



MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

FY 2015/2016 ANNUAL REPORT

I. Executive Summary

The Maryland Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 with a mission to expand access to health care services in underserved communities in Maryland. The CHRC is an independent commission whose members are appointed by the Governor and which functions within the Maryland Department of Health & Mental Hygiene (DHMH). Since its inception, the CHRC has expanded access to health services in Maryland's medically underserved communities by awarding 154 grants totaling \$52.3 million and supported programs in every jurisdiction of the state, serving more than 260,000 Marylanders who receive quality health care in health centers, clinics, and neighborhood locations. The initial funding provided by the CHRC has also enabled its grantees to leverage \$18.8 million in additional federal and private/non-profit resources, which has been used in communities to provide even more needed health care.

Reflecting the importance and continued relevance of the CHRC's mission, the Maryland General Assembly approved legislation in 2014 that reauthorized the CHRC through June 2025. The Commission's demonstrated track record in distributing public resources in an efficient and strategic manner has led to increased roles and responsibilities for the CHRC. The CHRC ensures that state resources are efficiently and effectively used by its grantees through monitoring of progress and expenditures. The roles of community health resources and safety net providers supported by the CHRC have taken on greater importance as Maryland implements the Affordable Care Act (ACA). Nationwide, according to the Kaiser Foundation, 70% of ACA assister programs were supported by a safety net provider. Additionally, with an eye on comparable progressive health care changes in other states, health policymakers recognized that after the implementation of health care reform, increasing insurance coverage did not remove all barriers to improving health care. Barriers for many of the newly insured included the shortages of providers serving newly insured Medicaid or Qualified Health Plan enrollees; limited health and health insurance literacy; inability of newly insured people to afford needed copays and deductibles; and other underlying social determinants of health (i.e., lack of transportation, unsafe housing, or food deserts). Even with the advantages to citizens of the expansion of Medicaid and health insurance coverage via Qualified Health Plans in Maryland, the state's health care system was faced with providing primary care services to an increasing number of new patients. The CHRC has awarded grants and provided other technical assistance to help these safety net providers to expand their health care services and implement essential new

programs in underserved communities. The collective impact of CHRC's grant-making is: (1) to increase the administrative capacity of safety net providers to serve more low-income individuals and meet the rising demand of Maryland's newly insured for their essential health care services; (2) to expand access to primary, behavioral health, and dental services in medically underserved areas, building interconnected systems of care in local communities; and (3) to assist the state's implementation of the hospital All-Payer Model by reducing avoidable Emergency Department (ED) visits and hospital utilization by linking at-risk, "high-need" individuals with health care in the community, a much lower-cost setting than hospital EDs.

The CHRC fulfills its statutory responsibility of expanding access in underserved communities by issuing annual Calls for Proposals and has focused its grant-making activities to support the state's public health needs and priorities. The CHRC has granted funds to community health resources to address priorities described in the State Health Improvement Process (SHIP), including Maternal and Child Health, Childhood Obesity, Behavioral Health and Substance Use, and Dental Care. In 2015, grants were awarded to address infant mortality rates in Prince George's County, to improve primary care access and reduce avoidable emergency department usage throughout the state, and to increase the availability of dental care in four underserved jurisdictions. The CHRC has also supported innovative community-hospital partnerships throughout the state to improve the health of underserved populations and help reduce avoidable hospital utilization.

II. Background and Mission

The Maryland General Assembly created the Community Health Resources Commission in 2005 to expand access to affordable, high-quality health care services in the state's underserved communities; support the adoption of health information technology in community health resources; increase access to specialty health care services for the uninsured and low-income individuals; promote interconnected systems of care and partnerships among community health resources and hospitals; and help reduce preventable hospital ED visits. The CHRC is an independent commission within the Maryland Department of Health & Mental Hygiene, and its 11 members are appointed by the Governor (see Appendix A). The CHRC fulfills its authorizing statutory responsibilities through its grant-making activities, awarding 154 grants totaling \$52.3 million, supporting programs in all 24 jurisdictions of the state. These programs have collectively served more than 260,000 Marylanders and enabled CHRC grantees to leverage \$18.8 million in additional federal and private/non-profit resources.

