a mobile dental van and expanded the transportation program to include a high-demand specialty transportation service. Integrating the work of HEZ practitioners with existing community resources such as MedStar St. Mary's "Get Connected to Health" mobile clinic allowed the GLP HEZ to collectively provide 22,139 visits to 3,847 patients. The GLP HEZ served a higher proportion of Black/African American patients as compared to the total HEZ population. Trauma informed care training was provided for all staff of the HEZ and MSMH.

As a result of these efforts, the following patient outcomes were accomplished by September 30, 2016:

- 1,415 patients served by "Get Connected to Health" mobile clinic
- 2,335 patients provided behavioral health services
- 981 patients received care at MSMH Primary Care Office

- 77 patients provided serves by mobile dental van
- 11,359 patient encounters with community health workers
- 1,464 patients provided care coordination services
- 15,364 rides provided by HEZ Mobile Medical Route
- 738 rides provided by medical specialty service

Overall, the GLP HEZ significantly increased access to primary care, behavioral health and community health resources in St. Mary's County by expanding and integrating services with community partners. Through connecting thousands of patients to primary care and specialty services, the HEZ was able to reduce risk factors and improve outcomes related to hypertension, asthma, diabetes and other cardiovascular diseases.

Prince George's County (PGC) HEZ

The PGC HEZ utilized funds to increase access to primary care services in Capitol Heights by expanding the health workforce and establishing four Patient Centered Medical Homes (PCMH) and one specialty care practice. The primary goals of the HEZ were to provide services to at least 10,000 residents and improve outcomes related to asthma, diabetes, and cardiovascular disease.

The PGC HEZ added over 18 jobs (18.3 FTEs) in Prince George's County including physicians and nurse practitioners. Collectively, through enhanced practices with community partners, 63,748 visits to 38,343 patients were provided throughout the HEZ. The PGC HEZ utilized community health workers, care coordination services targeting high risk patients, a case management software system for tracking patient activities, and the use of individualized patient Wellness Plans. In addition, the PCMHs in the HEZ were supported by a robust Community Care Coordination Team and a county-wide Public Health Information Network that linked to the Maryland health information exchange. The Care Coordination Team established partnerships with two local hospitals, eight County agencies, state/federal partners and numerous other providers in the area including Fire/EMS personnel, case managers, home health providers and pharmacists. To link HEZ clients to medical, clinical and social services, the Community Care Coordination Team created over 20 standardized, evidence-based Care Pathways (Gaskin & Thorpe, 2018).

A Health Literacy Mobile App and comprehensive health literacy campaign was also developed by the PGC HEZ, inclusive of Health Literacy Ambassadors and cultural/linguistic competency training for all HEZ providers and staff. Community health workers were also required to complete training in management of chronic conditions, diabetes self-management and trauma informed care. Five health literacy community forums were held and 8,000 "Medical Action Plan" booklets were distributed to households in Capitol Heights (Carter, 2018). In concordance with the total HEZ population, the PGC HEZ primarily served Black/African American patients (84.4%), but also served a higher proportion of Hispanic/Latino patients as compared to the total HEZ population (14% vs. 6.7%).

The PGC HEZ also deployed Prime Time Sister Circles, a behavioral health intervention operated by the Gaston and Porter Health Improvement Center, designed to assist African American women with addressing stress management, nutrition, fitness and hypertension.

As a result of these efforts, the following patient outcomes were accomplished by September 30, 2016:

- 896 patients served by CHW Care Coordination Program
- 14,587 patient encounters with care coordinators
- 2,232 Wellness Plans created for HEZ patients
- 11,574 completed client resource connections
- 87% of women attending Prime Time Sister Circles reported gaining additional knowledge and skills; significantly decreasing their stress and unhealthy nutrition habits; and increasing their exercise behaviors (Carter, 2018)

Overall, the PGC HEZ increased access to primary care in the Capitol Heights community and exceedingly reached their goal of providing services to 10,000 residents. The HEZ expanded the community health workforce, increased community health literacy and engaged with a number of community partners to establish an effective population health approach to care. In turn, these efforts reduced risk factors related to asthma, diabetes, and cardiovascular disease.

West Baltimore Primary Care Collaborative (WBPCC) HEZ

The WBPCC utilized HEZ funds to increase access to primary care and community health resources in Baltimore City. The primary goal of the HEZ was to improve outcomes related to cardiovascular disease, diabetes, hypertension and obesity.

The WBPCC HEZ increased the primary care workforce by adding nearly 10 jobs (9.8 FTEs) in West Baltimore and extensively integrating health care practices with community partners. Collectively, the HEZ and their community partners provided 187,981 visits to 118,339 patients throughout the zone. Most of the residents in the WBPCC HEZ were Black/African American, but the HEZ also served higher proportions of Hispanic-Latino and Asian patients as compared to the total HEZ population. HEZ providers and staff received extensive cultural competency training.

The WBPCC HEZ strategy included: developing a two-tier (30 day and 60 day) care coordination program with special emphasis on high emergency department utilizers, training and deploying community health workers for targeted outreach, facilitating PCMH training for clinical partners, and offering chronic disease self-management classes and fitness programs. Community health workers provided health screenings, education and conducted patient visits in the emergency department, home and clinic. In addition, the HEZ provided over 100 health or social service career scholarships and internships to HEZ residents. These scholarships were predominantly awarded to students in entry level health professional programs and are anticipated to add a significant number of future FTEs in the community.

To support programs and strategies to improve cardiovascular health, the HEZ also provided 16 mini-grants to community-based organizations. Community outreach and health education events held in the HEZ included health fairs, a bi-monthly Produce Market, and free health promotion courses on nutrition, healthy cooking, physical activity, blood pressure screenings and smoking cessation. Weekly fitness classes offered free of charge through neighborhood recreation centers

included activities such as kick-boxing, line dancing, yoga, and Zumba. To further incentivize risk reduction, the WBPCC HEZ also implemented the Passport to Health Program which enrolled participants and awarded points for healthy behaviors.

As a result of these efforts, the following patient outcomes were accomplished by September 30, 2016:

- 10,368 individuals connected with a community health worker
- 430 participants in Stanford Chronic Disease Self-Management Program
- 4,151 participants in WB CARE Fitness Program
    - Average weight loss of 15 pounds and reduction in 1.5 of BMI among 2,017 sample of fitness class participants
- 6,121 residents enrolled in Passport to Health Program
- 25,000 residents served through community cardiovascular disease prevention programs

Overall, the WBPCC HEZ increased capacity for primary care and community health resources in West Baltimore. Through enhanced care coordination services for targeted patients and offering extensive community-based health programming like walking groups and cooking classes, the HEZ was able to reduce risk factors and improve health outcomes related to cardiovascular disease, diabetes, hypertension and obesity.

Summary & Conclusion

Maryland's five Health Enterprise Zones were each able to improve the health of their respective community members. Although there was variation between the activities conducted by each HEZ, the common goals were to reduce health disparities, improve health care access and health outcomes, and reduce healthcare costs and hospital admissions/readmissions. All of the HEZs sought to reduce diabetes and cardiovascular disease related illnesses and associated risk factors. In addition, some HEZs also addressed asthma, behavioral/mental health and obesity. The main activities of each HEZ are briefly described below:

- The Annapolis Community Health Partnership HEZ established a primary care medical home in a residential public housing facility to provide care and coordination services to residents living in and around the building, especially high utilizers of hospital care.
- The Caroline/Dorchester Counties' HEZ expanded primary care and behavioral health services in a rural area by establishing a school-based wellness center, opening an adult mental health clinic, providing a community health worker training program, offering care coordination services through community partnerships, supporting an intensive obesity treatment program and deploying a mobile mental health crisis team.
- The Prince George's County HEZ established four Patient Centered Medical Homes and one specialty care practice, created a Community Care Coordination Program to link high-risk patients with services and implemented a Public Health Information Network and comprehensive Health Literacy Campaign.
- The Greater Lexington Park HEZ expanded primary and behavioral health care services in St. Mary's County by opening a primary care office, community health center and a mobile dental van, in addition to implementing a transportation program and providing clinical care coordination services to high utilizers.

- The West Baltimore HEZ developed a tiered care coordination program to target high utilizers, awarded health career scholarships and career readiness trainings, provided community-based health education programs and health screenings, and delivered fitness classes to reduce risk factors for obesity and other chronic conditions.

Each HEZ utilized the financial incentives of the HEZ initiative to expand the availability of primary care in their communities and to employ community health workers to address clinical and social risk factors of vulnerable patients. In total, the five HEZs provided over 300,000 visits to more than 170,000 individual patients during this pilot program.

In addition, residents and providers in the HEZs both had positive experiences with the initiative. During interviews and focus groups with HEZ residents, the majority expressed that they were either very satisfied or satisfied with the services they received and that the quality of care was either excellent or good. Residents also reported improved access to health care services and that the HEZ initiative helped them change their health behavior or healthcare practices. For instance, participants shared examples of increased physical fitness and decreased alcohol consumption. Participants unanimously thought that the HEZ should continue. During interviews with HEZ providers, all expressed that the objectives of the HEZ initiative were well suited to the needs of the community. All providers felt that the HEZ initiative had been successful in improving access to care and also helping patients with chronic disease management. In particular, HEZ providers highlighted the importance of preventive services and health education for patient populations that are often marginalized.

Overall, the Health Enterprise Zones were able to positively impact individual health behaviors and favorably influence health in the community. Improved health outcomes associated with diabetes, cardiovascular related illness and other chronic conditions are the result of a variety of creative community-based solutions. The Health Enterprise Zones Initiative can serve as a model for future programs aiming to address racial/ethnic health disparities, improve access to health care, and reduce health care costs in low-income and medically underserved communities.

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Table 1: The Location, Size, Lead Organization and Disease Focus of Each Health Enterprise Zone.

Health Enterprise Zone	Jurisdiction	Community (Zip Codes)	Population	Coordinating Organization /Coalition	Budget (2013-2016)	Core Disease States/Focus
Annapolis Community Health Partnership	Anne Arundel County	Annapolis, Morris Blum Public Housing Building (21401)	36,805 (Suburban)	Anne Arundel Medical Center	$800,000	- Diabetes - Hypertension - Obesity - Smoking
Competent Care Connections	Caroline & - Dorchester Counties	Mid-Shore Region (21613, 21631, 21643, 21835, 21659, 21664, 21632)	36,123 (Rural)	Dorchester County Health Department	$2,936,000	- Asthma - Behavioral/Mental Health - Diabetes - Hypertension - Obesity
Greater Lexington Park	St. Mary's County	Greater Lexington Park (20634, 20653, 20667)	34,035 (Rural)	MedStar St. Mary's Hospital	$3,000,000	- Asthma - Behavioral/Mental Health - Congestive Heart Failure - COPD - Diabetes - Hypertension
Prince George's County	Prince George's County	Capitol Heights (20743)	38,626 (Suburban)	Prince George's County Health Department	$4,400,000	- Asthma - Diabetes - Hypertension
West Baltimore Primary Care Access Collaborative	Baltimore City	West Baltimore (21216, 21217, 21223, 21229)	137,823 (Urban)	Bon Secours Baltimore Health System	$4,200,000	- Diabetes - Heart disease - Hypertension - Obesity

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The Maryland Health Enterprise Zone Initiative Reduced Hospital Cost And Utilization In Underserved Communities

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ABSTRACT **The State of Maryland implemented the Health Enterprise Zone Initiative in 2013 to improve access to health care and health outcomes in underserved communities and reduce health care costs and avoidable hospital admissions and readmissions. In each community the Health Enterprise Zone Initiative was a collaboration between the local health department or hospital and community-based organizations. The initiative was designed to attract primary care providers to underserved communities and support community efforts to improve health behaviors. It deployed community health workers and provided behavioral health care, dental services, health education, and school-based health services. We found that the initiative was associated with a reduction of 18,562 inpatient stays and an increase of 40,488 emergency department visits in the period 2013–16. The net cost savings from reduced inpatient stays far outweighed the initiative's cost to the state. Implementing such initiatives is a viable way to reduce inpatient admissions and reduce health care costs.**

Health disparities continue to be a problem in the United States. Disparities in health outcomes are due in part to inadequate access to medical care and poor health behaviors; they are also associated with social and environmental risk factors.[1–5] Previous studies have shown that multicomponent community-based interventions can be effective in improving access to care and health outcomes.[6,7] The Health Enterprise Zone Initiative is a program created and implemented by the State of Maryland to address health and health care disparities among residents who are members of minority groups or have low socioeconomic status living in medically underserved areas by improving their access to care and providing services that improve their health behaviors.[8] The initiative provided support to coalitions of health departments, other local government agencies, health care providers, and community-based social services organizations in working together to address health care needs in a designated underserved community.

Although there was a great deal of programmatic variation among the Health Enterprise Zones, the primary elements of the initiative included recruiting primary care physicians to underserved areas, recruiting and deploying community health workers, improving care coordination, providing health education and screening, and increasing access to both health services and relevant social services. Each Health Enterprise Zone was configured to meet its community's unique combination of barriers to access to care, health problems faced in the zone, and availability of community-based services.

There is evidence that programs such as the initiative have the potential to improve access to care and health outcomes. The initiative's design is similar to that of the recent Accountable Health Communities Model of the Centers for

Medicare and Medicaid Services (CMS). That model addresses health-related social needs by linking health services providers and the community to improve health outcomes and reduce cost.[9] Like the Health Enterprise Zone Initiative, the goal of Accountable Health Communities was to build capacity within a community to address residents' health-related needs.[10] Another model, Hennepin Health in Minnesota, was a community-based intervention that combined health care and social services. A study found that Hennepin Health shifted care from the hospital to the outpatient care setting and improved the quality of care for people with chronic conditions.[11] In addition, several studies evaluating the impact of community health worker interventions on disease management and health outcomes found that community health worker programs enhanced patients' self-management and improved their quality of life.[12–14] There is also evidence that approaches involving tax incentives, grants, loans, technical assistance, job training, and community serviceshave been effective in addressing health and social issues.[3,7]

Two goals that Maryland policy makers had for the Health Enterprise Zone Initiative were to reduce health care costs and to reduce potentially avoidable hospital admissions and readmissions in the five Health Enterprise Zone communities. This study examined whether the initiative was associated with reductions in hospital use.

Description Of The Initiative

Contiguous geographic communities, defined by ZIP code boundaries, with populations of at least 5,000 people who demonstrated economic disadvantage and poor health outcomes were eligible to apply for the Health Enterprise Zone Initiative.[15] Specifically, a ZIP code was eligible if its Medicaid enrollment rate was above the median for all Maryland ZIP codes or its Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation rate was above the median for all Maryland ZIP codes. Additional eligibility requirements stipulated that the ZIP code have a life expectancy below the state median or percentage of low-birthweight infants above the state median. In October 2012 nineteen Health Enterprise Zone applications were submitted by local health departments, hospitals, or community-based nonprofit organizations from seventeen jurisdictions in Maryland.[16] In January 2013 the Maryland Community Health Resources Commission and the Maryland Department of Health designated five geographic areas as Health Enterprise Zones: Annapolis/Morris Blum, in Anne Arundel County; Capitol Heights, in Prince George's County; Caroline and Dorchester Counties; Greater Lexington Park, in St. Mary's County; and West Baltimore, in Baltimore City.[3] In three of the zones (Annapolis/Morris Blum, Greater Lexington Park, and West Baltimore), hospital systems led the effort, while the other two (Capitol Heights and Caroline and Dorchester Counties) were led by the local health departments. The five zones varied in population density—one urban, two suburban, and two rural.[15]

The state provided each zone with resources and incentives to attract private health care practitioners to medically underserved communities. The lead organization received the funds and subcontracted with partners in its coalition to provide an array of services to residents of the zone, specifically targeting diabetes, cardiovascular disease–related illnesses, asthma, obesity, and behavioral health problems. (See online appendix exhibit S1 for a description of each zone.)[17] The resources and incentives included grant funding from the Community Health Resources Commission, priority for entering Maryland's multipayer Patient Centered Medical Home Program, loan repayment assistance, and tax credits for income and hiring. The zones used these resources to, for example, open new community health centers; operate mobile medical, mental health, and dental care units; deploy community health workers; implement healthy food programs; and offer school-based services. In addition, the initiative encouraged leaders of local health care and social service organizations to work together to address the health needs of residents in their communities.

Study Data And Methods

DATA SOURCES The primary data sources for this study were hospital inpatient stay and emergency department (ED) visit data for 2009–16 from the Maryland Health Services Cost Review Commission and hospital readmissions data for 2012–15 from the Chesapeake Regional Information System for our Patients.[18,19] These data contain a census of inpatient and ED use by Maryland residents in Maryland hospitals. We obtained ZIP code–level Medicaid enrollment data for 2009–16 from the Maryland Medicaid program through the Hilltop Institute at the University of Maryland, Baltimore County. We combined these data with publicly available sociodemographic data from the 2010 US census and from the 2010–14 American Community Survey. We used those five years of survey data to compute reliable estimates of the composition of each ZIP code's population by age, race/ethnicity, poverty status, median household income,

educational attainment, employment status, household composition, and marital status, as well as the occupancy rate of homes in each ZIP code.[20]

OUTCOMES ZIP codes were our primary unit of analysis. There are 458 ZIP codes in Maryland. Health care providers and community-based organizations serving residents in 110 ZIP codes were eligible for Health Enterprise Zone funding (see appendix exhibit S2).[17] We compared adult hospital utilization rates in Health Enterprise Zone–awarded communities located in sixteen ZIP codes with rates in Health Enterprise Zone–eligible communities located in ninety-four ZIP codes. For each ZIP code, we computed the number of inpatient stays, readmissions, and ED visits per 1,000 residents for each study year. We excluded inpatient stays and ED visits with a diagnosis of cancer, trauma, injury, normal delivery, or delivery with complications because the initiative did not target these conditions. We computed utilization rates for subsets of inpatient stays and ED visits for specific conditions as defined by Prevention Quality Indicators and Health Enterprise Zone–related conditions. We used the Agency for Healthcare Research and Quality's Prevention Quality Indicator composite measure, which includes the following conditions: short- and long-term diabetes, perforated appendix, chronic obstructive pulmonary disease (COPD) or asthma in older adults, hypertension, heart failure, dehydration, bacterial pneumonia, urinary tract infection, uncontrolled diabetes, asthma in younger adults, and lower extremity amputation among patients with diabetes.[21] As stated above, Health Enterprise Zone–related conditions are diabetes, cardiovascular disease–related illnesses, asthma, obesity, and behavioral health problems; for this study, we included inpatient stays or ED visits with a primary diagnosis of one of those conditions.

To estimate the economic impact of the initiative, for each ZIP code we calculated charges per 1,000 residents for inpatient stays and ED visit outcomes. This entailed summing the allowable charge amounts for every inpatient stay or ED visit by ZIP code and dividing by the population by 1,000. Because Maryland is an all-payer state, charges measure what insurers (including Medicare and Medicaid) and patients pay for hospital services.

STATISTICAL ANALYSIS We conducted a multivariate difference-in-differences analysis to determine whether implementation of the Health Enterprise Zone Initiative was associated with changes in hospital use.[22] Given that the zones required time to fully implement their programs once they were awarded funds in 2013, we used a dummy variable to indicate that a ZIP code was in a community that had been awarded funds and interacted it with dummy variables for the application year (2012) and each implementation year (2013, 2014, 2015, and 2016). This allows the estimate of the impact of the initiative to vary over time. Preliminary analyses showed that there were no significant differences between the ZIP codes in the pre-implementation period. The interactions for 2010 and 2011 were not significantly different from the interaction with 2009 ($p > 0.10$). We expected the coefficients on the pre-implementation interaction terms to be nonsignificant and those on the implementation interaction terms to be significant. Readmission data were not available for years before 2012. Therefore, for this outcome, 2012 was used as the reference year to compare changes in readmissions during the implementation period of 2013–16.

We estimated these linear regression models using both fixed and random effects. The fixed-effects models included annual Medicaid enrollment in each ZIP code. In the random-effects models, we added ZIP code–level control variables for demographic and socioeconomic characteristics. Hausman tests consistently rejected the null hypothesis that the random-effects models were more efficient. Therefore, we report the results from the fixed-effects models only. (See appendix exhibit S3 for random-effects results.)[17]

We used the coefficients on the zone-year interaction terms from the fixed-effects models to estimate the impact of the initiative on inpatient stays, inpatient charges, ED visits, and ED charges. To calculate the total change in stays, visits, and charges, we multiplied these coefficients by the population in the ZIP codes where Health Enterprise Zone funds had been awarded. We converted the charges to 2016 dollars using the Consumer Price Index for Medical Care. The regression models were weighted by the ZIP code population and estimated using Stata, version 14.

QUALITATIVE INTERVIEWS To provide context for the quantitative findings, we conducted structured interviews with thirty-one residents and twenty-one health care providers (including physicians, nurse practitioners, pharmacists, and care coordinators) and focus groups with eighteen residents from the five Health Enterprise Zones. We asked participants how the initiative had affected access to care and health behaviors for residents of the zones.

SENSITIVITY ANALYSES As a sensitivity analysis, we estimated semi-log models because the outcome variables are skewed. The results were consistent with those of our main analysis. The

coefficients had the same sign but were not significant. However, the linear models had more explanatory power than the semi-log models (see appendix exhibit S4).[17] Finally, we estimated the models using ZIP codes not eligible to participate in the initiative as the comparison group (see appendix exhibit S5).[17]

To test the robustness of our findings, we conducted falsification tests.[23] We explored the impact of the Health Enterprise Zone Initiative on inpatient stays and ED visits for marker conditions that are not sensitive to timely ambulatory care (appendicitis/appendicitis with appendectomy, gastrointestinal obstruction, and fracture of the hip or femur)[24,25] and for pregnancy, childbirth, or the puerperium. By definition, we did not expect the initiative to have an impact on the marker and pregnancy conditions.

LIMITATIONS The study had some limitations. First, the analysis included the hospital use of all residents in the Health Enterprise Zone ZIP codes, including residents who did not actively participate in the initiative. Second, we did not observe hospital use by residents of neighboring jurisdictions.

Third, we did not have data on nonemergency outpatient visits and ambulatory care services. Care may have shifted from relatively costly inpatient settings to less expensive outpatient and ambulatory care settings. Also, the Health Enterprise Zone Initiative may have encouraged new episodes of care, with residents using additional nonemergency outpatient and ambulatory care services. The costs of these services could partially offset associated reductions in charges for inpatient care.

Fourth, we did not control directly for two programs that were implemented during the study period: Maryland's All-Payer Global Budget Cap Model in 2014 and CareFirst BlueCross BlueShield's Patient-Centered Medical Home Program in 2011. Lastly, the findings of this study might not be generalizable because Maryland has an all-payer global budget payment program; this structure creates an incentive in the hospital industry that is not typical in other states.[26–28]

Study Results

DEMOGRAPHICS AND PAYER MIX Compared to the ZIP codes that were eligible to participate in the Health Enterprise Zone Initiative but did not receive awards, ZIP codes that received Health Enterprise Zone awards had higher percentages of black residents, lower socioeconomic status, lower marriage rates, and higher percentages of vacant homes (exhibit 1). The payer mix of the two groups of ZIP codes also varied (data not shown). In 2016 a higher percentage of hospital use was covered by Medicaid in awarded ZIP codes (56.6 percent versus 43.7 percent for ED visits, and 38.8 percent versus 28.9 percent for inpatient stays) than in eligible ZIP codes. This gap was completely offset by differences in the percentages of ED visits and inpatient stays cov-

EXHIBIT 1

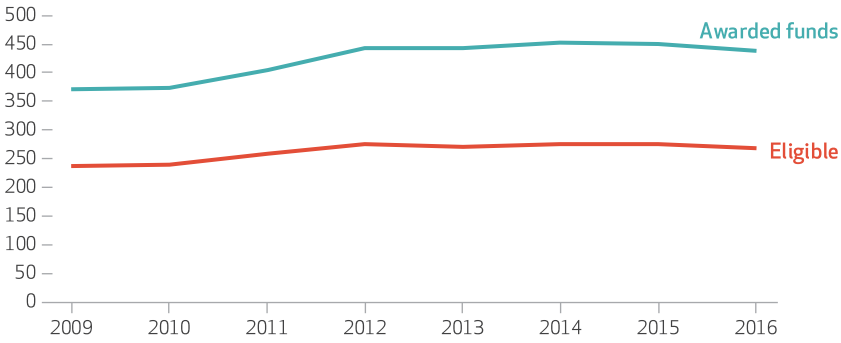
Selected characteristics of ZIP codes that were eligible for or awarded funds from the Health Enterprise Zone Initiative in Maryland

	Awarded funds ($n = 16$)	Eligible ($n = 94$)	p value
Mean population	17,580.4	26,196.4	0.048
Race/ethnicity			
White	29.2%	42.5%	0.150
Black	62.1	39.7	0.029
Asian	1.6	4.3	<0.001
Native American/other	2.4	2.9	0.230
Hispanic	4.6	10.6	0.002
Age range (years)			
0–17	23.3%	22.8%	0.649
18–24	10.1	10.1	0.996
25–44	26.1	29.0	0.012
45–64	26.8	25.8	0.072
65–79	9.8	8.8	0.205
80 or more	3.6	3.3	0.513
Income distribution (percent of FPL)			
0–99	21.0	13.6	0.048
100–124	4.4	3.5	0.207
125–149	5.1	3.8	0.051
150–174	5.3	4.1	0.097
175–184	1.7	1.7	0.774
185–199	2.7	2.5	0.536
200 or more	63.5	74.1	0.043
Median household income	$49,989	$60,564	0.141
Employment status			
Unemployed	8.6%	6.6%	0.072
Employed	54.0	61.6	0.004
Not in the labor force	36.9	31.4	0.016
Highest level of education			
No high school	4.9%	6.0%	0.224
Some high school	13.0	8.8	0.017
Finished high school	32.5	30.0	0.304
Some college	22.2	20.8	0.237
Associate's degree	5.4	6.3	0.017
College degree	12.9	16.3	0.147
Advanced degree	9.0	11.8	0.240
Marital status			
Married	32.2%	40.5%	0.040
Never married	45.3	39.5	0.104
Widowed	7.1	6.1	0.019
Separated	4.0	3.2	0.049
Divorced	11.4	10.8	0.149
Homes			
Occupied	81.3%	90.0%	0.021
Vacant	18.7	9.9	0.021

SOURCE Authors' analysis of data for 2010 from the Decennial Census of Population and Housing and for 2010–14 from the American Community Survey. **NOTES** Eligibility for the initiative is explained in the text. Percentages were weighted by the ZIP code population. FPL is federal poverty level.

EXHIBIT 2

Numbers of emergency department visits per 1,000 residents of ZIP codes that were eligible for or awarded funds from the Health Enterprise Zone Initiative in Maryland, 2009–16



SOURCE Authors' analysis of hospital utilization data for 2009–16 from the Maryland Health Services Cost Review Commission. **NOTES** Eligibility for the initiative, which was implemented in 2013, is explained in the text. Visits for childbirth, trauma, or cancer were excluded. Results were weighted by the ZIP code population.

ered by commercial insurance. Medicare covered similar percentages of ED visits and inpatient stays (about 16 percent and 43 percent, respectively) in awarded ZIP codes compared to eligible ZIP codes.

EMERGENCY DEPARTMENT VISITS AND HOSPITAL STAYS The awarded ZIP codes had higher rates of hospital ED visits and inpatient stays than eligible ZIP codes did (exhibits 2 and 3). ED visits per 1,000 residents rose from 2010 to 2012 and then flattened out in both groups of ZIP codes. Inpatient stays per 1,000 residents declined in both groups of ZIP codes throughout the study period, although the difference between the two groups narrowed over time.

