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.

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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

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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.

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‘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 Absolute-CARE, 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-

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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

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

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.

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

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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." ■

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