When the Maryland General Assembly created the CHRC, it recognized the need to have an independent commission that focused on strengthening Maryland's diverse network of community health centers and other safety net providers. Although the ACA increased the number of insured Marylanders, service delivery gaps still exist in Maryland's health care marketplace. In a U.S. Census report issued in 2015, Maryland continues to have more than

460,000 individuals who do not have health insurance, which corresponds to 7.9% of its population.¹ Even those who have been recently covered by a health plan may have difficulty finding appropriate primary care, as many areas of the state have been designated by HRSA as Health Professional Shortage Areas,² and many of the newly insured do not have an understanding of how to fully use their new coverage. The importance of the health care safety net was clearly shown after reform of the health care system in Massachusetts, where it was found that although the number of people with health insurance was substantially increased, the demand for services from safety net facilities also grew.³ In fact, the number of patients served in community health centers rose by 31% from 2005 to 2009, while the percentage of patients without insurance decreased from 35.5% of their caseload to 19.9%. Many of the newly insured were comfortable with their safety net providers and chose to retain their safety net providers, even after obtaining coverage. For uninsured patients, safety net providers became an even more important source of primary care, perhaps because of increasing difficulty obtaining care from other primary care physicians' offices. The CHRC helps to strengthen these community health resources by funding programs to build the capacity of safety net providers, to assist those providers in data collection, IT and business planning, and to promote long-term financial sustainability of providers of last resort.

As Maryland implements its Medicare All-Payer Model (the Model), community-based providers and community-hospital partnerships will become more and more important. The Model presents enormous challenges for Maryland's hospitals and may provide an increased focus on the importance of the delivery and accessibility of services in community-based settings. Previous CHRC funds have been used to provide "seed" funding for community-hospital partnerships, to fund community-based intervention strategies that help achieve reductions in avoidable hospital utilization, and to support population health improvement activities. The CHRC has hosted regional forums that resulted in issuing a white paper entitled "Sustaining Community-Hospital Partnerships to Improve Population Health" (authored by Frances B. Phillips). Community-hospital partnerships to reduce avoidable hospital utilization and build capacity of community health resources was a strategic priority in the most recent Call for Proposals released by the CHRC (in FY 2016). Grant awards from the FY 2016 Call for Proposals are expected in mid-March 2016.

The CHRC-granted funds have addressed priorities described in the State Health Improvement Process. Grant monies have gone to programs that have focused on the SHIP metrics: (1) increasing the numbers of women accessing early prenatal care; (2) reducing the rates of low birthweight babies; (3) reducing the rates of infant mortality; (4) reducing the rates of children and adolescents who are obese; (5) reducing the numbers of emergency department visits related to mental health conditions or (6) addictions-related conditions; and (7) increasing the rates of children receiving dental care in the last year. Previous CHRC funds have also boosted the infrastructure of Local Health Improvement Coalitions.

¹ <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf>

² <http://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx>

³ Ku L, Jones E, Shin P, Byrne F, Long SK. Safety-Net Providers After Health Care Reform: Lessons From Massachusetts. *Arch Intern Med.* 2011;171(15):1379-1384. doi:10.1001/archinternmed.2011.317.

III. Grant-making Activity and Program Impact

Since its inception, the CHRC has awarded 154 grants totaling \$52.3 million, which have supported programs in every jurisdiction in Maryland. Each year, the requests for funding exceed the Commission’s available budget, with grant funding typically equaling 18%-19% of requests. The CHRC has aligned its grant-making activities to address the greatest unmet health care needs in the state. As shown in the table below, CHRC grants have supported programs which have provided services for 260,456 patients, resulting in 669,741 patient visits.

