



Maryland
Hospital Association

Anne Arundel Medical Center Brings Health Care Home for Patients

When Dr. Patricia Czapp talks about her job, she is downright giddy. The chairwoman of clinical integration at Anne Arundel Medical Center says, after many years, she's finally able to practice medicine in a manner consistent with her reason for going to medical school in the first place — to promote and maintain health, rather than simply eliminate disease. Or, from an organizational perspective, practice population health management.

“With what we're doing, we have the ability to reach thousands of folks,” she says. “That's phenomenal.”

The changes Czapp are referring to are part of AAMC's Vision 2020, an organizational roadmap focused on three goals:

- **Improving care for individuals** by empowering people to be more involved in their care
- **Improving the health of our communities** through many partnerships
- **Creating a more affordable health system** inclusive of better medical access and technologies

It's no coincidence that these goals are similar to those of the Triple Aim and the tenets of Maryland's new waiver agreement with the Centers for Medicare and Medicaid Services. Nationally and especially in Maryland with the new waiver, health care organizations are working to shift their services from volume to value, and those with definitive plans are well equipped to make a successful transition.

At AAMC, rapid progress has been made in just a few years. Vision 2020, which lays out the framework of a comprehensive population health management strategy, was approved as the organization's 10-year strategic plan, and in just a little more than three years, the early results are impressive.

- MyChart (AAMC's patient portal for electronic health records) has nearly 32,000 active users
- AlecConnect (the portal offering physicians access to patient records) has 109 partners, including nursing homes, skilled nursing facilities, and physician practices
- At least 60 percent of the primary care practices in AAMC's service area are involved in some form of PCMH program
- AAMC is in the top third of readmission reduction performers in the state while serving four counties with a 6.2 percent cumulative readmission rate as of December 2013

The improvements are due to multiple initiatives, such as:

- the implementation of Epic's electronic record-keeping system (2009) — AAMC uses data in three ways — to learn lessons regarding performance, to make clinical decisions in real time, and to plan for the future by identifying rising risk populations and deploying appropriate resources

- serving as CareFirst’s pilot patient-centered medical home (2009) — One innovative component of AAMC’s PCMH program is its “medical assistant university,” which works to train and retrain staff members so they are working to the top of their skill set in that environment
- the development of a patient/family engagement effort (2009-2010) — In addition to a web-based portal that empowers patients by providing them direct access to their health records, this initiative includes wellness promotion programs like Living Well with Chronic Conditions
- the creation of a collaborative care network (2012) — This iteration of an ACO went live in January 2013 and now spans four counties; it employs community health workers who are each responsible for the health management of between 75 and 100 of AAMC’s highest utilization patients

There are other programs that serve Vision 2020’s goals, but a broad strategy seems to be the formula for AAMC — identify a need where a nontraditional approach could make a statistical difference and then develop programs to fill that need.

Perhaps nothing AAMC is doing exemplifies that principle as well as a conference room-sized clinic in the Morris H. Blum Senior Apartments. The clinic, which houses a single physician and a handful of medical staff, was created within a state Health Enterprise Zone, which is designed to provide additional resources to areas with health care shortages or glaring health disparities.

The idea for the clinic came about after when AAMC executives began examining data on high-utilization patients and realized that a disproportionate number of them were coming from the same address in downtown Annapolis — an apartment building for low-income seniors. Here are some telling numbers: from November 2011 to November 2012, Morris Blum residents made 220 medically related 911 calls. In one six-month span, 73 Morris Blum residents made 175 emergency room visits.

The clinic opened in November and has already provided physicians with critical information to improve the community’s health. For Morris Blum AAMC patients who have with the medical center for a year or more: 90 percent have been screened for diabetes, 70 percent have elevated blood pressure, and 60 percent have dangerous cholesterol levels. Within a year, AAMC believes the center will be able to reduce medical 911 calls, emergency department visits, and readmissions from the apartment complex by 30 percent.

While AAMC may be well on the road to successful population health management, it’s worthwhile to note how Sherry Perkins, AAMC’s chief operating officer and chief nursing officer views what’s been accomplished.

“I feel like we have so much to do to get where we want to be,” she says. “There’s so much work still to be done.”