



# In the Zone: State Strategies to Advance Health Equity by Investing in Community Health

*A closer look at models in Connecticut, Delaware, Maryland, and Rhode Island*

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States and the federal government are investing heavily in initiatives to transform the health care delivery system, with states committing substantial resources to projects aimed at achieving the Triple Aim<sup>1</sup> goals of better population health, better health care, and lower costs.<sup>2</sup> However, these state investments may fail to achieve their goals without a plan to address the persistent disparities in health status and outcomes that plague underserved communities. Without addressing the disproportionately poor health outcomes of certain races or zip codes, states will continue to struggle to reduce costs, improve health, and improve quality.

Statistics show that poor health continues to disproportionately affect certain communities. For example according to a 2013 report from the Centers for Disease Control and Prevention (CDC), African American adults have a 50 percent greater likelihood of dying prematurely from heart disease and stroke than white adults, and the prevalence of diabetes was higher among African American (11.3 percent) and Hispanic adults (11.5 percent) than among white adults (6.8 percent) in 2010.<sup>3</sup> These disparities translate into poorer quality of life: African Americans on average can expect just over 59 years of life free of limitations on activities caused by chronic conditions, while whites can expect slightly more than 66 limitation-free years.<sup>4</sup> Income and geography affect health as well. A recent study<sup>5</sup> found that those with higher incomes tend to live longer than those with lower earnings, and that life expectancy varies “substantially across local areas” for lower-income people. Health disparities experienced in early childhood often correlate to lifelong struggles with educational attainment and preventable chronic health conditions, according to a study that asserted, “the costs of current disparities in both child health and healthy child development outcomes are enormous.”<sup>6</sup> In addition to their human costs, such disparities can undermine states’ health reform goals for children and adults. Just as a rising tide lifts all boats, effective reform cannot afford to leave any group behind.

This brief examines efforts in Connecticut, Delaware, Maryland, and Rhode Island to address the social determinants of health by building local capacity and leveraging cross-agency, multidisciplinary partnerships in targeted areas. It is important to note that the initiatives are in various stages of development. Connecticut is still early in the planning process, Delaware is concluding its planning phase and preparing to bring to scale three of 10 planned statewide Healthy Neighborhoods in 2016, and the Maryland and Rhode Island initiatives have been operational for at least a year. Although the initiatives have not yet had time to mature or demonstrate long-term sustainability, they represent a promising direction for

local health equity and population health improvements within the larger context of state and national health care payment and delivery system reforms.

## Current Models

While many initiatives target transformation at the regional level,<sup>7</sup> these states share a community-wide approach to improving population health and health equity by leveraging cross-agency, multidisciplinary partnerships to address the social determinants of health. They work to improve population health by building capacity in a target neighborhood or zone, instead of focusing only on improving clinical outcomes among disadvantaged groups.

Other local or regional models—such as Accountable Care Organizations (ACOs), Coordinated Care Organizations (CCOs), and Regional Care Collaborative Organizations (RCCOs)—work primarily by coordinating available physical and mental health care providers, often with an emphasis on prevention and person-centered care. The ACO, CCO, and RCCO models also tend to focus more on providers' financial accountability for outcomes, rather than on building a community's capacity to improve health equity. In communities without health care providers available to meet residents' needs, initiatives such as Maryland's Health Enterprise Zones help build the local provider workforce. In Rhode Island, Health Equity Zones aim to promote "social and physical environments that support healthy choices and safe living." These community-wide approaches to health equity merit a closer look.

ACOs and healthy neighborhoods or zones are not an either-or proposition. States may view accountable or coordinated care initiatives as providing a foundation on which to build neighborhood- or community-wide equity efforts, or vice versa. Evolving state efforts may encompass both community-based equity models and accountable care initiatives in a complementary process of health systems transformation.