Table 1:

Maryland Community Health Resources Commission				
Focus Area	# of Projects Funded	Total Award Provided	Cumulative Total	
			Patients Seen/Enrolled	Visits Provided
Expanding Access to Primary Care at Maryland's safety net providers	33	\$9,787,650	57,824	196,629
Increasing Access to Dental Care for Low-income Marylanders	27	\$5,850,606	46,631	104,940
Addressing Infant Mortality	16	\$3,315,697	13,005	39,759
Reducing Health Care Costs through ED Diversions	6	\$1,994,327	13,804	27,943
Promoting Health Information Technology at community health centers	9	\$3,268,661	Health Information Technology	
Providing Access to Behavioral Health and Drug Treatment Services	25	\$8,005,917	17,711	89,978
Supporting Local Health Improvement Coalitions (LHICs)	24	\$1,955,048	867	3,416
Health Enterprise Zones *	5	\$15,335,997	109,938	205,111
Safety Net Capacity Building	6	\$1,325,570	641	1,825
Childhood Obesity	3	\$1,510,000	35	140
Total Grant Funding Provided	154	\$52,349,473	260,456	669,741
Total Funding Requested	664	\$307,870,180		
Number of Patient/Clients Served	260,456			
Number of Patient/Client Encounters	669,741			
Additional federal and private resources leveraged	57	\$18,829,204		

The CHRC awards grants by issuing a Call for Proposals approximately once a year. Grants are awarded in a competitive process, and priority areas and review criteria are determined by the CHRC Commissioners. Grant proposals are evaluated by independent subject matter experts and CHRC staff on a range of criteria outlined in each Call for Proposals, including the ability of the grantee to achieve stated program objectives and achieve sustainability once initial grant funds are utilized. Evaluation criteria utilized include: (1) the use of evidenced-based practices in the proposed program; (2) capacity to collect and report outcomes data; (3) demonstration of a community need; (4) program sustainability; and (5) likelihood of overall program success. Applications are also prioritized based on how the applicant addressed the Commission’s three strategic priorities of: (1) building capacity; (2) addressing health disparities and promoting health equity; and (3) reducing avoidable hospital utilization.

Since the last report, the Commission has issued two Calls for Proposals. The most recent Call for Proposals was issued on November 10, 2015 and requested project proposals in four categories: (1) promoting comprehensive women's health services and reducing infant mortality rates; (2) expanding access to dental care; (3) integrating behavioral health service delivery and addressing the heroin and opioid epidemic; and (4) expanding access to primary and preventative care services and chronic disease management. Grant awards are expected in mid-March 2016.

Promoting comprehensive women's health services and reducing infant mortality rates

The Commission has included supporting comprehensive women's health services in its Calls for Proposals for several years in recognition of the state's goal of reducing infant mortality rates. DHMH has articulated the current goal of reducing the state's infant mortality rate by 10% by 2017. The CHRC has awarded a total of 16 grants in recent years totaling \$3.3 million to expand access to women's comprehensive health services in the community by providing care coordination, screening for depression, and screening/care management for diabetes. CHRC funded programs have served more than 13,000 women. In FY 2015, the CHRC awarded a one-year grant to Community Clinic, Inc. to increase access to prenatal care services in Prince George's County.

Expanding Access to Mental Health and Substance Use Treatment

Promoting access to integrated mental health, substance use, and somatic health care services is a priority of the Commission as the state moves to support an integrated behavioral health care delivery system. The Commission has funded a total of 25 grants totaling \$8.0 million in recent years, including several re-entry projects in which local health departments and local detention centers have collaborated to provide wrap-around services for offenders with co-occurring behavioral health and addiction treatment needs. Projects funded by CHRC have also included emergency services for adolescents and young adults living with dual disorders; adding primary care services in a traditional outpatient mental health setting; and the co-location of the Screening, Brief Intervention and Referral to Treatment (SBIRT) and treatment service delivery in the community. To date, CHRC funded behavioral health programs have served more than 17,700 individuals. In FY 2016, particular emphasis will be given to supporting the recommendations of the Heroin and Opioid Emergency Task Force chaired by Lt. Governor Rutherford and the July 2015 report of the Baltimore City's Mayor's Heroin Treatment and Prevention Task Force.

Increasing Access to Dental Care Services

The CHRC has targeted efforts to increase access to dental services in the community, making significant investments in the state's public oral health infrastructure. CHRC has awarded 27 grants totaling more than \$5.8 million to expand access to dental care which have served more than 46,600 Marylanders. In 2015, the CHRC awarded 4 grants totaling \$575,000 which are currently under implementation. CHRC funds were awarded to Allegany Health Right, Inc., (Allegany County), Frederick Memorial Hospital (Frederick County), Total Health Care

(Baltimore City), and Health Partners (Charles County). These grants support programs which provide dental services and education in community-based settings through mobile dental clinics, school health and wellness centers, and programs that offer dental services at a discounted rate to underserved populations throughout the state.

