

# ▶ The Annapolis Community Health Partnership

# 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 community* in two ways:
  - Primary care medical services at reduced cost to the residents of the building and surrounding community
  - 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.
- Secondary Goal: Measurably reduce 911 calls, ED visits, admissions, readmissions of Morris Blum residents.

# What Works

- On demand services
- Team-based care: it's NOT all about the doctor!
- Fun health education events: it's all about THEM!
- Relationship building-trust
- Psychosocial needs competently identified and addressed
- Home visits
- Navigational services
- Medication Therapy Management
- Health coaching
- Tobacco Cessation Counseling

# What Works-continued

- Referral for Recovery Program-network of (6) behavioral health providers-ability to connect patients in need of mental health services obtain an appointment within 48 hours of referral
- Integrated EMR and supportive specialist community
- Build traditional and non traditional community partnerships to meet the non-medical needs-housing, EMS, police, food bank, etc.
- Team interview and team decision to hire candidates who want to join our team
- Welcoming, forgiving, tolerant atmosphere: NO JUDGEMENT-patients-family and staff!
- Ongoing staff training/coaching

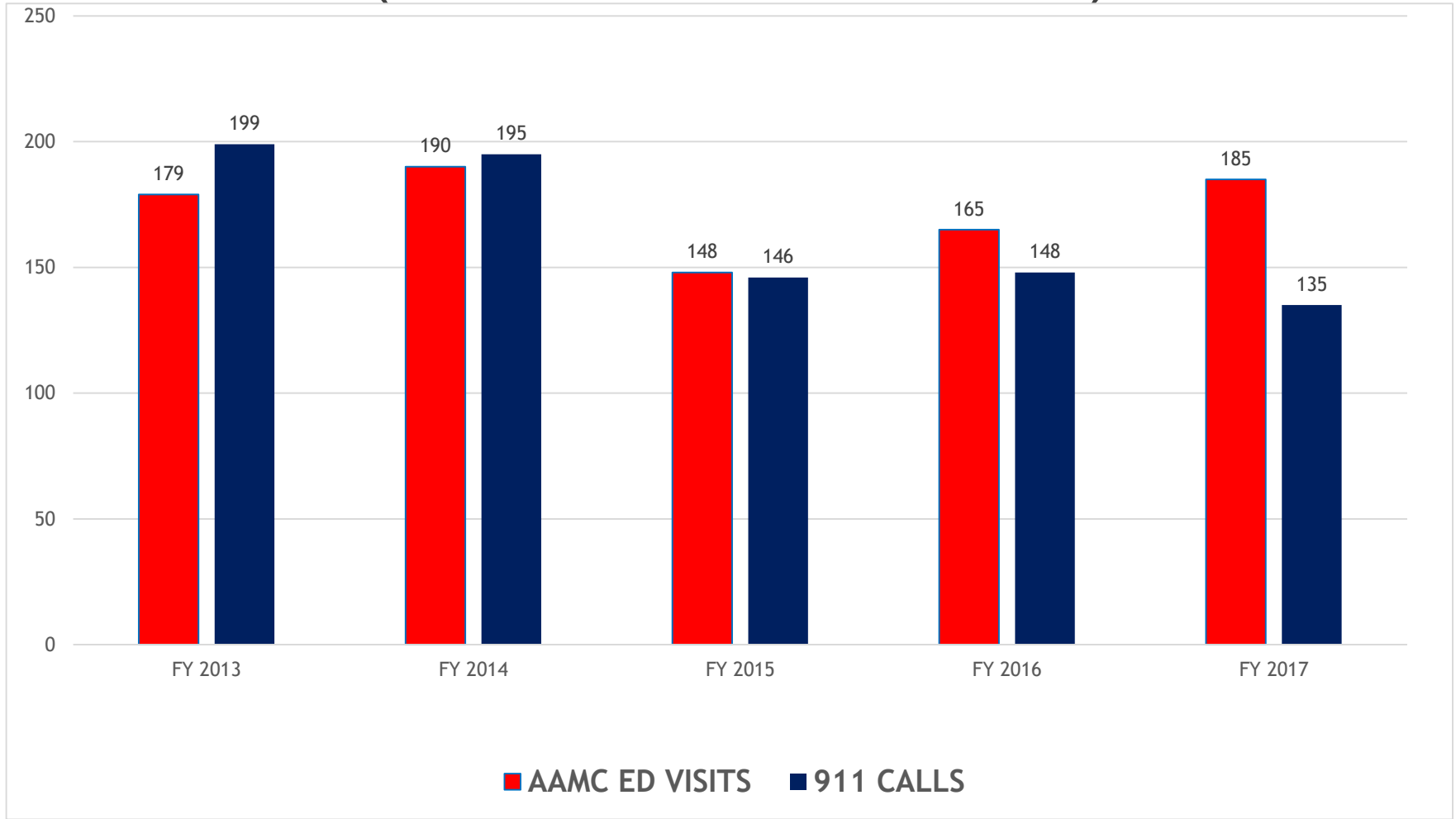
# What Works-continued

- Specialized staff training
  - CLAS standards
  - Crisis Prevention Intervention (CPI)
  - Team based training
  - Medical Assistant Training provided by our Essential Skills Team 2-3 times per year
- Annual staff retreat
- Team huddles (daily)
- Humor

