HealthCare Access MARYLAND
COVERAGE. CARE. CONNECTIONS.

SINAI HOSPITAL
a LifeBridge Health center

Maryland Community Health Resources Commission: Access Health

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And

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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

Program Overview

"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):**

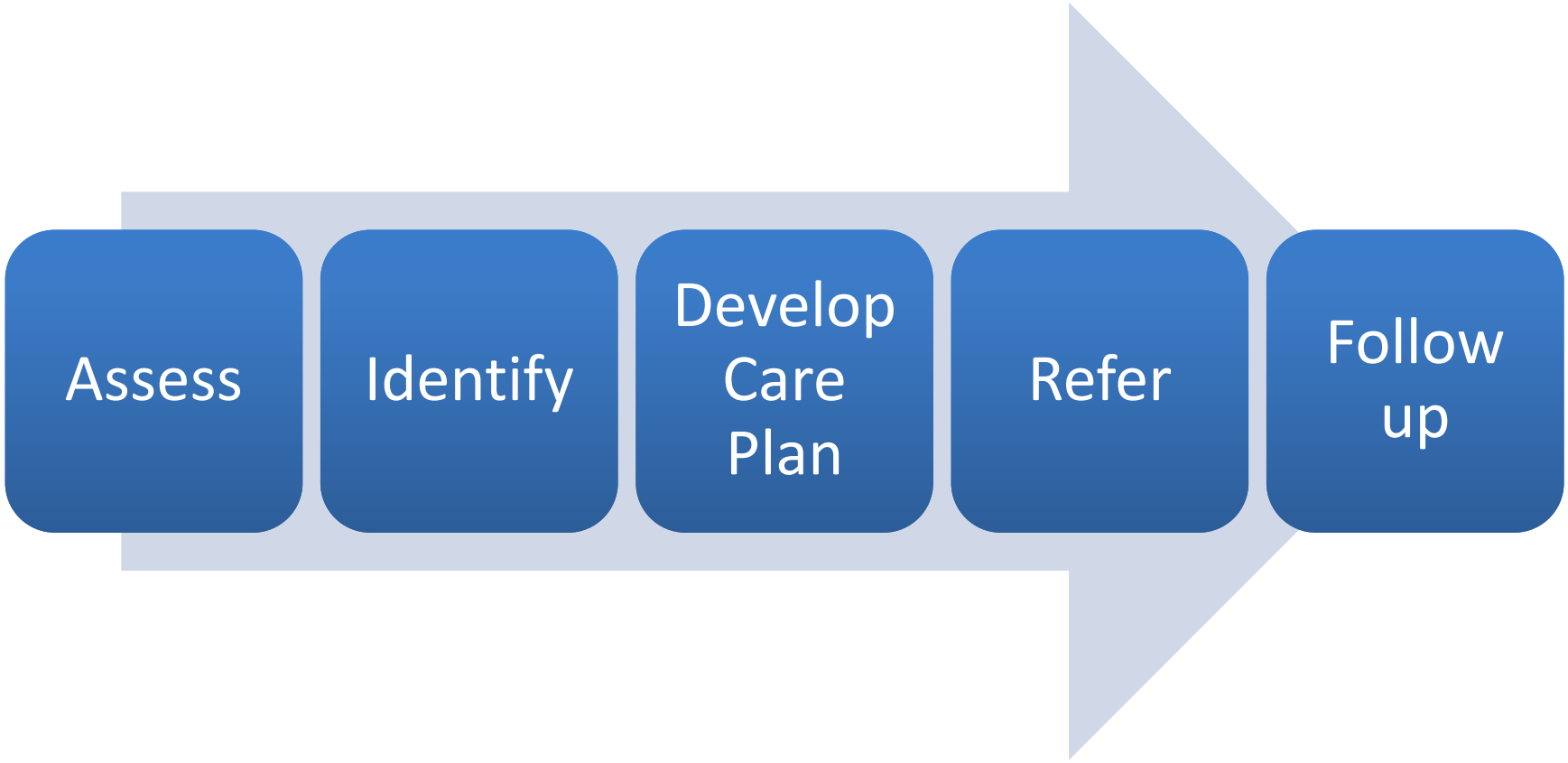
Specializes in connecting vulnerable Maryland residents to needed social services and health-promoting resources

