

Celebrating 20 Years of Connecting Communities & Healthcare

2018 ANNUAL REPORT



CEO MESSAGE

Dear Supporters,

HealthCare Access Maryland celebrated 20 years of providing health coverage, care and connections to Maryland residents. The event highlighted the history of the organization starting in April 1997 with only 40 staff to present day 200 plus staff and serving over 145,000 residents. Our mission and vision remain focused on ensuring all Maryland residents are connected to health coverage and understanding how to navigate the health care delivery system. Identifying unique ways to ensure that residents have multiple support systems to address their complex health and social needs, is a priority.

In collaboration with the Board of Directors, HCAM celebrated with over 200 friends, partners, vendors and donors. We were honored to have a personal message from Dr. Peter Beilenson, our founder and previous Health Commission for Baltimore City. Rep Dutch Ruppersberger provided our keynote address discussing the importance of nonprofits in health care enrollment and improving systems related to social needs. His staunch support of the Affordable Care Act has been evident in his ongoing support of HealthCare Access Maryland over the past two decades.

After the celebration, fundraising and photos were finished, HCAM continues to focus on its strategic plan within our four pillars: People, Programs, Infrastructure and Resource Development. Over the next twenty years, HCAM views itself as a partner across all health care entities in the state. We must and can do better to ensure that all Maryland residents have access to affordable, quality health care. However, we cannot overlook the importance of addressing the complex social needs of the population we are serving. Affordable housing, food security, transportation and behavioral health services only touch the surface of the needs of our clients. HCAM is eager to continue to address these social barriers to improved health outcomes.

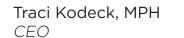
HCAM continues to expand our reach across the state and build our board of directors in technology, higher education and corporate partnerships.

Buy Herman

Bill McLennan

Board President

Thank you again for your continued partnership and support of HCAM's mission. We could not be successful without all of you.





Traci Kodeck, MPH



Bill McLennanBoard President

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20 YEAR TIMELINE

1997

Baltimore HealthCare Access (original name): Established two core functions: Eligibility and Care Coordination/Ombudsman Services due to a change in Medicaid model

2000

40 Staff: 3 million dollar budget; Robert Wood Johnson Foundation funding for three years to support insurance enrollment to children in Baltimore City Schools

2006

Baltimore Buprenorphine Initiative:
Collaboration between the Baltimore City
Health Department, Baltimore HealthCare
Access and Baltimore Substance Abuse
Services to address Opioid epidemic with care
coordination services to those in drug
treatment programs across the city.

2008-2009

United Way of Central Maryland/211 Collaborative to create Health Care Hotline to link Baltimore City residents to health insurance and low cost health care; MATCH Program; collaboration with Baltimore City DSS, created to provide Medical Case Management to children in foster care; Operation Care Program: collaborative with Baltimore City Fire Department, initiated to provide care coordination to clients identified as high utilizers of 911; Homeless Services team began street outreach to connect chronically homeless adults to shelter and housing

2011

Rebranding Event; name change to HealthCare Access Maryland in preparation of ACA rollout Connected more than 100,000 clients to healthcare and community resources

2013

HCAM awarded Connector grant for Central Region under the Affordable Care Act; Partnership with Sinai Hospital to reduce ED utilization: Funded by the Maryland Community Health Resource Commission for three years

2016

Traci Kodeck, MPH, named new CEO of HealthCare Access Maryland after 16 years of service

1998

Mail-in applications received for Maryland Children Health Program; Care Coordination Services and Service Ombudsman; School Health Program assisting to ensure that school age children have access to health insurance

2004

Maternal Infant Health Improvement Project to outreach all pregnant women referred via prenatal risk assessments from OB Providers in the City; approximately 6000 women a year. Kathleen Westcoat, MPH, named new CEO of Baltimore HealthCare Access

2007

Baltimore HealthCare Access celebrates 10 years at Visionary Arts Museum; Emergency fund renamed Veronica Guthrie (BHCA staff who succumbed to long-term illness) Emergency Fund; Medicaid Expansion Programs - Primary Adult Care and Medicaid 4 Families provided coverage to single adult and parents of dependent children

2010

Second Chance Jail Project, connecting incarcerated client to health benefits and primary care services prior to release. Funded by Abell Foundation, Harry and Jeanette Weinberg Foundation, and Open Society Institute for three years

2012

HealthCare Access Maryland celebrates 15 years, celebration at Baltimore Aquarium

2015

Population Health Based Programs developed with hospital partners: Health Link

2017

HCAM is awarded Midwestern Region; now Connector Entity in Baltimore City, Baltimore County, Anne Arundel County, Carroll County, Howard County and Frederick County; HCAM celebrates 20 years of service to the residents of Maryland; 200 staff; 18 million dollar budget

OUR PROGRAMS

COVERAGE. CARE. CONNECTIONS.