Expanding Access to Primary Care Services in Underserved Communities

A core policy mission of the CHRC is to promote comprehensive, interconnected systems of care in the local communities and to expand access to affordable, high-quality primary care services in underserved areas of the state. As Maryland implements the ACA, it is essential that the state expand its capacity to deliver primary care services in the community. The CHRC has awarded a total of 33 grants totaling \$9.8 million in recent years. These programs have collectively expanded access to primary care services for 57,800 Maryland residents. In 2015, the CHRC awarded 4 grants totaling \$1.2 million to Harford County Health Department (Harford County), MedStar Union Memorial Hospital (Baltimore City), Esperanza Center (Baltimore City), and HealthCare Access Maryland (Baltimore City). These grants fund programs that support the opening of new access points implemented by Federally Qualified Health Centers and programs that will encourage the reduction of hospital emergency department visits, admissions, and readmissions.

IV. Grantee Performance Monitoring

The CHRC has developed and implements a robust system for grantee performance management that requires grantees to report on a series of standard and customized process and outcome measures. The grant monitoring system is designed to ensure that public resources are utilized efficiently and effectively and that program objectives are achieved. These performance measures include a core set of common data variables that all grantees are required to report, focus-area specific measures (i.e., measures specific to all infant mortality grants), as well as many grant-specific evaluation measures. Common process measures have included the number of unduplicated patients seen, the number of individuals completing a program, or the number of procedures performed. Outcome measures have included hospital utilization metrics, clinical metrics, and cost savings. In addition to programmatic performance metrics, CHRC grantees are required to meet fiscal reporting requirements, providing line-item detail that accounts for how grant funds are expended.

The CHRC requires data reporting as a condition of payment of Commission grant funds. At the beginning of the grant period, grantees are required to submit projected totals for the duration of the program and then report actual figures in subsequent reporting periods. Bi-annual reporting includes three separate documents:

- An expenditure report, which includes a summary of monies spent and the documentation to support the use of funds

- A Milestones and Deliverables (M&D) report, which tracks process and outcome measures for an individual project
- A narrative report, which discusses program progress and any successes that have been achieved. The report also includes how the grantee plans to overcome any challenges that may have been encountered.

CHRC staff reviews the actual data reported by the grantees and compares these figures to the grantee's projections. Grantees are held accountable for performance and progress towards meeting the goals of the programs. When programs do not achieve objectives, the Commission withholds funding from underperforming grantees and redirects grant funding to other successful grantees.

V. Sustainable Systems of Care and Leveraging Additional Resources

Promoting sustainable, interconnected systems of care in local communities and facilitating long-term financial sustainability of grant programs are key priorities of the Commission. The initial grant funding provided by the CHRC (\$52.3 million) has enabled grantees to leverage approximately \$18.8 million in additional federal, private/non-profit, and other resources. The Commission has served as an "incubator" for innovative programs and supports the efforts of grantees to continue programs once initial CHRC grant funding has been expended. Following are several recent examples of CHRC grantees utilizing Commission grant funding to leverage significant additional resources.

Mobile Medical, Inc., a new Federally Qualified Health Center in Montgomery County, utilized CHRC grant funding to increase health care access for multi-cultural, low-income patients in Germantown, Rockville, and Aspen Hill. MobileMed, which participates in the Montgomery Cares program, delivers primary care at several fixed sites and mobile health van locations throughout Montgomery County. MobileMed utilized the current grant of \$480,000 to initiate services in Aspen Hill, designated as a Medically Underserved Area. This expansion enabled the organization to apply successfully for a two-year, \$900,000 New Access Point award from the federal government, which makes it possible for MobileMed to enhance its services and serve more individuals in need.