Target Population

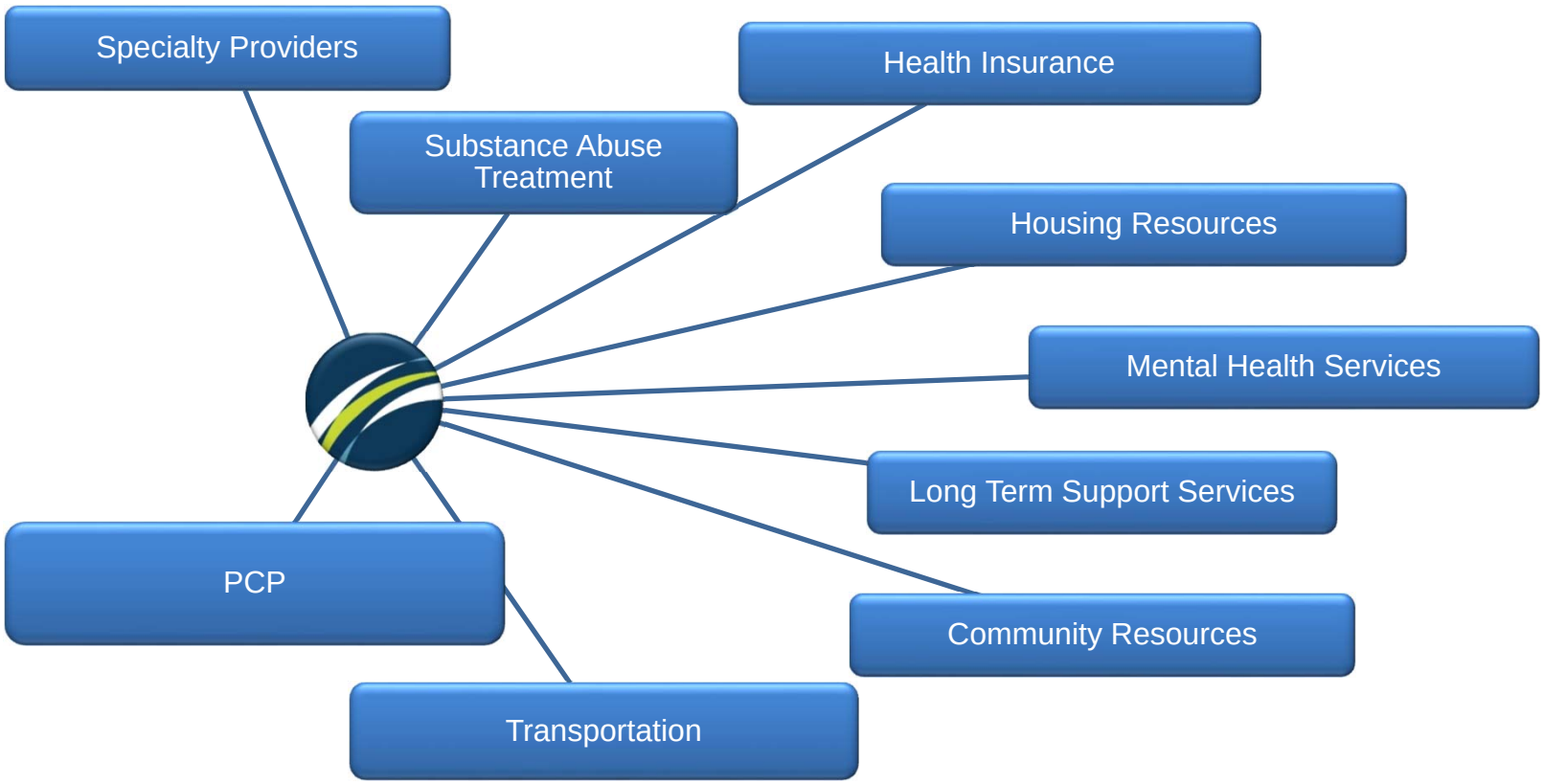
- High Utilizers: 10 or more visits in 4 months
- At Risk: 3 or more visits in 4 months
- Low Risk: Uninsured; 1-2 visits

*pregnant population as well as those medically unmanaged

Our Model



Access Health?

