TACKLING HEALTH DISPARITIES

Considering Health Enterprise Zones for North Carolina

BY

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FOR

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# Table of Contents

1. BACKGROUND ......................................................................................................................... 2  
   1.1 Available Resources ............................................................................................................. 3  

2. MARYLAND .............................................................................................................................. 3  
   2.1 Opportunities and Lessons .................................................................................................. 6  
   2.2 Complementary Health Disparity Activities in Maryland ...................................................... 7  

3. NORTH CAROLINA .................................................................................................................. 8  
   3.1 North Carolina’s Efforts to Address Health Disparities .......................................................... 9  
   3.2 Complementary Health Disparity Activities in North Carolina ............................................ 11  

4. NORTH CAROLINA SHOULD CONSIDER HEALTH ENTERPRISE ZONES ......................... 12  
   4.1 Geo-Mapping ....................................................................................................................... 13  
   4.2 Conduct Community Listening Sessions ........................................................................... 13  
   4.3 Identify and Catalog Resources ......................................................................................... 13  
   4.4 Convene a Statewide Conference ....................................................................................... 14  
   4.5 Complementary Multi-Year Effort ...................................................................................... 14  

5. CONCLUSION .......................................................................................................................... 14  

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## About the Author

Lee Dixon is an experienced health policy manager who has worked at the local, federal, academic, and state levels in analyzing and affecting health care policy. In 2007, Dixon established the Albemarle State Policy Center, a non-partisan resource dedicated to identifying, researching, and analyzing State and Federal programs, policies, and legislation that affect the scope, quality, delivery, and financing of healthcare in the public and private sectors.

In late 2006, Lee came to North Carolina to work for the General Assembly as fiscal and health policy analyst with oversight responsibility for the Department of Health and Human Services’ Division of Public Health, Division of Medical Assistance, and Health Choice Programs. In 2011, he left the General Assembly to become the Director of Policy Research and Development at the North Carolina Community Care Networks. From 2013-2016, Lee facilitated and directed NC Get Covered, a non-partisan initiative committed to improving health outcomes in North Carolina through outreach, education and enrollment in the health insurance marketplace.

Lee honed his analytical and policy skills during a career of researching legislation and policies across the 50 states. He directed the Health Policy Tracking Service (HPTS) and he has held key positions at the National Institute of Mental and the HEW Task Force to Implement the President’s Commission on Mental Health and began his career as a Public Health Advisor for the Centers for Disease Control and Prevention.
What are health disparities and why do they matter? As a country, we have achieved significant health improvements over the past century. We have benefited from progress in automobile safety, better workplace standards, good schools and medical clinics, and reductions in smoking.

But when we look closer, within each state across the country—including North Carolina—there are significant differences in health outcomes according to where people live, learn, work, and play. It is clear that not all Americans have the means nor the opportunity to be their healthiest.¹

This Issue Brief will

- Provide a background on health disparities and place the social and medical determinants of disparities into context.
- Describe the innovative approach Maryland is taking to address health disparities.
- Describe North Carolina’s current programs and activities, and
- Recommend that NC policymakers consider adopting health enterprise zones.

1. Background

In 2003, the landmark Institute of Medicine (IOM) report “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” drew national attention to disparities in the health care of racial and ethnic minorities.² While in the decade since, some disparities in health care have narrowed, disparities in the health of minority and disadvantaged populations have persisted.

Health equity is the opposite of health disparity and is achieved when everyone has a fair chance and opportunity to attain his or her full health potential. ³ (See Figure 1)

Since the IOM issued its report, healthcare stakeholders and policymakers have come to realize that health begins where we live, learn, work and play. Therefore, understanding health disparities requires a fresh look at the determinants of health itself, the most obvious being intrinsic biological attributes such as age, sex, and genes. However, there are other risk factors that affect health and are referred to as “downstream” determinants because they are often shaped by “upstream” societal conditions. Downstream determinants include medical care; environmental factors, such as air pollution; and health behaviors, such as smoking, seeking or forgoing medical care, and not adhering to treatment guidelines.

Exposure to these determinants is influenced by “upstream” social determinants of health—personal resources such as education and income and the social environments in which people live, work, study, and engage in recreational activities.

Income is one of the most familiar social determinants to have a striking association with health. Adults living in poverty⁴ are more than five times as likely to report being in fair or poor health as adults with higher incomes.⁵

Education, like income, has a large influence on health. Adults without a high school diploma or equivalent are three times as likely as those with a college education to die before age sixty-five.⁶

Communities, Unhealthy behavior is partly a matter of personal choice, but the environment in which people live, work, and play influences their health behavior and status.

