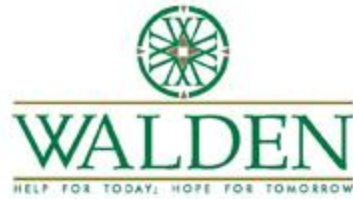


St. Mary's County  
Department of  
Social Services



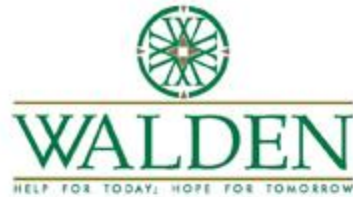
# *Greater Lexington Park Health Enterprise Zone (HEZ) Project*



MedStar St. Mary's  
Hospital

Lori Werrell  
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MedStar St Mary's Hospital

St. Mary's County  
Department of  
Social Services



SMCIL  
Southern MD Center for Independent Living



Minority  
Outreach  
Coalition

GREATER  
Baden Medical Services  
Taking care of our community

HASMC

## ***Vision***

Establish accessible, integrated, culturally competent healthcare in the HEZ supported by clinical care coordination, prevention services, community outreach and education

## ***Core Disease States***

Diabetes, Asthma, Hypertension, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Behavioral/Mental Health Diseases



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# Greater Lexington Park Health Enterprise Zone

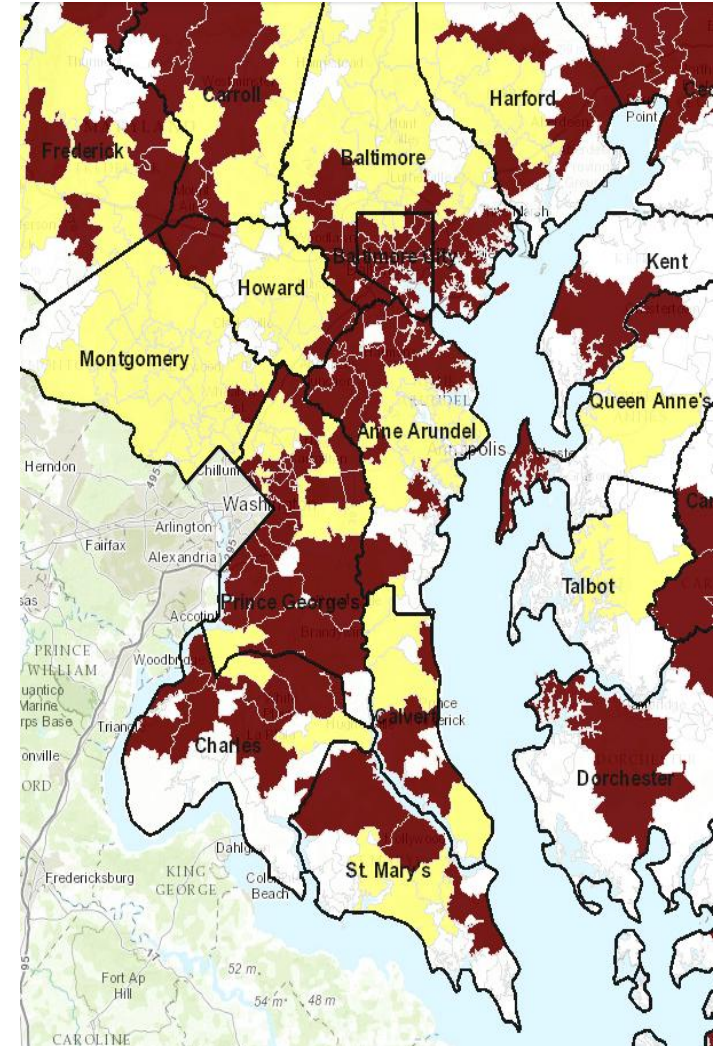
- **Lexington Park:**

- Life Expectancy: 77.6 (lower than 79.1 years eligible)
- Medicaid Enrollment: 200.93 (higher than 109.1 per 1000 eligible)
- WIC participation: 38.77 (higher than 18.0 per 1000 eligible)

- **Great Mills:**

- Average % low birth rate: 7.4 (higher than 6.4 per 1000 births eligible)
- Medicaid enrollment: 128.84
- WIC participation: 20.49

