MCHRC
Maryland Community Health Resources Commission

Care Transitions Steering Committee

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BACKGROUND ON THE COMMISSION

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- **Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access to health care for low-income Marylanders and underserved communities in the state.**
- **The CHRC is a quasi-independent agency operating within the Maryland Department of Health and Mental Hygiene. Its 11 members are appointed by the Governor.**
- **Since its inception, the CHRC has awarded 142 grants totaling approximately $41.3 million supporting programs in all 24 jurisdictions in Maryland. These programs have collectively served more than 139,000 Marylanders.**
- **Grantees have utilized CHRC grant funding to leverage $13.4 million in additional federal and private/non-profit resources.**

PRIMARY ACTIVITIES OF THE COMMISSION

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1. **Issue annual Call for Proposals and award grants to expand access to care in underserved areas to improve population health**

2. **Support the State Health Improvement Process (SHIP) and Local Health Improvement Coalitions (LHIC); 24 grants totaling $1.9 million**

3. **Implement Health Enterprise Zones (HEZs)**
   - **$4 million per year, four-year duration of the program**
   - **1 urban, 2 rural, 2 suburban Zones designated**
   - **47 new practitioners hired; 87 jobs added**

SUPPORTING LHICS THROUGH GRANT AWARDS

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- **Invested $1.35 million to support SHIP and LHICs in FY 2014**
  - Allegany County Health Department $185,048
  - Cecil County Health Department $120,000
  - The Partnerships for a Healthier Charles County $125,000
  - Harford County Health Department $200,000
  - Howard County Health Department $275,000
  - Montgomery County Dept. of HHS $200,000
  - Tri-County/Worcester County Health Department $250,000

- **These grants have supported the following activities in local communities:**
  - Development of new Patient-Centered Medical Homes (PCMHs)
  - Establish Community Health Worker (CHW) programs
  - Develop and implement regional diabetes care management teams
  - Support hospital ED diversion programs and identify primary and preventative care services in the community

FY 2014 CALL FOR PROPOSALS

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- **The FY 2014 Call for Proposals was designed to support proposals that support the state's ongoing efforts to:**
  - (1) Expand access and build capacity;
  - (2) Address health disparities; and
  - (3) Reduce hospital admissions and readmissions.
- **The FY 2014 Call for Proposals targeted six types of projects:**
  - Infant mortality
  - Dental care
  - Expanding primary care
  - Behavioral health integration
  - Building safety net provider capacity
  - Childhood obesity
- **The Call for Proposals generated 66 applications requesting $27.1 million.**
- **The Commission awarded 20 grants for $2.85 million projected to serve an estimated 50,000 individuals.**

FY 2014 GRANT AWARDS

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INFANT MORTALITY
- Access to Wholistic and Productive Living ($50,000)
- Mary's Center ($200,000)
- Calvert County Health Department ($85,000)
- Planned Parenthood-Maryland ($125,000)

DENTAL CARE
- Allegany Health Right ($45,000)
- Charles County Health Department ($100,000)
- Frederick Community Action Agency ($90,000)

ACCESS TO PRIMARY CARE
- West Cecil Community Health Center ($180,000)
- Health Care for the Homeless (HCH) ($140,000)
- Mobile Medical Care Aspen Hill Multicultural Clinic ($180,000)
- Health Care Access Maryland ($200,000)

BEHAVIORAL HEALTH
- Frederick Mental Health Association ($120,000)
- Mosaic ($300,000)
- Worcester County Health Department ($250,000)

CAPACITY OF SAFETY NET PROVIDERS
- Access Carroll ($125,000)
- Health Partners ($110,000)
- Allegany County Health Department ($30,000)

CHILDHOOD OBESITY
- University of Maryland-Baltimore Department of Pediatrics ($195,000)
- Baltimore City Health Department ($275,000)
- Somerset County Health Department ($50,000)

CHRC GRANT: MOSAIC'S NEXT GENERATION OF INTEGRATED HEALTH

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- Focus on high need & high cost consumers in public mental health and addictions system and safety net providers
- Designing best practices in both primary care and behavioral health for integrated health; builds on EBPs and best practices
- Optimize ideal locus of care for consumers
- All individuals screened for somatic and BH needs
- Bi-directional – BH practitioners in somatic settings and PCPs in BH settings
- Utilizes the health home concept of population management-nurse care manager
- Provides integrated care training to practitioners
- Utilizes CRISP data to measure outcomes
- Optimizes the strengths of two successful organizations

MOSAIC COMMUNITY SERVICES

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- BMS will place a primary care practitioner at the Charles Street location to augment primary care and BH practice at Mosaic
- All Mosaic BH clinicians will be screening for primary health and linking consumers to primary health needs
- Mosaic clinicians will have access to real time consultation and training with primary care practitioners on and off Mosaic site
- RN care manager will alert practitioners to at-risk clients needing additional intervention

BALTIMORE MEDICAL SYSTEMS

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- Mosaic will place BH practitioners in 3 BMS sites
- Positive BH screen – immediate assessment by BH practitioner
- The BH assessment will determine need for short- or long-term intervention and specialty BH services
- PCPs will have access to real time consultation and training with psychiatrists and psych NPs
- RN care manager will alert practitioners to at-risk clients needing additional intervention

HEALTHCARE ACCESS MARYLAND

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- Specializes in connecting Maryland residents to needed health services
- Intensive Care Coordination for the most vulnerable populations
- Targets those who experience homelessness, pregnant women and children, addiction treatment, and immigrant populations
- Access Health
- Embedded care coordinators onsite at Sinai Hospital
- Three care coordinators
- One program director

THE GOAL

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FIND COST-EFFECTIVE WAYS TO:

- Reduce readmissions
- Eliminate unnecessary emergency room visits
- Control costs
- Improve health

ENGAGE COMMUNITY:

- Link patients to necessary primary and specialty care
- Cut across demographic lines
- Assist in system navigation
- Tear down environmental barriers for our clients

TARGETED SERVICES

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- Provides new access points for those with health disparities
- Expands primary care
- Reduces infant mortality
- Facilitates enrollment into Medical assistance
- Reduces hospital admissions/ readmissions
- Reduces visits to ED

- Patients being d/c meeting high utilizer criteria including:
  - Frequent visits
  - Unmanaged chronic conditions
  - Non-compliant w meds
- Non-emergency
- Uninsured requiring assistance in QHP

EXPECTED NUMBER SERVED

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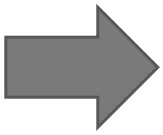
2,700 people per year



Total reduction of ED visits by those with 4+ visits per year from 18,857 to 9,429 = 50% reduction.

EXPECTED OUTCOMES

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- Increase access points to safety net providers for preventive and chronic conditions
- Increased % of pregnant mothers that access and engage in prenatal care to reduce infant mortality
- Reduce readmission rates for the target population
- Reduce high utilizer ED visits
- Increase proportions of person with health insurance to access primary health care