- A family may desire to eat a healthy diet but find nutritious foods too costly, or live too far from a supermarket that sells fresh produce.
- Parents want their children to play outside and take advantage of recreational opportunities. However, their neighborhoods may be unsafe, lack playgrounds or recreational facilities.
- Disadvantaged communities often have a shortage of health primary care providers.⁷

Economic opportunity, the vibrancy of neighborhoods, access to education and sufficient income are conditions set by society, not by physicians, hospitals, health plans, or even the public health community. The leaders who can best address the root
causes of disparities may be the decision makers outside of health care who are in a position to strengthen schools, reduce unemployment, stabilize the economy, and restore neighborhood infrastructure.

1.1 Available Resources and Action

Annually, the United Health Foundation, along with the American Public Health Association, collects vital public health data at the state and county level and issues two seminal reports on status of state and county public health

- America’s Health Rankings® Annual Report (AHR) is all about actions and initiatives that can be taken by state policymakers. The report goes beyond where a state is in the rankings to where it could be. AHR uses the data it collects to investigate why the state fell or rose in the rankings, and then examines the actions that could be taken.

- County Health Rankings & Roadmaps—Building a Culture of Health County by County® is used as a go-to-source for local communities in raising awareness of the broad range of factors that matter to our health and drive change in these areas.

Together these reports draw policymakers’ attention to the gaps in public health, chronic conditions, and health status, and rank the best to worst counties in a state in how long and how well residents live. They encompass a fundamental commitment to empowering local communities to close health gaps and advance health equity. The rankings were used as a wake-up call for Maryland policymakers to take action.

2. Maryland

In 2012, Maryland state policymakers became concerned where the state fell in America’s Health Rankings. Despite the state’s having outstanding medical schools, the highest median household income, and the second highest number of primary care physicians per 100,000 population, it lagged behind other states in several key health indicators.

In 2012, according to America’s Health Rankings, Maryland ranked:

- 31st in infant mortality,
- 30th in cardiovascular deaths,
- 20th in cancer deaths,
- 22nd in obesity prevalence and
- 20th overall, among the 50 states.

Furthermore, Maryland policymakers found unfortunate and persistent health disparities across these health indicators by race/ethnicity and by place of residence in the state.

As a result, Maryland policymakers directed the state’s Health Quality and Cost Council to convene a Health Disparities Workgroup. The workgroup was composed of public health experts, research scholars, and community health leaders and charged with identifying strategies to reduce and eliminate health disparities. The workgroup chose to apply principles of economic development and revitalization to public health and health care delivery. The concept included a range of incentives, including tax credits and loan repayment to attract a range of healthcare providers, including primary care physicians, to expand current or open new primary care practices. Other community-level initiatives of the HEZs involved community health workers (CHW) and strategies to address the medical and social determinants of health disparities. The key recommendation of the workgroup was to implement this comprehensive strategy and its initiatives through the creation of “Health Enterprise Zones”. The zones were to encompass contiguous geographic areas where the population was experiencing poor health outcomes that were contributing to racial/ethnic and geographic health disparities.

The Workgroup’s recommendations became the basis for SB 234, “The Maryland Health Improvement and Disparities Reduction Act of 2012”, establishing Health Enterprise Zones (HEZ) and targeting resources to:

1) Reduce health disparities;
2) Improve health outcomes; and
3) Reduce health costs and hospital admissions and readmissions in specific area of the State.

The Act authorizes community-based organizations (CBO) to apply for a range of incentives and resources for HEZs, including:

1) Income tax credits;
2) Hiring tax credits;
3) Loan repayment assistance, and
4) Grant funds.
In the fall of 2012, Maryland’s Department of Health and Mental Hygiene (DHMH) solicited applications from community-based organizations and local health departments across the state to become an HEZ. To be eligible for HEZ funding a community had to:

- Define the geographic area it would serve, i.e. identify a set of contiguous zip code areas, with at least 5,000 residents.
- Demonstrate an economic need through the:
  - Percentage of residents who were Medicaid eligible;
  - Percentage of women eligible for the Supplemental Nutrition Program for Women, Infant, Children (WIC);
  - High rate of Infant Mortality; and
  - Reduced rate of Life Expectancy

No other risk factors, such as the rate of stroke, heart disease, asthma, HIV/STDs, or cancer were required. The DHMH believed that by minimizing the requirements a community based organization (CBO) had to meet, it could encourage a greater number of applicants to apply.

To further encourage and facilitate CBOs and local health departments to apply, DHMH created a database by geo-mapping the state’s 240 zip codes by economic need, infant mortality, and life expectancy. Maryland’s decision and investment to geo-map the state at the zip code level has proven to be an excellent investment in resources. The DHMH has repeatedly used the zip code database to identify local communities within counties and cities where the state policymakers can garner the best return on investment with federal, state, and/or philanthropic funds.

The Maryland General Assembly authorized and appropriated $16 million for the four-year HEZ program. Each HEZ would develop its own implementation plan, based on its approved application, but, in general, each HEZ was expected to fulfill the following annual sequence of goals.