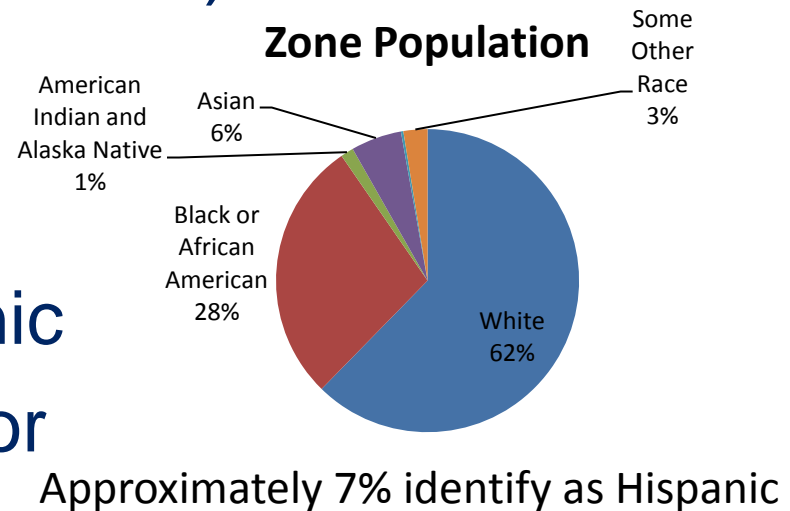
\*\*Needed to meet either life expectancy or low birth weight and Medicaid enrollment or WIC participation thresholds.



# HEZ Demographics

- Population of approximately 34K in 3 zip codes (20653,20634,20667)

- Clients being assisted
  - 31% identify as Hispanic
  - 46% identify as Black or African American







- Care Coordination
- Community Health Workers
- Transportation
- Dental
- Primary Care
- Behavioral Health
- Trainings, classes, events and screenings
- Health Disparities/Hispanic outreach/Cultural Competency



# Provider Recruitment

## Primary Care and Get Connected To Health

- Primary care with Psychiatry
- Safety net clinic on “Big Blue”



# East Run



# Major Program Components

## Hospital encounter

- Inpatient (readmission risk factors triggers Care Coordinator)
- Emergency Room (follow up by Community Health Worker)

## Care Coordinator

- Home visits, care plans, phone support, medication reconciliation
- Working with other care coordination programs and primary care

## Community health worker

- Removing Barriers to self management and health prioritization
- Transportation (shuttle and medical specialty routes)

## Outpatient Care

- Primary and specialist appointments, Dental
- PT ,Dialysis, Cardiac Pulmonary Rehab etc

## Self management programs

- Walk with Ease, CDSMP, NDPP, diabetes self management program, support groups, Walden Sierra programs