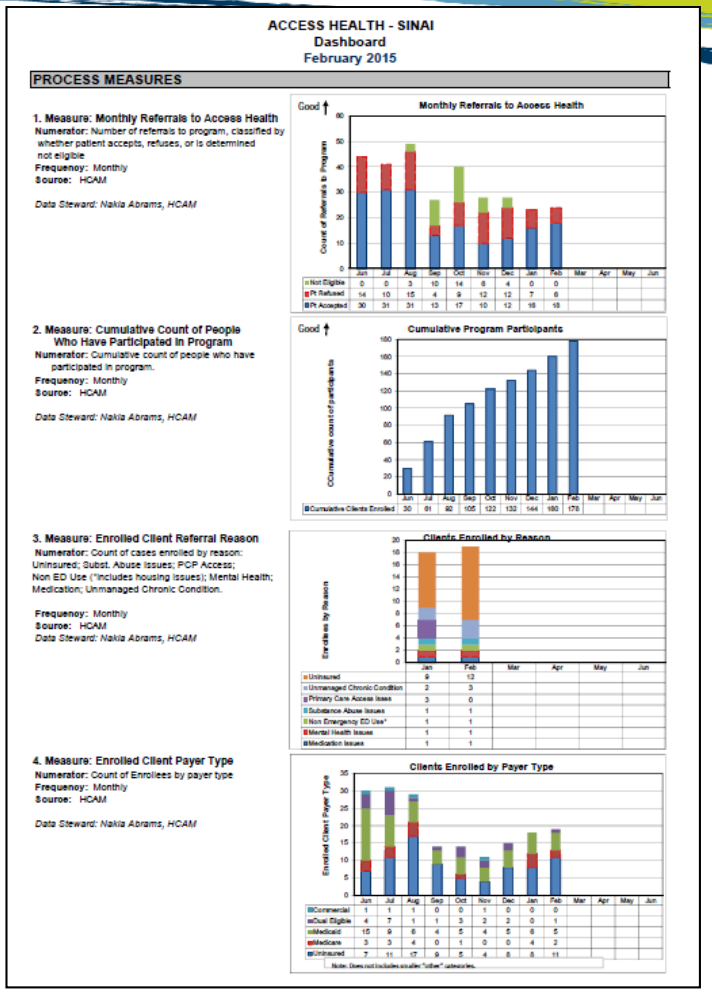


Lessons Learned

- 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:
  - o **40%** Low-risk
  - o **55%** At-risk
  - o **5%** Super utilizer


ACCESS HEALTH - SINAI
Dashboard
February 2015

PROCESS MEASURES

1. Measure: Monthly Referrals to Access Health
Numerator: Number of referrals to program, classified by whether patient accepts, refuses, or is determined not eligible
Frequency: Monthly
Source: HCAM
Data Steward: Nakia Abrams, HCAM

Monthly Referrals to Access Health

2. Measure: Cumulative Count of People Who Have Participated in Program
Numerator: Cumulative count of people who have participated in program.
Frequency: Monthly
Source: HCAM
Data Steward: Nakia Abrams, HCAM