Exhibit 4 presents coefficients from the fixed-effects difference-in-differences model, which estimate the effects of the Health Enterprise Zone Initiative on emergency department visits and inpatient stays. There is evidence that the Health Enterprise Zone Initiative was associated with a reduction in numbers of inpatient stays and an increase in numbers of ED visits throughout the study period. For example, the initiative was associated with a reduction of 13.73 inpatient stays per 1,000 residents in 2013, which increased to a reduction of 18.03 in 2014. The magnitude of the estimates was similar for 2015 and 2016 (reductions of 16.76 and 17.47, respectively). The findings were stronger for stays related to Prevention Quality Indicators or conditions targeted by the initiative: For the former, inpatient stays had decreases ranging from 3.43 in 2013 to 10.84 in 2016, and readmissions had decreases ranging from 1.33 in 2013 to 3.78 in 2016. The estimates for Health Enterprise Zone–related (targeted) conditions showed decreases as well.

The initiative was associated with increases in ED visits per 1,000 residents of 32.40 in 2013, 41.01 in 2014, 38.78 in 2015, and 31.75 in 2016. It was also associated with increases in ED visits for conditions related to the Prevention Quality Indicators and targeted by the initiative.

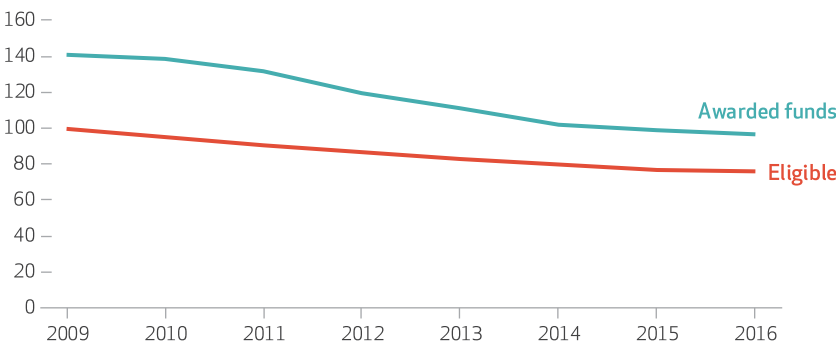
EMERGENCY DEPARTMENT AND HOSPITAL INPATIENT CHARGES The pattern for charges per 1,000 residents was similar to that observed for inpatient stays and ED use (exhibit 4). For inpatient stay charges, the initiative was associated with a reduction of $149,997 in 2013, $125,308 in 2014, $166,764 in 2015, and $156,593 in 2016. Conversely, for ED visit charges, it was associated with an increase of $48,702 in 2013. The pattern from 2013 to 2016 is an inverted U shape, rising to $63,553 in 2014 and falling back to $46,301 in 2016.

The random-effects models yielded results similar to those of the fixed-effects models, and all but one of the coefficients were significant (appendix exhibit S3).[17] The estimate using ZIP codes not eligible for the initiative as the comparison group also yielded similar results. The estimated reduction in inpatient stays tended to be larger and was always significant (see appendix exhibit S5).[17]

For our falsification tests, we explored the impact of the initiative on inpatient stays for the marker and pregnancy-related conditions. First, for the marker conditions, we expected to see no difference in the number of inpatient stays and ED visits per 1,000 residents after the initiative was implemented; indeed, we found that implementation was not associated with such a change (exhibit 4). The results were similar for the pregnancy-related conditions, with the exception of

EXHIBIT 3

Numbers of inpatient stays per 1,000 residents of ZIP codes that were eligible for or awarded funds from the Health Enterprise Zone Initiative in Maryland, 2009–16



SOURCE Authors' analysis of hospital utilization data for 2009–16 from the Maryland Health Services Cost Review Commission. **NOTES** Eligibility for the initiative, which was implemented in 2013, is explained in the text. Stays for childbirth, trauma, or cancer were excluded. Results were weighted by the ZIP code population.

EXHIBIT 4

Estimated differences in emergency department (ED) visits and inpatient stays and in charges, per 1,000 residents, between ZIP codes that received funds and those that were eligible for funds from the Health Enterprise Zone Initiative in Maryland, 2013–16

	2013	2014	2015	2016
EMERGENCY DEPARTMENT VISITS				
All visits				
Number	32.40***	41.01***	38.78**	31.75***
Charges	$48,702**	$63,554**	$54,501**	$46,301**
PQI-related visits				
Number	6.05***	5.15*	5.71***	2.89
Charges	$9,663**	$9,429**	$11,138**	$7,252**
Targeted condition visits				
Number	4.21*	7.16**	6.31*	3.53*
Charges	$8,231*	$14,933**	$13,418**	$7,987**
INPATIENT STAYS				
All stays				
Number	−13.73***	−18.03**	−16.76*	−17.47*
Charges	−$149,997***	−$125,308	−$166,764*	−$156,593**
PQI-related stays				
Number	−3.43***	−4.26***	−3.56**	−10.84****
Charges	−$35,334**	−$28,729	−$31,114*	−$44,340*
Targeted condition stays				
Number	−1.79*	−3.37**	−3.54*	−5.16*
Charges	−$20,372*	−$19,626	−$29,949*	−$47,908*
Readmissions[a]				
Number	−1.33*	−2.87**	−2.31*	−3.78*
FALSIFICATION TEST RESULTS				
Marker conditions				
ED visits	−0.12	−0.12	−0.11	−0.11
Inpatient stays	−0.03	0.08	0.05	0.14
Pregnancy-related conditions				
ED visits	−1.93	−1.11	−1.10	−2.30
Inpatient stays	−0.03	−0.58	−0.85**	−0.88**

SOURCE Authors' analysis of data for 2010 from the Decennial Census of Population and Housing, for 2010–14 from the American Community Survey, for 2009–16 from the Maryland Health Services Cost Review Commission, and for 2012–16 from the Chesapeake Regional Information System for our Patients (CRISP). **NOTES** Results are expressed as coefficients from fixed-effects difference-in-differences models. Eligibility for the initiative is explained in the text. Charges were adjusted for inflation to 2016 dollars. Marker conditions (listed in the text) are not sensitive to timely ambulatory care. Pregnancy-related includes pregnancy, childbirth, and the puerperium. PQI is Prevention Quality Indicators of the Agency for Healthcare Research and Quality. [a]We did not have charge data for readmissions. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

significant reductions in inpatient stays for deliveries in 2015 and 2016. The initiative discouraged risky sexual behavior but did not include family planning services. Therefore, we expected to find no difference in deliveries per 1,000 residents associated with its implementation.

SAVINGS AND PROGRAM COSTS We compared the net savings in hospital charges to the cost of the program. During 2013–16 the ZIP codes that were awarded funds from the initiative had an increase of 40,488 ED visits, which cost insurers and patients $59.9 million (exhibit 5). However, this was offset by an overall reduction of 18,562 inpatient stays, which saved insurers and patients $168.4 million. The state spent $15.1 million on the initiative in the same period, and combining that amount with the net reduction in charges of $108.5 million suggests an overall net savings of $93.4 million for Maryland's health care system. All five Health Enterprise Zones had net savings. West Baltimore saved the most, $50.1 million, which compared favorably to $4.2 million spent there by the state. Annapolis had the greatest return on investment, receiving $800,000 from the state and saving $13.1 million.

QUALITATIVE FINDINGS The qualitative findings from the structured interviews and focus groups support the quantitative findings reported above. Residents and health care providers indicated that the initiative improved access to care and enabled residents to adopt health behaviors and practices that improved their health outcomes. Residents started becoming aware of their health, exercising more, and monitoring their diets. Providers also felt that

EXHIBIT 5

Estimated impact of the Maryland Health Enterprise Zone Initiative on emergency department (ED) visits, inpatient stays, and charges, for each zone and all ZIP codes combined that were awarded funds, 2013–16

	Annapolis/ Morris Blum	Dorchester and Caroline Counties	Capitol Heights	Greater Lexington Park	West Baltimore	All ZIP codes
VISITS AND INPATIENT STAYS						
ED visits	5,184	5,036	5,559	4,448	20,261	40,488
Inpatient stays	−2,376	−2,309	−2,549	−2,039	−9,289	−18,562
CHARGES (MILLIONS OF DOLLARS)						
ED visits	$7.67	$7.45	$8.23	$5.08	$29.99	$59.93
Inpatient stays	−$21.56	−$20.95	−$23.12	−$18.50	−$84.27	−$168.39
FINANCIAL IMPACT OF INITIATIVE (MILLIONS OF DOLLARS)						
Cost to the state	$0.80	$2.87	$4.30	$2.90	$4.20	$15.07
Net cost savings	−$13.09	−$10.63	−$10.59	−$10.52	−$50.08	−$93.39

SOURCE Authors' analysis of data for 2010 from the Decennial Census of Population and Housing, 2010–14 from the American Community Survey, 2009–16 from the Maryland Health Services Cost Review Commission, and 2012–16 from the Chesapeake Regional Information System for our Patients (CRISP). **NOTE** Charges were adjusted for inflation to 2016 dollars.

the initiative helped patients manage chronic conditions. They highlighted the importance of the provision of preventive services and health education that enabled patients who are often marginalized to improve their health-seeking behavior and be more aware of their health-related issues.

Discussion

The objective of the study was to examine changes in hospital use and associated health care costs for the five Health Enterprise Zones in Maryland. The results demonstrate that the Health Enterprise Zone Initiative was associated with a reduction in inpatient stays and an increase in ED visits per 1,000 residents, even though two unrelated statewide changes took place at the same time.

The rate of inpatient stays statewide was decreasing in part because a global budget payment model was implemented on January 1, 2014.[28] Under the global budget payment model, all Maryland hospitals are encouraged to decrease potentially avoidable use of care. However, the decrease in inpatient stays observed in the Health Enterprise Zones was even greater than that observed statewide. This may be because the initiative targeted high users of hospital care as well as people with chronic conditions, and it may have helped residents better manage those health conditions—thus reducing the need for inpatient care. Indeed, it is unlikely that our findings can be attributed to the implementing of global budgets. A 2018 study showed that the All-Payer Global Budget Cap Model did not have a consistent impact on hospital use for Medicare beneficiaries.[29] This differs from our finding of reductions in inpatient stays.

A second change taking place statewide was the CareFirst Patient Centered Medical Home Program. Evaluations of this program found that it reduced hospital inpatient and ED use.[30,31] However, only one of the Health Enterprise Zones had a patient-centered medical home operating in it, and just 16 percent of hospital patients in the zones were covered by commercial insurance. Consequently, the CareFirst Patient Centered Medical Home Program could affect only relatively few residents of Health Enterprise Zone ZIP codes.

Although we found a decrease in inpatient stays when we compared Health Enterprise Zone residents to residents in eligible ZIP codes whose communities were not included in the zones, there was also a relative increase in ED use. The reduction in inpatient stays was consistent with our expectations, but the increase in ED visits was unexpected. One possible explanation is that hospitals were more likely to send ED patients home instead of admitting them because the patients had access to Health Enterprise Zone resources. Another reason for the relative increase in ED use is that the Maryland Health Services Cost Review Commission encouraged hospitals to use observation status instead of short inpatient stays after 2010, which would allow patients to receive observation services (for example, x-rays, lab tests, and medications) in the ED and depress the numbers of inpatient stays. CMS's Two-Midnight rule, which followed a few years later, did the same.[32] However, it is unclear why this would disproportionately affect Health Enterprise Zones. In addition, as a result of the Affordable Care Act, Medicaid enrollment expanded in Maryland, and prior re-

search shows that previously uninsured people increase their ED use when they obtain Medicaid coverage.[33] However, we controlled for Medicaid enrollment in our analysis. While the Health Enterprise Zone–awarded ZIP codes had more Medicaid enrollees than the eligible ZIP codes that did not receive Health Enterprise Zone awards, the expansion increased their Medicaid enrollment by similar proportions.

Our findings are consistent with those of other studies that show that interventions that improve both access to care and health behaviors of underserved populations can result in a significant reduction in their hospital use.[34,35] The initiative improved access to primary care and preventive services and encouraged health behaviors through care coordination, health education, and patient engagement, which likely reduced the use of costly inpatient care.

This study had several strengths. We analyzed eight years of data, including sufficient observations before and after the Health Enterprise Zone Initiative was implemented. We applied a quasi-experimental study design with a comparison group (residents of ZIP codes eligible to participate in the initiative but not awarded funds by it), and we used a difference-in-differences model to control for fixed differences in hospital utilization between the comparison group and the ZIP codes that were awarded funds. We also examined a subset of conditions that should be sensitive to the intervention's activities. Our falsification tests suggest that our findings of reductions in inpatient stays were valid. Lastly, in the cost analysis we used charge data for the state—which, because of Maryland's all-payer model, is closely aligned to resource use since it is what insurers and patients actually pay for services.[26]

Conclusion

Improving access to care and reducing health care costs are key factors in reducing health care disparities. The Health Enterprise Zone Initiative demonstrated how states can use funds to create opportunities for community-based organizations and health care systems to leverage resources to benefit underserved communities. The initiative provided incentives and funding to attract health care providers to underserved communities, since limited access to health care professionals such as primary care providers, behavioral health specialists, and community health workers contributes to health disparities.[4,5] It also supported the coordination of health care and social services for vulnerable populations. The program was associated with improved access to care and reduced inpatient admissions and their associated costs. These reductions could justify continued financial investment from the State. Policy makers should consider promulgating the intervention to other eligible communities. Additional support could be provided by the health plans that benefit the cost savings as a result of lower hospital use, or hospitals could fund additional zones as part of their community benefit responsibility. ■

An earlier version of this article was presented at the American Statistical Association's Twelfth International Conference on Health Policy Statistics in Charleston, South Carolina, January 11, 2018, and at the Robert Wood Johnson Foundation's Sharing Knowledge to Build a Culture of Health Conference in Louisville, Kentucky, February 24, 2017. Funding was provided by the Maryland Department of Health.

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HFAM Testimony SB 172 Final.pdf
Uploaded by: DeMattos, Joseph
Position: FAV

TESTIMONY BEFORE THE
SENATE BUDGET AND TAXATION COMMITTEE
January 27, 2021
Senate Bill 172: Maryland Health Equity Resource Act
Written Testimony Only

POSITION: SUPPORT

On behalf of the members of the Health Facilities Association of Maryland (HFAM), we appreciate the opportunity to express our support for Senate Bill 172. HFAM represents over 170 skilled nursing centers and assisted living communities in Maryland, as well as nearly 80 associate businesses that offer products and services to healthcare providers. Our members provide services and employ individuals in nearly every jurisdiction in the state.

HFAM members provide the majority of post-acute and long-term care to Marylanders in need: 6 million days of care across all payer sources annually, including more than 4 million Medicaid days of care and one million Medicare days of care. Thousands of Marylanders across the state depend on the high-quality services that our skilled nursing and rehabilitation centers offer every day.

Senate Bill 172 would require the Secretary of Health to designate certain areas as Health Equity Resource Communities, which would be geographic areas that demonstrate measurable and documented health disparities and poor health outcomes. These areas would be small enough to allow for the incentives offered to have a significant impact on improving health outcomes and reducing disparities, and have a minimum population of 5,000 residents. The purpose of these communities would be to target state resources to reduce health disparities, improve health outcomes, improve access to primary care, promote prevention services, and reduce healthcare costs and hospital admissions and readmissions.

Under this legislation, the Secretary of Health also would establish a Health Equity Resource Community Advisory Committee to provide guidance, approval, and monitoring of Health Equity Resource Communities. For an area to receive designation as a Health Equity Resource Community, a nonprofit community-based organization, nonprofit hospital, institution of higher education, or a local government agency shall apply to the Secretary on behalf of the area. Areas designated as Health Equity Resource Communities would be supported through a Health Equity Resource Community Reserve Fund.

The highest honor of my work is visiting with residents, patients, and staff in Maryland skilled nursing and rehabilitation centers and on assisted living campuses. Before it became unsafe to visit due to the COVID-19 pandemic I was made these visits, on average, every two weeks. I bring up these visits relative to our support for SB 172 because the majority of Marylanders providing and receiving quality care in our setting come from diverse backgrounds. They have experienced and suffered from healthcare inequity, social determinants of health, and tragic outcomes of racism.

(more)

As I have often shared, and as this legislation points out, COVID-19 has highlighted the disparities that exist in healthcare, among both those providing and receiving care, and especially in communities of color and among those who are economically disadvantaged. Healthcare disparity and social determinants of health are a national embarrassment. Together, we MUST do better.

In order to do better, we must identify areas that need assistance and provide that assistance in tangible, measurable ways that are data-driven and documented. SB 172 is critical to ensuring we fully understand and can better advocate to improve minority health and find solutions to inequities in healthcare.

While none of us caused COVID-19, we all have ownership in public policies associated with and our individual actions on healthcare, transportation, local access to key businesses, access to care, and homelessness that are in part to blame for people and communities of color being disproportionately attacked by COVID-19.

I admired the late Kaiser Permanente CEO Bernard Tyson, who said about the intersection of healthcare disparity and public policy, “Such a small part of healthcare actually happens in the doctor’s office.” He was right.

For these reasons we request a favorable report from the Committee on Senate Bill 172.

Submitted by:

Joseph DeMattos, Jr.
President and CEO
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Health Care for the Homeless - SB 172 FAV - Maryla
Uploaded by: Diamond, Joanna
Position: FAV

HEALTH CARE FOR THE HOMELESS TESTIMONY
IN SUPPORT OF
SB 172 - MARYLAND HEALTH EQUITY RESOURCE ACT

Senate Finance Committee
January 27, 2021

Health Care for the Homeless supports SB 172, which would establish a process in which MDH approves "Health Equity Resource Communities" designed to funnel state resources to specific communities to reduce health disparities and improve health outcomes in those areas.

Health Care for the Homeless is deeply committed to deliberately addressing health inequities. While homelessness was pervasive before COVID-19, the pandemic exacerbated already the already existing inequities that lead to and perpetuate homelessness. Health Equity Resource Communities would be underserved communities around the state that compete for grants and other financial incentives to address poor health outcomes that contribute to inequities by race, ethnicity, disability, and geographic location.

Based on the 2012-2016 pilot that increased access to health care, reduced hospital admissions and created cost savings, this bill is a critical step to addressing inequities in our health care system. We urge a favorable report.

Health Care for the Homeless is Maryland's leading provider of integrated health services and supportive housing for individuals and families experiencing homelessness. We work to prevent and end homelessness for vulnerable individuals and families by providing quality, integrated health care and promoting access to affordable housing and sustainable incomes through direct service, advocacy, and community engagement. We deliver integrated medical care, mental health services, state-certified addiction treatment, dental care, social services, and housing support services for over 10,000 Marylanders annually at sites in Baltimore City, and in Harford, and Baltimore Counties. For more information, visit www.hchmd.org.

SB172-HERCs-MdPHA_testimony2021-FNL.pdf
Uploaded by: Eck, Raimee
Position: FAV

Maryland Public Health Association

Mission: *We champion health equity for Marylanders through advocacy and community collaborations.*

Vision: *Healthy Marylanders Living in Healthy Communities*

SB172 Maryland Health Equity Resource Act
Hearing Date: January 27, 2021
Committee: Budget & Taxation
Position: SUPPORT

Thank you Chairman Guzzone and members of the Budget & Taxation Committee for this opportunity. We submit this testimony on behalf of the Maryland Public Health Association to express our support for SB172, the Maryland Health Equity Resource Act. This bill's purpose is to deliver fairness in access to health care resources regardless of race, ethnicity, geographic location, and disability. This initiative is based on a 2012-2016 pilot that effectively increased access to health resources, enhanced residents' health, decreased hospital admissions and created cost savings. Health Equity Resource Communities would be funded through a penny per dollar increase in the alcohol beverage sales tax.

We have witnessed massively unfair gaps in health care access in Maryland because of health inequities by race and ethnicity. For example, Black Marylanders experience higher rates of cardiovascular disease, asthma, and diabetes compared with white Marylanders.[1] In Maryland, black mothers die due to pregnancy 4 times more than white mothers, with the disparity continuing to widen over time.[2] The COVID-19 pandemic has further exposed health inequities and highlighted the necessity to address them and otherwise advance health outcomes in our state. Statewide, according to the COVID Tracking Project, African Americans account for 29% of the population but 41% of the deaths from the virus. While the Latino community makes up just 10% of the population, over a quarter (26%) of all confirmed cases of COVID-19 were found in this group.[3]

Location is also an issue. For example, there is a lack of healthcare specialists in rural areas compared to urban areas. In Maryland, about 499 gastroenterologists (GI) specialists perform colonoscopies, but none of them are on the eastern shore. In rural places like Ocean City and Salisbury, the nearest GI specialist is at Anne Arundel Gastroenterology.[4] One of our members reports that while working as a medical assistant for GI specialists at Gastro Associates in Glen Burnie, many patients had to drive 3 to 4 hours from Ocean City or other rural areas of Maryland for colonoscopy and other GI issues. More than 30% of colorectal cancer patients have a family history of the disease, making it one of the most critical and actionable risk factors.[5] The American Cancer Society recommends new colorectal cancer screening from age 45 because of family medical history and excessive colon cancer deaths. It is estimated that in 2020, there were 53,200 deaths from colorectal cancer for all ages.

It is critical that the Health Equity Resource Communities have a funding mechanism, and a penny per dollar increase in the alcohol beverage sales tax is the right way to do it. The 2011 alcohol beverage sales tax increase led to significant reductions in underage drinking, binge drinking, driving under the influence, and sexually transmitted infections.[6] Maryland has not raised its alcohol beverage sales tax

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since 2011 and its rate has fallen behind that of Washington D.C. Raising the state's alcohol beverage sales tax will generate necessary funds and reduce drinking, including by underage Marylanders and heavy drinkers, which in turn will save lives and reduce health care costs.

It is essential that all Marylanders have equitable access to health care resources, such as primary doctors and specialists, so that they will be able to get the medical treatments they need. We urge you to give SB 172 a favorable report to reduce healthcare inequities in Maryland.

The Maryland Public Health Association (MdPHA) is a nonprofit, statewide organization of public health professionals dedicated to improving the lives of all Marylanders through education, advocacy, and collaboration. We support public policies consistent with our vision of healthy Marylanders living in healthy, equitable communities. MdPHA is the state affiliate of the American Public Health Association, a nearly 145-year-old professional organization dedicated to improving population health and reducing the health disparities that plague our state and our nation.

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Support-SB 172_ Health Equity Resource Act- UULM-M
Uploaded by: Egan, Ashley
Position: FAV

Testimony to Support SB 172: Maryland Health Equity Resource Act

To: Senator Guy Guzzone and the Members of the Senate Budget and Taxation Committee

From: Betty McGarvey Crowley and Christine Hager, Ph.D Co-Chairs, Health Task Force, Unitarian Universalist Legislative Ministry of Maryland

Date: January 27, 2021

The Unitarian Universalist Legislative Ministry of Maryland (UULM-MD) is an advocacy organization, with members in UU congregations throughout the state. Since its founding in 2005, health care issues have been a priority and we are a member of the Health Care for All Coalition. As a faith community UUs translate our focus on health equity into actions that reflect our belief in the inherent worth and dignity of each person. UULM-MD supports SB 172.

This proposed legislation would provide services to underserved areas of the state. It is modeled on the 2012-2016 Health Enterprise Zones (HEZ) Program which increased access to health resources, improved residents' health, reduced hospital admissions, and created cost savings. The new Equity Act will address the poor health outcomes that contribute to racial, ethnic, and geographic health inequities which have been evident in the COVID-19 pandemic. If this program had continued, residents of underserved zones could have received more appropriate education on prevention, testing, vaccinations, and treatment for COVID- 19.

From the examples of the prior HEZ programs, we learned how effectively people can be served in their communities when local groups and individuals partner to determine the needs, develop programs to meet them, and hire staff who can relate to the residents. However, many of the successful HEZ funded programs were discontinued as there was no sustained funding. The adoption of SB 172 could again fund equity zones to facilitate these highly effective strategies. For example, funding will enable hiring of "community health workers" who are members of the underserved communities, and who relate to their fellow community members – by knowing their barriers, culture and language. These workers can help residents access resources like transportation, health insurance and free medication from pharmaceutical company programs, and guide them in following their doctors' advice, all of which help prevent hospitalization, and ER visits, and enhance wellness. The bill would help recruit and retain needed health professionals for these areas by providing tax credits which aids with huge student loans. It is inspiring to meet dedicated people working to advance health in these underserved communities and hear of the success of collaboration (between the

doctors, nurses, nurse practitioners, community health workers, pharmacists, social workers, hospitals, universities, and community organizations.) They are effective as they gain the trust of local residents, know their concerns, and what is needed in their community to meet the disparities.

The proposed raise by a mere one cent on a dollar for the alcohol beverage tax is a reasonable way to help this program become quickly implemented and continued. The tax would be raised initially on beverages sold in liquor stores; but delayed in restaurants and bars that are being hurt by the economic downturn. When the tax was last raised in 2011, it helped support health services and decreased significantly binge drinking and underage drinking. Maryland's tax rate is below rates in surrounding jurisdictions and this tax increase is supported by Maryland residents.

UULM-MD asks you to vote for it. This program can reduce the obvious and unconscionable lack of programs that meet the needs of those who are often forgotten.

Thank you!

Betty McGarvie Crowley and Cristine Hager, Ph.D., Co-Chairs, Health Task Force

CASA_FAV_SB172.pdf
Uploaded by: Escobar, George
Position: FAV

Testimony in Support of Senate Bill 172

January 25, 2021

Senate Budget and Taxation Committee

SB-172 Maryland Health Equity Resource Act

George Escobar

CASA, Chief of Programs and Services

Honorable Members of the County Council:

My name is George Escobar, I am Chief of Programs and Services at CASA, the mid-Atlantic region's largest immigrant serving and advocacy organization with over 90,000 members statewide. On behalf of my organization and our members, I urge you to vote in favor of Senate Bill 172, which would prioritize health resources for traditionally under resourced communities through officially designating them as Health Equity Resources Communities.

As an organization with over 25 years of experience providing health education, navigation, assessment and enrollment assistance, CASA has witnessed firsthand how health disparities experienced chronically by the Latino and immigrant population in particular led to devastating consequences as seen in the disproportionate impact of the COVID-19 pandemic on communities of color. These disparities, a result of generations of structural inequities present in our health system, which allow you to predict an individual's health outcomes depending on their race, ethnicity, immigration status, or place of residence, requires a dedicated effort to reverse. It is such an effort that this bill intends to begin to tackle.

Through the designation of Health Equity Resource Communities, underserved communities around the state may compete for grants and other financial incentives to address poor health outcomes that contribute to inequities by race, ethnicity, disability, and geographic location. Further these Communities would be working to collaboratively leverage state and local non-profit resources in a transparent and inclusive process that will count the local population as an integral planning partner. The ability to leverage and coordinate these various resources may help to further scale the impact of the project. Similar initiatives across the country have proven to be successful as well as right here in Maryland where a 2012-2016 pilot successfully increased access to health resources, improved residents' health, reduced hospital admissions, and created cost savings.

It is our hope that as we build Health Equity Resource Communities, we also lay the groundwork to address one of our community's greatest disparities – access to healthcare itself. As a State, Maryland has much to be proud of in its efforts to address barriers accessing health care. Through its embrace of the Affordable Care Act, expansion of Medicaid, and investments in navigation support, it can deservedly boast about its accomplishments in significantly reducing the rate of uninsured Marylanders statewide. However, still these accomplishments mask some glaring disparities in the composition of the population that remains uninsured without any access to reliable healthcare. According to the Pew Research Center for example, more than 27% of the Latino population in Maryland remain uninsured. That's more than one in every 4 Latinos across the state. In fact, the experience of being an immigrant is in itself a significant social determinant affecting health and mental health, which has a profound impact on one's wellbeing. And the lack of access to healthcare has been a major factor in determining exposure and treatment to the Coronavirus.

