The Annapolis Community Health Partnership

A <1,000 square foot remedy for a big problem
ACHP
Intervention Strategy and Goals

• Collaboration between Anne Arundel Medical Center and the Housing Authority of the City of Annapolis to insert a community health resource in public housing to serve the building’s residents and the surrounding underserved community in two ways:
  – Primary care medical services at reduced cost (1,748 individuals served to date)
  – Navigational services for all at no cost: care coordination, coaching, education, advice, and support

• **Primary Goal:** Provide culturally and linguistically appropriate primary care services to the Morris Blum residents and surrounding community. **Accomplished!**

• **Secondary Goal:** Measurably reduce 911 calls, ED visits, admissions, readmissions of a defined population: Morris Blum residents. **Accomplished!**
Lessons Learned: What Works

• On demand services: it’s not about our schedule
• Team-based care: it’s NOT all about the doctor!
• Fun health education events: it’s all about THEM!
• Relationship building: a trusted, consistent team - NOT the “free clinic” parade of volunteers
• Psychosocial needs competently identified and addressed
• Navigational services, particularly for the newly insured
• Medication Therapy Management
• Health coaching, e.g. tobacco use cessation counseling
What Works-continued

• Ready and willing referral network of behavioral health, dental, and medical subspecialty providers
• Integrated EMR
• Traditional and non traditional community partnerships to meet the non-medical needs-housing, EMS, police, food bank, etc.
• Welcoming, forgiving, tolerant atmosphere: NO JUDGEMENT-patients-family and staff!
• Ongoing staff training/coaching: annual retreat, daily team huddles, constant humor and good will
Lessons Learned

• Just because you build it does not necessarily mean they will come! Trust and consistency are essential
• Inter-cultural conflicts can be overcome
• Newly insured individuals need to be oriented and navigated
• Awareness of and respect toward our hosts: we are in their living room
• Importance of hiring staff (all levels) that have passion and the skill set to work with a marginalized population
Summary

• Right care is given at the right time in the right place, thus improving quality and cost-effectiveness of care.

• Chronic disease in marginalized populations is identified and treated earlier, thus decreasing preventable, costly complications.

• A trusted, community-based health care resource provides a better alternative to the ED.
Sustainability

• ACHP was and continues to be “the right thing to do”
  – Improve access to care
  – Reduce potentially avoidable hospital and ED utilization
  – Promote health as a priority
• Gaining the trust of marginalized populations is key to reducing disparities in care and promoting population health
  – We will continue our ACHP efforts
  – The program can be replicated by others elsewhere
• “Back Pocket Slides”
AAMC ED Visits and 911 Calls

- FY 2013: AAMC ED Visits = 179, 911 Calls = 199
- FY 2014: AAMC ED Visits = 190, 911 Calls = 195
- FY 2015: AAMC ED Visits = 148, 911 Calls = 146
- FY 2016: AAMC ED Visits = 165, 911 Calls = 148
AAMC Admission-Re-Admission Events

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<th>Year</th>
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<th>AAMC Re-Admission Events</th>
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