### Connecticut

Connecticut will develop Health Enhancement Communities (HECs) as part of its State Innovation Model (SIM) model test initiative. The state department of public health plans to work with the SIM population health council<sup>8</sup> to develop the HECs. The HECs are expected to encompass the geographic areas with the greatest health disparities and improve health through local cross-sector coordination, evidence-based programs, and reimbursement strategies that reward investment in improving health equity.

### Delaware

Delaware's initiative will provide resources to support Healthy Neighborhoods, including dedicated full-time staff to convene and coordinate the community health work of Neighborhood Councils and other cross-sector stakeholders to "create integrated—rather than parallel" initiatives.<sup>9</sup> The state plans to have 10 non-overlapping Healthy Neighborhoods Communities each containing between 50,000 and 100,000 residents, governed by a Council meant to be inclusive and representative of the community. The Healthy Neighborhoods initiative is one of several Delaware Center for Health Innovation initiatives, each of which is intended to bring delivery system reforms to scale to achieve the state's SIM goals.

## Maryland

To address health disparities, improve access, and reduce costs, Maryland's Health Enterprise Zones provide financial incentives such as hiring tax credits and loan assistance to providers who practice in underserved areas. There are currently five Zones located in areas with "measurable and documented economic disadvantage and poor health outcomes."<sup>10</sup> Each Zone is coordinated by an organization such as a hospital, health system, or county health department.

Local Health Improvement Coalitions (LHIC) award grants to "areas of greatest population health need."<sup>11</sup> Grants can be used to hire and train personnel, including community health workers; purchase equipment; and support other capacity-building measures. LHICs are co-chaired by a local health department officer and senior leader of a health system. The LHIC initiative is aligned with the State Health Improvement Process.

## Rhode Island

Rhode Island's Health Equity Zones assess the needs and strengths of local communities and implementation projects to meet those needs. The eleven Zones each have a population of at least 5,000, and have documented "health disparities, poor health outcomes, and identifiable social and environmental conditions to be improved."<sup>12</sup> Each Zone has a local backbone organization (a community organization, health center, or local government office), an organization coordinator and evaluator, and a state project officer and evaluator. The Zones engage local education and housing agencies, city halls, Federally Qualified Health Centers, and residents.<sup>13</sup> The backbone organizations receive funding on behalf of the community collaboratives, and disburse it to key community partners to support community-level activities, such as a community garden.

## Targeting Resources

These four states are embedding local and regional strategies to improve health equity into larger statewide system transformations such as enhanced primary care and prevention, innovative multi-payer state payment and delivery models, and value-driven health care. These locally focused models improve health equity by addressing community-wide needs, rather than by focusing on clinical interventions for individuals. A number of these efforts seek to promote healthy lifestyles and prevent chronic disease by targeting resources to the areas with greatest need. By promoting community investment, these initiatives also have the potential to drive economic development and strengthen community infrastructure in the targeted neighborhoods or zones.

## Building Local Capacity

All these local initiatives either do or plan to dedicate state staff or fund the local hiring of personnel to build capacity in target communities (see Table 1). By recognizing human capital as one of the most pressing needs of communities seeking to reduce health disparities, the initiatives have the potential to serve also as engines of economic development. For example, Maryland's Health Enterprise Zones could stimulate local economies by attracting more clinicians to underserved areas through loan forgiveness and tax credits, although the programs have not yet matured enough to determine their impact.<sup>14</sup>