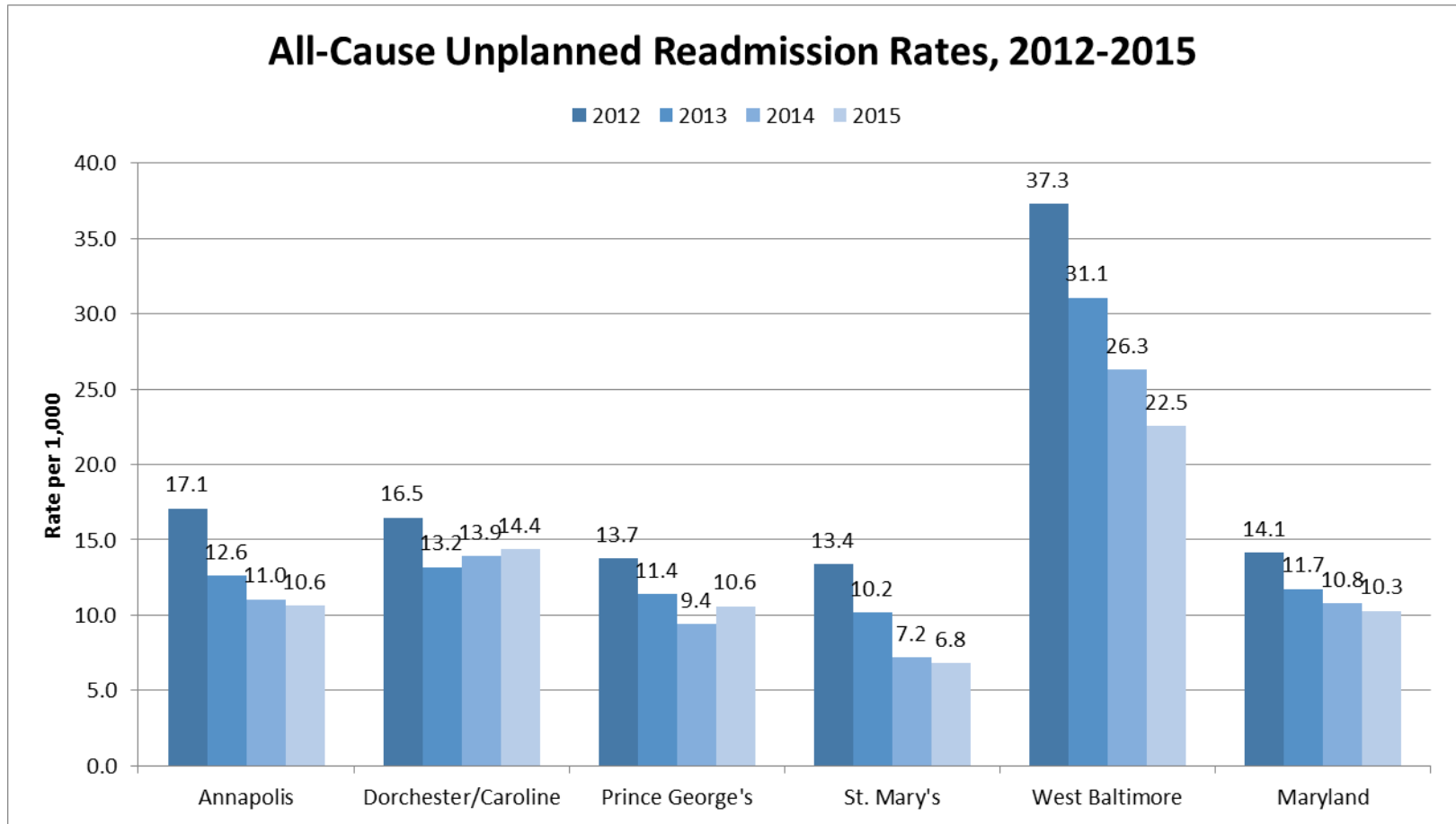


# A Success Story

Just wanted to share.....

*On Friday morning (1/6/17), Antonio (CHW) had gone to The Mission to assist a client we had been working with. While there, he met a family who were relatively new to the area, from Virginia. Antonio was telling this family about AccessHealth and how we help folks in the community. The patient stated he had been out of diabetic testing strips for over a week. The patient also said his insurance was not active yet and the next available appt with a new provider was not until 2/9/17. Antonio called me (RN care coordinator), and we started looking into options. Debbie (NWA) looked up the insurance, found out that it was, in fact active, and was able to print out the information for the family. They had just not received the card in the mail yet and were surprised to hear it was active. MedStar St Mary's Primary Care was called and they confirmed they could see gentleman the same day. The family was given the phone number and called to schedule a time. He was seen Friday afternoon and received his prescription refill for diabetic testing strips. Good stuff!!*

# Readmissions



# Participant Impact

- Readmission rate of RN Care Coordinated patients - 7.03%
  - State data has the overall zone Readmissions rate dropping from 13.4% to 6.8% (around a 50% drop)
  - Emergency Room Visits are down (this is still a challenge)
  - PQI Composite scores are below state averages
- # of new clients served by CHWs – 271
- # of client encounters with CHWs – 4421
- A set of 4<sup>th</sup> year HEZ clients (N=383) showed a reduction in ED and inpatient utilization of approximately 210 visits in the 6 months after most recent intervention compared to the 6 months prior to intervention for an estimated reduction in charges of 420K.
- Shuttle ridership – 7497
- Medical Specialty rides – 440
- # of patients served behavioral Health – 656
- # of unduplicated Psychiatric patients– 87
- # Dental patients seen – 42
- # Primary Care patients seen - 2105

# Challenges

- Lost Key partner for sustainability
- Incentives did not work
- Pressures on hospital budgets





# Sustainability Update

- A work in progress
- A commitment from MedStar to East Run
  - Primary care
  - Psychiatry
  - Dental
  - Care coordination/Community Health Workers
  - Chronic disease self management programming
    - Support groups
    - Smoking Cessation
    - Chronic Disease programs
  - Transportation
    - Shuttle – looking for partner
    - Medical transport with CHWs and partner organizations



# AccessHealth

Wellness within reach.

***QUESTIONS?***

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