Maryland Community Health Resources Commission: Access Health

Traci Kodeck, MPH
Vice President HCAM, Population Health
And
David R. Baker, DrPH, MBA
Director, Ambulatory Quality, LifeBridge Health
Project Origin

• Sinai identifying scope of issues within ED
• Sinai explores potential partners with Innovation projects
• Discussions began 2012/2013 possible ED collaboration
• CHRC funding approved Feb 2014
• Go Live June 2014
“Access Health”

- Embedded Care Coordinators in Sinai ED
- Patients meeting ED high-utilizer criteria, e.g.,:
  - Frequent visits
  - Unmanaged chronic conditions (somatic, behav, subst abuse)
  - Ambulatory-sensitive conditions
- Intensive Care Coordination
  - 3 months
  - Home visits

HealthCare Access Maryland (HCAM):
Specializes in connecting vulnerable Maryland residents to needed social services and health-promoting resources
Target Population

• High Utilizers: 10 or more visits in 4 months
• At Risk: 3 or more visits in 4 months
• Low Risk: Uninsured; 1-2 visits

*pregnant population as well as those medically unmanaged
Our Model

- Assess
- Identify
- Develop Care Plan
- Refer
- Follow up
Access Health?

- Specialty Providers
- Substance Abuse Treatment
- Health Insurance
- Housing Resources
- Mental Health Services
- Long Term Support Services
- Community Resources
- Transportation
- PCP
Lessons Learned

- Hospital Champion
- Embedded within ED
- Access to EMR system
- Flagging System
- Shared Data
- CRISP ENS alerts
- Delineation by Risk Stratification (June 2015)
Current Status (through Aug 2015)

- **315 clients enrolled** (51% of referred patients)
- **198 home visits**
- Enrolled client profile:
  - 40% Low-risk
  - 55% At-risk
  - 5% Super utilizer
Services Connected To

Services Enrolled Clients Are Connected To

<table>
<thead>
<tr>
<th>Connections for Enrollees</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<th>Mar</th>
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<td>7</td>
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<td>4</td>
<td>11</td>
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<td>9</td>
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<td>2</td>
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<td>Substance Abuse</td>
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Impact To-Date (through Aug 2015)

- Insurance sign-up: 159 clients
- Obtained primary care provider: 116 clients

Pre/Post Utilization of At-Risk Clients*

*140 enrolled clients through June 5, 2015

<table>
<thead>
<tr>
<th>Sinai Hospital</th>
<th>4 mos PRE</th>
<th>4 mos POST</th>
<th>% Reduction</th>
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<tbody>
<tr>
<td>ED Visits</td>
<td>336</td>
<td>152</td>
<td>55%</td>
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<tr>
<td>Inpatient Stays</td>
<td>91</td>
<td>43</td>
<td>53%</td>
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<tr>
<td>Total Visits</td>
<td>427</td>
<td>195</td>
<td>54%</td>
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</table>
Impact To-Date (cont.)

- Estimated Avoided Utilization - At-Risk Clients:

*140 enrolled clients through June 5, 2015

<table>
<thead>
<tr>
<th>Sinai Hospital</th>
<th>Avoided Visits</th>
<th>Average Charge/Visit</th>
<th>Est. Avoided Charges Through 6/5/15</th>
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<tbody>
<tr>
<td>ED Visits</td>
<td>184</td>
<td>$1,181</td>
<td>$217,304</td>
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<tr>
<td>Inpatient Stays</td>
<td>48</td>
<td>$9,935</td>
<td>$476,880</td>
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<tr>
<td>Total</td>
<td>232</td>
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<td>$694,184</td>
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In a five-day period in July, a 54-year-old man had come to the Sinai ED three times. He was referred to an Access Health Care Coordinator. The Coordinator learned that, in addition to having a hernia, the client lacked health insurance and frequently went hungry.

The Coordinator worked with the client for 6 weeks—including three home visits. She connected him to Medicaid, a primary care provider, and food stamp benefits. She also helped the patient schedule hernia surgery.

Since working with the Care Coordinator, the client has not visited the ED.
The client is a 56 year old woman who often came to the ED for non-emergency reasons, such as a stomach ache. Prior to enrollment, the client visited Sinai’s ED 14 times within a 4-month period. The Coordinator met with her in the ED and the client agreed to program services.

The Coordinator established a relationship with the client and arranged a new PCP, medication support, and a therapist. HCAM is in the process of obtaining a home aide. The client has followed through on her appointments to-date.

Since development of her care plan, the client has returned to the ED only once.
Questions?