**Table 1. Capacity-Building Strategies**

Initiative	Capacity-Building Strategies
Connecticut Health Enhancement Communities	<ul style="list-style-type: none"> <li>Plan to <b>coordinate</b> community resources and foster cross-sector collaboration between community organizations, providers, local public health agencies, consumers, and other stakeholders.</li> </ul>
Delaware Healthy Neighborhoods	<ul style="list-style-type: none"> <li>Plan to dedicate full-time <b>staff</b> to convene community organizations and stakeholders.</li> <li>Plan to provide technical <b>expertise</b> on identifying funding sources, collecting and using data, and techniques for determining the impact of initiatives.</li> <li>Plan to implement a <b>Learning Collaborative</b> for Healthy Neighborhoods to share best practices.</li> </ul>
Maryland Health Enterprise Zones	<ul style="list-style-type: none"> <li>Provide <b>loan repayment</b> assistance and <b>income tax credits</b> for practitioners hired to work in the Zones.<sup>15</sup></li> <li>Provide Health Enterprise Zone <b>Hiring Tax Credits</b> for employers who hire clinicians, community health workers, or interpreters to work in Zones.<sup>16</sup></li> </ul>
Maryland Local Health Improvement Coalitions	<ul style="list-style-type: none"> <li>Pay for <b>personnel</b> hiring and training, including program administrators and community health workers.</li> <li>Pay for equipment purchasing.</li> </ul>
Rhode Island Health Equity Zones	<ul style="list-style-type: none"> <li>Pay for <b>assessments</b> of community needs and assets, and the development of local cross-sector <b>action plans</b></li> <li>Support a <b>learning collaborative</b> and a state-level team of subject matter experts to build capacity across Zones.</li> <li>Create community profiles reflecting the resources in each Zone.</li> </ul>

All five initiatives fund staff to bolster community efforts to promote health and reduce disparities, primarily by acting as a convener and coordinator for other stakeholder efforts. Although Maryland's Health Enterprise Zones stand alone in paying to attract physicians and other licensed clinical practitioners to work in underserved areas experiencing health disparities, Connecticut, Maryland, and Rhode Island all incorporate or plan to incorporate community health workers (CHWs) into community health efforts. It remains to be seen whether the CHWs operate primarily as part of clinical care teams, or as community advocates and educators. Delaware dedicates program management staff and Healthy Neighborhoods Coordinators to convene community partners and support Healthy Neighborhoods programs, and staff from the Rhode Island Department of Health support local projects undertaken by the Health Equity Zones.

Delaware and Maryland both include technical assistance to help Healthy Neighborhoods and Health Enterprise Zones implement their health equity projects and incentives. Delaware and Rhode Island have built learning collaboratives into their local initiatives, and Delaware expects its Healthy Neighborhoods to meet quarterly to share their best practices and implementation experiences.<sup>17</sup>

**Table 2. Planned or Current Investments in Local Capacity-Building**

State	Licensed Clinicians	Other staff (CHWs, interpreters, administrators, community coordinators)	Learning Collaborative and/or TA
Connecticut		X	
Delaware		X	X
Maryland - HEZ	X	X	
Maryland - LHIC		X	X
Rhode Island		X	X

## Measuring Success

Built into these initiatives is the idea that communities know what resources are needed to improve community health and promote health equity. Measuring success may, therefore, vary depending on the goals of each local initiative. While most initiatives have not matured enough to measure success, some have acknowledged the need for effective measures of impact.

- Connecticut has built the development of population health and health equity metrics for its Health Enhancement Communities into year two of its SIM plan.<sup>18</sup>
- Delaware has tasked Healthy Neighborhoods governing bodies with determining what success would look like, and how data to measure success will be collected and analyzed.<sup>19</sup> They will provide or coordinate support to the Healthy Neighborhoods to help guide them in this effort.
- Rhode Island is working with a team of local experts to create statewide core measures of success from a health equity perspective. Each Health Equity Zone has an evaluator from the Zone's own backbone agency as well as an evaluator from the state department of health.<sup>20</sup>
- Maryland is statutorily required to report on the impact of practitioner tax credits and loan repayment on a) attracting health practitioners to the Health Enterprise Zones and b) reducing health disparities and improving outcomes. The state tracks a set of measures across a range of health determinants as part of the state health improvement process. Measures data is stratified by race and ethnicity when possible to examine impact on disparities and health equity. Outcomes measures include hospital admissions and readmission rates and hospital costs.