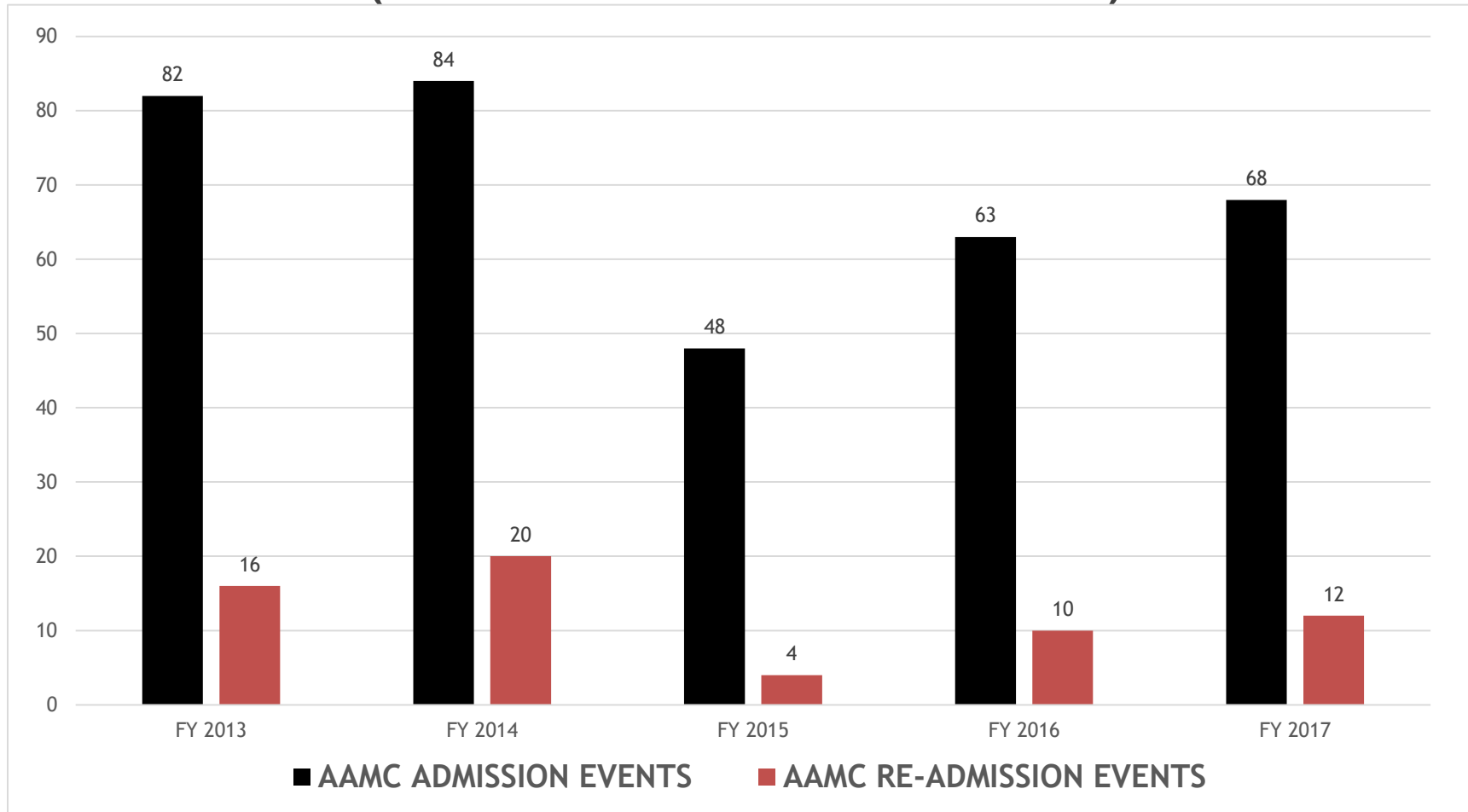
# Lessons Learned

- 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 and respect of a primary care clinic sharing space in a residential apartment building-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

# AAMC ED Visits and 911 Calls (Morris Blum Residents)



# AAMC Admission-Re-Admission Events (Morris Blum Residents)





# FY 2018 Quality Metrics

| Measure   | Definition  | Baseline Performance | Performance Goal by 6/30/18 | Performance Q4-17 | Interventions   |
|---|---|----------------------|-----------------------------|-------------------|---|
| A1C poorly controlled                             | Percent of current diabetic patients age 18-75 with NO A1C in past 12 months, or latest A1C is >9.0                                   | 45.15%               | 40.0%                       | 25%               | Patient Panel Managers (PPMs) will regularly “scrub” provider dashboards to ensure proper patient attribution and ensure follow up of outlier patients. Outlier patients will be assessed for barriers to adherence (e.g. medication cost, complicated regimen, improper use of medication). Outlier patients will be referred for diabetes education and endocrinology consultation, as needed. One Call Care Management (OCCM) will be consulted to help with nonmedical issues that complicate care. |
| Hypertension Control                              | Percent of patients age 18-85 with hypertension with latest office reading <140/90  | 58.41%               | 65%                         | 67%               | PPMs to scrub provider dashboards as above. Outlier patients will be assessed as above. OCCM consultations to help with nonmedical issues that complicate care  |