The annual goals were established to achieve a step-by-step process to fulfill the overall goals of the HEZ program:

- Create economic and community-driven incentives to enhance the number of healthcare providers, at all levels, and access to services;
- Reduce the utilization of hospital emergency room services;
- Reduce hospital admissions and readmissions;
- Improve health outcomes in racial/ethnic minority populations, and
- In fulfilling the above goals, engage the community-based organizations and the business, education, and community leaders to recognize and address the social and medical determinants for HEZ residents.

DHMH received 19 applications from 17 communities across the state that were considered in a two-step review process. The first step was to evaluate the 19 applications and select 10 finalists. The second step was for representatives from the 10 CBOs to make a public presentation to the Maryland Health Council. From the 10, five HEZs were selected for implementation.

Table 1

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Annual Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>Focus on capacity expansion, including HEZ healthcare providers and community health workers (CHW)/case managers. Priority areas include recruitment and training.</td>
</tr>
<tr>
<td>Year 2</td>
<td>Focus on the productivity of the HEZ healthcare providers, programs, and CHWs, to utilize new capacity with the neediest patients. Priority areas are program development, outreach, and additional training.</td>
</tr>
<tr>
<td>Year 3</td>
<td>Focus on the quality care provided by healthcare providers and CHWs including relevant metrics for all personnel.</td>
</tr>
<tr>
<td>Year 4</td>
<td>Focus on health outcomes—hospital utilization and cost reductions.</td>
</tr>
<tr>
<td>Entity</td>
<td>Location Zone’s Population</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Morris Blum Public Housing, Anne Arundel Medical Center</td>
<td>Annapolis 36,805 people in 1 zip code Suburban Community</td>
</tr>
<tr>
<td>Dorchester County Health Department</td>
<td>Dorchester and Caroline Counties 36,123 people in 7 zip codes Rural Eastern Shore</td>
</tr>
<tr>
<td>Prince Georges Health Department</td>
<td>Capitol Heights 38,626 people in 1 zip code D.C. Suburb</td>
</tr>
<tr>
<td>Lexington Park, Medstar, St. Mary’s Hospital</td>
<td>St. Mary’s County 34,035 people in 3 zip codes Rural So. Maryland</td>
</tr>
<tr>
<td>Bon Secours Baltimore Health System</td>
<td>West Baltimore 137,823 people in 4 zip codes Urban Community</td>
</tr>
</tbody>
</table>
2.1 Opportunities and Lessons

The five HEZs recently completed their third year, of the four-year initiative. The activities and accomplishments to date validate the goals and commitments first set out by Maryland’s Health and Quality Cost Council and the Maryland General Assembly to address the medical and social determinants of health disparities amongst racial/ethnic minority communities.

Community involvement

A key to the success of Maryland’s HEZs, or any initiative to address health disparities is involvement at the community level. Following the General Assembly’s enactment of the HEZ legislation (SB 234), DHMH staff conducted a series of public forums to gather community insight. The involvement, from the start, of community-level stakeholders representing the interests and involvement of healthcare providers, faith-based organizations, municipal government, schools, businesses, and community-based organizations is a key to success.

In preparation to conducting the state-wide listening sessions, state-level policymakers need to be briefed and made aware of both the socio-economic and medical/health determinants of health disparities, e.g. income, education, and a community’s environment.36

Obtaining buy-in and commitment, at the start, from the broad community involved and the population to be served significantly increases their commitment to the success of the effort. Concurrently, the collaborative and coordinated efforts on the part of state-level staff and community leaders and healthcare providers from across the state will result in an effective working relationship. Furthermore, it allows for DHMH staff to partner with the HEZs in implementation, as opposed to solely looking over their shoulder.

Geo-Mapping

As noted in the text and table above, the HEZ initiatives and services are focused on the residents living within the contiguous zip codes. The five HEZs encompass up to seven zip codes and between 34,000 and 138,000 residents. Public health experts have commented to this author on the foresight of Maryland’s mapping the state by zip code in identifying areas of greatest need with regard to health resources and the prevalence of chronic and acute healthcare conditions.37

The zip code database assisted reviewers to identify applications from areas of greatest need, it also allowed for the HEZs, once selected, to focus their efforts on the residents of the contiguous zip codes and have a significant impact on the health status of racial/ethnic persons living in those designated areas. This, in turn, has led to a return on investment (ROI). It also underscored the business rationale and application of economic principles in the development and revitalization of public health and healthcare delivery services.

Community Health Workers

The HEZs’ emphasis on and implementation of CHWs coincided with national healthcare reforms to identify gaps in services, emphasize communication with patients, coordinate care, optimize utilization and outcomes, and minimize costs. The effectiveness of the CHW’s responsibilities was enhanced by the Maryland’s utilization of its state health information exchange. The Chesapeake Regional Information System for our Patients (CRISP) provided the HEZs and other healthcare providers with daily notification of services. HEZ patients were accessing, e.g. emergency departments and hospital admissions and readmissions. Hospitals have their own patient information systems, so HEZs affiliated with hospitals received hospital alerts on the similar activity of HEZ residents, including high-end utilizers.