In FY18, HCAM programs served a wide spectrum of more than 145,000 Maryland residents ranging from children, parents, pregnant women, childless adults and immigrants to people experiencing homelessness, youth in foster care, people with substance use disorders and recent jail releasees. Each year our programs grow, as we fulfill our mission to go-further to reach people where they are in the continuum of life.

CARE COORDINATION

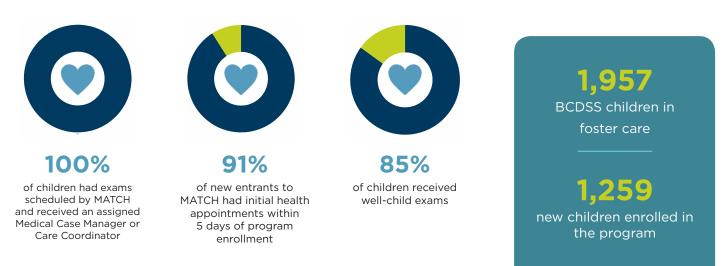
As the cornerstone of HCAM, the Care Coordination Program (CCP) provides short-term care coordination services to Baltimore City residents, to include, education about low-cost/no-cost health services, linkage to primary care providers or specialists, and referrals for long-term case management.

The Care Coordination program collaborates with 100 clinics, 10 hospitals (8 delivery hospitals) and 9 Managed Care Organizations.



MATCH

Through MATCH, HCAM provides health care coordination, education, and advocacy services to make sure Baltimore City children in foster care receive the health care they need.



BEHAVIORAL HEALTH

The Behavioral Health Outreach Programs (BHOP) provide behavioral health treatment connections, outreach and care coordination to vulnerable populations as well as housing options for individuals experiencing homelessness.



893 intake opointments

532 Itimore residents olled in Homeles



Collaborated with **25 agencies** to assist **104 households** with housing services

Placed 76 households in permanent housing



Enrolled **2,330 people** into **State Care Coordination Services,** which provides care coordination for those accessing treatment for substance use disorders



27 families were served in a 12-month Women & Children's Housing Project program

that targets women who are in or have completed treatment for a substance use disorder and have custody of at least one child



Provided **49 pregnant or postpartum women** who
are in recovery or struggling
with substance use disorder with
community resource assistance

CONNECTOR PROGRAM

Since 2013, HCAM has been the State's Central Region Connector Entity for The Maryland Health Benefit Exchange, helping residents of Baltimore City, Baltimore County, and Anne Arundel County learn about, apply for, and enroll in health insurance through Maryland Health Connection. In July 2017, HCAM began serving as the Connector Entity for the Midwestern Region, which includes Howard, Frederick and Carroll Counties.

Fielded 32,963 calls

Managed **27,287 calls** in the Central region and an additional **5,676 calls** in the Midwestern region



Enrolled **23,326 individuals** across Maryland for health benefits



7,887 enrollments in Qualified Health Plans

Central: 4,366 Midwestern: 3,521

15,439 enrollments in Medical Assistance programs:

Central: 14,415 Midwestern: 1,024

POPULATION HEALTH

HCAM's Population Health program focuses on the health outcomes for patients with chronic health conditions, specifically addressing the social determinants of health that impact one's long term health outcomes. Team members address transportation barriers, food insecurity and affordable, appropriate housing to name the most common social needs.

West Baltimore Collaborative

A partnership with UMMC, UMMC Midtown, St. Agnes and Bon Secours hospitals, formed to identify and manage the needs of their respective patients for short-term case management, and to connect patients that are high users of emergency and inpatient services to appropriate levels of care.



St. Agnes HealthLink

A program targeting high cost/high need clients that were utilizing inpatient hospital services to receive their health care. The goal of this project was to provide more cost effective, quality health care and reduce inpatient admission costs. In 2018, HCAM embedded Care Coordinators at St. Agnes Hospital to meet the clients at bedside and enroll them in HealthLink services.



ELIGIBILITY DEPARTMENT

The Eligibility Department assists consumers applying for Medicaid services through the Maryland Children Health Program (MCHP).

In 2018, HCAM established a Parole and Probation program which bolstered our efforts to reach vulnerable citizens.

Working with 4 Parole and Probation agencies and enrolling 842 individuals for Medicaid services.

