West Baltimore Primary Care Access Collaborative

Working in Partnership for a Healthier Community

Collaborative Partners

- Baltimore Medical System
- Bon Secours Baltimore Health System
- Coppin State University
- Equity Matters
- Light Health & Wellness Comprehensive Services, Inc.
- Mosaic Community Services
- National Council on Alcohol and Drug Dependence
- Park West Health System
- People's Community Health Centers
- St. Agnes Hospital
- Senator Verna Jones-Rodwell
- Sinai Hospital of Baltimore
- Total Health Care
- University of Maryland Medical Center
- University of Maryland, Midtown Campus
- University of Maryland, Baltimore

For more information:

HealthyWestBaltimore.org
HEZ_Info@bshsi.org

Facebook.com
/WestBaltimoreCARE

Twitter.com
/HEZhero

OUR PARTNERSHIP

The West Baltimore Primary Care Access Collaboration (WBPCAC) is a group of sixteen organizations that aim to improve the overall health of the residents of west Baltimore. The mission of the Collaborative is to create a sustainable, replicable system of care to reduce health disparities, improve access to health care, reduce costs and expand the primary care and community health workforce.

The collaborative is focused on four zip codes **(21216, 21217, 21223, 21229)** in west Baltimore. Covering just over fourteen square miles, the targeted area contains as unofficial boundaries several of Baltimore City's famous landmarks, tourist attractions, and access points.

OUR FUNDING

In **January 2013**, the West Baltimore Primary Care Access Collaborative was awarded a $5 million **four-year grant** from the **Maryland Community Health Resources Commission,** to reduce cardio-vascular disease(CVD) in west Baltimore in the four zip codes outlined by the collaborative. This area is know as the west Baltimore Health Enterprise Zone (HEZ) or *West Baltimore CARE.*

TARGET POPULATION

These combined west Baltimore zip codes have the highest disease burden and worst indicators of social determinants of health than most any other community in Maryland. These neighborhoods establish the lower extremes for health disparities in the City and the State across all major chronic illnesses. Further contributing to poor health outcomes is compromised access to health care services, earning the community's unfortunate designation by HRSA as a medically-underserved area (MUA) and medically-underserved population (MUP).

OUR STRATEGY

To accomplish the goals outlined by the HEZ, the Collaborative has launched multiple culturally-competent, evidence-based, innovative, and promising interventions through dual overarching strategies: (1) development of an infrastructure to foster enduring system change and (2) implementation of a community-wide, patient-centered medical home approach to caring for patients with CVD. Collective Impact theory supports this tack, maintaining that the actual intervention in such efforts should be establishment of an infrastructure to serve as the foundation of concerted strategies that, over time, foster significant, sustainable systemic change.

RESULTS

To date, this is being accomplished by improving access to and the quality of healthcare by hiring 23 health care providers and providing training to many others. The WBPCAC has also deployed 11 Community Health Workers into the ZIP codes to partner with 172 community members to maximize their utilization of health and social services. Additionally, they have offered free fitness classes such as Zumba, yoga, and boot camp to more than 450 west Baltimore residents who now exercise regularly. This year, they will award community members health career scholarships for up to $8,000, allowing them to become a part of the healthcare teams that serve their neighbors in west Baltimore who have or are at risk for heart disease.

WEST BALTIMORE HEALTH ENTERPRISE ZONE(HEZ) GOALS

- By 2016, reduce by 15 percent cardiovascular disease risk factor prevalence among west Baltimore residents.
- Increase by 48 the number of primary care professionals within the HEZ by 2015.
- By 2016, reduce by 15 percent the number of preventable E.R. visits, and by 10 percent the number of preventable hospitalizations of cardiovascular patients.
- Increase by 11 the number of community health workers, by December 2013.
- By 2014, create a mechanism to identify and implement interventions to increase community resources for health.
- By 2016, reduce by 10 percent the number of preventable hospitalizations of west Baltimore residents with cardiovascular disease.
- By 2016, reduce by 10 percent unnecessary costs of caring for west Baltimore residents with cardiovascular disease.