Recently and coincidentally, Kaiser Health News® reported on the role of CHWs in Maryland. The following is an excerpt from the article:

“...hospitals across the country are turning to CHWs in a bid to revamp patient care. They are using these aides to strengthen their relationships with patients and surrounding neighborhoods — improving the community’s health and, along the way, their own finances.

Part of it is spurred by the 2010 federal health reform, which introduced a number of changes in how Medicare pays hospitals.

Similar efforts are underway on the state level, through Medicaid payments and health insurance regulations as health insurers show interest in reimbursing these services.

In Maryland, the state has taken steps to reform hospital payments — rewarding health systems for keeping patients healthy enough that they don’t need hospital treatment. That adds financial incentives for Johns Hopkins and other hospitals, encouraging them to use strategies such as community health workers...”38

Effectiveness

The federal Agency for Healthcare Research and Quality’s Prevention Quality Indicators (PQI) are composite measures used with inpatient discharge data to identify quality of care for ambulatory care sensitive conditions that are avoidable hospitalizations in patients ages 18 years and older.
PQI chronic composite rates were on a general downward trend for Maryland and all five HEZs from 2009 to 2014. All-cause, unplanned readmission rates (per 1,000 population) decreased for each HEZ from 2012 to 2014 (data not available prior to 2012) with the following decreases in Maryland overall and by zone:

- Maryland: 14.8%
- Annapolis HEZ: 28.7%
- Dorchester/Caroline HEZ: 0.01%
- Prince George’s County HEZ (PGCHEZ): 21.9%
- Greater Lexington Park HEZ (GLP HEZ): 39.6%
- West Baltimore HEZ: 22.8%

Recruitment of healthcare providers

The National Health Service Corps encourages states (like Maryland) and non-profit healthcare providers to participate in its Loan Repayment Incentives program for primary care providers. In addition, some states—like North Carolina—have state-operated loan repayment programs for healthcare providers. In authorizing a loan repayment incentive to attract healthcare providers to serve HEZ programs, the legislation restricts eligibility to providers that had graduated from Maryland universities and colleges. This restriction limited the HEZ’s ability to attract healthcare providers. In addition, older practitioners who may be attracted to relocating to rural areas no longer have loans to repay.

As a result, the HEZs petitioned the DHMH for the ability to convert the loan repayment funds to bonuses that could be offered to providers and attract them to become HEZ healthcare providers.

The tax incentive program for healthcare providers and facilities was a new and unique program for Maryland. Its value has yet to be tested and evaluated because the regulations and guidelines were not ready until the second year of operation. The complexity, newness, and delay in implementation led the CBOs to step back from this opportunity. Subsequently, some of the HEZs have requested the authority to convert funds designated for the tax incentive program to be used for operations and services.

As of March 31, 2016, the HEZs have:

- Opened or expanded 20 health care delivery sites.
- Recruited and hired an additional 75 FTEs, i.e. health care personnel, including:
  - 27 practitioner to provide services in the HEZs
  - 12 licensed independent practitioners, and
  - 15 CHWs.

The HEZ providers and their clinics have collectively provided 255,194 visits to 139,211 patients.

Sustainability

Now, in their final year of funding HEZs are earnestly developing sustainability plans to support their future activities. Their strategies are taking advantage of Maryland’s All-Payer Hospital Payment Rate.

In 2014, the Centers for Medicare and Medicaid Services (CMS) and the State announced a new hospital payment design that focuses on overall per capita expenditures for hospital services, as well as on improvements in the quality of care and population health outcomes. For five years beginning in 2014, Maryland will limit the growth of per capita hospital costs to 3.58% or 0.5% less than the actual national growth rate for 2015 through 2018, whichever is less. The change is forecast to save Medicare at least $330 million.

Thus the HEZs with the legislated goals of reducing ED use, hospital utilization, population management through CHWs, and enhanced primary care services to racial/ethnic residents and their disproportionate rate of acute and chronic illnesses have become an integral part of a hospital’s and Maryland’s effort to cut costs and save resources.

The revenue saved by the hospital, through the services of the HEZs can thus be used to fund and sustain future HEZ programs’ activities and services.

2.2 Complementary Health Disparity Activities in Maryland

The HEZs represent a concerted effort on the part of state policymakers to address health disparities. At the same time, Maryland policymakers are seeking to reinforce and incorporate attention to health disparities through several parallel efforts, two of which are:

State Partnership Initiative

Maryland’s Office of Minority Health and Health Disparities (MHHD) recently received a federal grant for the purpose of “Educating Minorities on the Benefits they receive after Enrollment.” The Office’s initiative aligns with the Federal government’s “Coverage to Care” initiative to assist consumers who have enrolled in health insurance, through the ACA, on how best to use their newly acquired health insurance.