Although CASA will continue to fight for health coverage for all regardless of immigration status, we see SB-172 as a key, innovative and proven tool in addressing the many health disparities experienced by communities of color and thus highly recommend enactment of the bill.

Thank you for your time

George Escobar

Chief of Programs and Services

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Position: FAV

THE EPISCOPAL DIOCESE OF MARYLAND

Support – SB172

Maryland Health Equity Resource Act
Senate Budget and Taxation/Finance Committee, January 27, 2021

Written testimony submitted by the Rev. Dr. Diane Fadely,
The Maryland Episcopal Public Policy Network (MEPPN)

. . . 'Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to me.' (Matthew 25:40)

The Episcopal Diocese of Maryland supports SB172, the Maryland Health Equity Resource Act because it is designed to address the healthcare needs of underserved communities around the State that disproportionately experience poor health outcomes. SB172 would designate selected underserved areas around the state as Health Equity Resource Communities where healthcare disparities would be reduced, access to medical care would be improved, and wellness and prevention services would be provided to reduce the incidence of disease. These goals reflect the human rights healthcare advocacy of Resolutions 2018-C041 and 2018-D014 of the General Convention of the Episcopal Church.

The Covid-19 pandemic has exposed serious deficits in our health system. Blacks and Latinos are disproportionately dying from COVID and are suffering more serious illness than whites, as are other vulnerable groups such as people with low incomes, disabilities, and people living in areas with scant health services.

People in areas with insufficient healthcare services suffering from illnesses such as hypertension, heart disease, asthma, diabetes, substance abuse, and mental health disorders are at high risk for poor health outcomes. Besides improving the health and well-being of these people, implementing the measures contained in SB172 is expected to result in lower health care costs and reduced hospital admissions. The basis for a positive outcome is supported by data from a pilot program conducted between 2012-2016 that resulted in increased access to healthcare resources, improved participants' health, reduced hospitalizations, and cost effectiveness.

Funding proposed for SB172 would require raising the alcoholic beverage sales tax by one cent on the dollar. This would be the first such increase since 2011, funds well-spent to save a significant number of lives, reduce overall health care costs for underserved populations, and enable many Marylanders to enjoy improved health and more productive and fulfilled lives.

We respectfully ask you to show strong support for SB172.

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NASW MARYLAND CHAPTER
National Association of Social Workers

Testimony before Budget and Taxation
Senate Bill 172: Maryland Health Equity Resource Act

****SUPPORT****
January 27, 2021

The National Association of Social Workers, Maryland Chapter (NASW-MD) requests your support for Senate Bill 172: Maryland Health Equity Resource Act. This bill would reduce health disparities by requiring the Secretary of Health to designate certain areas as Healthy Equity Resource Communities and improve access to primary care, promote prevention services, thereby reducing the need for hospitalizations and the inherent costs of high end care. The bill would also authorize tax credits for certain health care providers and organizations.

NASW is the largest national organization of social workers, representing over 120,000 social workers nationally. The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living.

Social Workers from across the state of Maryland who work with communities of color have firsthand knowledge of the damage caused by inadequate health care resources from those they serve. One of the goals of the Grand Challenges for Social Work is to have a socially-oriented model of healthcare that breaks down and removes the root causes of health inequity and promotes upstream interventions and primary care prevention that will eradicate the gap that exists for marginalized populations

SB172 will empower communities to reduce the health disparities that have impacted people of color for far too long. This has been especially highlighted within the past year, as we have witnessed the COVID-19 pandemic impact Black and Brown communities harder than White communities.

NASW-MD urges you to support SB-172 and create a safer, more inclusive Maryland. Thank you for all you do to reach a healthier Maryland.

Daphne McClellan, Executive Director, NASW-MD

5750 Executive Drive, Suite 100, Baltimore, MD 21228
(410) 788-1066 · Fax (410) 747-0635 · nasw.md @verizon.net · www.nasw-md.org

SB172 - MoCo - (GA2021) Support.pdf
Uploaded by: Frey, Leslie
Position: FAV

OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

January 27, 2021

TO: The Honorable Guy Guzzone
Chair, Budget and Taxation Committee

FROM: Marc Elrich
County Executive

RE: SB 172, Maryland Health Equity Resource Act, Support

Senate Bill 172 would establish a Health Equity Resource Community Advisory Committee to facilitate a program for Health Equity Resource Communities and Health Equity Research Practitioners, for the purpose of reducing health disparities, improving health outcomes and access to primary care, promote prevention services and reduce health care costs. Health care practitioners and community health workers that practice in a Health Equity Resource Community may receive tax credits, loan repayment assistance, or may apply for grants. The bill designates a dedicated funding stream for this program: 10% of income generated from alcoholic beverage tax revenue would be set aside for this purpose. Under certain circumstances a health care practitioner or a community health worker in a Health Equity Resource Community may apply for a State income tax credit.

Health inequities persist across the State and in every jurisdiction. In 2019, Montgomery County released a report detailing the health disparities faced by different demographic groups in the County. The report showed higher incidence of ER utilization, infant mortality and pre-term births, and adverse health outcomes among non-White populations groups as compared to non-Hispanic Whites. Maryland needs to direct resources to eliminating these disparities and addressing the root causes- Senate Bill 172 is a meaningful tool to achieve this.

In addition to supporting the use of alcoholic beverage tax revenue to achieve the work of the Health Equity Resource Community Advisory Committee, I would also encourage the Legislature to consider the legalization and taxation of recreational cannabis as a funding source for reducing health disparities among Marylanders.

The Montgomery County Executive supports Senate Bill 172 and respectfully urges the Committee to issue a favorable report.

cc: Members of the Budget and Taxation Committee
Members of the Finance Committee

SB0172--01.27.21--Maryland Health Equity Resource
Uploaded by: Fry, Donald
Position: FAV

POSITION STATEMENT

TESTIMONY PRESENTED TO THE SENATE BUDGET & TAXATION COMMITTEE

SENATE BILL 172 - MARYLAND HEALTH EQUITY RESOURCE ACT
Sponsor – Senator Hayes, et al

January 27, 2021

DONALD C. FRY
PRESIDENT & CEO
GREATER BALTIMORE COMMITTEE

Position: Support

The Greater Baltimore Committee (GBC) supports Senate Bill 172, which would enable state officials to designate certain areas of the state as equity zones, qualifying them for tax credits, grants, and health care provider loan repayment assistance. It would be funded by a 1 percentage point increase in the state's alcohol tax, boosting it to 10% from 9%.

Senate Bill 172 builds on a previous pilot program that ran from 2012 to 2016 and created five health enterprise zones using money from the state's general fund. The pilot program proved that equity zones could help prevent unequal outcomes and lower health care costs.

As outlined in the GBC's 2021 Legislative Priorities, this bill is aligned with with the GBC's organizational focus on advancing racial equity and social justice. The GBC is committed to reviewing all legislative proposals through an equity lens and to consider the impacts of proposed legislation on small and minority owned businesses, minority populations, and economically disadvantaged residents, balanced with the need to support economic growth. Senate Bill 172 is a proposal that supports our racial equity and social justice focus, and supports the economy by keeping health costs down and maintaining the health of disadvantaged populations.

For these reasons, the Greater Baltimore Committee urges a favorable report on Senate Bill 172.

The Greater Baltimore Committee (GBC) is a non-partisan, independent, regional business advocacy organization comprised of hundreds of businesses -- large, medium and small -- educational institutions, nonprofit organizations and foundations located in Anne Arundel, Baltimore, Carroll, Harford, and Howard counties as well as Baltimore City. The GBC is a 66-year-old, private-sector membership organization with a rich legacy of working with government to find solutions to problems that negatively affect our competitiveness and viability.

Johns Hopkins - SB 172 Maryland Health Equity Reso
Uploaded by: Hafey, Elizabeth
Position: FAV

JOHNS HOPKINS
UNIVERSITY & MEDICINE
Government and Community Affairs

HB 172
Favorable

TO: The Honorable Guy Guzzone, Chair
Senate Budget and Taxation Committee

The Honorable Delores Kelly, Chair
Senate Finance Committee

FROM: Ron Daniels, President, Johns Hopkins University
Kevin Sowers, President, President, Johns Hopkins Health System; executive vice president, Johns Hopkins Medicine

DATE: January 27, 2021

Johns Hopkins University and Medicine strongly supports **Senate Bill 172 – Maryland Health Equity Resource Act**. This bill establishes Health Equity Resource Communities ("HERCs"). HERCs would be underserved communities around the state that compete for grants and other financial incentives to address poor health outcomes that contribute to inequities by race, ethnicity, disability, and geographic location. These HERCs would create a critically needed strategy empowered by a dedicated new resource in Maryland to systematically lift up communities that do not have adequate access to health care. Now, more than ever, is the time to take action.

A pilot program from 2012-2016 that successfully increased access to health resources, improved residents' health, reduced hospital admissions, and created cost savings is the genesis of this initiative. At Johns Hopkins, researchers, including those led by Dr. Lisa Cooper at the Johns Hopkins Urban Health Institute and the Center for Health Equity, have shown definitively that health disparities are not simply a result of our healthcare system, but are, in fact, often linked to broader disparities and inequities that converge upon and unfairly burden some of our most economically fragile and underserved communities. At Hopkins, we have seen this kind of work in action: From the pioneering, community-based initiatives of the Urban Health Institute (UHI) and Dr. Cooper, which have cultivated stronger community partnerships to improve community safety and well-being, strengthen food security and improve health education to our economic inclusion program, HopkinsLocal, that helps our neighbors through targeted neighborhood hiring and Live Near Your Work program, which offers grants to employees looking to put down roots in their neighborhoods through homeownership. The HERC legislation will not only make use of these principles of evidence-based policy, it will also capitalize on the tremendous promise across Maryland.

Nowhere is this promise more urgent than in the Maryland communities that have borne the unfair burden of racial, economic, and health disparities, particularly our Black and Latinx communities. Crucially, this initiative is part of a critical strategy that will help expand access to high-quality healthcare to many around the state. And, as we know, COVID-19 has revealed deep-seated inequities in health for communities of color and amplifies the social and economic factors that contribute to poor outcomes. COVID-19 has shone a bright light on

the disproportionate impacts borne by those communities and tremendous hardship has been caused by the COVID-19 pandemic. For example, from the outset of the pandemic, we observed that certain zip codes had a significantly higher positivity rate, particularly in very vulnerable areas. In collaboration with our community partners, we launched initiatives to provide COVID-19 testing to hard-hit areas of Baltimore by establishing mobile testing sites. In addition, our clinicians have also traveled to homeless shelters, substance use facilities, skilled nursing facilities, and nursing homes, also hard-hit by COVID-19, to provide much-needed testing.

HERC provides a powerful tool in the arsenal necessary to turn the tide in the battle against health inequities. And, all Marylanders deserve access to high-quality, affordable health care. Johns Hopkins applauds the sponsors for their leadership on this issue and strongly urges a favorable report on **Senate Bill 172 – Maryland Health Equity Resource Act.**

Signed,

Ronald J. Daniels
President, Johns Hopkins University

Kevin W. Sowers
President, Johns Hopkins Health System; Executive Vice President

cc: Members of Senate Budget & Taxation Committee
Members of Senate Finance Committee
Senator Antonio Hayes

Final Testimony 2021 SB 172 Support Health Equity

Uploaded by: Hale, Laura

Position: FAV

January 24, 2021

Testimony of Laura Hale
American Heart Association
Support of SB 172 Maryland Health Equity Resource Act

Dear Chair Guzzone, Vice Chair Rosapepe, and Honorable Members of the Budget and Tax Committee and Finance Committee,

Thank you for the opportunity to submit written testimony. My name is Laura Hale and I am the Director of Government Relations for the American Heart Association. The American Heart Association offers our support of this legislation.

SB 172 takes key steps to create investments in communities that have been historically underinvested in. Due to systemic and structural racism, communities of color have been disinvested in as well as strategically be placed at a disadvantage. These actions have shorten the lives of African Americans and has decrease their access to healthcare, healthy food, and other essentials for longer lives. It is essential that Maryland takes steps to invests in these communities and bring about equity. The focus on communities of color is essential as we take steps as a state to overcome systemic racism which is a public health crisis[1]. SB 172 does just that by placing healthcare investment into key communities in the state.

Healthcare is only one step in addressing health equity. The state must continue to make investments such as funding the Maryland Money Market program and Complete Streets.

The American Heart Association urges a favorable report on SB 172.

[1] https://www.ahajournals.org/doi/10.1161/CIR.0000000000000936

Maryland Health Equity Resource Act Testimony .pdf
Uploaded by: Hayes, Antonio
Position: FAV

ANTONIO HAYES
Legislative District 40
Baltimore City

Finance Committee

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410-841-3656 · 301-858-3656
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Antonio.Hayes@senate.state.md.us

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

January 27, 2021

Testimony of Senator Antonio Hayes in Support of SB 172:
Maryland Health Equity Resource Act

Chairman Guzzone and Members of the Budget and Taxation Committee,

It is with great enthusiasm that I introduce the Maryland Health Equity Resource Act. I and many of my colleagues strongly believe that Marylanders have a right to good healthcare no matter their socioeconomic status, geographic location, or their racial background. Despite this, racial and ethinic minorities living in underserved communities have historically had disparate access to healthcare. This has translated into higher rates of chronic diseases in these groups. When compared to White people, Black Maryland residents are 20% more likely to die from heart disease, 35% more likely to die of a stroke, twice as likely to die from diabetes, and almost five times as likely to die from asthma.

In terms of infectious diseases, the COVID-19 pandemic has laid bare how social determinants impact disparities in the state. Black and Hispanic Marylanders make up a disproportionately high percentage of cumulative COVID-19 cases, hospitalizations, and deaths. These outcomes can partially be explained by barriers to proper care illustrated by increased usage of emergency care for both chronic and acute issues by Black Marylanders, which is not only more expensive but a less effective method of care when it comes to maintaining the health of an individual.

The Maryland Health Equity Resource Act (**SB 172**), creates a framework to bring about new Health Equity Zones throughout the state, allows for the creation of community specific health programs that increase access to care, and reduces healthcare spending. This policy shows a large base of support in the state of Maryland. A recent poll of 838 registered voters conducted last September showed a strong majority favored the bill (66%) compared to a small percentage opposing (9%), with the remaining respondents saying they were not sure.

SB 172 will be administered through the Maryland Department of Health. The Secretary of Health will be tasked with designating certain areas as **Equity Resource Communities**,

considering geographic diversity among other factors when choosing. Those communities wanting to participate must submit applications describing a sustainable plan to meet the goals of **SB 172**: reducing health disparities, reducing costs/producing savings to the healthcare system, and improving health outcomes. Application material will include how funding is to be used to address the policy goals as well as a plan with objectives that sets forth how the initiative is strongly based in evidence, is innovative, and is in collaboration with important stakeholders.

Communities deemed eligible will receive grants or tax credits to be used for different community based organizations such as clinics, higher education, and local government agencies. In order to ensure effectiveness of the programs; awarded entities are required to submit yearly reports to the Health Secretary detailing their progress towards the objectives laid out in their application along with a description of objectives to be met the following year. Upon review, the secretary will approve or revoke the Health Equity Community(HEC) status. Information from said review will be detailed in a report that the secretary must provide to the governor at the end of each year.

In order to fund this program, **SB 172** sets forth a Health Equity Resource Community Reserve Fund, to be overseen by the secretary, which is to be kept separate from the general fund. Money will come from the proceeds of a one penny-per dollar increase in the state alcohol sales tax (section 11-1049G of the tax-general article). In addition to providing tax credits and grants to specified Health Equity Communities, the law will also provide fiscal support to the Maryland Department of Health for the purpose of supporting behavioral health programs that provide prevention, recovery support, and harm reduction services for individuals with substance abuse and mental health disorders. The increase in the alcohol sales tax, which will also reduce underage drinking and drunk driving, is delayed for two years for alcohol consumed in bars and restaurants hurt by COVID 19. The alcohol sales tax increase will bring in $14 million per year in the first two years and $22 million per year after that, with $1 million per year in the first two years and $2 million per year after that allocated to statewide behavioral health programs and the remainder to fund Health Equity Resource Communities.

The pilot program funded five Health Enterprise Zones (HEZ) (Health Equity Communities in the proposed legislation) in the State of Maryland. All of the HEZs aimed to reduce chronic diseases such as diabetes, cardiovascular disease, asthma, and the risk factors associated with them. In previous analysis of the pilot program: the HEZ initiative was associated with a net savings of over $93 million for Maryland's healthcare system. Overall, the initiative showed success in positively impacting health outcomes in their respective areas.

The Health Equity Community initiative proved the concept as effective for improving the wellbeing of Marylanders. Expanding upon this proven success with **SB 172** will make moves to further support community based initiatives, expanding the success of the program in reaching

the policy's overall goals. It is our duty to ensure that all Marylanders have access to competent and fiscally sound healthcare benefits. Passing this bill will be another monumental step in that direction.

I strongly urge a favorable report on SB 172.

Respectfully,

Senator Antonio L. Hayes
40th Legislative District - MD

SB0172_FAV_MACHC_MD Health Equity Resource Act.pdf
Uploaded by: Hoban, Nora
Position: FAV

MID-ATLANTIC ASSOCIATION OF COMMUNITY HEALTH CENTERS

TO: The Honorable Guy Guzzone, Chair
Members, Senate Budget and Taxation Committee
The Honorable Antonio Hayes

FROM: Nora Hoban, Chief Executive Officer
Mid-Atlantic Association of Community Health Centers
4319 Forbes Boulevard, Lanham, MD 20706
nhoban@machc.com

DATE: January 27, 2021

RE: **SUPPORT CONCEPT** – Senate Bill 172 – *Maryland Health Equity Resource Act*

The Mid-Atlantic Association of Community Health Centers (MACHC) is the federally designated Primary Care Association for Delaware and Maryland Community Health Centers. As the backbone of the primary care safety net, Federally Qualified Health Centers (FQHCs) are united by a shared mission to ensure access to high-quality health care to all individuals, regardless of ability to pay. FQHCs are non-profit organizations providing comprehensive primary care to the medically underserved and uninsured. MACHC supports its members in the delivery of accessible, affordable, cost effective, and quality primary health care to those most in need. To this end, MACHC **supports the concept** of Senate Bill 172.

Senate Bill 172 proposes to establish a framework for the establishment of Health Equity Communities in areas of the State with demonstrated health inequities and disparities. Mirroring the framework of the Health Equity Zones program that sunset in 2017, funding provided through this legislation is designed to implement innovative strategies for addressing health disparities in communities with the highest health disparities.

FQHCs are a critical component of the safety-net provided to Marylanders and are excited about the potential opportunity to play a critical role in advancing the objectives of this legislation. FQHC's federal designation requires them to be located in medically underserved areas, the very areas where Maryland's health disparities are most significant. Maryland's FQHCs provide services to more than 340,000 Marylanders annually at 129 locations throughout the State. They serve 1 in 18 Maryland residents providing more than 1.5 million visits annually. Furthermore, FQHC's federal designation requires them to provide health care services to all residents regardless of patients' ability to pay, including Maryland's immigrant population. To that end, as the committee works with relevant stakeholders to craft the final framework to advance this legislation, **MACHC requests consideration be given to providing FQHCs a more definitive role in framing the program and specific designation as an entity that will be entitled to receive funding through this initiative**.

Reducing health disparities is a priority for MACHC and its members. Senate Bill 172 provides an opportunity to significantly address disparities in communities across the State. MACHC looks forward to working with all affected stakeholders to move this initiative forward. To share more about community health centers, please see below and more information can be found at www.machc.com.

What Are Community Health Centers?

Community Health Centers – also known as Federally Qualified Health Centers (FQHCs) – offer comprehensive, quality primary medical, behavioral, and dental health care. FQHCs deliver care to the most vulnerable, including the homeless, agricultural workers, public housing residents, and veterans.

F

Fees based on ability to pay

Care for patients regardless of ability to pay and charge for services based on sliding fee scale

Q

Quality primary health care open to all

Deliver culturally-competent comprehensive primary care, health education, and translation and social services

H

Highly competent professional team

Integrate care tailored to unique needs of diverse medically underserved populations

C

Consumer/community control

Operate under community-based board of directors composed mostly of patients

Maryland Community Health Centers By The Numbers

Serve **342,565** Marylanders annually at **129 sites**

Serve **1 in 18** Marylanders

Provide more than **1.5 million** visits annually

Contribute **$785.6 million** to economy

Provide more than **3,000 jobs** in Maryland

Patients with a community health center as their medical home, save the healthcare system an average of $1,263 per year translating into more than **$432 million** in savings

Why Community Health Centers?

Comprehensive services

Trusted providers

Positive outcomes

Boards comprised of patients

Responsive to community needs

Cost-efficient & high-quality care

True to mission caring for most vulnerable

A constant during periods of being uninsured

sb172 health equity 1-27-21.pdf
Uploaded by: Hudson, Lee
Position: FAV

Delaware-Maryland Synod
Evangelical Lutheran Church in America
God's work. Our hands.

Testimony Prepared for the
Finance
and
Budget & Taxation Committees
on
Senate Bill 172
January 27, 2021
Position: **Favorable**

Madam Chair, Mr. Chairman, and members of the Committees, thank you for the opportunity to support access to health care for all Marylanders. I am Lee Hudson, assistant to the bishop for public policy in the Delaware-Maryland Synod, Evangelical Lutheran Church in America, a faith community with congregations in three synods in every part of our State.

Our community has advocated for access to appropriate and adequate health care for all people in the United States and its territories since 2003. We support Senate Bill 172 because it can expand access to care in Maryland and reduce health inequities by race, ethnicity, disability, and location.

Medically underserved communities typically have few providers and less service capacity because of market allocations. The reason for allocation choices typically is said to be economic; that is, there's industry financial risk associated with providing care to communities constrained by disinvestment. Market allocation, therefore, infrequently expands access.

Among its developed-nation peers, the United States pays the most, gets the least, and has the worst outcomes. We spend the highest percentage of GDP on healthcare; we insure a smaller portion of our population; and as a result we are sicker and have lower life expectancy. This last data-point is statistically valid even after eliminating other health risk factors.

The Affordable Care Act facilitated important, incremental expansion of access to care. Maryland, to its credit, implemented ACA with a committed and credible policy regime. We thank Maryland General Assemblies for the decades of work and resource allotted to improving the health of its citizens. Access to insurance, however, must be accompanied by sufficient medical resources for access to care to be realized.

Life-expectancy in Maryland can vary by as much as twenty years depending on where one lives. That is a signature of failed market allocation. The testimony of my community restates what mathematics demonstrates across the extent of health policy discourse in the United States: denying access to care and treatment does not save money. It does not even save health care dollars because it ignores cost measured as health outcomes.

Senate Bill 172 expands access to health care by addressing inequity of resource allocation. Maryland tested elements of the Bill in underserved locations after 2012. The Bill uses a suite of incentivizing instruments, made available to medically underserved communities, measured by infrastructure and health outcomes. A 2018 assessment found outcome improvements and net cost savings resulted, benefitting both community and State.

Because more people likely will receive appropriate medical care, my community supports Senate Bill 172 and urges a favorable report from the Committees.

Lee Hudson

575 South Charles Street, Suite 202 • Baltimore, Maryland 21201 • 410-230-2860 • 410-230-2871 (fax) • demdsynod.org

SB 172 MD Health Equity Resource Act- Dr.J B-T and

Uploaded by: Jarrell, President Bruce

Position: FAV

UNIVERSITY of MARYLAND MEDICAL SYSTEM

UNIVERSITY of MARYLAND BALTIMORE

January 27, 2021

The Honorable Guy Guzzone
Chair, Senate Budget & Taxation Committee
3W Miller Senate Office Building
Annapolis, MD 21401

The Honorable Delores G. Kelley
Chair, Senate Finance Committee
3E Miller Senate Office Building
Annapolis, MD 21401

Re: Support for Senate Bill 172 Maryland Health Equity Resource Act

Dear Chairs Guzzone and Kelley,

In 2012 the Maryland Health Improvement and Disparities Reduction Act of 2012 established Health Enterprise Zones (HEZs) to target state resources to reduce health disparities, improve health outcomes and reduce health costs and hospital admissions and readmissions in designated areas of the state. As this body may recall, Dr. Albert Reece, dean of the University of Maryland School of Medicine chaired the Health Disparities Workgroup on behalf of the Governor's Health Quality and Cost Council in 2011 that led to the recommendations found in the 2012 initiative. Several University of Maryland Medical System hospitals, University of Maryland Medical Center, Shore Regional Health and Capital Region Health, participated in three of the state's five geographically dispersed health enterprise zones. This four year initiative proved to be a viable way to reduce inpatient admissions and reduce health care costs in communities across the state by providing support to coalitions of health departments, other local government agencies, health care providers, and community-based social services organizations to address health care needs in designated underserved communities.

Based on the successful outcomes of establishing HEZs and with the COVID-19 pandemic once again highlighting health disparities across our state, we strongly support SB 172 which seeks to extend and expand the goal of HEZs by establishing Health Equity Resource Communities. In addition to the recent reminder of glaring health disparities COVID-19 continues to reveal, people with chronic conditions such as hypertension, heart disease, asthma, diabetes, and substance and mental health disorders continue to have worse health outcomes and are less able to get the care and treatment they need. These disparities are grounded in multiple, vexing issues which require sustained attention and which can be addressed by the goals and concomitant work plans contemplated by this bill.

As evidenced by the past pilot and data driven studies multicomponent community-based interventions are effective in improving access to care and health outcomes. As with HEZs, a Health Equity Resource Community will be configured to meet the area's unique combination of barriers to access to care, health problems faced in the zone, and availability of community-based services. Equity Resource Communities will build capacity within a community to address residents' health-related needs and broaden the health care safety net overall in that jurisdiction.

It is our firm belief that the health care industry needs to have a stronger presence and modern infrastructure throughout the state, but especially in areas where health disparities are most pronounced. Important steps must be taken to improve community factors that fall outside of the health care realm but directly affect health care outcomes.

In conclusion, to effectively promote health and improve health outcomes requires involvement from a broad spectrum of health care providers and community leaders. We look forward to partnering with the state and all appropriate stakeholders to create a seamless health care delivery system that empowers communities across Maryland.

Thank you for your support and consideration of SB 172.

Sincerely,

Bruce E. Jarrell, MD, FACS
President
University of Maryland, Baltimore

Mohan Suntha, MD, MBA
President & CEO
University of Maryland Medical System

SB 172 from AAUW MD.pdf
Uploaded by: King, Roxann
Position: FAV

Testimony to the Senate Budget and Taxation Committee; Finance Committee

Support for SB 172: Health Equities Resource Communities Act

By Roxann King, Co-Vice President for Public Policy, AAUW MD

Hearing Date: 1/27/2021

The American Association of University Women of Maryland supports the passage of SB 172. Health inequities in underserved communities persist in Maryland as evidenced by the continuing high death rates during the pandemic in our Hispanic and African American communities; by the high death rate for African American women during pregnancy; and by the high infant mortality in the black community.

The Health Equity Resource Communities have the same focus and structure as the successful 2012-2016 Health Enterprise Zones, which increased access to health resources, improved residents' health, reduced hospital admissions, and created cost savings. But this program will not end after five years. Because the funding would result from a permanent one cent per dollar increase in the alcohol tax, the benefits from the program will make a lasting impact on the health of the underserved communities. This funding would help create new mental health and substance use disorder programs. Communities would compete for grants, tax incentives and health care provider loan repayment assistance to reduce disparities and improve health equity.

Even before the pandemic, life expectancies were considerably less for people living in these underserved Maryland communities. In Baltimore City, life expectancy was 20 years less for people in certain West Baltimore neighborhoods, compared to those in more affluent whiter areas just a few miles away. The expectancy for underserved communities inside the beltway in Prince George's County was 16% below predominantly white suburbs. We can and should act to end these disparities.