*"Where is the funding for doing this kind of work? There is no equity funding being given to us, but nearly every proposal or grant we receive mentions disparities. We looked at the funding we were receiving...we pulled that funding together, and we released a request for proposals and asked the community to come and define themselves [as Health Equity Zones]."*\*

*\*Rhode Island state official, January 28, 2016 webinar, National Partnership for Action to End Health Disparities.*

## Funding

All the initiatives are part of larger state health system transformations, and some rely on federal funding for those transformation efforts, as shown in the Table 3. Delaware and Rhode Island seek to braid multiple funding sources to support their local initiatives, including, in the case of Rhode Island, federal Centers for Disease Control and Prevention (CDC) chronic disease prevention funds for the prevention of obesity, diabetes, heart disease and stroke; CDC preventive health block grant funds; and early childhood

wellness funds from the Substance Abuse and Mental Health Services Administration (SAMHSA).<sup>21</sup> Delaware is looking into funding through grants, stakeholder support, and in-kind contributions, as well as indirect support from the department of public health for identifying and developing the roles of CHWs in Healthy Neighborhoods. Rhode Island is exploring hospital community benefit dollars as a potential source of funding. Maryland is also exploring various funding alternatives for sustainability.

Braiding or blending funding may facilitate cross-sector collaboration on health equity, as well as provide financial support for targeted local efforts to reduce health disparities. Alternatively, states with legislative support for their equity efforts could legislatively establish a fund to support them.<sup>22</sup>

**Table 3. Current or Potential Funding Sources**

	SIM	SHIP or other Federal Funding	State Funding	Private funding
Connecticut	X		X	
Delaware	X	X	X	X
Maryland - HEZ			X	X
Maryland - LHIC			X	X
RI Health Equity Zones		X	X	X

## Looking Ahead

As these initiatives develop and mature, it will be important to track and disseminate best practices and lessons learned to help other policymakers considering targeted community-level approaches to increasing health equity. Some preliminary questions include:

- If the targeted interventions are effective at reducing health disparities, is there benefit to expanding the interventions to a broader population?
- How will states and localities measure improvements in health equity and community health?
- How will these initiatives intersect with health in all policies approaches to city and town planning, transportation, air and water quality, and other policy frameworks?
- Will states and localities be able to coordinate their initiatives to avoid duplicating services and supports provided by other programs?
- How do states and localities partner most effectively in decision-making and governance? How can states best align and support initiatives while allowing for local flexibility?
- Will these efforts provide new money for needed services?
- How will savings from the initiatives be measured? Will they be reinvested in population health?

As part of broader health systems reforms, Connecticut, Delaware, Maryland, and Rhode Island are taking targeted, strategic approaches to investing in communities that have been affected by health disparities. As these approaches mature, they are likely to hold lessons for other state policymakers eager to protect their investments in health reforms and build a more healthy and equitable environment for all residents.