The grant focuses on newly enrolled racial/ethnic consumers living in specific zip codes, though not necessarily those of the HEZs. Here again, Maryland is targeting zip codes, geographic areas and establishing specific goals/targets:
• To decrease the percentage of persons uninsured in the target zip codes by 5 percent through community health workers (CHWs) and referrals from a hospital partner.

• To obtain a 20 percent decrease in the target zip codes, in the rate of ED visits or hospital admissions.

• To hold community educational sessions to improve health insurance literacy, and

• To help them overcome barriers to effective use of primary care services.

• To decrease, by 10 percent the number of Medicaid enrollees who have not had at least one primary care visit in the last two years.

Committee on Institutional Cooperation—Health Equity Initiative

The University of Maryland are members of The Committee on Institutional Cooperation—a consortium of Big 10® universities plus the University of Chicago. The University of Maryland and DHMH along with other universities and their state health departments are collaborating to bolster health equity in their respective states. By understanding and addressing the social determinants of health, the CIC Health Equity Initiative is poised to improve the health outcomes of vulnerable children and infants across the eleven state region of the CIC.

3. North Carolina

The 2015 reports from America’s Health Rankings® and County Health Report and Roadmap® provide comprehensive and detailed facts and figures on North Carolina’s status, rankings and gaps. America’s Health Rankings’ Overview of North Carolina noted the state’s overall ranking rose from 36th to 31st. The rise in the rankings was due in large part to the percentage of children receiving their prescribed immunizations, and the percentage of adolescent young women who received HPV immunizations. It also noted the challenges North Carolina policymakers face.

In 2015, America’s Health Rankings for North Carolina include:

• 42nd for infant mortality,
• 31st in cardiovascular deaths,
• 33rd in cancer deaths,
• 26th in the prevalence of obesity, and
• 31st overall, among the 50 states.

### Table 3

<table>
<thead>
<tr>
<th>Race</th>
<th>Pct. Living in Poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>34.8%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>33.9%</td>
</tr>
<tr>
<td>African-American</td>
<td>28.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>13.1%</td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>12.2%</td>
</tr>
<tr>
<td>State Average</td>
<td>18.0%</td>
</tr>
</tbody>
</table>

Federal Poverty for Family of 4 is $23,492

Furthermore, the report pointed to the large disparity in health status of North Carolinians based on the level of education, a high infant mortality rate, and the low per capita spending on public health.

Similar to AHR, the County Health Rankings & Roadmaps—Building a Culture of Health County by County report, draws attention to the gaps between the best to worst ranked counties in how long and how well residents live. The annual report asserts that rankings make the case for action to improve the opportunities for everyone’s good health, both for residents in our unhealthiest counties and for those who do not have a fair chance at achieving good health in counties that rank among the healthiest.
See Table 4 for the disparity between North Carolina’s 100 counties for a select number of conditions and statuses according to CHR&R.

### Table 4

<table>
<thead>
<tr>
<th>Condition</th>
<th>Range Across NC’s 100 Counties&lt;sup&gt;xix&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lowest Rate</td>
</tr>
<tr>
<td>Infant Mortality per 100,000 Live births</td>
<td>5 per 100,000</td>
</tr>
<tr>
<td>Adult Obesity</td>
<td>20%</td>
</tr>
<tr>
<td>Life Expectancy: Number of Deaths at or under age 75 per 100,000 people</td>
<td>230 per 100,000</td>
</tr>
</tbody>
</table>

#### 3.1 North Carolina’s Efforts to Address Health Disparities

North Carolina’s efforts to address health disparities lie with the NC Office of Minority Health and Health Disparities (OMHHD)<sup>xix</sup> The Office’s role is to engage in projects and activities in communities across North Carolina that promote and advocate for the elimination of health disparities of all racial and ethnic minorities and other underserved populations. The focus areas include: 1) research and data; 2) culture and language; 3) leadership development; and 4) partnership development.

**Community Focused Eliminating Health Disparities Initiative**

In 2005, the North Carolina General Assembly established the Community Focused Eliminating Health Disparities Initiative (CFEHDI) to close the gap in the health status of racial/ethnic minorities, as compared to the health status of Whites through the use of preventive measures to support healthy lifestyles. Administered by OMHHD, the focus areas of CFEHDI are asthma, cancer, diabetes, heart disease, HIV/AIDS and other sexually transmitted infections, infant mortality, obesity, and stroke. In addition, it seeks to successfully prepare community leaders and their organizations to become effective and informed public health leaders, advocates, and partners.

In the budget for SFY 2015-16 the North Carolina General Assembly appropriated $2 million to the Division of Public Health for the OMHHD to award up to 12 new CFEHDI contracts to the following entities, with no entity receiving more than $300,000. The contracts were made in February 2016. See Table 5.