The American Association of University Women of Maryland urges passage of SB 172 to improve the health of our underserved Marylanders.

SB0172-BT_MACo_SUP.pdf
Uploaded by: Kinnally, Kevin
Position: FAV

MARYLAND Association of COUNTIES

Senate Bill 172

Maryland Health Equity Resource Act

MACo Position: **SUPPORT**

To: Budget and Taxation and Finance Committees

Date: January 27, 2021

From: Kevin Kinnally and Michael Sanderson

The Maryland Association of Counties (MACo) **SUPPORTS** SB 172. This bill would establish a statewide framework to target health inequities, and promote better health service and offerings in underserved areas of our state.

Maryland, like many states, faces a worrisome gap in health outcomes based on demography and geography. A multi-tiered approach to help better identify communities and neighborhoods of concern, and to promote greater access and quality care, should be a priority in addressing and confronting this insidious health problem.

SB 172 sets forth just such a plan. Identifying communities of concern and need – in the bill "Health Equity Resource Communities" – is a critical step toward better serving those areas. The model in SB 172 has a structural parallel to Maryland's Enterprise Zone program, but rather than targeting economic distress, it targets health disparities. Creating incentives for health care practitioners to locate in these areas, and hopefully embed into these communities, provides hope for a turnaround in the health outcomes gap.

County governments, and local health departments, are among the substantial list of stakeholders in the processes envisioned under the bill, but its long-term oversight and success will depend on that wide range of contributors to remain committed to these difficult tasks. Counties are eager to play their role in moving forward and bridging the gap in health care access and outcomes for all our residents.

SB 172 creates a new framework to identify, isolate, and combat health inequities. MACo **SUPPORTS** SB 172 to advance more equitable health services and outcomes across our state.

169 Conduit Street, Annapolis, MD 21401
410.269.0043 BALT/ANNAP ◆ 301.261.1140 WASH DC ◆ 410.268.1775 FAX
www.mdcounties.org

SB172KoulHealthEquity Testimony.pdf
Uploaded by: Koul, Michelle
Position: FAV

I am writing to you because of concerns about health care inequality in Maryland. People should not have difficulty accessing primary and specialty health care because of where they live or who they are. Health inequities primarily based on race, ethnicity, disability, and place of residence persist throughout the state. The global COVID-19 pandemic has further exposed how severe these inequities are.

House Bill 473/Senate Bill 172 can address this problem. It would create Health Equity Resources Communities in Maryland to focus health resources in the neighborhoods where they are needed the most. These resources would be paid for by a one penny on the dollar increase on the alcohol beverage sales tax, imposed first on liquor stores, and two years later on bars and restaurants.

HB 473/SB 172 will address inequities by race, ethnicity, disability, and geography and ensure that every Marylander, regardless of who they are or where they live, has access to the healthcare they deserve.

Thank you for your consideration and I ask for you to vote favorably for SB 172.

Michelle Koul

Severna Park, MD

3015120422

TESTIMONY OF BETSY KRIEGER.pdf
Uploaded by: Krieger, Betsy
Position: FAV

411 Hawthorne Rd
Baltimore, MD 21210

**TESTIMONY OF BETSY KRIEGER, CO-FOUNDER,
BE THE CHANGE BMORE,
IN SUPPORT OF SB 172, THE MARYLAND HEALTH EQUITY RESOURCE ACT
JANUARY 27, 2021**

On behalf of Be the Change, an organization of several hundred activists living primarily in Baltimore City and County, I am writing to you because of our concern about health care inequality in Maryland.

Our group is dedicated to reducing inequality in all its forms, and the difference in the availability and quality of healthcare among Maryland residents is one of the areas where inequality is most evident.

Fortunately, House Bill 463/Senate Bill 172 can address this problem. It would create Health Equity Resources Communities in Maryland to focus health resources in the neighborhoods where they are needed the most. These resources would be paid for by a one penny on the dollar increase on the alcohol beverage sales tax, imposed first on liquor stores, and two years later on bars and restaurants. As we know, liquor stores have done well in the pandemic, and adding this small increase will not hurt their businesses.

HB 463/SB 172 will address inequities by race, ethnicity, disability, and geography and ensure that every Marylander, regardless of who they are or where they live, has access to the healthcare they deserve.

SB 172 (BCHD - Favorable).pdf
Uploaded by: Mehu, Natasha
Position: FAV

BRANDON M. SCOTT
MAYOR

Office of Government Relations
88 State Circle
Annapolis, Maryland 21401

SB 172

January 27, 2021

TO: Members of the Budget & Tax Committee, and
Members of the Finance Committee

FROM: Natasha Mehu, Director of Government Relations

RE: SENATE BILL 172 – MARYLAND HEALTH EQUITY RESOURCE ACT

POSITION: SUPPORT

Chair Guzzone and Chair Kelley, Vice Chair Rosapepe and Vice Chair Feldman, and Members of the Committees, please be advised that the Baltimore City Administration (BCA) **supports** Senate Bill (SB) 172.

SB 172 would require the Maryland Department of Health Secretary to designate certain areas of the State as Health Equity Resource Communities to target state resources, including revenue from state alcohol taxes, to specific areas of the State for the purposes of reducing health disparities and improving overall health outcomes.

The BCA is genuinely concerned with public health disparities across Baltimore City's incredibly diverse population. The COVID-19 pandemic has further exposed the influence of social, economic, and environmental conditions on health outcomes for our City's populations. The pandemic has widened economic and health disparities, with Hispanic/Latino communities, African-American communities, and older adults disproportionately impacted by COVID-19. Hispanic/Latino Marylanders make up 10% of the population and account for 21% of COVID-19 cases, while African-Americans make up 29% of the population and account for 38% of deaths from COVID-19 in the State.[1] In Baltimore City, similar patterns are seen:

1. The older adult community, which is the most susceptible to severe and fatal cases of COVID-19; as of 12/16/20, 493 of Baltimore City's 575 confirmed deaths were to residents age 60 and older, with progressively higher case fatality

[1] Racial Data Dashboard | The COVID Tracking Project

rates for each ten-year group of older residents (age 60-69: 4.0%; age 70-79: 9.2%; age 80-up: 22.3%).

2. Latinx population, which is experiencing the highest cases-per-1000 rate in the City among identifiable demographic groups, at 99.1.

3. African Americans have suffered about 70% of the Baltimore City COVID-19 fatalities (while comprising about 63% of the population).

In a setting of entrenched health and economic disparities compounded by the COVID-19 pandemic, there is an increased need to provide high-quality, high-touch services to Baltimore City residents who are disproportionately impacted by COVID-19.

Understanding how its population is impacted by disparities in public health, the Baltimore City Health Department (BCHD) has enacted a number of policies and programs to achieve health parity. One model program is the Baltimore City Health Department's Accountable Health Communities (AHC) model. Through AHC, BCHD partners with hospitals to identify and address health-related social needs of Medicare and Medicaid beneficiaries. Close to 2,000 Baltimore City residents a year are screened for social needs and referred to resources through the AHC.

As part of the Accountable Health Community grant, the Baltimore City Health development developed CHARMCare, a resource directory publicly available to any resident in Baltimore. CHARMCare currently has over 250 public and private organizations providing resources for food, housing, utilities, financial strain, mental health, substance use, and employment. Resource information is updated weekly and provides the information residents need to find and access resources that will meet their basic needs. Hundreds of providers, community health workers, and Baltimore residents use CHARMCare every year to find the resource information they need to address their social determinants of health.

Additionally, throughout the COVID-19 pandemic, equitable allocation and administration of vaccine is paramount to ending the pandemic and saving the lives of Baltimore City residents. The Health Department has developed a multi-level strategy for vaccine allocation and administration with a focus on reaching the most vulnerable populations. Said populations may be unable to access the mass vaccination points of dispensing due to social, economic, or medical barriers, which may include limited broadband access, the lack of insurance or a primary care provider, and limited mobility. Vaccine allocation and administration for certain groups should aim to reduce health disparities and not widen or create disparities.

SB 172 could further the BCA's and BCHD's ambitions of achieving health parity across its diverse population in multiple ways. It creates an avenue by which the state and local governments can direct resources to local health-oriented entities to achieve collectively-shared health equity goals. This is in alignment with the Health Department's strategic plan to improve outcomes and inequities across key health indicators through the

reconvening of its Local Health Improvement Council (LHIC). The LHIC will, in turn, be charges with promoting the synchronization, collaboration, and cross-pollination of ideas and programs between community-based partners, health system organization, and the local health department in the development of health equity goals and policies for the City.

We respectfully request a **favorable** report on Senate Bill 172.

MD CollabTestimony in favor of SB 172 Final 1.25.2
Uploaded by: Mitchell, Molly
Position: FAV

THE MARYLAND COLLABORATIVE
TO REDUCE COLLEGE DRINKING AND RELATED PROBLEMS

Testimony in favor of SB 172, Health Equity Resource Act
Before the Senate Budget and Taxation Committee
January 27, 2021

As members of the Maryland Collaborative to Reduce College Drinking and Related Problems, and as leaders of colleges and universities across the state, we are writing to express our strong support of SB 172, the Maryland Health Equity Resource Act. This legislation would increase the state alcohol tax by a penny per dollar to fund Health Equity Resource Communities (HERCs), which research has shown, is one of the most effective ways to reduce excessive alcohol use, especially among young people. These HERCs will receive funds to support programs that seek to reduce health inequities based on race, ethnicity, disability, and geographic location.

Following the state's alcohol sales tax increase in 2011, Maryland saw a 26 percent drop in underage drinking and a 28% drop in underage binge drinking.[1] The number of alcohol-positive drivers between the ages of 15 and 34 on Maryland's roadways fell by 12 percent.[2] A systematic review of 50 studies support these results, finding that increased prices and taxes of alcoholic beverages were associated with decreased alcohol-related harms, including violence, suicide, motor-vehicle crashes, sexually-transmitted diseases, drug use, and crime.[3] Furthermore, research among college students has found higher beer taxes to be associated with reductions in several indicators of violence, including damaging property, getting into a fight or argument, and sexually being taken advantage of or taking advantage of someone else.[4] We are pleased that Maryland has made such progress in reducing the prevalence and impact of underage drinking in previous years, and with your support, SB 172 will ensure that these improvements continue in future years while also generating funds through the sales tax increase to reduce health disparities in our state.

Our state takes well-justified pride in its commitment to education. Our students come to college with high hopes and dreams; excessive drinking and its related harms can deter the fulfillment of those dreams. Please vote in favor of SB 172 and support the health, safety, and success of our college students.

Sincerely,

---

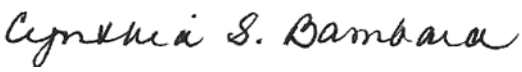
[1] Keshia Pollack Porter, Shannon Frattaroli, and Harpreet Pannu. "Public Health Policy in Maryland: Lessons from Recent Alcohol and CigaretteTax Policies." The Abell Report31, no. 2 (2018): 1-20.

[2] Marie-Claude Lavoie, Patricia Langenberg, Andres Villaveces, Patricia C. Dischinger, Linda Simoni-Wastila, Kathleen Hoke, and Gordon S. Smith. "Effect of Maryland's 2011 Alcohol Sales Tax Increase on Alcohol-Positive Driving." American Journal of Preventive Medicine53, no. 1 (2017): 17-24. Accessed 2017/05/14. https://dx.doi.org/10.1016/j.amepre.2016.12.011.

[3] Wagenaar AC, Tobler AL, Komro KA. Effects of alcohol tax and price policies on morbidity and mortality: A systematic review. *Am J Public Health.* 2010;100(11):2270-2278.

[4] Grossman M, Markowitz S. *Alcohol regulation and violence on college campuses.* Cambridge, MA: National Bureau of Economic Research; 1999. NBER working paper 7129. Available at: http://www.nber.org/papers/w7129.

President Ronald J. Daniels
Johns Hopkins University
Co-Chair, Maryland Collaborative



President Cynthia Bambara
Allegany College of Maryland

President Brian F. Linnane, S.J.
Loyola University Maryland

President Panayiotis Kanelos
St. John's College

President Ronald Nowaczyk
Frostburg State University

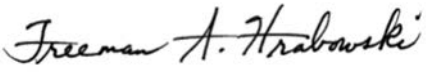
President Richard Midcap
Garrett College

President Tuajuanda C. Jordan
St. Mary's College of Maryland

President Darryll J. Pines
University of Maryland, College Park

President Kim E. Schatzel
Towson University

President Andrea E. Chapdelaine
Hood College



President Freeman A. Hrabowski, III
University of Maryland, Baltimore County

President Marylou Yam
Notre Dame of Maryland University

President Roger N. Casey
McDaniel College

President Kent Devereaux
Goucher College

President Heidi M. Anderson
University of Maryland, Eastern Shore

SB172 - MLAW Testimony.pdf
Uploaded by: Morgan, Jessica
Position: FAV

Bill No:	SB172
Title:	Maryland Health Equity Resource Act
Committee:	Budget and Taxation
Hearing:	January 27, 2021
Position:	SUPPORT

The Maryland Legislative Agenda for Women (MLAW) is a statewide coalition ofwomen's groups and individuals formed to provide a non-partisan, independent voice for Maryland women and families. MLAW's purpose is to advocate for legislation affecting women and families. To accomplish this goal, MLAW creates an annual legislative agenda with issues voted on by MLAW members and endorsed by organizations and individuals from all over Maryland. **SB172 a priority on the 2021 MLAW Agenda and we urge your support**.

SB172 would create Health Equity Resource Communities which would be geographic locations in the state with poor health outcomes that compete for grants, tax incentives, and health care provider loan repayment assistance to increase access to culturally competent care and ultimately reduce health inequities; funding for the Communities, as well as programs to address substance use and mental health disorders, will come from a one penny per dollar increase in the state alcohol beverage sales tax starting in 2021.

Health inequities based on race, ethnicity, disability and place of residence persist throughout the state, as shown in maternal and infant mortality rates and other measures. Inequities are stark at the intersection of gender, race, and location. In Maryland, black mothers die due to pregnancy 4 times more than white mothers, with the disparity continuing to widen over time. The infant mortality rate for Black non-Hispanic infants is 2.5 times the rate for White non-Hispanic infants, with rates worse for rural black infants than urban black infants.

Health Equity Resource Communities would improve health equity, including for women. Communities would compete for grants, tax incentives, and health care provider loan repayment assistance to reduce disparities, including by race and gender, and improve health equity. Funding for the Communities, as well as programs to address substance use and mental health disorders, would come from a one penny per dollar increase in the state alcohol beverage sales tax starting in 2021. Unlike the Health Enterprise Zones pilot which ended after 5 years, money raised by the alcohol tax for the Health Equity Resource Communities would go directly into a dedicated fund for the program to help ensure longevity. This funding would also help create new mental health and substance use disorder programs. In addition to generating much needed funds, the tax itself will save lives and lower health care costs by reducing underage drinking, binge drinking, driving under the influence, and sexually transmitted infections, just like what happened after the last alcohol sales tax increase in 2011. Binge drinking comes with health risks and binge drinking rates are currently rising faster for women than men.

For these reasons, MLAW strongly urges the passage of SB172.

Maryland Legislative Agenda for Women
305 W. Chesapeake Avenue, Suite 201 ▪ Towson, MD 21204 ▪ 443-519-1005 phone/fax
mdlegagenda4women@yahoo.com ▪ www.mdlegagendaforwomen.org

GHHI Written Testimony - SB172.pdf
Uploaded by: Norton, Ruth Ann
Position: FAV

Green & Healthy Homes Initiative®

2714 Hudson Street
Baltimore, MD 21224-4716
P: 410-534-6447
F: 410-534-6475
www.ghhi.org

January 25, 2021

Guy Guzzone, Chair
Senate Budget and Taxation Committee
Miller Senate Office Building, 3 West Wing
11 Bladen Street
Annapolis, Maryland 21401

Re: **SB172 – Maryland Health Equity Resource Act - SUPPORT**

Dear Chairman Guzzone and Members of the Committee:

The Green & Healthy Homes Initiative (GHHI) is dedicated to addressing the social determinants of health and the advancement of racial and health equity through the creation of healthy, safe and energy efficient homes. By delivering a standard of excellence in our work, GHHI aims to eradicate the negative health impacts of unhealthy housing and unjust policies for children, seniors, and families to ensure better health, economic and social outcomes with an emphasis on black and brown low-income communities. GHHI achieves healthy homes through the alignment of resources to eliminate health hazards and upgrade houses with improved energy efficiency measures. Housing quality and conditions significantly impact occupant health and well-being for vulnerable children and senior populations. Low-income communities and communities of color contain substandard housing with environmental health hazards that contribute to widespread health, economic and social inequities. We are writing in **SUPPORT of SB172** which will be critical in advancing health equity for Marylanders through the promotion of healthy and safe housing through preventive services.

Problem That Needs to be Addressed

Achieving health equity in Maryland will require addressing the social determinants of health, of which housing is a key component. Asthma and lead poisoning are housing related health conditions that have strong equity implications.

Asthma

The burden of asthma, a chronic disease, is a growing problem that greatly contributes to social inequalities in health outcomes and health disparities, which are neither inevitable nor irremediable, especially for children and minorities in Maryland. Determinants of health related to air quality and indoor environments are known to be significant contributing causes of asthma morbidity and exacerbations and disproportionately burden populations, especially children and minorities. Poor outdoor and indoor air quality and housing conditions such as mold, pests, and other allergens contribute to asthma episodes for Maryland residents. 25 million Americans have asthma and it has been shown to be the cause of the biggest loss in productivity through school and work absenteeism. Nationally, over 14.4 million school days and 14.2 million work days are missed due to asthma episodes.

Over 500,000 adults in Maryland have been diagnosed with asthma. Maryland spends $42.1 million annually for asthma related hospitalizations and $93.3 million for asthma related emergency department visits. Research has shown that race, ethnicity and income are also common risk factors in asthma diagnoses. Asthma-related health disparities have disproportionally affected African American residents in Maryland, specifically children. Data available from the Maryland Asthma and Surveillance Report demonstrates that African American asthmatics in Maryland visit the emergency room for asthma 5 times more often than White asthmatics and are hospitalized 2.5 times more often than White asthmatics in Maryland.

Lead Poisoning

In 2019, there were 1,526 children with elevated blood levels (EBLs) of 5 μg/dl or higher in Maryland. Lead poisoning from lead in paint, lead in water and contaminated soil contributes to significant brain damage, learning disabilities, speech development problems, attention deficit disorder, and poor school performance. Lead poisoning is irreversible and has a significant impact on societal costs including thousands of school age children. Millions of dollars are spent on special education and juvenile justice costs in Maryland to combat the effects of lead poisoning, and thousands of children enter our public-school systems, disproportionately in black and brown communities, with impediments to their development, unable to achieve academically at the rate of their classmates.

Lead poisoning directly contributes to the cycle of learning disabilities, poor school performance, steep school dropout rates and juvenile delinquency that prevent low income children in particular from being able to thrive and which burdens the State through increased special education and criminal justice costs. Lead poisoning has a disparate impact on minority, low income communities in Maryland and in children's ability to reach their full potential. Children poisoned by lead are 7 times more likely to drop out of school and 6 times more likely to end up in the criminal justice system than the population as a whole. A child poisoned by lead has decreased lifetime earnings of $1,086,645 per child.

Energy Insecurity and Energy Burden

As the Committee and legislature look longer term to address the social determinants of health, the role of energy insecurity and energy burden in health outcomes should be considered. Low-income communities and communities of color experience higher levels of energy insecurity. Energy insecurity refers to the inability of households to meet their basic energy needs and can include the inability to afford energy bills or the inability to sufficient heat or cool the home because of physical deficiencies. In 2015, the U.S. Energy Information Administration found that over 37 million Americans were energy insecure. Of that number, over 22 million households were low-income and over 20 million were Black or African American. Energy insecurity is related to the substandard housing conditions as deteriorated housing often include energy-related issues such as poor indoor air quality, poor insulation, air leaks and drafts, inefficient and poorly maintained heating, cooling and ventilation (HVAC) systems, and outdated lighting and

appliances from poorly weatherization homes.

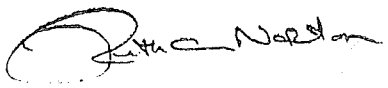
Energy burden refers to the percentage of household income that is spent on energy/utility services. A recent 2020 study by the American Council for an Energy Efficient Economy (ACEEE) found that over 25 million low-income households, including over 10 million African American or Hispanic households, across the U.S. experience a high energy burden (over 6% of income is spent on energy/utilities). The study found that Baltimore's low-income population experienced the second highest median energy burden (10.5%) of all low-income populations within the top 25 most populated metro areas in the country. Energy insecurity and high energy burdens often overlap other health and social issues such as food insecurity, high housing cost burdens, and inadequate access to healthcare in the same communities. The study found that low-income households and households of color are disproportionately subject to trade-offs such as foregoing food and medicine to pay for energy and utilities.

The Case for Investing in Prevention Resources

Providing for prevention resources through SB172 can produce significant impact for Maryland's children in improved health and education outcomes and result multiple cost savings for the state. Every dollar invested in lead hazard remediation prevention in homes results in health, educational, and other savings of at least $17-$221 in return. Every dollar invested in prevention asthma programs and interventions results in savings of $5.30-$14 in return. Every dollar invested in residential energy efficiency and weatherization, which are interventions that simultaneously improve housing quality and upgrade energy infrastructure, return $1.72 in energy benefits and an additional $2.78 in health and other societal benefits.

SB172 establishes the Health Equity Resource Community Advisory Committee to give greater voice to health equity and creates a vehicle to better direct new and existing resources by establishing Health Equity Resource Communities in which critical state resources will be targeted to 1) reduce health disparities, 2) improve health outcomes, 3) improve access to care, 4) promote primary and secondary prevention services and 5) reduce healthcare costs and hospital admissions/readmissions. The creation of a Health Equity Resource Community Reserve Fund to support Health Equity Resource Communities through grants or tax credits will produce groundbreaking investments to address health disparities. SB172 will enable communities disproportionately impacted by conditions like asthma, lead poisoning and household injury to access much-needed resources to address the root causes, including housing and other social determinants of health to improve health and racial equity. We ask you to **SUPPORT SB172.**

Respectfully Yours,



Ruth Ann Norton
President and CEO

Maryland Health Equity Resource Act.pdf
Uploaded by: O'Connor, Monica
Position: FAV

Maryland Health Equity Resource Act – HB 463/SB 172

Favorable

January 25, 2021

Dear Members of the Committee,

We support creating and funding Health Equity Resource Communities in Maryland. Health inequities based on race, ethnicity, disability, and place of residence persist throughout the state and have been further exposed by the COVID-19 pandemic. In response, we are proud to join Maryland Citizens' Health Initiative and a coalition of over 260 organizations across the state advocating for the creation of these communities which are to be funded by a proposed one penny per dollar alcohol sales tax increase.

Favorable of HB463/SB172

Monica O'Connor

WISE

SB0172_Support__Attorney General.pdf
Uploaded by: O'Connor, Patricia
Position: FAV

BRIAN E. FROSH
Attorney General

ELIZABETH F. HARRIS
Chief Deputy Attorney General

CAROLYN QUATTROCKI
Deputy Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

FACSIMILE NO.
(410) 576-6571

WRITER'S DIRECT DIAL NO.
(410) 576-6515

January 27, 2021

To: The Honorable Guy Guzzone
Chair, Budget and Taxation Committee

From: The Office of the Attorney General

Re: Senate Bill 172 (Maryland Health Equity Resource Act): Support

The Office of the Attorney General (the Office) supports Senate Bill 172 which would create Health Equity Resource Communities (HERC) and implement a program to reduce health disparities, health care costs, hospital admissions and hospital readmissions while improving health outcomes, access to primary care, and promoting preventive services. As detailed in the Attorney General's COVID-19 Access to Justice Task Force report, the COVID–19 crisis has highlighted that black and brown Marylanders have fared worse than others during the pandemic. Black residents in Maryland make up 31 percent of the population but account for nearly 40 percent of COVID-19 deaths; Hispanics account for 11 percent of the population but 19 percent of COVID-19. The bill would help to eliminate health outcome disparities for the duration of the pandemic and beyond.

The bill would build on the progress spearheaded by the Health Enterprise Zone Initiative, a previous program that was in effect from 2013 through 2017. According to an October 2018 study, the previous program's goal was "to improve access to health care and health outcomes in underserved communities and reduce health care costs and avoidable hospital admissions and readmissions. … [T]he initiative was associated with a reduction of 18,562 inpatient stays and an increase of 40,488 emergency department visits in the period 2013–16. The net cost savings from reduced inpatient stays far outweighed the initiative's cost to the state."
https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.0642

The bill also would address the challenges of attracting primary care providers to work in underserved communities. The bill would provide PCPs financial incentives such as state income tax credits, loan repayment assistance, practice equipment and capital improvement grants. Funding for these incentives would result from the bill's proposed increase to the alcohol tax from 9% to 10%, effective October 1, 2021 for off-sales retailers and October 1, 2023 for on-sales retailers which include restaurants, bars, and carry-out beverages. From there, 10% of the alcohol tax revenues would be credited to the HERC Reserve Fund created by the bill.

Health outcome disparities will not be eliminated unless we take meaningful action, as the Attorney General observed in the COVID-19 Access to Justice Task Force's report:

> COVID-19 did not create the systemic failings and inequities of our social safety net and civil justice system. Those most vulnerable to any setback have disproportionately experienced the effects of these deficiencies for generations. Yet the pandemic exacerbated and brought to light with painful clarity these deficiencies and the suffering that they cause. We must, therefore, seize this unprecedented chance and collectively work together to fix them. As much suffering and loss as this public health crisis has wrought, let us not compound that tragedy by failing to ensure that it paves the way to progress.

We urge the Committee to give Senate Bill 172 a favorable report.

cc: Sponsor

MRHA SB172 - Maryland Health Equity Resource Act.p
Uploaded by: Orosz, Samantha
Position: FAV

Statement of Maryland Rural Health Association

To the Budget and Taxation Committee

January 27, 2021

Senate Bill 172 Maryland Health Equity Resource Act

POSITION: SUPPORT

Chair Guzzone, Vice Chair Rosapepe, Senator Hayes, and members of the Budget and Taxation Committee, the Maryland Rural Health Association (MRHA) is in SUPPORT of Senate Bill 172 Maryland Health Equity Resource Act.

MRHA supports this legislation that establishes Health Equity Resource Communities (HERC) to reduce health disparities, improve health outcomes, improve access to primary care, promote primary and secondary prevention services, and reduce health care costs and hospital admissions and readmissions. In the establishment of HERC, MRHA also recommends that there be adequate rural representation on the Advisory Committee. In addition to MRHA and its rural members, the Maryland Community Health Resources Committee is well established across the rural health community and would also be a useful Advisory Committee member. MRHA believes this representation on the governing body is a key action in maintaining and expanding quality and equitable health care for rural Marylanders and underserved populations.

MRHA's mission is to educate and advocate for the optimal health and wellness of rural communities and their residents. Membership is comprised of health departments, hospitals, community health centers, health professionals, and community members in rural Maryland.

Rural Maryland represents almost 80 percent of Maryland's land area and 25% of its population. Of Maryland's 24 counties, 18 are considered rural by the state, and with a population of over 1.6 million they differ greatly from the urban areas in the state.

Maryland law states that "many rural communities in the State face a host of difficult challenges relating to persistent unemployment, poverty, changing technological and economic conditions, an aging population and an out-migration of youth, inadequate access to quality housing, health care and other services, and deteriorating or inadequate transportation, communications, sanitations, and economic development infrastructure." (West's Annotated Code of Maryland, State Finance and Procurement § 2-207.8b)

MHRA believes this legislation is important to support our rural communities and we thank you for your consideration.