Allegany Health Right, Inc. is a 501(c)3 nonprofit organization that serves as a referral and coordinating agency for underserved and uninsured adults in Allegany County. The organization has received two grants from CHRC to support emergency dental services for disabled adults and Medicaid-eligible adults. Allegany Health Right has leveraged its CHRC grant and received a three-year, \$375,000 grant award from HRSA to continue its outreach efforts for uninsured and underserved adults in the community. The grantee states that a large proportion of hospital emergency department visits to Western Maryland Health System (WMHS) are for dental conditions, and the grant monies obtained expand their existing dental program by utilizing a

community health worker and targeting Medicaid adults who generate dental visits at WMHS. Allegany Health Right leveraged the CHRC grant to obtain additional operating support from WMHS.

The Esperanza Center, a Volunteer in Medicine clinic offering free primary care services in Baltimore City, has received two grants from the CHRC to serve the Hispanic/Latino population. Esperanza has leveraged CHRC funding to obtain another \$200,000 grant from the Leonard and Helen R. Stulman Charitable Foundation. The first CHRC grant, awarded in 2012, enabled Esperanza to hire a bilingual nurse practitioner and serve more than 3,150 patients.

Health Partners, Inc. is a 501(c)3 non-profit organization dedicated to delivering quality health care in a respectful and compassionate environment to the citizens of Charles County and the surrounding area who are economically disadvantaged by utilizing the skills and resources of the community. Health Partners received a two-year, \$250,000 grant from the CHRC in 2014 to assist the organization in their efforts to expand their dental program/practice. In October 2015, Health Partners utilized the initial CHRC seed grant funding to leverage an additional \$75,000 grant from CareFirst.

The Mental Health Association of Frederick County, a private, not-for-profit agency, received a grant from CHRC in February 2014 to open a behavioral health walk-in center. Funding from CHRC and the local CSA (Mental Health Management Agency) helped secure \$15,000 in additional funds from Frederick Memorial Hospital to cover the staffing and operations cost of the center. In addition to the hospital funds, the Mental Health Association of Frederick County has received an award of \$120,000 from the Stulman Foundation to help fund the transition of their group practice to an Outpatient Mental Health Clinic over the next two years. The grantee will also receive \$15,000 in FY 2016 funding and \$30,000 in FY 2017 from the Frederick County Government. These partnerships allow the program to offer the walk-in service at no cost to the client.

VI. Promoting Community-Hospital Partnerships

The CHRC has prioritized its grant-making to support programs that bring together community health resources and hospitals in collective efforts to achieve the federal goals of the Medicare All-Payer Model. The CHRC has funded programs that focus on advancing our state's collective health IT infrastructure; implementing the State Health Improvement Process; supporting patient-centered medical homes, and enhancing primary care and behavioral health integration. The CHRC has also supported effective community-hospital collaborations which are essential in making the population health improvements required in the implementation of the Model.

To facilitate community-hospital collaboration, the CHRC, with support from the Maryland Hospital Association, Department of Health and Mental Hygiene, and the Health Services Cost Review Commission, hosted four regional forums across the state in the fall of 2014. The purpose of the forums was to highlight a number of promising community-hospital partnerships and innovative intervention strategies; to discuss the lessons learned and challenges confronted during implementation; and to develop strategies through which these programs could be sustained and replicated in other areas of the state. These forums also informed a white paper that was delivered to the CHRC in January 2015. The white paper, “Sustaining Community-Hospital Partnerships to Improve Population Health,” presented recommendations to replicate and sustain these innovative partnerships. The white paper followed the four regional forums and analyzed the implementation experiences of five programs that are supported with CHRC grant funding. The white paper, developed by Frances B. Phillips, presents recommendations that include providing access to toolkits and support for future proposals; determining a return on investment of grants aimed at upstream improvements to a community’s social or economic conditions; and exploring multi-investor partnerships around projects of mutual interest. The white paper also helped to guide the two most recent Calls for Proposals issued by the CHRC.

The CHRC has awarded grants to programs that were aimed at ED referral/diversion, specifically providing services to individuals identified as high utilizers of Maryland’s hospital system. In 2014, CHRC awarded HealthCare Access Maryland a three-year, \$800,000 grant to target super-utilizers of the LifeBridge/Sinai Hospital’s Emergency Department. The project began implementation in June 2014 and has enrolled 434 individuals. As of January 2016, Sinai hospital reported a 64% reduction in ED visits and an 80% reduction in inpatient stays for enrolled individuals in the four months post-program participation as compared to the four months before participation. This reduction translates into total cost savings/avoided charges of \$632,492 as of September 10, 2015 (Presentation of results in Appendix B).