## Endnotes

1. Institute for Healthcare Improvement, "The IHI Triple Aim," <http://www.ihl.org/engage/initiatives/tripleaim/pages/default.aspx>, Accessed April 1, 2016.
2. For example, states are required to contribute a non-federal share to their Delivery System Reform Incentive Payment (DSRIP) programs authorized under Medicaid Section 1115 waivers. For more information on state funding of DSRIP programs, see NASHP's March 2015 report to the Medicaid and CHIP Payment and Access commission, "State Experiences Designing and Implementing Medicaid Delivery System Reform Incentive Payment (DSRIP) Pools," <https://www.macpac.gov/wp-content/uploads/2015/06/State-Experiences-Designing-DSRIP-Pools.pdf>, accessed April 15, 2016.
3. "Diabetes — United States, 2006 and 2010," Centers for Disease Control and Prevention (2013) CDC Health Disparities and Inequalities Report — United States, 2013. Technical Report. Morbidity and Mortality Weekly Report, p. 101. Available at: <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>
4. "Expected Years of Life Free of Chronic Condition—Induced Activity Limitations — United States, 1999–2008," Centers for Disease Control and Prevention (2013) CDC Health Disparities and Inequalities Report — United States, 2013. Technical Report. Morbidity and Mortality Weekly Report, p. 88. Available at: <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>
5. Chetty, R. et al. "The Association Between Income and Life Expectancy in the United States, 2001–2014." JAMA. Published online April 10, 2016. <http://jama.jamanetwork.com/article.aspx?articleid=2513561>, accessed April 15, 2016.
6. Charles H. Bruner and Edward L. Schor, "Clinical Health Care Practice and Community Building: Addressing Racial Disparities in Healthy Child Development," presented to the Institute of Medicine Roundtable on Racial and Ethnic Health Disparities Public Workshop, January 24, 2008. <http://bit.ly/1O5gW5J>, accessed May 9, 2016.
7. Innovative strategies such as Accountable Communities for Health, Accountable Care Organizations, Coordinated Care Organizations, Regional Care Collaborative Organizations, and the new Accountable Health Communities all focus efforts at the community level but vary in the degree to which they focus on clinical care as opposed to community health promotion, prevention, and the social determinants of health.
8. "Proposed Composition and Criteria for Participation in the Population Health Council," [http://www.healthreform.ct.gov/ohri/lib/ohri/work\\_groups/pop\\_health/charter\\_pop\\_health\\_council\\_03102016.pdf](http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/pop_health/charter_pop_health_council_03102016.pdf), accessed June 1, 2016.
9. Operating Model p. 8
10. <http://dhmh.maryland.gov/healthenterprisezones/Pages/HOME.aspx>
11. [http://dhmh.maryland.gov/mchrc/Pages/chrc\\_support.aspx](http://dhmh.maryland.gov/mchrc/Pages/chrc_support.aspx)
12. National Partnership for Action to End Health Disparities, "Rhode Island: Health Equity Zones," January 28, 2016 webinar, <http://bit.ly/1VwezJE>. Accessed June 1, 2016.
13. <http://www.health.ri.gov/publications/guides/HEZLeads.pdf>
14. See HEZ 2014 annual report p. 17
15. Maryland DMMH, HEZ 2014 annual report p. 14–15. <http://dhmh.maryland.gov/healthenterprisezones/Documents/HG%2020-1407%20-%20CHRC%20-%20HEZ%20-%20Final%20Signed.pdf>, accessed June 6, 2016.
16. [http://taxes.marylandtaxes.com/Resource\\_Library/Tax\\_Publications/Business\\_Tax\\_Credits/Health\\_Enterprise\\_Zone\\_Hiring\\_Tax\\_Credit.shtml](http://taxes.marylandtaxes.com/Resource_Library/Tax_Publications/Business_Tax_Credits/Health_Enterprise_Zone_Hiring_Tax_Credit.shtml)
17. Healthy Neighborhoods Operating Model p. 11
18. CT SIM Test plan narrative p. 3.
19. Healthy Neighborhoods operating model, p. 7.
20. Rhode Island Department of Health HEZ Leads List, <http://www.health.ri.gov/publications/guides/HEZLeads.pdf>
21. CDC, "State and Local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke," <http://www.cdc.gov/chronicdisease/about/foa/2014foa/public-health-action.htm>. Accessed May 31, 2016. SAMHSA, "Project LAUNCH: Promoting Wellness in Early Childhood," [http://media.samhsa.gov/samhsaNewsletter/Volume\\_18\\_Number\\_3/PromotingWellness.aspx](http://media.samhsa.gov/samhsaNewsletter/Volume_18_Number_3/PromotingWellness.aspx). Accessed May 31, 2016.
22. Maryland Health Improvement and Disparities Reduction Act of 2012, <http://mgaleg.maryland.gov/webmga/frmMain.aspx?ys=2012rs%2fbillfile%2fsb0234.htm>

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