Lara Wilson, Executive Director, larawilson@mdruralhealth.org, 410-693-6988

SB 172 SUPP Healthcare Resource Equity Act 1.27.21

Uploaded by: Owusu-Acheaw, Pokuaa

Position: FAV

MARYLAND STATE EDUCATION ASSOCIATION

140 Main Street
Annapolis, MD 21401
800 448 6782
410 263 6600

marylandeducators.org

Testimony in Support of Senate Bill 172
Maryland Health Equity Resource Act

Senate Budget & Taxation
January 27, 2021
1:00 PM

Pokuaa Owusu-Acheaw
Government Relations

The Maryland State Education Association supports Senate Bill 172 which establishes Health Equity Resource Communities in a targeted attempt to reduce health disparities, improve health outcomes, improve access to primary care, promote primary and secondary prevention services, and reduce health care costs and hospital admissions and readmissions, throughout the state.

MSEA represents 75,000 educators and school employees who work in Maryland's public schools, teaching and preparing our 896,837 students for careers and jobs of the future. MSEA also represents 39 local affiliates in every county across the state of Maryland, and our parent affiliate is the 3 million-member National Education Association (NEA).

MSEA supports the belief that all Marylanders deserve access to high-quality, affordable health care. Unfortunately, there are health inequities in our state that many individuals face based on their race, ethnicity, disability, or their zip code. The COVID-19 pandemic has further exposed these health inequities and highlighted the need to address comorbidities and otherwise improve health outcomes in our state. This initiative builds upon a 2012-2016 pilot that successfully increased access to health resources, improved residents' health, reduced hospital admissions, and created cost savings. With a continued and guaranteed funding source, this act will further positive impacts of the original pilot program to increase improved and cost-saving healthcare, and provide holistic approaches to making our communities safer and healthier places for all to thrive.

MSEA requests a favorable report on Senate Bill 172.

SB172 - Health Equity.pdf
Uploaded by: Peterson, Matt
Position: FAV

BALTIMORE JEWISH COUNCIL

WRITTEN TESTIMONY

Senate Bill 172 Maryland Health Equity Resource Act

Budget and Tax Committee
Finance Committee

January 27, 2021

SUPPORT

Background: Senate Bill 172 (SB172) would establish Health Equity Resource Communities as designated by the Department of Health. This program would incentivize healthcare and other service providers with tax credits and grants, to build a presence in communities most in need. Community based nonprofit organizations including hospitals and universities, may apply on behalf of their service areas to receive this designation, after thorough state vetting. This program would build off of a similar pilot program from 2012-16, which created five zones throughout urban, suburban, and rural Maryland. This program would be funded by a temporary two-year increase of 1 percent in the State alcohol sales tax.

Written Comments: The COVID-19 pandemic has highlighted healthcare disparities like never before. It is no coincidence that certain communities have been disproportionately ravaged by the Coronavirus. This is the result of generations of systemic neglect and lack of adequate healthcare. Maryland has some of the greatest, and most advanced healthcare in the world, yet too many Marylanders are excluded from accessing it because of their address. SB 172 offers us an opportunity to begin addressing this generational and societal neglect, and build a better healthcare system for all Marylanders.

Since the start of the pandemic the 21215 zip code in Northwest Baltimore City has consistently been considered a COVID-19 hotspot. Whereas mere miles away in Baltimore County, case counts have remained stable. As a member organization of the One Park Heights initiative, we work with our partners in the area to help deconstruct disparities like these, and to bring resources into the community that do not currently exist there. Park Heights is the exact type of community that stands to significantly benefit from the Maryland Health Equity Resource Act. With this in mind, the Baltimore Jewish Council respectfully urges a favorable report of SB172.

The Baltimore Jewish Council, a coalition of central Maryland Jewish organizations and congregations, advocates at all levels of government, on a variety of social welfare, economic and religious concerns, to protect and promote the interests of The Associated Jewish Community Federation of Baltimore, its agencies and the Greater Baltimore Jewish community.

BALTIMORE JEWISH COUNCIL
5750 Park Heights Avenue, Suite 329 • Baltimore, Maryland 21215
410-542-4850 • fax 410-542-4834 • baltjc.org
Member of the Jewish Council for Public Affairs

SB 172 - Maryland Health Equity Resource Act - Med

Uploaded by: Purnell, Vanessa

Position: FAV

I. Vanessa Purnell
Assistant VP, Government Affairs
9 State Circle, Suite 303
Annapolis MD 21401
443-604-5393 CELL

SB 172 – Maryland Health Equity Resource Act

Position: *Support*

Bill Summary

SB 172 establishes a Health Equity Resource Community Advisory Committee. It establishes procedures for applying to become designated as a Health Equity Resource Community and it establishes a Health Equity Resource Community Reserve Fund.

Bill Rationale

MedStar Health is committed to advocating on behalf of patients, for a better health care system, and on behalf of providers, to help them provide the best care possible. MedStar Health acknowledges that racial inequities create impediments to reaching those ends. Although we have advocated to eliminate injustice and inequity in health care, the COVID-19 pandemic has brought further, and deeper, issues to light that simply cannot be allowed to persist any longer.

Across Maryland, gaps in health are large, persistent, and increasing—many of them caused by barriers set up at all levels of our society. It's hard to be healthy without access to good jobs and schools and, safe, affordable homes. Health equity means increasing opportunities for everyone to live the healthiest life possible, no matter who they are, where they live, or how much money they make.

We support funding the Health Equity Resource Communities through a one cent per dollar increase in the state alcohol beverage sales tax. Raising the state's alcohol beverage sales tax in 2021 will generate necessary funds to create and provide continuous funding to the Health Equity Resource Communities and create more community-based prevention, treatment, and recovery support programs to address substance use and mental health disorders.

It is imperative that we work together to help eliminate the significant social, cultural, physical, and economic barriers that continue to impede communities of color and others from obtaining quality care. The provisions of the Maryland Health Equity Resources Act builds on the progress of the Affordable Care Act by providing additional investments to create a sustainable, cost-effective health care system that is rooted in fairness, justice, and equal opportunity.

We thank you for your steadfast commitment to achieving health equity for all.

For the reasons above, we ask that you give SB 172 a ***favorable*** report.

SB0172 Maryland Health Equity Resource Act_MHAMD S
Uploaded by: Quinlan, Margo
Position: FAV

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

Heaver Plaza
1301 York Road, #505
Lutherville, MD 21093
phone 443.901.1550
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www.mhamd.org

Senate Bill 172 Maryland Health Equity Resource Act
Senate Budget and Taxation Committee
January 27, 2021
Position: Support

The Mental Health Association of Maryland is the state's only volunteer, nonprofit citizen's organization that brings together consumers, families, professionals, advocates and concerned citizens for unified action in all aspects of mental health and mental illness. We appreciate this opportunity to submit testimony in support of Senate Bill 172.

SB 172 seeks to require the Secretary of Health to designate Health Equity Resource Communities, and to be guided by a Health Equity Resource Community Advisory Committee. This is building off the successful work of the Maryland Health Improvement and Disparities Reduction Act of 2012, establishing Health Enterprise Zones which have since been shown as a strong return on investment for the state.

This legislation would also establish a Health Equity Resource Community Reserve Fund, which would provide much needed funding to, "behavioral health programs that provide prevention, recovery support, and harm reduction services for individuals with substance use and mental health disorders," with the stated intent to, "facilitate reduction of health disparities, improve health outcomes, provide drug treatment and rehabilitation, and reduce health costs and hospital admissions and readmissions in specific areas of the state."

By taking an equity-centered approach to addressing regional healthcare, this bill can move us forward in the undoing of centuries of historical harms inflicted upon communities across our state. The impacts of racial discrimination, redlining and segregation, of historical and contemporary traumas all contribute to the fatally discordant health outcomes which play out in our healthcare system here in Maryland. The impacts of racism on mental and behavioral health has been likened to Adverse Childhood Experiences (ACEs)[1], and has been shown to have lasting impacts on individuals well into older adulthood. This presents itself in over-diagnosing and mis-diagnosing of mental illnesses,[2] of increased likelihood that Black youth end up in detention

[1] Lanier, P. "Racism is an Adverse Childhood Experience (ACE)." 2020, The Jordan Institute for Families. https://jordaninstituteforfamilies.org/2020/racism-is-an-adverse-childhood-experience-ace/
[2] Perzichilli, T. "The historical roots of racial disparities in the mental health system." 2020, Counseling Today. https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/

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instead of treatment,[3] and in Black adults being 20% more likely to report serious psychological distress than white adults.[4]

The Covid-19 pandemic is further exacerbating these issues. Existing health inequities have set the stage for the pandemic to impact Black communities at rates of 2 to 5 times those of their white counterparts. The impacts of job loss, housing insecurity and homelessness, and community loss of life due to Covid-19 may all contribute to increased risk of depression, anxiety, substance use and misuse, and suicidality.[5] We are yet to know the full impact of this pandemic, but SB 172 presents an opportunity to act with strategic intention to begin addressing these life threatening inequities.

The Mental Health Association of Maryland supports the goals and intents of this bill and urges a favorable report on Senate Bill 172.

[3] American Psychiatric Association. "Mental Health Disparities: Diverse Populations." 2017, https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts

[4] U.S. Department of Health and Human Services, Office of Minority Health. "Mental and Behavioral Health - African Americans." 2019. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4

[5] Gibbs, T., Pauselli, L., Rosenfield, P., Solan, M., Vieux, U. "Mental Health Disparities Among Black Americans During the COVID-19 Pandemic." Psychiatric Times, October, 2020. https://www.psychiatrictimes.com/view/mental-health-disparities-among-black-americans-during-covid-19-pandemic

SB0172_FAV_MedChi_MD Health Equity Resource Act.pd
Uploaded by: Ransom, Gene
Position: FAV

MedChi

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TO: The Honorable Guy Guzzone, Chair
Members, Senate Budget and Taxation Committee
The Honorable Antonio Hayes

FROM: Gene M. Ransom, Chief Executive Officer

DATE: January 27, 2021

RE: **SUPPORT** – Senate Bill 172 – *Maryland Health Equity Resource Act*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports** Senate Bill 172. Senate Bill 172 proposes the establishment of Health Equity Communities, an approach analogous to the Health Enterprise Zones initiative enacted in 2012 (*see House Bill 439: Maryland Health Improvement and Disparities Reduction Act of 2012*) to address Maryland's continuing struggle to eliminate racial and ethnic health disparities in many communities across the State.

Health disparities by their very nature are reflective of the deficiencies in access, delivery system responsiveness, and health outcomes specific to a given community. To appropriately address and eliminate those disparities it is essential that the solution be community specific and incorporate the collective involvement of community stakeholders – local health officials, community advocacy interests, and health care providers.

A critical component of Senate Bill 172 are the tax credits created for physicians, other health care providers and organizations located in areas designated as health equity communities. The provision of tax credits reflects a recognition that lack of adequate access to care is a critical factor in the incidence of health disparities. It has been well documented that Maryland faces significant physician shortages across the State. Those shortages are especially notable in medically underserved areas. Recruitment and retention of physicians to areas demonstrating high incidence of health disparities is essential to succeeding in their elimination. To that end, Senate Bill 172 moves the State in the appropriate direction.

Maryland can no longer afford to tolerate the inequity in health care access and health outcomes that are evident in communities across the State. MedChi looks forward to working collaboratively with the General Assembly and relevant stakeholders to enact an effective framework for addressing inequity and health disparities in Maryland.

Testimony for Senate T and B Comm SB 172 Health Eq

Uploaded by: Raznick, Josh

Position: FAV

My name is David Glenn and I live in Silver Spring, in District 19. As a registered nurse, I see every day that patients' ability to maintain good health is heavily shaped by where they live. Entrenched patterns of racial and economic injustice mean that some Marylanders have far more exposure than others to environmental hazards that can cause asthma or cancer. Entrenched patterns of racial and economic injustice mean that some Marylanders have far easier access than others to cancer screening, HIV treatment, and other crucial elements of health care.

That's why I urge every member of the Assembly to support HB463/SB172, which would provide new health resources for the Maryland communities that need them most.

The bill would establish Health Equity Resource Communities, which would provide grants and incentives for health providers to offer new kinds of care in neighborhoods with some of the state's worst health outcomes. These new resources should reduce barriers to care and reduce visits to hospitals' emergency departments, potentially bringing down costs for the health system as a whole.

In my work as a nurse and in my volunteer activism with Progressive Maryland, I'm often astonished by the severity of place-based health disparities in our state. The Baltimore City Health Department estimated in 2017 that life expectancy at birth in the city's most affluent neighborhoods is as high as 84 -- but in the city's most resource-deprived neighborhoods, it's as low as 66.9. In Prince George's County, a 2019 report found that 69.3 percent of white, non-Hispanic expectant mothers received adequate prenatal care, but that only 53.3 percent of Hispanic mothers received

adequate prenatal care. Meanwhile, we have all seen the stark patterns of place-based disparities in COVID-19 cases and deaths over the last year. Two of the hardest hit zip codes, 20902 and 20906, are near my home in Silver Spring.

The financing mechanism for HB463/SB172 -- a 1 percent tax on alcohol sales -- seems like an excellent tool for the job. The experience of other states suggests that higher taxes will at least modestly reduce alcohol consumption. As an oncology nurse, I know that alcohol is an underappreciated risk factor for several types of cancer. Just last week, the American Cancer Society released a report estimating that 4.6 percent of Maryland's cancer cases among adults older than 30 during the period 2013-2016 could be attributed to alcohol consumption.

During the last year, Marylanders have been through a severe public health crisis and a severe economic crisis. I'm sure those crises are weighing on the minds of every member of the Assembly. I urge you all to support HB463/SB172, which would help move Maryland toward better health and a stronger, fairer society.

CareFirst Testimony in Support of SB 172.pdf
Uploaded by: Rivkin, Deborah
Position: FAV

Deborah Rivkin
Vice President
Government Affairs – Maryland

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SB 172 – Maryland Health Equity Resource Act

Position: Support

Thank you for the opportunity to provide written comments in support of Senate Bill 172. This bill establishes Health Equity Resource Communities (HERCs) to target resources to specific areas of the state to reduce health disparities, improve health outcomes, improve access to primary care, and reduce health care costs and hospital admissions and readmissions. A community-based organization, nonprofit hospital, institution of higher education, or a local government agency may apply to the Secretary on behalf of an area to receive the HERC designation. The bill also establishes an Advisory Committee to evaluate, assess, assist, and implement the HERC program.

CareFirst is committed to driving the transformation of the healthcare experience with and for all our members and communities, with a focus on quality, equity, affordability, and access to care. We support establishing HERC designated areas in communities with significant health disparities and health outcomes. We have seen deep health disparities that have been exacerbated by the COVID-19 pandemic and the disproportionate burden racial and ethnic minority populations bear as a result of longstanding structural racism. As these inequities continue to profoundly impact our members and communities, CareFirst believes that Senate Bill 172 can meaningfully advance health equity by providing much needed resources and support to improve access to care and health outcomes, while reducing costs of care for traditionally underserved communities.

The concept of HERCs is modeled after the Health Enterprise Zones (HEZ) initiative that Maryland implemented between 2013-2016, which successfully improved access to care, changed health behaviors such as exercising and diet monitoring, reduced 18,562 inpatient stays, and resulted in significant net cost savings of $93.4 million for Maryland's healthcare system. Through collaborations between local health departments, hospitals, and community-based organizations, we believe that HERCs can build on the HEZ initiative's experience and best practices to transform health care for the better for Marylanders in need.

We respectfully request the addition of three additional members to the HERC Advisory Committee, to be appointed by either the Speaker of the House or the Senate President: one representative of a nonprofit group model health maintenance organization; one representative of a nonprofit health service plan; and one representative of a managed care organization. Including payer perspectives in discussions of health equity solutions will provide meaningful and substantive insight to the critical work of the HERC Advisory Committee.

CareFirst strongly supports the policy goals advanced by Senate Bill 172. We look forward to partnering with legislators, health departments, public health groups, and other stakeholders to advance health equity, as we deploy targeted strategies through our own organization to ensure the health and wellbeing of our members, provider partners, employees, and communities.

We urge a favorable report.

About CareFirst BlueCross BlueShield

In its 83rd year of service, CareFirst, an independent licensee of the Blue Cross and Blue Shield Association, is a not-for-profit healthcare company which, through its affiliates and subsidiaries, offers a comprehensive portfolio of health insurance products and administrative services to 3.4 million individuals and employers in Maryland, the District of Columbia and Northern Virginia. In 2019, CareFirst invested $43 million to improve overall health, and increase the accessibility, affordability, safety and quality of healthcare throughout its market areas. To learn more about CareFirst BlueCross BlueShield, visit our website at www.carefirst.com and our transforming healthcare page at www.carefirst.com/transformation, or follow us on Facebook, Twitter, LinkedIn or Instagram.

NCADD-MD - SB 172 FAV - Health Equity Resources Ac
Uploaded by: Rosen-Cohen, Nancy
Position: FAV

Senate Budget & Taxation Committee
January 27, 2021

Senate Bill 172
Maryland Health Equity Resource Act
Support

NCADD-Maryland supports Senate Bill 172 – Maryland Health Equity Resource Act. This legislation proposes to create and fund Health Equity Resource Communities to help reduce health disparities throughout Maryland. The Communities will provide grants, tax incentives, and health care provider loan repayment assistance to areas in the state with poor health outcomes that contribute to health inequities.

The manifestation of health disparities is seen in all areas of health care, including with regard to opioid overdoses. Attached to this testimony is an infographic from Maryland's Opioid Operational Command Center from this past summer with new data showing that the number of Black Marylanders dying of overdoses is sadly catching up with White Marylanders. Also attached are data showing the impact of the social determinants of health on communities of color.

NCADD-Maryland also supports the funding mechanism proposed in this legislation. A one cent per dollar increase in the state alcohol beverage sales tax would be used to support these Health Equity Resource Communities as well as community-based prevention, treatment, and recovery support programs to address substance use and mental health disorders. The last time the alcohol tax was passed – 10 years ago – the benefits included reductions in underage drinking, binge drinking, driving under the influence, and sexually transmitted infections.

Senate Bill 172 proposes a modest tax increase on the one area of our economy that has not suffered during the COVID-19 pandemic. Alcohol retail outlets have seen spikes in sales, which in and of itself is concerning when it comes to the damage that over-consumption of alcohol can create. This bill will help Maryland's overall public health in several ways and we urge a favorable report.

The Maryland Affiliate of the National Council on Alcoholism and Drug Dependence (NCADD-Maryland) is a statewide organization that works to influence public and private policies on addiction, treatment, and recovery, reduce the stigma associated with the disease, and improve the understanding of addictions and the recovery process. We advocate for and with individuals and families who are affected by alcoholism and drug addiction.

National Council on Alcoholism & Drug Dependence – Maryland Chapter
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SB 172_MDCEP_FAV.pdf
Uploaded by: Schumitz, Kali
Position: FAV

MDCEP
MARYLAND CENTER ON ECONOMIC POLICY

JANUARY 27, 2021

Funding Health Equity Resource Communities is the Right Choice for Maryland

Position Statement Supporting Senate Bill 172

Given before the Budget and Taxation Committee

All Marylanders deserve access to high-quality, affordable health care. Health inequities based on race, ethnicity, disability and place of residence persist throughout the state, as shown in maternal and infant mortality rates and other measures. In underserved areas of the state, people with chronic conditions such as hypertension, heart disease, asthma, diabetes, and substance and mental health disorders have worse health outcomes and are less able to get the care and treatment they need. **The Maryland Center on Economic Policy supports Senate Bill 172 because there shouldn't be a 20 year gap in life expectancy depending on where you live in Maryland.**

Health Equity Resource Communities would provide additional resources to underserved communities around the state. Service providers in those communities could compete for grants and other financial incentives to address poor health outcomes that result from inequitable access to care by race, ethnicity, disability, and geographic location. This initiative is based on a 2012-2016 pilot program that successfully increased access to health resources, improved residents' health and reduced hospital admissions. Supporting improved health and reducing preventable hospital admissions will result in lower overall health care costs, including lower insurance premiums for everyone.

A slight increase in the state's alcoholic beverage sales tax will generate necessary funds to pay for this initiative. Increased alcohol taxes are also linked to a reduction in drinking, including by underage Marylanders and heavy drinkers, which in turn will save lives and reduce health care costs. Maryland has not raised its alcoholic beverage sales tax since 2011 and its rate has fallen behind that of Washington, D.C. A recent report found that the 2011 alcohol beverage sales tax increase contributed to reductions in underage drinking, binge drinking, driving under the influence, and sexually transmitted infections[i].

While Maryland is a leader in many health and public health initiatives, we still have longstanding inequities and disparities ingrained in our system. Additional barriers to accessing health care and meeting other basic needs mean that Marylanders of color, on average, experience reduced life expectancy, educational attainment, home ownership compared to white Marylanders. The COVID-19 pandemic has further exposed these health inequities and highlighted the need to address them and otherwise improve health outcomes in our state. **For these reasons, the Maryland Center on Economic Policy respectfully requests the Budget and Taxation Committee to make a favorable report on Senate Bill 172.**

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Equity Impact Analysis: Senate Bill 172

Bill Summary

Senate Bill 172 will established Health Equity Resource communities around the state that compete for grants and other financial incentives to address poor health outcomes that result from inequities by race, ethnicity, disability, and geographic location. The initiative would be funded by increasing the alcoholic beverage tax by one penny per dollar.

Background

This initiative is based on a 2012-2016 pilot that successfully increased access to health resources, improved residents' health, reduced hospital admissions, and created cost savings. Maryland has not raised its alcoholic beverage sales tax since 2011 and its rate has fallen behind that of Washington D.C. The 2011 alcoholic beverage sales tax increase led to significant reductions in underage drinking, binge drinking, driving under the influence, and sexually transmitted infections. Supporting health and reducing preventable hospital admissions will result in lower overall health care costs, including lower insurance premiums for everyone.

Equity Implications

Senate Bill 172 would bring significant equity benefits to disadvantage communities in Maryland such as;

- Reducing health disparities
- Improving health outcomes
- Improving access to primary care
- Promoting primary and secondary prevention services
- Reducing health care costs and hospital admissions

Impact

If passed, the bill would have a significant impact with reducing health disparities that are closely linked with social, economic, and environment disadvantages that adversely affects Marylanders who systematically experience greater obstacles to health care. **Senate Bill 172 would like improve racial, ethnic, and economic equity in Maryland.**

[i] The Abell Foundation (2018) Public Health Policy in Maryland: Lessons from Recent Alcohol and Cigarette Tax Policies https://abell.org/sites/default/files/files/Abell%20Public%20Health%20Report%20022718.pdf

BCA_FAV_SB172.pdf
Uploaded by: Scott, Brandon
Position: FAV

BRANDON M. SCOTT
MAYOR

Office of Government Relations
88 State Circle
Annapolis, Maryland 21401

SB 172

January 27, 2021

TO: Members of the Budget and Taxation Committee

FROM: Natasha Mehu, Director of Government Relations

RE: SENATE BILL 172 – MARYLAND HEALTH EQUITY RESOURCE ACT

POSITION: SUPPORT

Chair Guzzone, Vice Chair Rosapepe, and Members of the Committee, please be advised that the Baltimore City Administration (BCA) **supports** Senate Bill (SB) 172.

SB 172 would require the Maryland Department of Health Secretary to designate certain areas of the State as Health Equity Resource Communities to target state resources, including revenue from state alcohol taxes, to specific areas of the State for the purposes of reducing health disparities and improving overall health outcomes.

The BCA is genuinely concerned with public health disparities across Baltimore City's incredibly diverse population. The COVID-19 pandemic has further exposed the influence of social, economic, and environmental conditions on health outcomes for our City's populations. The pandemic has widened economic and health disparities, with Hispanic/Latino communities, African-American communities, and older adults disproportionately impacted by COVID-19. Hispanic/Latino Marylanders make up 10% of the population and account for 21% of COVID-19 cases, while African-Americans make up 29% of the population and account for 38% of deaths from COVID-19 in the State.[1] In Baltimore City, similar patterns are seen:

1. The older adult community, which is the most susceptible to severe and fatal cases of COVID-19; as of 12/16/20, 493 of Baltimore City's 575 confirmed deaths were to residents age 60 and older, with progressively higher case fatality rates for each ten-year group of older residents (age 60-69: 4.0%; age 70-79: 9.2%; age 80-up: 22.3%).

[1] Racial Data Dashboard | The COVID Tracking Project

2. Latinx population, which is experiencing the highest cases-per-1000 rate in the City among identifiable demographic groups, at 99.1.

3. African Americans have suffered about 70% of the Baltimore City COVID-19 fatalities (while comprising about 63% of the population).

In a setting of entrenched health and economic disparities compounded by the COVID-19 pandemic, there is an increased need to provide high-quality, high-touch services to Baltimore City residents who are disproportionately impacted by COVID-19.

Understanding how its population is impacted by disparities in public health, the Baltimore City Health Department (BCHD) has enacted a number of policies and programs to achieve health parity. One model program is the Baltimore City Health Department's Accountable Health Communities (AHC) model. Through AHC, BCHD partners with hospitals to identify and address health-related social needs of Medicare and Medicaid beneficiaries. Close to 2,000 Baltimore City residents a year are screened for social needs and referred to resources through the AHC.

As part of the Accountable Health Community grant, the Baltimore City Health development developed CHARMCare, a resource directory publicly available to any resident in Baltimore. CHARMCare currently has over 250 public and private organizations providing resources for food, housing, utilities, financial strain, mental health, substance use, and employment. Resource information is updated weekly and provides the information residents need to find and access resources that will meet their basic needs. Hundreds of providers, community health workers, and Baltimore residents use CHARMCare every year to find the resource information they need to address their social determinants of health.

Additionally, throughout the COVID-19 pandemic, equitable allocation and administration of vaccine is paramount to ending the pandemic and saving the lives of Baltimore City residents. The Health Department has developed a multi-level strategy for vaccine allocation and administration with a focus on reaching the most vulnerable populations. Said populations may be unable to access the mass vaccination points of dispensing due to social, economic, or medical barriers, which may include limited broadband access, the lack of insurance or a primary care provider, and limited mobility. Vaccine allocation and administration for certain groups should aim to reduce health disparities and not widen or create disparities.

SB 172 could further the BCA's and BCHD's ambitions of achieving health parity across its diverse population in multiple ways. It creates an avenue by which the state and local governments can direct resources to local health-oriented entities to achieve collectively-shared health equity goals. This is in alignment with the Health Department's strategic plan to improve outcomes and inequities across key health indicators through the reconvening of its Local Health Improvement Council (LHIC). The LHIC will, in turn, be charges with promoting the synchronization, collaboration,

and cross-pollination of ideas and programs between community-based partners, health system organization, and the local health department in the development of health equity goals and policies for the City.

We respectfully request a **favorable** report on Senate Bill 172.

Health Enterprise Zone Study.pdf
Uploaded by: Spencer, Michelle
Position: FAV

By Darrell J. Gaskin, Roza Vazin, Rachael McCleary, and Roland J. Thorpe Jr.

DOI: 10.1377/hlthaff.2018.0642
HEALTH AFFAIRS 37,
NO. 10 (2018): 1546–1554

The Maryland Health Enterprise Zone Initiative Reduced Hospital Cost And Utilization In Underserved Communities

Darrell J. Gaskin (dgaskin1@jhu.edu) is the William C. and Nancy F. Richardson Professor in Health Policy in the Department of Health Policy and Management and director of the Hopkins Center for Health Disparities Solutions, both at the Johns Hopkins Bloomberg School of Public Health, in Baltimore, Maryland.

Roza Vazin was a graduate student research assistant in the Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, at the time this research was conducted.

Rachael McCleary is a research data analyst in the Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health.

