Annapolis Community Health Partnership

Maryland Community Health Resources Commission

April 2, 2015
ACHP

• Collaboration between Anne Arundel Medical Center (AAMC) and Housing Authority of the City of Annapolis (HACA)

• Insertion of a community health resource in a public housing unit (“MB”) to serve residents and the surrounding community
  – Primary care medical services at reduced cost
  – Navigational services at no cost: care coordination, coaching, education, advice and support
ACHP Structure

• **One medical practice**, < 1,000 sq feet:
  – MD
  – RN Care Coordinator
  – Office assistant/medical assistant (bilingual)

• **Many partners:**
  – HACA congregant program, AAMC care management and social work, contracted CHWs, AskAAMC, behavioral health resources, medical specialist community

• **Infrastructure**: AAMC’s integrated electronic medical record
What ACHP Has Accomplished

• Expanded and Filled Service Capacity
  – Provided direct primary care services to 1,119 unduplicated patients since opening in October 2013
  – Engaged >50% of MB residents in direct primary care services, provided navigational services to many more

• Assured Quality of Care
  – Reduced medical 911 calls, ED visits, admissions and readmissions from MB
More stats: ALL MB RESIDENTS (not necessarily ACHP patients)
MB Opened in October 2013

<table>
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<th>1/1/13 - 6/30/13</th>
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<td>ED visits</td>
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<td>Medical 911 calls</td>
<td>n/a</td>
<td>87</td>
<td>111</td>
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Lessons Learned Since Opening

- Navigational services are at least as important as medical services in reducing preventable utilization.
- Longitudinal relationships allow us to move from crisis intervention to prevention and self-management.
- Building trust requires tolerance, respect, perseverance and listening.
Getting Insurance Coverage or Access to Care Does Not Confer Instant Health Literacy

• Tales from the frontline:
  – The newly insured
  – The new immigrant
  – The new entrant to primary care
ACHP’s Year 3 Work Plan: Consolidating and Building Upon Early Success

• Reduce prevalence of risk factors for developing chronic disease, and reduce the risk of complications in those with chronic disease
• Increase community resources for health
• Reduce preventable ED visits and hospitalizations
• Reduce unnecessary costs in healthcare
1) **Reduce risk factors for chronic disease and risk for complications of chronic disease**

- 100% of patients age ≥ 18 screened for tobacco use.
  - Improve provision of interventions for those screening positive by 20%

- 100% of patients age ≥12 screened for depression
  - Improve provision of interventions for those screening positive by 20%

- 100% of patients age ≥18 screened for abnormal BMI
  - Improve provision of interventions for those screening positive by 20%
Risk Factor Reduction, cont’d

• Improve control (<140/90) of blood pressure in hypertensive patients age 18-85 by 20%
• Reduce by 20% the percentage of diabetics age 18-75 with A1C > 9.0
• Improve by 20% the percentage of diabetics with an annual retinopathy screen.
• Improve by 20% the percentage of diabetics with an annual foot exam.
How ACHP Will Accomplish This

• EMR workflow and tools
  – Point-of-care reminders
  – Population registries and dashboards

• Patient outreach and follow up
  – Interventions provided at clinic
  – Interventions provided by network of community specialists, educators, peer-to-peer coaching
2) Increase Community Resources for Health

• Provide diabetes self-management workshops to at least 20 high-risk patients
• Provide COPD self-management workshops to at least 20 high-risk patients
• Provide one-on-one coaching to at least 10 individuals seeking help to cease tobacco consumption
• Implement Referrals for Recovery (RforR) to ensure timely evaluation for those with urgent need for behavioral health services
How ACHP Will Accomplish This

• AAMC nurses have been trained to lead diabetes workshops
• AAMC respiratory therapists and pharmacists will lead the COPD workshop
• AAMC cancer prevention specialists will provide one-on-one coaching on site.
• Funding has been provided to implement RforR, a program that involves a network of 6 behavioral health providers.
3) Continue to Reduce Preventable ED Visits and Hospitalizations

• Implement program of identifying “medically homeless” individuals in the ED and referring them to MB for care.
• Implement changes in hours of operation at MB clinic to better meet population needs
How ACHP Will Accomplish This

• Engage ED care managers and staff as well as key community specialty providers to refer “medically homeless” patients to MB, particularly those who are uninsured, underinsured and/or Spanish-speaking.

• Examine volume patterns of demand, no-show rates and walk-ins to determine what change of hours would optimize utilization.
4) Reduce Unnecessary Costs in Healthcare

- Perform quarterly assessment of ED visits by MB residents to assess reasons for visit.
- Promote use of the MB clinic for services that can easily be performed there.
How ACHP Will Accomplish This

• Configure report from hospital warehouse data that blindly lists “reason for visit” of patients from address of MB.

• Review report to determine which types of ailments could have been addressed at MB (e.g. UTI, cerumen impaction, COPD exacerbation).

• Use local marketing in 3 new ways to increase awareness and promote use of the clinic as an alternative to the ED.
Projected Year 3 Budget Expenditures

• Total annual HEZ funding to ACHP is $200,000. This offsets the physician’s salary and fringe benefits.

• Remaining costs of staffing, medical supplies and equipment, vaccines, office supplies and equipment, management, communication hardware, EMR, et cetera are covered by AAMC.
ACHP Partnerships and Opportunities

• Faith-based Community
• Behavioral Health
  – Arundel Lodge
  – Other behavioral health providers
• Private Donations
  – Individual
  – Corporate, e.g. Charm City Run
• External Funding Partnerships
  – Stulman Foundation
  – Pending Grants
“The power of community to create health is far greater than any physician, clinic or hospital.”

Mark Hyman