In June 2016, the North Carolina General Assembly enacted the SFY 2016-17 budget with language that directs the Department of Health and Human Services to stop all new grants from the Community Focused Eliminating Health Disparities Initiative. In addition, it reallocates the $2.7 million from the Office of Minority Health and Health Disparities to the Injury and Prevention Section of the Division of Public Health for community-based diabetes prevention. The reallocation leaves the OMHHD with a minimum of resources.

OMHHD also is working to implement “Health in All Policies” which is a collaborative approach of health care professionals and policymakers to improve the health of all North Carolinians by incorporating health considerations into decision-making across all DHHS sectors and policy areas. Adopting this philosophy the Division of Public Health and OMHHD have sought to bring attention to the medical and social determinants of health disparities in the Department of Health and Humans Services’ decision making processes.

**Culturally and Linguistically Appropriate Services**

In 2013, the US/DHHS established the Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. By tailoring services to an individual’s culture and language preference, health professionals can help bring about positive health outcomes for diverse populations.

NC OMHHD offers CLAS trainings and technical assistance to organizations and community members interested in learning more about cultural competence and the National CLAS Standards. The goal of the CLAS Program is to equip organizations with the information and resources to address the changing demographics and health care needs of North Carolinians. To date it has conducted trainings in 37 counties across the state.
<table>
<thead>
<tr>
<th>CFEHDI</th>
<th>Counties Served Population</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>AccessCare</td>
<td>Alamance, Caswell, Chatham, and Orange Counties 393,000 residents</td>
<td>Diabetes and Heart Disease</td>
</tr>
<tr>
<td>Appalachian Regional Healthcare System, Inc.</td>
<td>Avery and Watauga Counties 71,000 residents</td>
<td>Cancer, Diabetes, Obesity, Heart Disease and Stroke</td>
</tr>
<tr>
<td>Buncombe County Health Dept.</td>
<td>Buncombe County 254,000 residents</td>
<td>Cancer, Diabetes, HIV/AIDS/STDs/Obesity, Heart Disease, Stroke, and Asthma</td>
</tr>
<tr>
<td>Community Health Interventions &amp; Sickle Cell Agency Inc.</td>
<td>Cumberland and Hoke Counties 382,000 residents</td>
<td>Diabetes and HIV/AIDS/STDs</td>
</tr>
<tr>
<td>Lincoln Community Health Ctr.</td>
<td>Durham 298,000 resident</td>
<td>Diabetes and HIV/AIDS/STDs</td>
</tr>
<tr>
<td>Lumbee Nations Tribal Program</td>
<td>Cumberland, Hoke, Robeson, and Scotland Counties 55,000 Members Lumbee Tribe</td>
<td>Cancer, Diabetes, and Obesity</td>
</tr>
<tr>
<td>Henderson County Hospital Corp.</td>
<td>Henderson County 112,000 residents</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Margaret Pardee Mem. Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Onslow County Health Dept.</td>
<td>Onslow County 195,000 residents</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Scotland Community Health Clinic (FQHC)</td>
<td>Scotland, and surrounding Counties 36,000+ residents</td>
<td>Diabetes, Obesity, Heart Disease, and Stroke</td>
</tr>
<tr>
<td>Southern Piedmont Community Care Plan, Inc.</td>
<td>Cabarrus and Rowan Counties 335,000 residents</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Wake County Medical Society—Community Health Foundation</td>
<td>Wake and Johnston Counties 1,195,000 residents</td>
<td>Diabetes, Obesity, Heart Disease and Stroke</td>
</tr>
<tr>
<td>Wayne County Health Dept.</td>
<td>Wayne County 126,000 residents</td>
<td>Diabetes, HIV/AIDS/STDs, Obesity, Heart Disease, and Stroke</td>
</tr>
</tbody>
</table>
Community Health Ambassadors Program

The Community Health Ambassadors Program (CHAP) engages faith communities, health ministries, and health organizations to mobilize CHWs to implement infant mortality reduction strategies in their perspective communities and become health influencers within their networks. DPH’S CHAP aligns with other DHHS’ effort to develop a statewide support-system for community health workers in North Carolina.

3.2 Complementary Health Disparity Activities in North Carolina

Kate B. Reynolds Charitable Trust

In 2012, the Kate B Reynolds Charitable Trust (KBR) established a signature program to improve the health and overall quality of life for people in rural North Carolina—Healthy Places North Carolina.

Residents in rural communities are less likely to have access to health services, are more likely to engage in risky health behaviors and have a higher mortality rate on average than North Carolinians living in non-rural areas. KBR realized that improving health involves more than improving health care. Health challenges are often driven by factors beyond behavior and access to health care—i.e. the social determinants of racial/ethnic health disparities cited previously in this issue brief. KBR specifically noted that rural communities consistently have higher unemployment rates when compared to urban communities and more rural residents live below the federal poverty level.