Roland J. Thorpe Jr. is an associate professor in the Department of Health, Behavior, and Society and deputy director of the Hopkins Center for Health Disparities Solutions, both at the Johns Hopkins Bloomberg School of Public Health.

ABSTRACT **The State of Maryland implemented the Health Enterprise Zone Initiative in 2013 to improve access to health care and health outcomes in underserved communities and reduce health care costs and avoidable hospital admissions and readmissions. In each community the Health Enterprise Zone Initiative was a collaboration between the local health department or hospital and community-based organizations. The initiative was designed to attract primary care providers to underserved communities and support community efforts to improve health behaviors. It deployed community health workers and provided behavioral health care, dental services, health education, and school-based health services. We found that the initiative was associated with a reduction of 18,562 inpatient stays and an increase of 40,488 emergency department visits in the period 2013–16. The net cost savings from reduced inpatient stays far outweighed the initiative's cost to the state. Implementing such initiatives is a viable way to reduce inpatient admissions and reduce health care costs.**

Health disparities continue to be a problem in the United States. Disparities in health outcomes are due in part to inadequate access to medical care and poor health behaviors; they are also associated with social and environmental risk factors.[1–5] Previous studies have shown that multicomponent community-based interventions can be effective in improving access to care and health outcomes.[6,7] The Health Enterprise Zone Initiative is a program created and implemented by the State of Maryland to address health and health care disparities among residents who are members of minority groups or have low socioeconomic status living in medically underserved areas by improving their access to care and providing services that improve their health behaviors.[8] The initiative provided support to coalitions of health departments, other local government agencies, health care providers, and community-based social services organizations in working together to address health care needs in a designated underserved community.

Although there was a great deal of programmatic variation among the Health Enterprise Zones, the primary elements of the initiative included recruiting primary care physicians to underserved areas, recruiting and deploying community health workers, improving care coordination, providing health education and screening, and increasing access to both health services and relevant social services. Each Health Enterprise Zone was configured to meet its community's unique combination of barriers to access to care, health problems faced in the zone, and availability of community-based services.

There is evidence that programs such as the initiative have the potential to improve access to care and health outcomes. The initiative's design is similar to that of the recent Accountable Health Communities Model of the Centers for

Medicare and Medicaid Services (CMS). That model addresses health-related social needs by linking health services providers and the community to improve health outcomes and reduce cost.[9] Like the Health Enterprise Zone Initiative, the goal of Accountable Health Communities was to build capacity within a community to address residents' health-related needs.[10] Another model, Hennepin Health in Minnesota, was a community-based intervention that combined health care and social services. A study found that Hennepin Health shifted care from the hospital to the outpatient care setting and improved the quality of care for people with chronic conditions.[11] In addition, several studies evaluating the impact of community health worker interventions on disease management and health outcomes found that community health worker programs enhanced patients' self-management and improved their quality of life.[12–14] There is also evidence that approaches involving tax incentives, grants, loans, technical assistance, job training, and community serviceshave been effective in addressing health and social issues.[3,7]

Two goals that Maryland policy makers had for the Health Enterprise Zone Initiative were to reduce health care costs and to reduce potentially avoidable hospital admissions and readmissions in the five Health Enterprise Zone communities. This study examined whether the initiative was associated with reductions in hospital use.

Description Of The Initiative

Contiguous geographic communities, defined by ZIP code boundaries, with populations of at least 5,000 people who demonstrated economic disadvantage and poor health outcomes were eligible to apply for the Health Enterprise Zone Initiative.[15] Specifically, a ZIP code was eligible if its Medicaid enrollment rate was above the median for all Maryland ZIP codes or its Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation rate was above the median for all Maryland ZIP codes. Additional eligibility requirements stipulated that the ZIP code have a life expectancy below the state median or percentage of low-birthweight infants above the state median. In October 2012 nineteen Health Enterprise Zone applications were submitted by local health departments, hospitals, or community-based nonprofit organizations from seventeen jurisdictions in Maryland.[16] In January 2013 the Maryland Community Health Resources Commission and the Maryland Department of Health designated five geographic areas as Health Enterprise Zones: Annapolis/Morris Blum, in Anne Arundel County; Capitol Heights, in Prince George's County; Caroline and Dorchester Counties; Greater Lexington Park, in St. Mary's County; and West Baltimore, in Baltimore City.[3] In three of the zones (Annapolis/Morris Blum, Greater Lexington Park, and West Baltimore), hospital systems led the effort, while the other two (Capitol Heights and Caroline and Dorchester Counties) were led by the local health departments. The five zones varied in population density—one urban, two suburban, and two rural.[15]

The state provided each zone with resources and incentives to attract private health care practitioners to medically underserved communities. The lead organization received the funds and subcontracted with partners in its coalition to provide an array of services to residents of the zone, specifically targeting diabetes, cardiovascular disease–related illnesses, asthma, obesity, and behavioral health problems. (See online appendix exhibit S1 for a description of each zone.)[17] The resources and incentives included grant funding from the Community Health Resources Commission, priority for entering Maryland's multipayer Patient Centered Medical Home Program, loan repayment assistance, and tax credits for income and hiring. The zones used these resources to, for example, open new community health centers; operate mobile medical, mental health, and dental care units; deploy community health workers; implement healthy food programs; and offer school-based services. In addition, the initiative encouraged leaders of local health care and social service organizations to work together to address the health needs of residents in their communities.

Study Data And Methods

DATA SOURCES The primary data sources for this study were hospital inpatient stay and emergency department (ED) visit data for 2009–16 from the Maryland Health Services Cost Review Commission and hospital readmissions data for 2012–15 from the Chesapeake Regional Information System for our Patients.[18,19] These data contain a census of inpatient and ED use by Maryland residents in Maryland hospitals. We obtained ZIP code–level Medicaid enrollment data for 2009–16 from the Maryland Medicaid program through the Hilltop Institute at the University of Maryland, Baltimore County. We combined these data with publicly available sociodemographic data from the 2010 US census and from the 2010–14 American Community Survey. We used those five years of survey data to compute reliable estimates of the composition of each ZIP code's population by age, race/ethnicity, poverty status, median household income,

educational attainment, employment status, household composition, and marital status, as well as the occupancy rate of homes in each ZIP code.[20]

OUTCOMES ZIP codes were our primary unit of analysis. There are 458 ZIP codes in Maryland. Health care providers and community-based organizations serving residents in 110 ZIP codes were eligible for Health Enterprise Zone funding (see appendix exhibit S2).[17] We compared adult hospital utilization rates in Health Enterprise Zone–awarded communities located in sixteen ZIP codes with rates in Health Enterprise Zone–eligible communities located in ninety-four ZIP codes. For each ZIP code, we computed the number of inpatient stays, readmissions, and ED visits per 1,000 residents for each study year. We excluded inpatient stays and ED visits with a diagnosis of cancer, trauma, injury, normal delivery, or delivery with complications because the initiative did not target these conditions. We computed utilization rates for subsets of inpatient stays and ED visits for specific conditions as defined by Prevention Quality Indicators and Health Enterprise Zone–related conditions. We used the Agency for Healthcare Research and Quality's Prevention Quality Indicator composite measure, which includes the following conditions: short- and long-term diabetes, perforated appendix, chronic obstructive pulmonary disease (COPD) or asthma in older adults, hypertension, heart failure, dehydration, bacterial pneumonia, urinary tract infection, uncontrolled diabetes, asthma in younger adults, and lower extremity amputation among patients with diabetes.[21] As stated above, Health Enterprise Zone–related conditions are diabetes, cardiovascular disease–related illnesses, asthma, obesity, and behavioral health problems; for this study, we included inpatient stays or ED visits with a primary diagnosis of one of those conditions.

To estimate the economic impact of the initiative, for each ZIP code we calculated charges per 1,000 residents for inpatient stays and ED visit outcomes. This entailed summing the allowable charge amounts for every inpatient stay or ED visit by ZIP code and dividing by the population by 1,000. Because Maryland is an all-payer state, charges measure what insurers (including Medicare and Medicaid) and patients pay for hospital services.

STATISTICAL ANALYSIS We conducted a multivariate difference-in-differences analysis to determine whether implementation of the Health Enterprise Zone Initiative was associated with changes in hospital use.[22] Given that the zones required time to fully implement their programs once they were awarded funds in 2013, we used a dummy variable to indicate that a ZIP code was in a community that had been awarded funds and interacted it with dummy variables for the application year (2012) and each implementation year (2013, 2014, 2015, and 2016). This allows the estimate of the impact of the initiative to vary over time. Preliminary analyses showed that there were no significant differences between the ZIP codes in the pre-implementation period. The interactions for 2010 and 2011 were not significantly different from the interaction with 2009 ($p > 0.10$). We expected the coefficients on the pre-implementation interaction terms to be nonsignificant and those on the implementation interaction terms to be significant. Readmission data were not available for years before 2012. Therefore, for this outcome, 2012 was used as the reference year to compare changes in readmissions during the implementation period of 2013–16.

We estimated these linear regression models using both fixed and random effects. The fixed-effects models included annual Medicaid enrollment in each ZIP code. In the random-effects models, we added ZIP code–level control variables for demographic and socioeconomic characteristics. Hausman tests consistently rejected the null hypothesis that the random-effects models were more efficient. Therefore, we report the results from the fixed-effects models only. (See appendix exhibit S3 for random-effects results.)[17]

We used the coefficients on the zone-year interaction terms from the fixed-effects models to estimate the impact of the initiative on inpatient stays, inpatient charges, ED visits, and ED charges. To calculate the total change in stays, visits, and charges, we multiplied these coefficients by the population in the ZIP codes where Health Enterprise Zone funds had been awarded. We converted the charges to 2016 dollars using the Consumer Price Index for Medical Care. The regression models were weighted by the ZIP code population and estimated using Stata, version 14.

QUALITATIVE INTERVIEWS To provide context for the quantitative findings, we conducted structured interviews with thirty-one residents and twenty-one health care providers (including physicians, nurse practitioners, pharmacists, and care coordinators) and focus groups with eighteen residents from the five Health Enterprise Zones. We asked participants how the initiative had affected access to care and health behaviors for residents of the zones.

SENSITIVITY ANALYSES As a sensitivity analysis, we estimated semi-log models because the outcome variables are skewed. The results were consistent with those of our main analysis. The

coefficients had the same sign but were not significant. However, the linear models had more explanatory power than the semi-log models (see appendix exhibit S4).[17] Finally, we estimated the models using ZIP codes not eligible to participate in the initiative as the comparison group (see appendix exhibit S5).[17]

To test the robustness of our findings, we conducted falsification tests.[23] We explored the impact of the Health Enterprise Zone Initiative on inpatient stays and ED visits for marker conditions that are not sensitive to timely ambulatory care (appendicitis/appendicitis with appendectomy, gastrointestinal obstruction, and fracture of the hip or femur)[24,25] and for pregnancy, childbirth, or the puerperium. By definition, we did not expect the initiative to have an impact on the marker and pregnancy conditions.

LIMITATIONS The study had some limitations. First, the analysis included the hospital use of all residents in the Health Enterprise Zone ZIP codes, including residents who did not actively participate in the initiative. Second, we did not observe hospital use by residents of neighboring jurisdictions.

Third, we did not have data on nonemergency outpatient visits and ambulatory care services. Care may have shifted from relatively costly inpatient settings to less expensive outpatient and ambulatory care settings. Also, the Health Enterprise Zone Initiative may have encouraged new episodes of care, with residents using additional nonemergency outpatient and ambulatory care services. The costs of these services could partially offset associated reductions in charges for inpatient care.

Fourth, we did not control directly for two programs that were implemented during the study period: Maryland's All-Payer Global Budget Cap Model in 2014 and CareFirst BlueCross BlueShield's Patient-Centered Medical Home Program in 2011. Lastly, the findings of this study might not be generalizable because Maryland has an all-payer global budget payment program; this structure creates an incentive in the hospital industry that is not typical in other states.[26–28]

Study Results

DEMOGRAPHICS AND PAYER MIX Compared to the ZIP codes that were eligible to participate in the Health Enterprise Zone Initiative but did not receive awards, ZIP codes that received Health Enterprise Zone awards had higher percentages of black residents, lower socioeconomic status, lower marriage rates, and higher percentages of vacant homes (exhibit 1). The payer mix of the two groups of ZIP codes also varied (data not shown). In 2016 a higher percentage of hospital use was covered by Medicaid in awarded ZIP codes (56.6 percent versus 43.7 percent for ED visits, and 38.8 percent versus 28.9 percent for inpatient stays) than in eligible ZIP codes. This gap was completely offset by differences in the percentages of ED visits and inpatient stays cov-

EXHIBIT 1

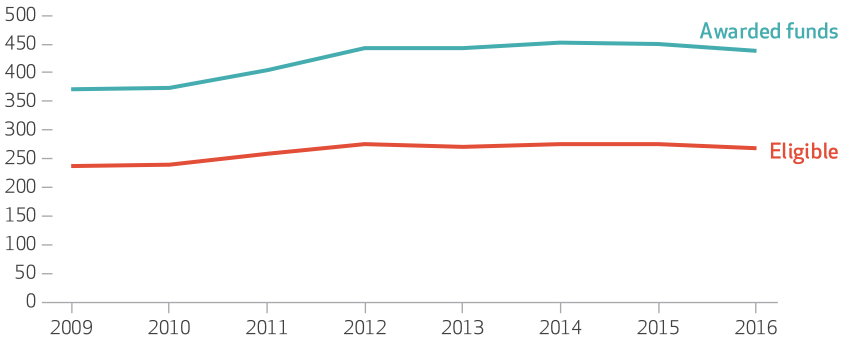
Selected characteristics of ZIP codes that were eligible for or awarded funds from the Health Enterprise Zone Initiative in Maryland

	Awarded funds ($n = 16$)	Eligible ($n = 94$)	p value
Mean population	17,580.4	26,196.4	0.048
Race/ethnicity			
White	29.2%	42.5%	0.150
Black	62.1	39.7	0.029
Asian	1.6	4.3	<0.001
Native American/other	2.4	2.9	0.230
Hispanic	4.6	10.6	0.002
Age range (years)			
0–17	23.3%	22.8%	0.649
18–24	10.1	10.1	0.996
25–44	26.1	29.0	0.012
45–64	26.8	25.8	0.072
65–79	9.8	8.8	0.205
80 or more	3.6	3.3	0.513
Income distribution (percent of FPL)			
0–99	21.0	13.6	0.048
100–124	4.4	3.5	0.207
125–149	5.1	3.8	0.051
150–174	5.3	4.1	0.097
175–184	1.7	1.7	0.774
185–199	2.7	2.5	0.536
200 or more	63.5	74.1	0.043
Median household income	$49,989	$60,564	0.141
Employment status			
Unemployed	8.6%	6.6%	0.072
Employed	54.0	61.6	0.004
Not in the labor force	36.9	31.4	0.016
Highest level of education			
No high school	4.9%	6.0%	0.224
Some high school	13.0	8.8	0.017
Finished high school	32.5	30.0	0.304
Some college	22.2	20.8	0.237
Associate's degree	5.4	6.3	0.017
College degree	12.9	16.3	0.147
Advanced degree	9.0	11.8	0.240
Marital status			
Married	32.2%	40.5%	0.040
Never married	45.3	39.5	0.104
Widowed	7.1	6.1	0.019
Separated	4.0	3.2	0.049
Divorced	11.4	10.8	0.149
Homes			
Occupied	81.3%	90.0%	0.021
Vacant	18.7	9.9	0.021

SOURCE Authors' analysis of data for 2010 from the Decennial Census of Population and Housing and for 2010–14 from the American Community Survey. **NOTES** Eligibility for the initiative is explained in the text. Percentages were weighted by the ZIP code population. FPL is federal poverty level.

EXHIBIT 2

Numbers of emergency department visits per 1,000 residents of ZIP codes that were eligible for or awarded funds from the Health Enterprise Zone Initiative in Maryland, 2009–16



SOURCE Authors' analysis of hospital utilization data for 2009–16 from the Maryland Health Services Cost Review Commission. **NOTES** Eligibility for the initiative, which was implemented in 2013, is explained in the text. Visits for childbirth, trauma, or cancer were excluded. Results were weighted by the ZIP code population.

ered by commercial insurance. Medicare covered similar percentages of ED visits and inpatient stays (about 16 percent and 43 percent, respectively) in awarded ZIP codes compared to eligible ZIP codes.

EMERGENCY DEPARTMENT VISITS AND HOSPITAL STAYS The awarded ZIP codes had higher rates of hospital ED visits and inpatient stays than eligible ZIP codes did (exhibits 2 and 3). ED visits per 1,000 residents rose from 2010 to 2012 and then flattened out in both groups of ZIP codes. Inpatient stays per 1,000 residents declined in both groups of ZIP codes throughout the study period, although the difference between the two groups narrowed over time.

Exhibit 4 presents coefficients from the fixed-effects difference-in-differences model, which estimate the effects of the Health Enterprise Zone Initiative on emergency department visits and inpatient stays. There is evidence that the Health Enterprise Zone Initiative was associated with a reduction in numbers of inpatient stays and an increase in numbers of ED visits throughout the study period. For example, the initiative was associated with a reduction of 13.73 inpatient stays per 1,000 residents in 2013, which increased to a reduction of 18.03 in 2014. The magnitude of the estimates was similar for 2015 and 2016 (reductions of 16.76 and 17.47, respectively). The findings were stronger for stays related to Prevention Quality Indicators or conditions targeted by the initiative: For the former, inpatient stays had decreases ranging from 3.43 in 2013 to 10.84 in 2016, and readmissions had decreases ranging from 1.33 in 2013 to 3.78 in 2016. The estimates for Health Enterprise Zone–related (targeted) conditions showed decreases as well.

The initiative was associated with increases in ED visits per 1,000 residents of 32.40 in 2013, 41.01 in 2014, 38.78 in 2015, and 31.75 in 2016. It was also associated with increases in ED visits for conditions related to the Prevention Quality Indicators and targeted by the initiative.

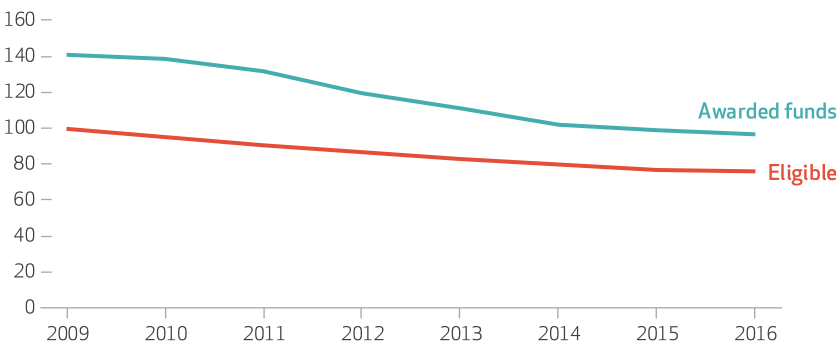
EMERGENCY DEPARTMENT AND HOSPITAL INPATIENT CHARGES The pattern for charges per 1,000 residents was similar to that observed for inpatient stays and ED use (exhibit 4). For inpatient stay charges, the initiative was associated with a reduction of $149,997 in 2013, $125,308 in 2014, $166,764 in 2015, and $156,593 in 2016. Conversely, for ED visit charges, it was associated with an increase of $48,702 in 2013. The pattern from 2013 to 2016 is an inverted U shape, rising to $63,553 in 2014 and falling back to $46,301 in 2016.

The random-effects models yielded results similar to those of the fixed-effects models, and all but one of the coefficients were significant (appendix exhibit S3).[17] The estimate using ZIP codes not eligible for the initiative as the comparison group also yielded similar results. The estimated reduction in inpatient stays tended to be larger and was always significant (see appendix exhibit S5).[17]

For our falsification tests, we explored the impact of the initiative on inpatient stays for the marker and pregnancy-related conditions. First, for the marker conditions, we expected to see no difference in the number of inpatient stays and ED visits per 1,000 residents after the initiative was implemented; indeed, we found that implementation was not associated with such a change (exhibit 4). The results were similar for the pregnancy-related conditions, with the exception of

EXHIBIT 3

Numbers of inpatient stays per 1,000 residents of ZIP codes that were eligible for or awarded funds from the Health Enterprise Zone Initiative in Maryland, 2009–16



SOURCE Authors' analysis of hospital utilization data for 2009–16 from the Maryland Health Services Cost Review Commission. **NOTES** Eligibility for the initiative, which was implemented in 2013, is explained in the text. Stays for childbirth, trauma, or cancer were excluded. Results were weighted by the ZIP code population.

EXHIBIT 4

Estimated differences in emergency department (ED) visits and inpatient stays and in charges, per 1,000 residents, between ZIP codes that received funds and those that were eligible for funds from the Health Enterprise Zone Initiative in Maryland, 2013–16

	2013	2014	2015	2016
EMERGENCY DEPARTMENT VISITS				
All visits				
Number	32.40***	41.01***	38.78**	31.75***
Charges	$48,702**	$63,554**	$54,501**	$46,301**
PQI-related visits				
Number	6.05***	5.15*	5.71***	2.89
Charges	$9,663**	$9,429**	$11,138**	$7,252**
Targeted condition visits				
Number	4.21*	7.16**	6.31*	3.53*
Charges	$8,231*	$14,933**	$13,418**	$7,987**
INPATIENT STAYS				
All stays				
Number	−13.73***	−18.03**	−16.76*	−17.47*
Charges	−$149,997***	−$125,308	−$166,764*	−$156,593**
PQI-related stays				
Number	−3.43***	−4.26***	−3.56**	−10.84****
Charges	−$35,334**	−$28,729	−$31,114*	−$44,340*
Targeted condition stays				
Number	−1.79*	−3.37**	−3.54*	−5.16*
Charges	−$20,372*	−$19,626	−$29,949*	−$47,908*
Readmissions[a]				
Number	−1.33*	−2.87**	−2.31*	−3.78*
FALSIFICATION TEST RESULTS				
Marker conditions				
ED visits	−0.12	−0.12	−0.11	−0.11
Inpatient stays	−0.03	0.08	0.05	0.14
Pregnancy-related conditions				
ED visits	−1.93	−1.11	−1.10	−2.30
Inpatient stays	−0.03	−0.58	−0.85**	−0.88**

SOURCE Authors' analysis of data for 2010 from the Decennial Census of Population and Housing, for 2010–14 from the American Community Survey, for 2009–16 from the Maryland Health Services Cost Review Commission, and for 2012–16 from the Chesapeake Regional Information System for our Patients (CRISP). **NOTES** Results are expressed as coefficients from fixed-effects difference-in-differences models. Eligibility for the initiative is explained in the text. Charges were adjusted for inflation to 2016 dollars. Marker conditions (listed in the text) are not sensitive to timely ambulatory care. Pregnancy-related includes pregnancy, childbirth, and the puerperium. PQI is Prevention Quality Indicators of the Agency for Healthcare Research and Quality. [a]We did not have charge data for readmissions. *$p < 0.10$ **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

significant reductions in inpatient stays for deliveries in 2015 and 2016. The initiative discouraged risky sexual behavior but did not include family planning services. Therefore, we expected to find no difference in deliveries per 1,000 residents associated with its implementation.

SAVINGS AND PROGRAM COSTS We compared the net savings in hospital charges to the cost of the program. During 2013–16 the ZIP codes that were awarded funds from the initiative had an increase of 40,488 ED visits, which cost insurers and patients $59.9 million (exhibit 5). However, this was offset by an overall reduction of 18,562 inpatient stays, which saved insurers and patients $168.4 million. The state spent $15.1 million on the initiative in the same period, and combining that amount with the net reduction in charges of $108.5 million suggests an overall net savings of $93.4 million for Maryland's health care system. All five Health Enterprise Zones had net savings. West Baltimore saved the most, $50.1 million, which compared favorably to $4.2 million spent there by the state. Annapolis had the greatest return on investment, receiving $800,000 from the state and saving $13.1 million.

QUALITATIVE FINDINGS The qualitative findings from the structured interviews and focus groups support the quantitative findings reported above. Residents and health care providers indicated that the initiative improved access to care and enabled residents to adopt health behaviors and practices that improved their health outcomes. Residents started becoming aware of their health, exercising more, and monitoring their diets. Providers also felt that

EXHIBIT 5

Estimated impact of the Maryland Health Enterprise Zone Initiative on emergency department (ED) visits, inpatient stays, and charges, for each zone and all ZIP codes combined that were awarded funds, 2013–16

	Annapolis/ Morris Blum	Dorchester and Caroline Counties	Capitol Heights	Greater Lexington Park	West Baltimore	All ZIP codes
VISITS AND INPATIENT STAYS						
ED visits	5,184	5,036	5,559	4,448	20,261	40,488
Inpatient stays	−2,376	−2,309	−2,549	−2,039	−9,289	−18,562
CHARGES (MILLIONS OF DOLLARS)						
ED visits	$7.67	$7.45	$8.23	$5.08	$29.99	$59.93
Inpatient stays	−$21.56	−$20.95	−$23.12	−$18.50	−$84.27	−$168.39
FINANCIAL IMPACT OF INITIATIVE (MILLIONS OF DOLLARS)						
Cost to the state	$0.80	$2.87	$4.30	$2.90	$4.20	$15.07
Net cost savings	−$13.09	−$10.63	−$10.59	−$10.52	−$50.08	−$93.39

SOURCE Authors' analysis of data for 2010 from the Decennial Census of Population and Housing, 2010–14 from the American Community Survey, 2009–16 from the Maryland Health Services Cost Review Commission, and 2012–16 from the Chesapeake Regional Information System for our Patients (CRISP). **NOTE** Charges were adjusted for inflation to 2016 dollars.

the initiative helped patients manage chronic conditions. They highlighted the importance of the provision of preventive services and health education that enabled patients who are often marginalized to improve their health-seeking behavior and be more aware of their health-related issues.

Discussion

The objective of the study was to examine changes in hospital use and associated health care costs for the five Health Enterprise Zones in Maryland. The results demonstrate that the Health Enterprise Zone Initiative was associated with a reduction in inpatient stays and an increase in ED visits per 1,000 residents, even though two unrelated statewide changes took place at the same time.

The rate of inpatient stays statewide was decreasing in part because a global budget payment model was implemented on January 1, 2014.[28] Under the global budget payment model, all Maryland hospitals are encouraged to decrease potentially avoidable use of care. However, the decrease in inpatient stays observed in the Health Enterprise Zones was even greater than that observed statewide. This may be because the initiative targeted high users of hospital care as well as people with chronic conditions, and it may have helped residents better manage those health conditions—thus reducing the need for inpatient care. Indeed, it is unlikely that our findings can be attributed to the implementing of global budgets. A 2018 study showed that the All-Payer Global Budget Cap Model did not have a consistent impact on hospital use for Medicare beneficiaries.[29] This differs from our finding of reductions in inpatient stays.

A second change taking place statewide was the CareFirst Patient Centered Medical Home Program. Evaluations of this program found that it reduced hospital inpatient and ED use.[30,31] However, only one of the Health Enterprise Zones had a patient-centered medical home operating in it, and just 16 percent of hospital patients in the zones were covered by commercial insurance. Consequently, the CareFirst Patient Centered Medical Home Program could affect only relatively few residents of Health Enterprise Zone ZIP codes.