VII. Implementation of the Health Enterprise Zones Initiative

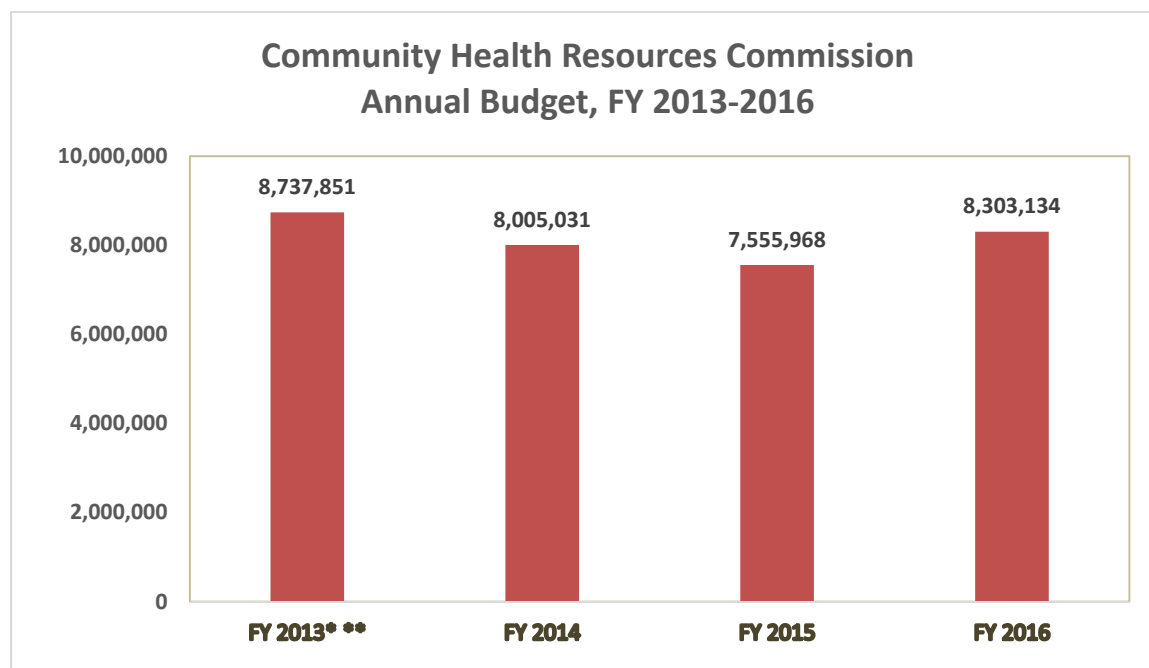
Health Enterprise Zones (HEZs) are geographically defined areas that demonstrate poor health outcomes and economic disadvantages. The policy objectives of the HEZ Initiative are to: (1) improve health outcomes and expand access in underserved areas; (2) reduce health disparities; and (3) reduce health care costs and hospital admissions and readmissions. Under the HEZ Initiative, the state is providing a total of \$4 million per year over the four-year duration of this pilot project. Funding is utilized by the HEZs to attract new health practitioners to serve in HEZs, to promote the use of community health workers, and to expand access in these underserved communities. For more information about the HEZ Initiative, please visit the HEZ website and review the annual report for 2014. This information can be found at: <http://dhmh.maryland.gov/healthenterprisezones/Pages/HOME.aspx>.

The HEZ Initiative is jointly implemented by DHMH and CHRC, with DHMH providing overall leadership and programmatic oversight and CHRC serving as the fiscal agent. The DHMH Secretary designated five HEZs in January 2013, and these HEZs are in the middle of their third program year. The second annual report, submitted in January 2014 can be found at <http://dhmh.maryland.gov/healthenterprisezones/Documents/HG%2020-1407%20-%20CHRC%20-%20HEZ%20-%20Final%20Signed.pdf>.

VIII. Legislation and Budget

The roles and responsibilities of the CHRC have grown in recent years in recognition of the Commission’s demonstrated track record in delivering resources in an efficient and strategic manner and in recognition of the critical role that community health resources are playing as Maryland implements the Affordable Care Act. In recognition of the CHRC’s track record and the critical role of community health resources, the Maryland General Assembly approved legislation during the 2014 session to reauthorize the Commission through June 2025.