Cumulative Program Participants

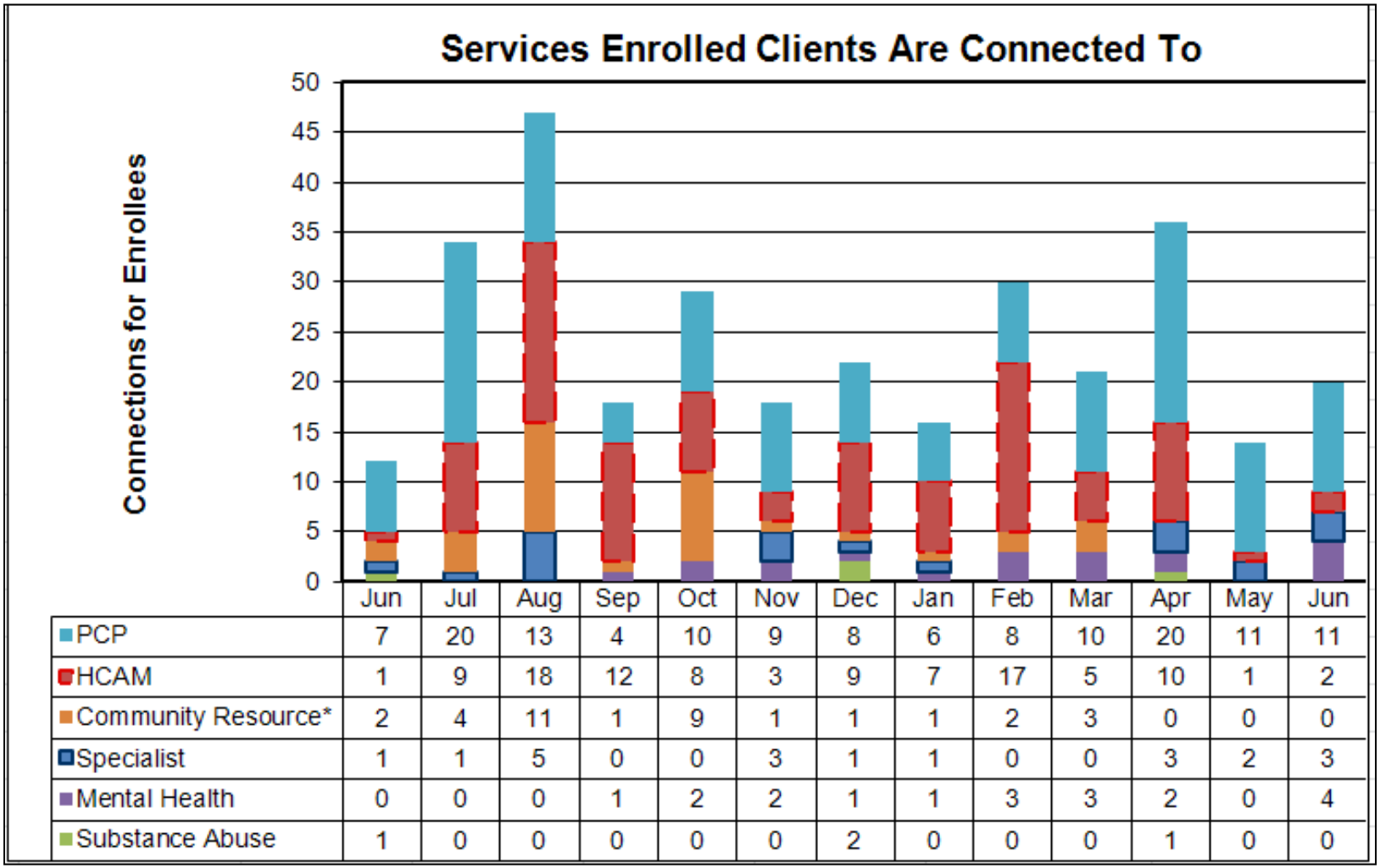
3. Measure: Enrolled Client Referral Reason
Numerator: Count of cases enrolled by reason: Uninsured; Subst. Abuse Issues; PCP Access; Non ED Use (*includes housing issues); Mental Health; Medication; Unmanaged Chronic Condition.
Frequency: Monthly
Source: HCAM
Data Steward: Nakia Abrams, HCAM

Clients Enrolled by Reason

4. Measure: Enrolled Client Payer Type
Numerator: Count of Enrollees by payer type
Frequency: Monthly
Source: HCAM
Data Steward: Nakia Abrams, HCAM

Clients Enrolled by Payer Type

Services Connected To



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
PCP	7	20	13	4	10	9	8	6	8	10	20	11	11
HCAM	1	9	18	12	8	3	9	7	17	5	10	1	2
Community Resource*	2	4	11	1	9	1	1	1	2	3	0	0	0
Specialist	1	1	5	0	0	3	1	1	0	0	3	2	3
Mental Health	0	0	0	1	2	2	1	1	3	3	2	0	4
Substance Abuse	1	0	0	0	0	0	2	0	0	0	1	0	0

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*

Sinai Hospital	4 mos PRE	4 mos POST	% Reduction
ED Visits	336	152	55%
Inpatient Stays	91	43	53%
Total Visits	427	195	54%

Impact To-Date (cont.)

- Estimated Avoided Utilization - At-Risk Clients:*

**140 enrolled clients through June 5, 2015*

Sinai Hospital	Avoided Visits	Average Charge/Visit	Est. Avoided Charges Through 6/5/15
ED Visits	184	$1,181	$217,304
Inpatient Stays	48	$9,935	$476,880
Total	232		$694,184

Sample Client Story #1

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.

Sample Client Story #2

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.

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Questions?