Although we found a decrease in inpatient stays when we compared Health Enterprise Zone residents to residents in eligible ZIP codes whose communities were not included in the zones, there was also a relative increase in ED use. The reduction in inpatient stays was consistent with our expectations, but the increase in ED visits was unexpected. One possible explanation is that hospitals were more likely to send ED patients home instead of admitting them because the patients had access to Health Enterprise Zone resources. Another reason for the relative increase in ED use is that the Maryland Health Services Cost Review Commission encouraged hospitals to use observation status instead of short inpatient stays after 2010, which would allow patients to receive observation services (for example, x-rays, lab tests, and medications) in the ED and depress the numbers of inpatient stays. CMS's Two-Midnight rule, which followed a few years later, did the same.[32] However, it is unclear why this would disproportionately affect Health Enterprise Zones. In addition, as a result of the Affordable Care Act, Medicaid enrollment expanded in Maryland, and prior re-

search shows that previously uninsured people increase their ED use when they obtain Medicaid coverage.[33] However, we controlled for Medicaid enrollment in our analysis. While the Health Enterprise Zone–awarded ZIP codes had more Medicaid enrollees than the eligible ZIP codes that did not receive Health Enterprise Zone awards, the expansion increased their Medicaid enrollment by similar proportions.

Our findings are consistent with those of other studies that show that interventions that improve both access to care and health behaviors of underserved populations can result in a significant reduction in their hospital use.[34,35] The initiative improved access to primary care and preventive services and encouraged health behaviors through care coordination, health education, and patient engagement, which likely reduced the use of costly inpatient care.

This study had several strengths. We analyzed eight years of data, including sufficient observations before and after the Health Enterprise Zone Initiative was implemented. We applied a quasi-experimental study design with a comparison group (residents of ZIP codes eligible to participate in the initiative but not awarded funds by it), and we used a difference-in-differences model to control for fixed differences in hospital utilization between the comparison group and the ZIP codes that were awarded funds. We also examined a subset of conditions that should be sensitive to the intervention's activities. Our falsification tests suggest that our findings of reductions in inpatient stays were valid. Lastly, in the cost analysis we used charge data for the state—which, because of Maryland's all-payer model, is closely aligned to resource use since it is what insurers and patients actually pay for services.[26]

Conclusion

Improving access to care and reducing health care costs are key factors in reducing health care disparities. The Health Enterprise Zone Initiative demonstrated how states can use funds to create opportunities for community-based organizations and health care systems to leverage resources to benefit underserved communities. The initiative provided incentives and funding to attract health care providers to underserved communities, since limited access to health care professionals such as primary care providers, behavioral health specialists, and community health workers contributes to health disparities.[4,5] It also supported the coordination of health care and social services for vulnerable populations. The program was associated with improved access to care and reduced inpatient admissions and their associated costs. These reductions could justify continued financial investment from the State. Policy makers should consider promulgating the intervention to other eligible communities. Additional support could be provided by the health plans that benefit the cost savings as a result of lower hospital use, or hospitals could fund additional zones as part of their community benefit responsibility. ■

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M. Spencer - Testimony - SB 172 Health Equity Reso
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TESTIMONY OF MICHELLE SPENCER
ASSOCIATE SCIENTIST AND ASSOCIATE CHAIR OF INCLUSION, DIVERSITY, ANTI-RACISM, AND EQUITY
DEPARTMENT OF HEALTH POLICY AND MANAGEMENT
JOHNS HOPKINS UNIVERSITY
BEFORE THE SENATE BUDGET AND TAXATION COMMITTEE AND THE SENATE FINANCE COMMITTEE
IN SUPPORT OF SB 172, THE MARYLAND HEALTH EQUITY RESOURCE ACT
JANUARY 27, 2021

Maryland has a number of advantages that allow its citizens access to quality health care. The state has outstanding medical schools, hospitals, and among the 50 states, it has one of the highest median household incomes and the second highest number of primary care physicians per 100,000 population. Despite these advantages, important and persistent health disparities by race/ethnicity and by place of residence, exist in our state.

Historically, racial/ethnic minorities and residents living in underserved areas have suffered unequal access to health care. These same communities have inequitable outcomes in infant mortality and maternal mortality, and disproportionate rates of chronic disease and death. Though very preventable, chronic diseases are among the most common and costly health problems in the country. In Maryland, chronic diseases disproportionally impact those of lower socioeconomic status, those with less than a high school education, and those within communities of color.

In some communities, neighborhoods within a 5 miles radius experience gaps in life expectancy up to 18 years, including some neighborhoods in Baltimore City and Prince Georges county.

In response, in 2012 the Maryland General Assembly passed SB234, authorizing the Maryland Health Improvement and Disparities Reduction Act which established the Health Enterprise Zone Initiative.

The goals of the legislation were three-fold:

1. reduce health disparities among racial/ethnic groups and geographic areas,
2. improve health outcomes, and
3. reduce health care costs and hospital admissions and readmissions.

Through a competitive process, five Health Enterprise Zones were selected which showed creative and tailored plans for targeted investments in community health and involved local coordinating organizations. Of the five HEZs, three were based in hospital systems and two HEZs in local health departments. Two HEZs were in rural settings, one in an urban area, and two in suburban areas.

Analysis conducted by my research colleagues at Johns Hopkins found the HEZ Initiative was associated with a reduction in inpatient hospital stays, an increase in emergency department visits and a net savings of over $93 million for Maryland's health care system.
As examples:

- The Prince George's County HEZ established four Patient Centered Medical Homes and one specialty care practice, created a Community Care Coordination/Community Health Worker Program to link high-risk patients with services and implemented a Public Health Information Network and a comprehensive Health Literacy Campaign.
- The West Baltimore HEZ developed a tiered care coordination program to target high utilizers of emergency and inpatient services, provided community-based health education programs and health screenings, and delivered health classes to reduce risk factors for obesity and other chronic conditions.

These are only a few examples of what the HEZs accomplished. All HEZs expanded primary care services, and all did so with a focus on community health.

Overall, the Health Enterprise Zones were able to:

- Positively impact individual health behaviors and favorably influence health in the community,
- Improve health outcomes and costs associated with chronic conditions, including diabetes and cardiovascular related illnesses,
- Develop and test a variety of creative community-based solutions, and
- Address racial/ethnic and geographic health disparities in Maryland by improving outcomes and access to resources in medically under-served communities.

I am pleased that SB 172 builds on the 2012 HEZ law by making the Heath Equity Resource Communities permanent so they do not abruptly end like the HEZs did in 2016, by giving them a permanent and dedicated funding source. The proposed one penny per dollar increase in the state alcohol sales tax will make sure the Health Equity Resource Communities have the funding they need and will have the added public health benefit of reducing underage drinking and drunk driving.

This afternoon, I am honored to stand with Johns Hopkins University President Ron Daniel, President of Johns Hopkins Medicine, Kevin Sowers, Vinny DeMarco, and many elected officials in supporting this bill. This bill builds on experience and evidence from previous state investment in the HEZs and serves as a model for future programs aiming to address the health and social needs of communities across our state. This bill addresses racial/ethnic health disparities, that will improve access to health care, and reduce health care costs in low-income and medically underserved communities. I stand with the experience and evidence of what is achievable.

I stand in support of **SB 172 - The Maryland Health Equity Resource Act** – and look forward to your favorable report.

Thank you.

Bloomberg American Health Initiative
615 N. Wolfe Street, Baltimore, MD 21205-2179 443-287-8771

Directorate Support letter Health Equity.pdf
Uploaded by: Sperlein, Joan
Position: FAV

BALTIMORE CITY
SUBSTANCE ABUSE DIRECTORATE

January 25, 2021

House Bill 463/Senate Bill 172 Support

The Baltimore City Substance Abuse Director (BSCAD) is an advocacy and provider organization comprised of 30 Baltimore City substance use disorders treatment providers representing all levels of care from prevention to residential treatment. Our mission is the promotion of high-quality, best-practice and effective substance use disorders treatment for the citizens of Baltimore City. We are also involved in and support legislation that ensures our citizens get the best possible care through active consideration of legislation as it relates to the health and well-being of our consumer population.

As such, BCSAD strongly supports House Bill 463/Senate Bill 172, as it would create Health Equity Resources Communities in Maryland to focus health resources in the neighborhoods where they are needed the most. These resources would be paid for by a one penny on the dollar increase on the alcohol beverage sales tax, imposed first on liquor stores, and two years later on bars and restaurants.

HB 463/SB 172 will address inequities by race, ethnicity, disability, and geography and ensure that every Marylander, regardless of who they are or where they live, has access to the healthcare they deserve.

Baltimore City Substance Use Disorder providers witness first hand the impact of these health care inequities on the persons they serve. The past year's pandemic has highlighted these disparities even further. When consumers do not have easy access to comprehensive health care to manage chronic illnesses, they turn to Emergency Departments for primary care or these conditions spiral out of control until the patient is hospitalized to treat what could have been preventable. The endpoint of this lack of access is a 20-year gap in life expectancy depending on where you live in Maryland.

Maryland raised its alcohol tax in 2011 which led to significant reductions in underage drinking, binge drinking, driving under the influence, and sexually transmitted infections. Maryland has not raised its alcohol beverage sales tax since 2011 and its rate has fallen behind that of Washington, D.C. Raising the state's alcohol beverage sales tax will not only generate necessary funds to improve health equity and boost behavioral health programs, but will also reduce drinking, including by underage Marylanders and heavy drinkers, which in turn will save lives and reduce health care costs.

BCSAD urges a favorable report on House Bill 463/Senate Bill 172 and we look forward to working with legislators and our communities to effectively incorporate this harm reduction strategy into the public behavioral health system.

c/o REACH Health Services
2104 Maryland Avenue
Baltimore, Maryland 21218
(410) 752-6080

2- MHA Racial Equity Commitment.pdf

Uploaded by: Stallings, Nicole

Position: FAV

Maryland Hospital Association

Commitment to Racial Equity

The evidence is indisputable: racism—overt, implicit and structural—has had catastrophic consequences impacting health and life expectancy for generations. The COVID-19 pandemic shines a powerful light on racial inequities we've already known to exist in access to care and disparities in health outcomes.

Racism amounts to a public health crisis. Those who experience racism suffer undue, often constant stress, which has ill health effects. Racism also underlies social determinants of health such as housing, education, nutrition, employment and public safety. Inequities in access to health care, as well as in the quality and outcomes of care, are detrimental to the health of our whole community. Moreover, racism strains the resilience of our own health care workforce. Such inequities are wholly avoidable and unjust.

To dismantle racism and its very real, incapacitating effects, MHA leans on its mission, "To advance health care across our state and the health of all Marylanders." We had already begun the journey toward health equity; we will now redouble our efforts.

Maryland Hospital Association will:

- Partner with other aligned groups within and beyond the health care sector to secure adoption of public policies that promote racial equity in social, economic, environmental and other domains
- Conduct and disseminate research on ways to eliminate bias and remove disparities in health care and to achieve equitable health outcomes
- Support expanded access to health care for marginalized groups, such as prioritizing health care resource allocation for underserved populations and eliminating gaps in health insurance
- Engage in community conversations about race, social determinants of health, institutional bias, and ways to elevate community members' trust in the health care system

The governing body of MHA asks Maryland's hospitals and health systems to:

- Ensure that equity and inclusion are embedded in organizational values; operationalize these values through policy and practice; apply a racial equity lens in evaluating performance
- Teach leaders and associates how to understand and to speak about race; to become equipped to undo implicit bias and structural causes of poor health; and to practice culturally competent care
- Change the make-up of governing boards and leadership staffs to reflect the diversity of the community; identify and remove systemic barriers to advancement
- Measure racial disparities in specific areas of organizational performance and undertake formal efforts to reduce those disparities, with accountability for those responsible
- Collaborate with educational institutions to grow the number of health care professionals of color in Maryland
- Adopt racially equitable and inclusive approaches to purchasing and investment decisions

Meaningful change will take time. MHA and Maryland's hospitals and health systems will hold themselves accountable to fulfill these commitments. We will set metrics and periodically publish reports on progress.

Updated August 4, 2020

3- Paving the Way to Health Equity_Infographic.pdf

Uploaded by: Stallings, Nicole

Position: FAV

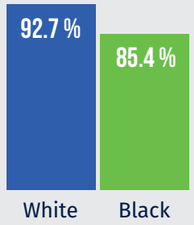
Paving the Way to **Health Equity**

Health equity = all Marylanders have the opportunity to attain **full health potential**

How **you** can help:

Support policies that promote health equity and the health of **ALL** Marylanders.

HIGH-SCHOOL GRADUATION IN MARYLAND



NON-HIGH SCHOOL GRADUATES DESCRIBE THEIR HEALTH AS POOR
- 2X MORE THAN H.S. GRADS
- 4X MORE THAN COLLEGE GRADS

More education reduces risk of heart disease and diabetes.

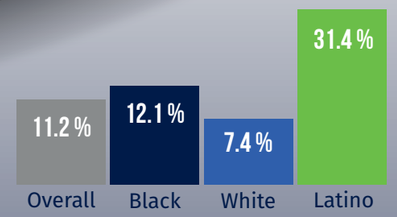
PATIENTS DRIVE 45+ MINUTES FOR YOUTH PSYCHIATRIC SERVICES IN 15 MD COUNTIES

Lack of transportation keeps 4 million Americans from accessing health care annually.

MD MEDIAN INCOME INEQUALITY AMONG HIGHEST IN U.S.

Marylanders of color are 3x more likely to be without health insurance, well above the national average.

FORGOING DOCTOR VISIT DUE TO COST



MARYLAND 39TH IN HOUSING AFFORDABILITY

Higher rates of infectious disease and chronic health conditions. Homeless 5x more likely to be hospitalized. Limits access to preventive health care.

11% OF MARYLAND HOUSEHOLDS ARE FOOD INSECURE

Percentage is higher for Black & Hispanic families, who suffer more disease, higher hospital readmissions.

Maryland Hospital Association | **mhaonline.org/advocacy**

SB 172- Maryland Health Equity Resource Communitie

Uploaded by: Stallings, Nicole

Position: FAV

Maryland
Hospital Association

Senate Bill 172- Maryland Health Equity Resource Act

Position: *Support*
January 27, 2021
Senate Budget & Taxation Committee

MHA Position

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 172. Marginalized communities in Maryland struggle with social and economic adversity. Limited access to educational opportunities, affordable housing, reliable transportation, healthy food, play spaces, and health care, contributes to poorer health outcomes. Racism adds stresses and other burdens that harm health. The dedicated caregivers in Maryland hospitals see the detrimental impact on the patients they treat and the health of the communities they serve. Caring for the most vulnerable among us is at the heart of our mission each day in Maryland's hospitals. Central to that mission is laser-like commitment to work with their communities and within their own organizations to reduce health disparities, eliminate implicit bias, and support the underserved.

For these reasons, the Maryland Hospital Association supports the SB 172 Maryland Health Equity Resource Act. The first iteration of this initiative, Health Enterprise Zones, proved the benefits of public-private partnerships and targeting resources where they're needed most. Maryland hospitals helped lead some of work done to ensure access to transportation and healthy food, to create jobs, and more. That pilot was associated with a reduction of over 18,000 inpatient stays and a proven model to reduce health care costs.[1] Financial incentives were used to recruit and retain health care practitioners, new health routes were created and access to behavioral health and dental services was expanded through mobile healthcare units.[2] Despite this success, those involved in the pilot identified opportunities to strengthen the initiative moving forward.

SB 172 builds from the lessons of the pilot and establishes a permanent mechanism to continue targeted investments communities around the state. By providing a dedicated funding source, communities will apply for grants and other financial incentives to address poor health outcomes that contribute to inequities by race, ethnicity, disability, and geographic location. The legislation creates a community driven, coalition approach to fundamentally improve the health of a

[1] Gaskin, D et al. The Maryland Health Enterprise Zone Initiative Reduced Hospital Cost and Utilization in Underserved Communities Health Affairs No. 10 2018
[2] https://health.maryland.gov/healthenterprisezones/Documents/HEZ%20Annual%20Report%202016.pdf

neighborhood. Dedicated funding from a penny increase on the sale of alcohol will not only enable the sustainability of the program and public health improvement.

This Health Equity Resource Communities initiative will direct significant new funding across our state, a critically needed step for Maryland to build healthier communities and address generations of inequity.

For more information, please contact:
Nicole Stallings, Senior Vice President, Government Affairs & Policy
Nstallings@mhaonline.org

Testimony-SB172-MD Health Equity Resource Act.pdf
Uploaded by: Stevenson, Christopher
Position: FAV

Testimony on SB172
Maryland Health Equity Resource Act
Position: FAVORABLE

Dear Mr. Chair and Members of the Budget and Taxation Committee,

My name is Ricarra Jones, and I am the Political Director with 1199SEIU- the largest healthcare union in the nation, where we represent over 10,000 healthcare workers in Maryland. Given the need to rectify gross health inequities in Maryland, we are supportive of SB0172- the Maryland Health Equity Resource Act.

All Marylanders deserve access to high-quality, affordable health care, regardless of race, ethnicity, disability, and place of residence. Unfortunately, deep inequities in service and affordability exist throughout the state. Many majority-minority regions suffer from healthcare disparities such as, heart disease, asthma, diabetes, and substance disorders. The rising cost of healthcare, abided with a lack of resources, funding, and socioeconomic opportunities, increases difficulties in obtaining care, even amidst a pandemic. The creation of Health Equity Resource Communities through this Act will assist with reducing these inequities.

Based on findings from previous pilots, equity zones created from the Act will prevent unequal outcomes and lower health care costs. It could also curb underage drinking, binge drinking and driving under the influence. For 1199SEIU members- the majority of whom are minorities- this Act is vital their job services and personal lives. Not only would this Act help better direct healthcare resources that our members provide, but this Act would also improve health outcomes and affordability for members.

For this reason, we believe that this Act will create the necessary structure in place to improve overall health equity for historically marginalized Marylanders and ask that you support the Maryland Health Equity Resource Act of 2021.

Respectfully,

Ricarra Jones
Maryland/DC Political Director
1199SEIU United Healthcare Workers- East
Cell: 443-844-6513

CMEC Testimony Health Equity Resourse Act[1652] -
Uploaded by: Weimert, Frederick
Position: FAV

Testimony of Rev. Frederick K. Weimert, Vice President of the Board of the Central Maryland Ecumenical Council
4 E. University Parkway, Baltimore, MD 21218
Before the Senate Budget and Taxation Committee
In Support of SB 172, The Maryland Health Equity Resource Act
January 27, 2021

Mr. Chairman and Members of the Committee thank you for this opportunity to testify in favor of this very important health care legislation sponsored by Senator Antonio Hayes. The Central Maryland Ecumenical Council is a Christian organization representing many denominational judicatories across the state of Maryland. Among them are: the United Methodist, Presbyterian Church USA, Evangelical Lutheran Church in America, Disciples of Christ, United Churches of Christ, Episcopal Diocese, Society of Friends, American Baptist Churches of the South, and, as such, we have a great concern for the health of all people in our congregations and communities. The COVID pandemic has magnified the inequities of health care delivery in our state and nation awaking churches leaders to our state's need to help provide care for the most vulnerable of our neighbors.

I thank the members of this body who have been so visionary in extending health care and providing prescription protection for many in Maryland. Among the actions you have taken was a bill that set up a pilot program, from 2012-2016, establishing Health Enterprise Zones in five of the most health insecure areas of our state. The Johns Hopkins' Bloomberg School of Public Health released a study of that program on October 1, 2018 which can be found: *(https://www.jhsph.edu/news/news-releases/2018/maryland-health-enterprise-zones-linked-to-reduced-hospitalizations-and-costs.html)*. That article concluded that even though emergency room visits increased in those Enterprise Zones the over all cost savings far exceeded those expenses. The conclusion of the author of the study, Dr. Darryll Gaskin, was *"Policymakers should consider extending the Health Enterprise Zones to other eligible communities."*

The pilot program initially covered 16 zip codes in our state and recognized that there were 94 other zip codes which would have met the same criterion of need. This legislation is seeking to begin the process of addressing the needs of these other areas of our state. It is also seeking to provide a method of financing this expansion through a sales tax of one cent per dollar on alcoholic beverages which, because of the pandemic, would be delayed for two years for alcoholic beverages served in restaurants and bars. We also believe that this sales tax may help contribute to a reduction in drunk driving and underage drinking.

As religious leaders in Maryland we strongly endorse this program which would aid so many of our congregants and neighbors in finding health and wholeness.

Thank you for this opportunity to testify for SB 172, the Maryland Health Equity Resource Act.

sB172_Strongfuturemaryland_FAV.pdf
Uploaded by: Wilkerson, Alice
Position: FAV

A sustainable, just, and prosperous economic future for all Marylanders

STRONG FUTURE MARYLAND

Testimony in Support of Senate Bill 172 (Senator Hayes)
Maryland Health Equity Resource Act

January 27, 2021

Dear Chairman Guzzone and Members of the Budget and Taxation Committee:

On behalf of Strong Future Maryland, we write in strong support of Senate Bill 172. Strong Future Maryland works to advance bold, progressive policy changes to address systemic inequality and promote a sustainable, just, and prosperous economic future for all Marylanders. We urge you to support this legislation to reduce health disparities throughout the state, eliminating barriers in the health field, giving all Marylanders the same access to preventative care.

Maryland's healthcare system requires significant improvements to expand its inclusivity and promote equity for all Marylanders regardless of race, religion, socioeconomic status, age, and to address other systemic obstacles. According to the Health Resources and Services Administration, **20 of Maryland's main jurisdictions are identified as "Medically Underserved Areas," which means they have "too few primary care providers, high infant mortality, high poverty or a high elderly population."** In addition to this database, the effects of COVID-19 makes it even more difficult to refute or neglect inequalities in health. Prince George's County, which has a majority-black population, has experienced over 65,000 cases, the most in the state, and has recorded over 1,100 deaths. Prince George's also has a higher uninsured population, faces a higher primary care provider to patient ratio and a higher unemployment rate, all of which are health determinants of insufficient care in this jurisdiction, especially amid the ongoing pandemic.

In the past, there have been advancements to address the issues of health disparities in Maryland. In 2012, Governor O'Malley signed Senate Bill 234, *the Maryland Health Improvement and Disparities Reduction Act of 2012*, which implemented necessary legislative components to reduce health disparities among Marylanders until it expired in 2016. Still, there is more work to be done because the truth is, health inequality still exists within Maryland. The Maryland Health Equity Resource Act allows the state to impose a necessary luxury tax on alcoholic beverages, which finances the Health Equity Resource Community Reserve Fund. By this tax generated fund, the Department of Health would have the ability to perform necessary preventative measures and interventions for Marylanders to display more health equities in the future.

info@strongfuturemd.org
PO Box 164 | Arnold MD 21012
240-643-0024 | strongfuturemd.org
@FutureMaryland @StrongFutureMD

Senate Bill 172 is important legislation that is a step forward in making Maryland's healthcare system more just and equal by eliminating the burden of health disparities. Strong Future Maryland urges the committee to vote favorably on Senate Bill 172.

John B. King Jr.	Alice Wilkerson
Founder and Board Chair	Executive Director

CDN SB172 FAVORABLE.pdf
Uploaded by: Wilson Randall, Claudia
Position: FAV

COMMUNITY DEVELOPMENT NETWORK OF MARYLAND

Testimony SB 172
Budget & Taxation Committee
January 25, 2021
Position: FAVORABLE

Dear Chairman Guzzone & Members of the Budget & Taxation Committee:

The Community Development Network of Maryland (CDN) is the voice for Maryland's community development sector and serves nearly 200 member organizations. CDN—focuses on small affordable housing developers, housing counseling agencies and community-based non-profits across the state of Maryland. The mission of CDN is to promote, strengthen and advocate for the community development sector throughout Maryland's urban, suburban and rural communities. CDN envisions a state in which all communities are thriving and where people of all incomes have abundant opportunities for themselves and their families.

SB 172 creates Health Equity Resource Communities which would provide additional health care resources to communities with poor health outcomes in Maryland in order to reduce inequities by race, ethnicity, disability, and location. This initiative would be funded by a one penny per dollar increase in the state's alcohol beverage sales tax.

COVID-19 has raised the importance of sufficient public health funding; the role of our physical and social surroundings in determining our health; how policies, systems and environments contribute to health inequities; and how interconnected we all are – as individuals, communities, organizations and sectors – when it comes to health and well-being. Our health as individuals and communities is deeply intertwined. Just as important to acknowledge is that health itself is intertwined with affordable and quality housing, good schools, safe neighborhoods, sufficient family support such as child care, economic opportunity and the list goes on, and on and on.

To ensure that all Marylanders have access to opportunity, advances are needed not only in health care but also in fields such as education, childcare, housing, community planning, transportation, and business development. Health Equity Resource Communities are a tested strategy to close health disparities and begin making progress toward greater access to social and economic opportunities. Making these advances involves working together to address social determinants of health. The community development sector is poised to work in collaboration with the legislature and partners across the state to improve the lives of all people.

We urge your favorable report.

Submitted by Claudia Wilson Randall, Executive Director, Community Development Network

Health Equity Resource communities SB 0172 testimo

Uploaded by: Young, Lauren

Position: FAV

Disability Rights Maryland

Empowerment. Integration. Equality.

1500 Union Ave., Suite 2000, Baltimore, MD 21211
Phone: 410-727-6352 | Fax: 410-727-6389
www.DisabilityRightsMD.org

Testimony on SB 172
Health Equity Resource Communities
Senate Budget and Taxation Committee
January 25, 2021

Favorable

Disability Rights Maryland (DRM) is the state's protection and advocacy system, mandated to advance the rights of people with disabilities. DRM supports SB 172 as a measure to address health care inequities among persons with disabilities, including persons of color.

Individuals with disabilities represent 18.7% of the U.S. population. A diagnosis of a disability does not define individuals, their talents and abilities, or health behaviors. However, individuals with disabilities do experience serious health disparities.

For example, adults with disabilities are three times more likely than adults without disabilities to have heart disease, stroke, diabetes or cancer. Multiple studies demonstrate that people of color and people with disabilities make-up a disproportionate share of COVID-19 cases, hospitalizations and deaths. People with developmental disorders, as well as intellectual disabilities present with important risk factors for COVID-19 mortality, lung cancer, leukemia and lymphomas.

These disparities in health care outcomes stem from structural and systemic barriers across many sectors, influenced by racism and disability discrimination. Many of these same barriers result in people with disabilities living in poverty at a rate twice that of their non-disabled peers; and comprising a "chronically homeless" population, which is defined by our federal government as homeless persons who have chronic disabilities. Health disparities faced by people with disabilities include disparities in accessing health care for both acute needs and preventive care.

Consistent with the World Health Organization's model of social determinants of health, what defines health outcomes for individuals with disabilities most often depends on their community, social and environmental circumstances.

The Health Equity Resource Communities Act begins to address the barriers and inequities in a number of Maryland communities by offering services and resources. DRM applauds such efforts. If we have learned anything from the pandemic, it is that the health of all of us depends on the health of each of us.

Thank you for your time and consideration.

Contact: Lauren Young, Esq.
Director of Litigation
Disability Rights Maryland
410-727-6352
laureny@disabilitiyrightsmd.org

3. B&T - SB 172 - Maryland Health Equity Act- MDH

Uploaded by: Bennardi, Maryland Department of Health /Office of Governmen

Position: FWA

Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Acting Secretary

January 27, 2021

The Honorable Guy Guzzone
Chair, Budget and Taxation
3 West Miller Office Building
Annapolis, MD 21401-1991

RE: SB0172 – Maryland Health Equity Resource Act – Letter of Information with Amendments

Dear Chair Guzzone and Committee members:

The Maryland Department of Health (MDH) submits this letter of information with amendments for SB0172 – Maryland Health Equity Resource Act.

The MDH has submitted operational impact information to the fiscal and policy note for SB 172 should this committee report this bill favorable for its consideration.