| Measurement of BMI and follow up of abnormal BMI  | Percent of patients age 18 and up with BMI <18.5 and > 25 in the last 6 months who received individualized advice about improving BMI | 30.92%               | 50%                         | 100%              | Train MAs to capture height and weight so BMI will be calculated. MAs will also bring up the smartphrase “.bmfollowup” when rooming the patients, to remind the doctor to address BMI. A Best Practice Alert will also remind the providers.  |
| Tobacco Use: Screening and Cessation Intervention | Percent of patients 18 and older who screened positive for any tobacco use and were provided with an intervention 7/1/16 -6/30/18     | 63.38%               | 70%                         | 78%               | Retrain providers and MAs to use Epic’s Social History and check off “counseling given”, if it was. Enhance referrals to existing smoking cessation resources that are provided free at both clinics.   |

# Sustainability Efforts

- AAMC plays an integral role in the sustainability, operations and success of ACHP. Ongoing funding opportunities are being pursued including private donations and/or private or public sector grants to offset the deficit the health system incurs. ACHP has made great strides in demonstrating to the community AAMC's commitment to promoting the health of marginalized populations. Expansion to other neighborhoods and other public housing units would be ideal but is not possible in the absence of funding. Therefore, the focus of the future will be to maintain the success established by the ACHP.

# 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.