Healthy Places NC responds to the needs of a community by listening to the people, cooperating with local change-makers, and working with them to find ways to improve the health and overall quality of life. KBR believes that to have a lasting impact on major health challenges, communities must change the way they think about improving health, realize that health is everyone’s business, and develop a diverse infrastructure to tackle health-related issues.

Similar to Maryland policymakers, KBR acknowledges that addressing geographic health disparities is not a short term project and plans to stay involved in each of the following counties for up to 10 years.

- Beaufort County
- Burke County
- Edgecombe County
- Nash County
- Halifax County
- McDowell County
- Rockingham County

Blue Cross Blue Shield of North Carolina Foundation

In 2015, the Blue Cross Blue Shield Foundation awarded four grants of $15,000 and one grant for $125,000 to assist CBOs to build capacity to address several issues involving health disparities.

North Carolina Foundation for Advanced Health Programs

Under the leadership of the North Carolina Foundation for Advanced Health Programs, the North Carolina Rural Health Leadership Alliance (NCRHLA) is a coordinated network of leaders and practitioners representing rural health organizations with a commitment to improving rural health throughout the state of North Carolina.

NCRHLA increases awareness of rural health issues by hosting workshops, distributing fact sheets, releasing position statements, and maintaining a webpage with rural health resources. It promotes collaboration among health agencies, health practitioners, and rural residents in the state by connecting and convening health interests and coordinating forums and work groups to discuss and foster implementation of rural health solutions.

Similarly, Rural Forward NC provides free consulting services to the people, organizations, and coalitions leading the effort to build healthier rural counties in central and eastern NC. It works in partnership with local, regional, or statewide community leaders to support emerging efforts. In addition, it provides regional support for KBR’s Healthy Places North Carolina.
4. North Carolina policymakers should consider creating Health Enterprise Zones

As to why North Carolina state policymakers should consider creating Health Enterprise Zones, let’s examine Table 6 below. According to data from America’s Health Rankings North Carolina ranks in the bottom half among the 50 states in a number of key health indicators. Furthermore, NCDHHS data demonstrates the serious health disparity for African-Americans from the already distressing rankings for North Carolina, as a whole.

Consider

- **Stop** thinking about health as something we only get at the doctor’s office:
  - Instead, health is something that starts in our families, schools, workplaces, playgrounds and parks;
  - The more policymakers see health in this manner, the more opportunities there will be to improve health.

- **Assess** whether North Carolina has fallen short in assisting communities and individuals to develop a road map of their own on how to achieve better health status.

**Take Steps**

Build upon and adapt the concept of Maryland’s Health Enterprise Zones. The success of HEZs deserves serious attention and consideration on the part of North Carolina policymakers. Let’s review the accomplishments to date of HEZs, which include:

- Engagement of community leaders;
- Use of economic development and revitalization of public health and healthcare delivery;
- Focus on a defined community and its residents so as to demonstrate a return on investment.
- Increase in the availability of healthcare providers, including primary care physicians;

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>North Carolina</th>
<th>U.S</th>
<th>No. 1 State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Races</td>
<td>African-American</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Value</td>
<td>Rank</td>
<td>Value</td>
</tr>
<tr>
<td>Obesity (% of Adult Population)</td>
<td>29.7%</td>
<td>26</td>
<td>39.1%</td>
</tr>
<tr>
<td>Low Birthweight (% of live births)</td>
<td>8.8%</td>
<td>40</td>
<td>13.6%</td>
</tr>
<tr>
<td>Infant Mortality per 1,000 live births</td>
<td>7.2</td>
<td>42</td>
<td>12.9</td>
</tr>
<tr>
<td>Diabetes (% of population)</td>
<td>10.8%</td>
<td>33</td>
<td>25.9%</td>
</tr>
<tr>
<td>Cardiovascular Deaths per 100,000</td>
<td>251.1</td>
<td>31</td>
<td>301.3</td>
</tr>
<tr>
<td>Cancer Deaths per 100,000</td>
<td>195.2</td>
<td>33</td>
<td>234.2</td>
</tr>
<tr>
<td>Premature Deaths (years lost per 100,000)</td>
<td>7,604</td>
<td>33</td>
<td>n/a</td>
</tr>
<tr>
<td>Public Health Funding (dollars per person)</td>
<td>$44</td>
<td>42</td>
<td>n/a</td>
</tr>
</tbody>
</table>

• Reduction in health disparities;
• Employment of Community Health Workers to provide population management;
• Improvement in health outcomes;
• Reduction in health costs and hospital admissions and readmissions;
• Facilitate transportation and access to healthcare providers, pharmacies, food stores, and parks;
• Establish a pathway to HEZ sustainability by assisting hospitals to implement Maryland’s All-Payer Hospital Rate.