The MDH respectfully suggests that should the committee report this bill favorable it considers the following technical questions:
(1) Section 20-1403: Whether a term limit is appropriate for seat (B)(1)(VII) to the Committee membership to follow standard appointment procedures for Governor appointees;
(2) Section 20-1403: Whether seats (B)(1)(I) through (B)(1)(VI) should be appointed by the Secretaries of the Department, the Department of Human Services, and the Health Services Cost Review Commission Executive Director.
(3) We request clarification on the ambiguous language on page 21, lines 21-27 regarding CHW certification for eligibility for tax credit. The use of the term "certification" may be misinterpreted to mean that a CHW may apply for the CHW professional credential (certification) through entities including nonprofit organizations and local governments approved by the Secretary to establish a HERC or that professional certification by MDH makes a CHW eligible for the tax credit. The Department offers the following amendment to clarify the apparent intent of the term "certification":

AMENDMENT NO. 1
On page 21, strike "**FOR CERTIFICATION" in line 23 and substitute "<u>TO BE CERTIFIED AS ELIGIBLE FOR THE CREDITS".</u>**

I hope this information is useful. If you would like to discuss this further, please do not hesitate to contact me at webster.ye@maryland.gov /(410) 260-3190 or Heather Shek, Deputy Director of Governmental Affairs at heather.shek@maryland.gov and at the same phone number.

Sincerely,

Webster Ye
Assistant Secretary, Health Policy

APTA MD - Support with amendment - SB172 - Health
Uploaded by: Brocato, Barbara
Position: FWA

APTA Maryland

January 27, 2021

The Honorable Guy Guzzone, Chair
Senate Budget and Tax Committee
3 West, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: Senate Bill 172 – Maryland Health Equity Resource Act – SUPPORT w/Amendment

Dear Chair Guzzone,

The American Physical Therapy Association Maryland is writing to register our strong support of Senate Bill 172.

APTA Maryland represents over 1,900 physical therapists and physical therapist assistants in the State. Physical therapists provide essential services in today's health care delivery system. This includes but is not limited to addressing chronic and acute pain through non-pharmacological methods decreasing the reliance on opioid medications; improving recovery times that reduces reoccurrence of injury and disease, and ultimately hospital readmissions; and developing and managing essential rehabilitation programs for survivors of COVID-19. PTs work to improve outcomes which lead to long-term cost savings.

Senate Bill 172 requires the Secretary of Health to designate certain areas as Health Equity Resource Communities in a certain manner; specifying that the purpose of establishing Health Equity Resource Communities is to reduce health disparities, improve health outcomes, improve access to primary care, promote primary and secondary prevention services, and reduce health care costs and hospital admissions and readmissions.

This is an important and timely bill as the Covid-19 Pandemic has greatly exposed the extent of health disparities and inequities in Maryland and across the country. This bill represents a significant commitment of resources to find ways to remove barriers and work toward the equity that is needed in our healthcare system.

To that end we respectfully request a friendly amendment to include physical therapists on the work of the Advisory Committee.

Proposed Amendment:
On Page 7 after line 13, Insert:
ONE REPRESENTATIVE OF PHYSICAL THERAPISTS;

APTA Maryland Ph. 800.306.5596 Fax 877.622.0960 aptamd@aptamd.org

APTA Maryland
A Chapter of the American Physical Therapy Association

The coronavirus pandemic has resulted in a need for patients, health systems, payers, and providers to pivot and rapidly adopt or expand models and modes of care delivery that minimize disruptions in care and the risks associated with those disruptions. Physical therapists are committed to bringing value to our communities, hospital systems, and patients as we weather this pandemic and beyond.

For the reasons noted above we ask for a favorable report on Senate Bill 172 and favorable consideration of our amendment.

Sincerely,

Kevin Platt, PT, DPT, MBA
President, APTA Maryland

MAND SB 172 - Maryland Health Equity Resource Act
Uploaded by: Brocato, Barbara
Position: FWA

MARYLAND ACADEMY OF NUTRITION AND DIETETICS

Date: January 27, 2021
Bill: Senate Bill 172 – Maryland Health Equity Resource Act
Committee: Senate Budget and Taxation Committee
The Honorable Guy Guzzone, Chair
Position: Support with Amendment

The Maryland Academy of Nutrition and Dietetics (MAND), is an organization representing approximately 1,200 licensed dietitians and nutritionists, dietetic interns, and students within the state of Maryland.

Senate Bill 172 requires the Secretary of Health to designate certain areas as Health Equity Resource Communities in a certain manner; specifying that the purpose of establishing Health Equity Resource Communities is to reduce health disparities, improve health outcomes, improve access to primary care, promote primary and secondary prevention services, and reduce health care costs and hospital admissions and readmissions.

In light of the challenges to our health care delivery system brought about by the COVID-19 Pandemic, Licensed Dietitians and Nutritionists are more important than ever in creating positive outcomes. Licensed Dietitians and Nutritionists are on the front lines providing public health services. Studies have shown that Licensed Dietitian Nutritionists have the best outcomes teaching clients to adapt to their diets for diabetes, heart disease and obesity—the comorbidities that increase susceptibility to COVID-19.[1] Improving populations' health, eliminating barriers to care, and addressing social determinants of health will help Maryland citizens now and in the future, not to mention decrease healthcare costs.

To that end we respectfully request a friendly amendment to include licensed dietitians and nutritionists on the work of the Advisory Committee.

> **Proposed Amendment:**
> On Page 7 after line 13, Insert:
> **ONE REPRESENTATIVE OF LICENSED DIETITIANS AND NUTRITIONISTS;**

MAND stands ready as a resource and partner in this important undertaking. Thank you for your consideration of our comments. We respectfully ask for a FAVORABLE report on SB172 and Favorable consideration of this amendment.

Dr. Glenda L. Lindsey , Dr. PH, MS, RDN, LDN
Public Policy Coordinator
Public Policy Panel

Helene Fletcher MS, RDN, LDN
MAND President

[1] 1. Position of the Academy of Nutrition & Dietetics: The Role of Medical Nutrition Therapy and Registered Dietitian Nutritionists in the Prevention and Treatment of Prediabetes and Type II Diabetes, J of Acad. of Nutr & Diet, Feb. 2018, 118 (2).

2021 MCHS SB 172 Senate Side.pdf
Uploaded by: Elliott, Robyn
Position: FWA

Maryland Community Health System

Committee: **Senate Budget & Taxation Committee**

Bill Number: **SB 172 - Maryland Health Equity Resources Act**

Hearing Date: **January 27, 2021**

Position: **Support with Amendments**

Maryland Community Health System (MCHS) supports the underlying concepts of *Senate Bill 172 – Maryland Health Equity Resources Act*. Maryland should invest in communities struggling because of inequitable resources and the impact of institutionalized racism. MCHS was a participant in the workgroup on the legislation that established health enterprise zones, the concept upon which this bill is based. We believe the legislation before you is a strong start. We raise some questions for consideration as the Committee moves forward:

- Incorporating Local Planning Entities: Since the HEZ pilot, Maryland has invested considerable resources into Local Health Improvement Coalitions (LHICs). Can LHICs play a more formal role in the Health Equity Resource Communities?

- Supporting Essential Community Providers and Other Community-Based Organizations: Is the bill structured so that smaller, community-based organizations are receiving sufficient support? We want to support investment in organizations that are traditionally under-resourced.

- Investment in Other Equity Initiatives: We understand that the Maryland General Assembly will be considering investment in other health equity initiatives in the next couple of years. These initiatives could include extending postpartum Medicaid coverage and improving access to oral health services. Should funding be reserved for those initiatives or a greater investment in substance use disorder services? In an ideal world, there would be sufficient funds to fully resource all these initiatives.

Thank you for your consideration of our testimony. We are committed to working with the Committee and other stakeholders as you work on this legislation and other health equity initiatives. We have not developed specific amendments at this time, as we want to work collaboratively with all stakeholders on . If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net or (443) 926-3443.

5850 Waterloo Road, Suite 140, Columbia, Maryland 21045
410-761-8100

SB172_Health Equity Resource Communities_SWA 1-27-
Uploaded by: Taylor, Allison
Position: FWA

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

January 27, 2021

The Honorable Guy Guzzone
Senate Finance Committee
3 West, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 172 – Support with Amendments

Dear Chair Guzzone and Members of the Committee:

Kaiser Permanente enthusiastically supports SB 172, the Maryland Health Equity Resource Act, and offers two amendments for the Committee's consideration.

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for approximately 775,000 members. In Maryland, we deliver care to over 450,000 members.

Kaiser Permanente is committed to providing quality, culturally appropriate health care to all our members. The Health Equity Resource Act initiative also aligns with KP's community health work on place-based initiatives and builds on our decade-long experience leading multi-sector partnerships with government, business and community residents involved in design, development and implementation.

Kaiser Permanente strongly supports this legislation to establish Health Equity Resource Communities, which would target state resources to reduce health disparities and improve health outcomes. We were an active participant in the Health Enterprise Zones initiative and are pleased to see this proposal as the next phase of that important work. As an organization that provides comprehensive health services to individuals who experience health disparities, we are well positioned to provide ongoing advice and expertise to the initiative. To that end, we offer an amendment to expand the advisory committee.

Thank you for the opportunity to comment. Please feel free to contact Allison Taylor at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

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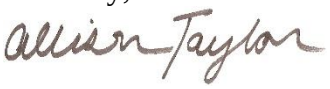
[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

Sincerely,



Allison Taylor, MPP JD
Director of Government Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.

AMENDMENT TO SENATE BILL 172
(First Reading File Bill)

On page 7, in line 25, strike "**AND**"; and after line 25, insert:

"**(IX) ONE REPRESENTATIVE OF A NONPROFIT GROUP MODEL HEALTH MAINTENANCE ORGANIZATION;**

(X) ONE REPRESENTATIVE OF A NONPROFIT HEALTH SERVICE PLAN;

(XI) ONE REPRESENTATIVE OF A MANAGED CARE ORGANIZATION; AND".

On page 7, in line 26, strike "**(IX)**" and substitute "**(XII)**".

SB172-OpposeTax.pdf
Uploaded by: Atticks, Kevin
Position: UNF

OPPOSE SB172

January 25, 2021

Mr. Chair, Mr. Vice-Chair and Committee Members
3 West
Miller Senate Office Building
Annapolis, Maryland 21401

Dear Committee Members,

On behalf of the organizations representing the alcohol producers of Maryland, I write in strong opposition to SB172.

While the cause is noble, the target of the taxes—and the timing of the increase—disporportionately impact small, local, family-owned businesses.

We urge an unfavorable vote.

Sincerely,
Kevin Atticks, DCD

Brewers Association of Maryland
Maryland Wineries Association
Maryland Distillers Guild

1783 Forest Drive #343 • Annapolis MD 21401 • 410-252-9463 • info@growandfortify.com

SB172.UNFAVORABLE.MDRTL.LBogley.pdf
Uploaded by: Bogley, Laura
Position: UNF

Opposition Statement SB172/HB463
Maryland Health Equity Resource Act

By Laura Bogley-Knickman, JD
Director of Legislation, Maryland Right to Life

We Oppose SB172/HB463 as Written

On behalf of our members in Baltimore City and across the state, we respectfully object to SB172/HB463 *as written*. We champion the cause of racial equity and the truth that each human being is created equal and with the inalienable RIGHT TO LIFE. Abortion is the greatest civil rights abuse of our time. Minority women and children have been historically targeted for abortion and population control with a genocidal effect. **Without your amendment, this bill could be exploited to expand abortion among Minority populations and require public funding of the abortion industry to the detriment of Black lives.**

LIFE is a Civil Right

Abortion is having a genocidal effect on Black Americans, who are disproportionately targeted by the abortion industry, with 78% of abortion clinics located in Black and Brown communities and with almost half of all pregnancies to Black women ending in abortion. While Black Americans make up less than 13% of the population, they account for more than 30% of all abortions. **As a result abortion is the leading cause of death of Black Americans, more than gun violence and all other causes combined.** (For more information see http://www.BlackGenocide.org.)

Pregnancy is not a Disease

Abortion is not healthcare. It is brutality that furthers a culture of violence in society. Abortion is America is an epidemic. Since the Supreme Court overturned the laws of 46 states when it legalized abortion in 1973, more than 61 million children have been killed through abortion, over 20 million of those abortions were of Black babies. Abortion in America remains unsafe, with many women experiencing medical complications, including severe infection, loss of fertility and even death. Many women suffer long-term psychological harm identified as Post-Abortion Syndrome. Women have better options for comprehensive care. There are 14 federally qualifying health care centers for every Planned Parenthood in Maryland. **Women deserve better than abortion.**

Funding restrictions are constitutional

The Supreme Court in the case of *Harris v. McRae* (1980), ruled that the government may distinguish between abortion and other procedures in funding decisions -- noting that "*no other procedure involves the purposeful termination of a potential life*" -- and affirmed that *Roe v. Wade* had created a limitation on government, not a government funding entitlement. Taxpayers should not be forced to fund elective abortions, which make up the vast majority of abortions performed in Maryland. A 2019 Marist poll showed that 54% of Americans, both "pro-life" and "pro-choice" oppose the use of tax dollars to pay for a woman's abortion. 83% of Americans polled instead favor laws that **protect both the lives of women and preborn children**. To become a just society, public funds should be prioritized to fund health and family planning services which have the objective of saving the lives of both mother and children, including programs for improving maternal health and birth and delivery outcomes, well baby care, parenting classes, foster care reform and affordable adoption programs.

For these reasons, we urge you to protect the fundamental Right to Life for <u>all Marylanders</u> and especially in any programs to advance *racial equity*, by excluding abortion funding or issuing and unfavorable report.

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Uploaded by: Douglas, Bob
Position: UNF

Sales and Use Tax
3% Tax on Alcohol

FY	Revenue
2012	$76,018,693
2013	82,950,859
2014	86,247,412
2015	89,204,389
2016	94,257,315
2017	97,305,338
2018	99,333,599
2019	103,548,010
2020	94,085,878

Source: Maryland Office of the Comptroller

Preapared by: Department of Legislative Services, January 2021

https___dlapiperusa-my.sharepoint.com_personal_jat
Uploaded by: Douglas, Bob
Position: UNF

LICENSED BEVERAGE DISTRIBUTORS OF MARYLAND, INC.

Leadership in Industry Cooperation
446 Park Creek Road
Pasadena, Maryland 21122

Members
BREAKTHRU BEVERAGE DISTRIBUTORS
REPUBLIC NATIONAL DISTRIBUTING
COMPANY, LLC

January 27, 2021 **OPPOSE SB 172**

Senate Budget and Taxation Committee members
Senate Finance Committee members

THE 2011 TAX INCREASE ON ALCOHOL HAS GENERATED ALMOST $1 BILLION AND VERY LITTLE OF IT HAS GONE TO HEALTH PROGRAMS AS PROMISED. THAT PAST TAX INCEASE NOW BRINGS IN NEARLY $100 MILLION EACH YEAR AND CAN EASILY FUND THE PROPOSALS IDENTIFIED IN THIS BILL.

Dear Senators:

Thank you for your support and appreciation of our industry, its workers and small business owners in both good times and now.

Ten years ago, officials **proposed as part of the Lorraine Sheehan Health and Community Services Act of 2011 a three-cent increase in the sales tax for wine, spirits, beer** and other alcoholic beverages by upping the sales tax from 6 to 9 cents just for alcohol. It was **a 50 % increase** that was **promoted** - and widely supported - as a way **to fund essential Maryland health programs**. The increased tax has collected almost $1 billion from taxpayers who paid the alcohol sales tax of 9% since 2012. . (See attached tracking chart created by Legislative Services.) Despite the promises made to garner support for the tax increase, less than 10% of those funds have gone specifically to health programs and apparently there has been **no health program directly financed by the tax for several years**. The tax proceeds have **gone into the general fund**. This not at all what was touted to get the tax passed.

The Sheehan proposal generated widespread support from health advocates and industry leaders who filled legsialtive halls and hearing rooms, many in wheel chairs. But In the final days of the 2011 session, the Sheehan Act was folded unceremoniously into SB 994 (captioned Supplentary Appropriation) which required that just $15 million generated by the tax increase go to the Development Disabilities Administration and only for FY 2012 - even though the tax generated $76 million that year. The bottom line is that the **tax** still **generates nearly**

$100 million a year. These funds **should be directed** to appropriate **health programs as intended and promised** 10 years ago and not spend elsewhere.

In short, there is **no need** for an unwanted and detrimental **tax increase to fund the health programs** and policies in this bill. In fact, the original tax increase still is generating many times more available funds than the proposed tax increase will generate. It generated $103 million in FY 2019 and $94 million last year.

We respectfully ask that the Comittees provide and **unfavorable report on SB 172** and **insert budget language to direct an appropriate amount of this year's $100 million proceeds from the original 3% tax increase to support the noble objectives outlined in the bill.** Thank you for your consideration of these points.

Very Truly Yours.
Joel Polichene (Republic National Disgtributing Company), Jeff Scarry and Jimmy Smith (Breakthru Beverage Distributors)

2021 SB 172 Tax Increase testimony_.pdf
Uploaded by: Harting, Marta
Position: UNF

DIAGEO

Honorable Guy Guzzone
Chair, Senate Budget and Taxation Committee
3 West, Miller Senate Office Building
Annapolis MD 21401

Honorable Delores Kelley
Chair, Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis MD 21401

Re: Senate Bill 172 (Maryland Health Equity Resource Act)

Dear Chairperson Guzzone and Chairperson Kelley:

This is written respectfully to express Diageo's opposition to SB 172 (Maryland Health Equity Resource Act) which would raise the State's sales tax on the sale of alcoholic beverages for the purpose of funding a Health Equity Resource Community Reserve Fund for programs aimed at reducing health disparities in the State. Under the bill, the sales tax would increase immediately to 10% for sales by "off-sale retailers" and would increase to 10% for sales by "on-sale retailers" beginning October 1, 2023.

To be clear, Diageo's opposition to SB 172 is solely to the proposed increase in the sales tax on alcoholic beverages. Diageo does not oppose the targeting of State resources to fund programs to reduce health disparities, but it opposes an increase in the sales tax on alcoholic beverages as the funding source for these programs.

As you may know, Diageo is a global leader in beverage alcohol with an outstanding collection of brands including Johnnie Walker, Crown Royal, Bulleit and Buchanan's whiskies, Smirnoff, Cîroc and Ketel One vodkas, Captain Morgan, Baileys, Don Julio, Tanqueray and Guinness. Diageo owns and operates the Guinness Open Gate Brewery in Baltimore County, where it employs roughly 240 Marylanders when fully operational, and where it invested more than $90 million to construct the brewery.

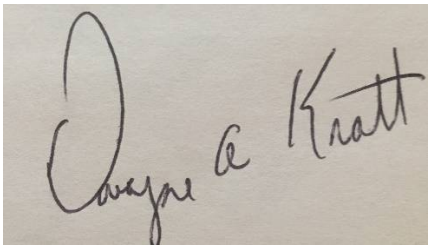
We oppose an increase in the sales tax on alcohol because we firmly believe now is not the time to raise additional taxes on the hospitality industry which we all know is reeling due to the Covid 19 pandemic.

We also wish to point out that the last time when the state of Maryland raised alcohol beverage taxes, it raised the sales tax in the same way this proposal does. The result of this increase was a loss of sales volume in Maryland specifically to neighboring Delaware. The other result of this proposal was a "baked in" tax increase for the state of Maryland anytime a manufacture decides to raise its prices. This means that the state already receives incremental tax revenue from the sale of alcohol beverages every year.

In conclusion, Diageo's opposition to SB 172 is solely to the proposed increase in the sales tax on alcoholic beverages. We do not oppose the targeting of State resources to fund programs to reduce health disparities, but we oppose an increase in the sales tax on alcoholic beverages as the funding source for these programs.

Thank you for your consideration.

Respectfully,



Dwayne A. Kratt

Sr. Director, State Government Affairs

SB0172_UNF_MSLBA_Maryland Health Equity Resource A
Uploaded by: Milani, Jack
Position: UNF

MARYLAND STATE
LICENSED BEVERAGE ASSOCIATION
150 E Main Street, Suite 104, Westminster, MD 21157

TO: The Honorable Guy Guzzone, Chair
Members, Senate Budget and Taxation Committee
The Honorable Antonio Hayes

FROM: Jack Milani, MSLBA Legislative Co-Chairman

DATE: January 27, 2021

RE: **OPPOSE** – Senate Bill 172 – *Maryland Health Equity Resource Act*

The Maryland State Licensed Beverage Association (MSLBA), which consists of 1,000 Maryland businesses holding alcoholic beverage licenses (restaurants, bars, taverns, and package stores), **opposes** the tax increase contained in Senate Bill 172.

While we support the use of State dollars to address health care disparities, we do not support raising taxes on alcohol to do so for the reasons set out below. General Fund revenues were used to fund the Health Enterprise Zones program initiated during the O'Malley Administration and should be used for the purposes outlined in Senate Bill 172 as well.

First, alcohol is already taxed twice in Maryland and at rates higher than our surrounding jurisdictions. There is an excise tax on alcohol which generates $30 million each year. There is also a 9% sales tax applied to alcohol at the point of sale, which generates another $300 million, for a total of $330 million dollars each year. The tax rate is already 50% higher than the 6% rate applied to other items. In effect, the proposed increase takes one of the highest taxed items in Maryland, and taxes it even more. The new rate also exacerbates the difference between Maryland's already high rate and that of surrounding states (Virginia (5.3%), Pennsylvania (6%), West Virginia (6%)). Only Washington, DC is higher at 10%.

Some history on alcohol tax increases in the State bears noting. For years, there were proposals in the General Assembly to increase the excise tax rates on alcohol. In 2011, the Legislature instead opted to raise the sales tax to 9% on the premise that as prices rose, the amount of tax generated would also go up and constant adjustments to the tax rates would no longer be required. In other words, the 2011 solution was intended to address alcohol tax revenues once and for all. Now, even more is being sought with this additional 10% increase.

Second, raising taxes that affect small businesses could not come at a worse time. Restaurants and bars are closing by the day and are reeling after being shut down for dining in response to the COVID-19 pandemic. Partial re-openings, outdoor dining and carry out orders have helped some of them remain viable, but the revenue produced from these sales pale in comparison to pre-pandemic levels. The Restaurant Association of Maryland predicts up to 40 percent of Maryland restaurants may close permanently because of the pandemic. The delay in implementation for on-premise retailers is little

consolation when they are relying on off-premise sales like carry-out and delivery to stay afloat, and these will be taxed at the higher rate immediately. Off-premise retailers like package stores experienced increased sales at the start of the pandemic, but the bulk purchases that accounted for some the uptick have waned, and the greatly reduced sales around holidays and large gatherings which used to exist have offset the gains. Even so, why would the General Assembly want to tax further a retail sector that has helped the State's economy through this difficult time?

For these reasons, the MSLBA strongly urges the General Assembly to reject this tax increase.

For more information call:
Maryland State Licensed Beverage Association
(410) 876-3464

NFIB - Maryland Health Equity Resource Act - SB172
Uploaded by: O'Halloran, Mike
Position: UNF

SB172

NFIB-Maryland – 60 West St., Suite 101 – Annapolis, MD 21401 – www.NFIB.com/Maryland

TO: Senate Budget and Taxation Committee

FROM: NFIB – Maryland

DATE: January 27, 2021

RE: **SENATE BILL 172** – Maryland Health Equity Resource Act

Founded in 1943, NFIB is the voice of small business, advocating on behalf of America's small and independent business owners, both in Washington, D.C., and in all 50 state capitals. With more than 250,000 members nationwide, and nearly 4,000 here in Maryland, we work to protect and promote the ability of our members to grow and operate their business.

On behalf of Maryland's small businesses, NFIB opposes Senate Bill 172's provision that will increase the state's sales tax on alcohol from 9% to 10%.

NFIB commends the sponsor for his efforts to address health disparities in communities across our state. Further that SB172 aims to improve access to health care facilities and physicians.

However, NFIB is concerned a primary source of funding for the "Health Equity Resource Community Reserve Fund," established under the bill, is through a hike to the state's sales tax on alcoholic beverages sold for on- and off-premises consumption. Raising the sales tax to 10% as the bill calls for will give Maryland the unwelcomed distinction of having the highest tax rate amongst its neighbors in Delaware (0%), Virginia (max of 7%), West Virginia (max of 7%), and Pennsylvania (max of 7%). Given Maryland's unique geography and compact size, SB172 will put many small businesses, restaurants, bars and taverns at a competitive disadvantage to their neighbors just over state lines.

NFIB strongly supported legislation last year establishing a commission to evaluate the State's current tax systems and make recommendations to ensure Maryland's tax policy is competitive with surrounding jurisdictions and encourages business growth and job creation. Our members and their workers have faced financial hardships not seen in generations because of the COVID-19 pandemic.

We encourage the General Assembly to revisit the idea of such a commission before passing legislation like SB172. For these reasons, **NFIB opposes SB172's** provision to raise the state's sales on alcohol.

SB 172- Windon testimony-01-27-21 (2).pdf
Uploaded by: Windon, Jaime
Position: UNF

TO:	Budget and Tax and Finance Committee Members
FROM:	Brewers Association of Maryland
	Maryland Distillers Guild
	Maryland Wineries Association
RE:	SB 172 – Maryland Health Equity Resource Act
Position:	OPPOSE
DATE:	January 27, 2021

Mr. Chairman and members of the Committee. My name is Jaime Windon and I am the President of the Maryland Distillers' Guild. I am also the owner of Lyon Rum Distillery and Tasting Room located in St. Michael's. I am testifying in OPPOSITION to the tax increase that is proposed in Senate Bill 172.

In the interest of your time, I am here representing all three of Maryland's alcohol manufacturing sectors. I am speaking on behalf of the 275 small businesses that are members of the Maryland Distillers' Guild, The Brewers Association of Maryland and the Maryland Wineries Association. We have the same common interest in this legislation and therefore our position is the same.

Our opposition is narrowly focused on the disparate impact this legislation would have on our small Maryland businesses. We recognize that the objectives of the bill are societal goals. However, SB 172 does not share the burden of meeting these societal goals across all of Maryland. Instead, it focuses disproportionately on our small businesses, which are all in an historic struggle to survive.

Our businesses are not large international conglomerates which market products world-wide. Only one of the 275 members of the three organizations I represent here today started outside Maryland. These businesses represent exactly what we would want to occur in Maryland. Local efforts, focused on selling local products to Marylanders, growing to provide jobs to Marylanders.

As start-ups, many of cannot afford to pay ourselves regularly or even to offer health insurance to our employees. Both are goals every one of would like to achieve as our business grows. We all fear that the tax provisions of SB 172 will make those goals even further away from attainment.

All our production is in Maryland and, as a result, our product is taxed twice by the State. All three products are levied with high excise taxes. Predominately, these taxes are paid by us at the time of manufacture and before we know we have a customer for our product. This is different than almost any other consumer product on which sales tax is paid. We find it shocking that the proponents of this bill would target small Maryland employers, who are already burdened with a tax levied on no other consumer product.

This double tax burden is in addition to the fact that the sales tax on alcohol is already levied at the highest rate of any other consumer product.

As you all well know, the effect of COVID-19 has been nothing short of devastating on small businesses. All 275 of our businesses previously depended depend on Marylanders visiting our locations to buy our consumer product. That changed in March as we closed our doors to visitors only to have many consumers shy away from visits now, even if they are allowed to enter. The effect has been profound, and all the small businesses will feel this negative effect for years to come.

Please know, I am not here to tell you how to craft Maryland tax policy. I am here to let you know how the unintended effects could affect the 275 Maryland alcohol manufacturers that are struggling every day to capture sales to keep the doors open and make payroll.

When you look at the tax provisions of SB 172, please remember that they fall equally on a marketplace that is very unequal. Maryland wine accounts for only 3% of wine consumed in The State. Maryland beer for less than 10% of all in-state beer sold. Maryland distilled products are below 1% of consumption in Maryland. Yet the new tax burden in SB 172 lumps our products in with those of much greater market share, with no consideration of that market disparity.

For these reasons Mr. Chairman and members of the Committee we ask you to re-visit the tax portions of SB 172 and to delete the disparate increase in the alcohol sales tax.

For more information contact Brad Rifkin, Camille Fesche or Pat Roddy at 410-269-5066.