The CHRC’s budget is derived from special funds and, based on statute, is to be funded “at no less than \$8 million per year.” In accordance with this language, the CHRC’s budget has been funded at approximately \$8 million since FY 2014, as shown in the chart below.



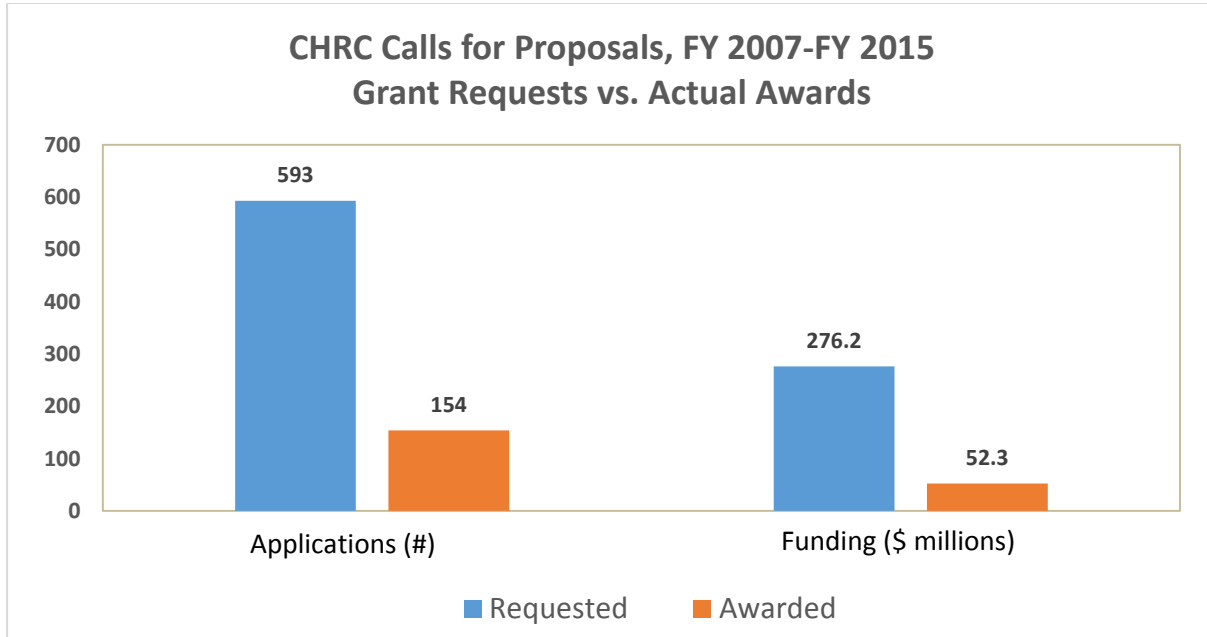
Notes:

The total budget amounts for FY 2014 and FY 2015 reflect actual expenses. The FY 2016 amount represents the budget appropriation, and the FY 2017 amount represents the budget allowance.

* The budget in FY 2013 contains a one-time transfer of DDA funds to the CHRC for the DDA Infrastructure grants.

** The FY 2013 budget reflects the first year of the Health Enterprise Zones Initiative, which provides \$4 million per year over the duration of the Act (FY 2013 through FY 2016).

The demand for CHRC grant funding far exceeds its available budget. Since its inception, the CHRC has released 12 Calls for Proposals, generating 593 grant proposals requesting \$276.2 million. Over this same time period, the CHRC’s budget has permitted 154 grants totaling \$52.3 million, or 19% of grant requests.



APPENDICES

Appendix A

CHRC Commissioners

The CHRC is an independent commission operating within the Maryland Department of Health & Mental Hygiene (DHMH) whose 11 members are appointed by the Governor. (1 Vacancy to be filled)

The Hon. John A. Hurson, Chairman

Executive Vice President, Personal Care Products Association

Nelson J. Sabatini, Vice Chairman

Former Secretary, Maryland Department of Health and Mental Hygiene

Elizabeth Chung

Executive Director, Asian American Center, Frederick

Charlene Dukes

President, Prince George's Community College

Maritha R. Gay

Senior Director of External Affairs at Kaiser Permanente

William Jaquis, M.D.