To create a roadmap for adapting Health Enterprise Zones to North Carolina, state policymakers will want to take the following steps:

1. Geo-mapping the state;
2. Conducting community listening sessions across the state;
3. Convene a statewide conference and
4. Designing health enterprise zones that are complementary with other multi-year efforts.

4.1 Geo-Mapping

North Carolina possesses outstanding academic and state resources to accomplish the necessary geo-mapping of socio-environmental and health determinants of health disparities at the zip code level.

- Department of Health and Human Services, Division of Public Health
- The University of North Carolina
  - Gillings School of Public Health, that works with America’s Health Rankings
  - Sheps Center for Health Research

These resources can be augmented with data from:

- US Department of Agriculture’s Economic Research Service
- CMS interactive map to understand geographic disparities in chronic disease.
- Community Commons, a non-profit organization using U.S. Census information to provide data and tools to improve communities and inspire change.

Maryland and other states have made excellent use of geo-mapping to identify the prevalence of socio-economic and medical determinants of health disparities and thus identify zip codes, communities and counties with racial/ethnic minorities that are experiencing an inordinate higher rate of morbidity and mortality.

Enhancing geo-mapping to the zip code level, as Maryland did, allows state policymakers to assist community leaders to develop a more focused roadmap and a route to more effective and efficient use of resources. As a result, community leaders are able to assume the responsibility to develop a better return on investment with the resources provided. Equipped with this data, the community itself can apply principles of economic development and revitalization of public health and healthcare delivery for racial/ethnic minorities.

4.2 Conduct Community Listening Sessions

Energized and strengthened with public health data down to the zip code level based on the geo-mapping, state policymakers should conduct listening sessions or forums across the state to learn from the many and varied leaders at the community level. What do they believe are their biggest obstacles, needs, or gaps in addressing health disparities? What are they lacking? Is it funding, technical assistance, equipment, facilities, or healthcare personnel?

Recently, New York State conducted a series of Community Listening Sessions in areas defined as Minority Areas (MA), e.g. areas with 40 percent or greater racial and ethnic populations, and which bore a disproportionate burden of poor health. The sessions utilized a community led, bottom-up approach to identifying and discussing complex health and social problems. It allowed the community to establish its own identity and set priorities, and discuss strategies that can achieve improved health and long-standing social change. To ensure that individuals and families had an opportunity to participate, the organizers provided child care services, along with food.

State policymakers will want to ensure the broadest participation in these listening sessions. To do so they will not only want to contact the “usual list of health profession and advocacy organizations”, but make sure to invite representatives from the business community, public education, academia, including community colleges, faith-based organizations, civic organizations, agriculture, representatives from the media, who report on affected individuals and communities, social service programs, and certainly individuals and families from the community.

4.3 Identify and Catalog Resources

To make the best use of current and future resources, state government will want to identify and catalog all federal, state, county, academic, and philanthropic resources that can affect health equality. This effort may
well identify some previously unknown sources of support and concurrently ensure that all efforts are in support of each other and complementary.

4.4 Convene a Statewide Conference

Based on the information gathered from Community Listening Sessions and utilizing the data from the geo-mapping, convene a one-day conference that brings together representatives at all levels from the community-based organizations, the business community, faith-based organizations, education, academia, healthcare, philanthropy, and municipal and state government. Concurrent sessions would be held to identify and discuss the social and medical determinants of health disparities. General Sessions would explore the success of Maryland’s HEZs and the economic strategies and principles they are based on, along with the activities, programs, and services provided. Like Maryland, the goal of the conference would be to develop an overall strategy that takes advantage of North Carolina’s strengths and is complementary of other efforts.

4.5 Complementary Multi-Year Effort

Several of the HEZ accomplishments—note above—along with the recommendations for geo-mapping the state and the hosting of listening forums are complementary to the current Healthy Places NC program. The Trust is committed to a long-term investment of up to 10 years. Similarly, Maryland’s HEZs are a four-year effort, with a specific and viable strategy for sustainability that is being put into place.

5. Conclusion

The Health Enterprise Initiative is innovative in its design, and its approach, has demonstrated its effectiveness in addressing health care priority outcomes and disparities. A notable key to their success and future sustainability is their ability to leverage new incentives enabled by systems changes at the federal level.

By incorporating economic development principles into public health, communities in North Carolina will have the opportunity to develop a range of incentives to expand access to care, reduce health disparities, and improve health outcomes in underserved areas by attracting primary care, dental and behavioral health clinicians and supporting community-level interventions to broaden the scope of care within a given community and thus address social determinants of health.

Primed and prepared with zip code level data and the critical input from community leaders, North Carolina policymakers have a unique opportunity to plan, develop, and implement a health enterprise zone initiative that addresses the state’s racial/ethnic health disparities that will complement and enhance Healthy Places NC.

Visit What Works for Health at countyhealthrankings.org/what-works-for-health for information on these and other strategies to improve health in North Carolina.

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