Chief, Department of Emergency Medicine, Sinai Hospital

The Hon. P. Sue Kullen

Former Member of Maryland House of Delegates, Health & Government Operations Committee

Paula McLellan

CEO, Family Health Centers of Baltimore

Barry Ronan

President and CEO, Western Maryland Health System

Maria Harris-Tildon

Senior Vice President, Public Policy and Community Affairs, CareFirst BlueCross BlueShield

Appendix B

Presentation of Results by HealthCare Access Maryland and LifeBridge Sinai Hospital



**Maryland Community Health Resources
Commission: Access Health**

Traci Kodeck, MPH
Interim-CEO, HealthCare Access Maryland
And
David R. Baker, DrPH, MBA
Director, Ambulatory Quality, LifeBridge Health



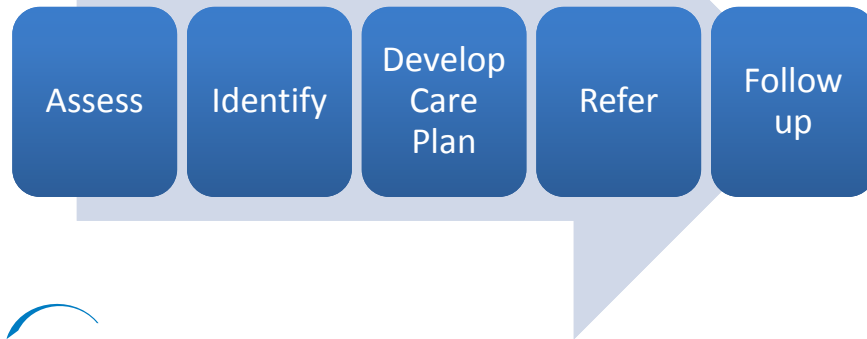

ED Frequent User Reduction

“Access Health” – Partnership with HCAM

- Launched in June 2014
- Embedded Care Coordinators in Sinai ED
- Engage patients returning with
 - Unmanaged chronic conditions (somatic, behav, subst abuse)
 - Ambulatory-sensitive conditions
- Intensive Care Coordination
 - 3 months
 - Home visits
 - Address social barriers

HealthCare Access Maryland (HCAM):
Baltimore-based nonprofit that specializes in connecting vulnerable Maryland residents to needed social services and health-promoting resources

Our Model



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Impact To-Date

- **434** clients enrolled (*Jan 11 2016*)
(51% of referred patients)
- **Client profile:**
 - 4% High-risk/super-utilizer
 - 37% At-risk*
 - 29% Low-risk
 - 30% Insurance only
- **Insurance sign-up:** 120 clients
- **Obtain a primary care provider:** 222 clients
- **Primary care appointments kept:** 73%

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Impact To-Date (cont.)

Estimated Avoided Utilization To-Date

Comparing 4 months pre-enrollment with 4 months post case closed

At-Risk Clients with Cases Closed through 9/10/15

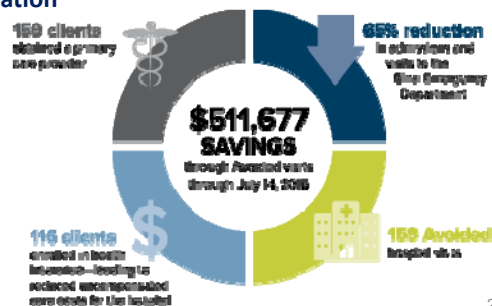
- 78% have 0 visits in the first month post case closed
- 65% have 0-1 visit 4 months post case closed

Sinai Hospital	% Reduction	Avoided Visits	Average Charge/Visit	Est. Avoided Charges
ED Visits	64%	157	\$1,181	\$185,417
Inpt Stays	80%	45	\$9,935	\$447,075
Total	67%			\$632,492

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Lessons Learned

- ❖ Hospital Champion
- ❖ Embedded within ED
- ❖ Access to EMR system/Flagging System
- ❖ Shared Data
- ❖ CRISP ENS alerts
- ❖ Delineation by Risk Stratification



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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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