Medicaid enrollment success for FY18:





GOING FURTHER TO PROVIDE CONTINUED CARE

A 27-year old pregnant woman sought out HCAM Eligibility services to obtain health coverage to access prenatal care. After accessing prenatal care, she was referred to me in our Care Coordination program via the Maryland Prenatal Risk Assessment form completed by the OB/Gyn.

I provided her with education and linkage to additional covered Medicaid benefits such as dental services. Her pregnancy was unintended, and with a history of anxiety, depression and sexually transmitted infections: this client had few resources. I provided her with education and linkage to additional Medical Assistance benefits. With my help, she also agreed to participate in home visiting for parenting support where she was told about the Safe Sleep program for infant safety and was given a portable crib.



Her baby was delivered early at 37 weeks. While the baby was in the NICU due to respiratory distress, the delivery hospital reached out to Care Coordination for outreach for this high-risk newborn.

Again, HCAM Eligibility stepped in to ensure this newborn had active Medicaid Assistance benefits. Through this connection, our Care Coordination program successfully outreached the postpartum mother to ensure that her family was linked to pediatric care, WIC for nutritional support and thorough postpartum support. We were successful in connecting her with mental health services utilizing our internal Crisis Information and Referral Line.

Stephanie Alston, LBSW Social Work Care Coordinator/MCH Team Leader collaborated with Eligibility Specialist **Urah Blackwell** on this case

GOING FURTHER

TO REACH WOMEN FACING PREGNANCY & POSTPARTUM DEPRESSION



Six-year-old Lola and four-year-old Peanut were in an out of home placement with their grandmother after having been severely neglected and physically abused by their parents. The courts granted custody of the children to their grandmother. While the grandmother was able to care for Lola and Peanut, she was struggling with their behaviors. One afternoon, in a state of sheer frustration, the grandmother contacted me and stated that she didn't think she could care for the children any longer. In response to her concerns, I immediately set up an emergency evaluation for Lola and Peanut and requested therapy services and any other support services that would aid in keeping this family intact. During this process I walked the grandmother through the steps she needed to understand the importance of mental health services and how to continue to access the services for the children. I also reinforced the importance of using the skills introduced in therapy while at home.

For two years, I continued working with this family. The grandmother would call to ask direction on services for Lola and Peanut: including speech therapy and a developmental delay clinic. She always kept me informed on how the family was doing and was very receptive to my regular telephone check-ins and recommendations. At the end of that second year, the grandmother decided to adopt her two grandchildren and asked me to assist with the process. I was able to give her resources through BCDSS as well as advise her on what questions she should ask the attorneys and her social workers. I was also able to educate her further regarding the children's health insurance, covered benefits and how to navigate the Medicaid system.

I was elated when I received the phone call from the grandmother stating that Lola and Peanut's adoption was finalized this year. She currently has all of the needed services in place to be able to provide for her grandchildren. In our last conversation she stated that my encouragement and knowledge of resources was a huge help along the way to thus allowing her to feel competent and confident to raise her grandchildren.

Rebecca Spare, LMSW Social Work Medical Case Manager

IMPORTANCE OF COLLABORATION

Over the last 6 months, MATCH has partnered with the Harriet Lane Pediatric Primary Care Clinic to help our providers identify our patients in foster care. The MATCH program provides our clinic with a monthly list of children in MATCH that are assigned to our clinic. Prior to this collaboration, we had no routine way of knowing which of our patients were entering or exiting foster care, which can impact their health and receipt of medical care. Kim and Kenya have been wonderful to work with and I look forward to continuing our collaboration together to improve the medical care we provide to children in foster care in Baltimore City.

Rebecca Seltzer, MD MHS

Assistant Professor, Division of General Pediatrics and Adolescent Medicine Johns Hopkins School of Medicine



GOING FURTHER

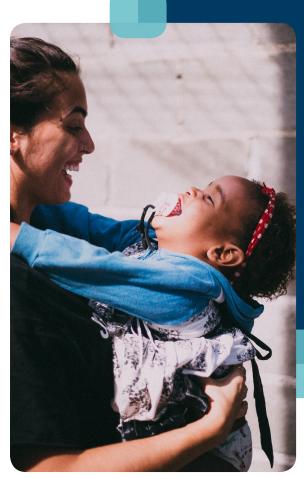
TO REACH WOMEN FACING PREGNANCY & POSTPARTUM DISTRESS

I met M.D. at the Park West Medical Center while she was pregnant with her 3rd biological child. M.D. overcame several difficult moments during her pregnancy, as she and her children were displaced when the electricity was turned off in her home after she had to terminate her employment. During this time, M.D. maintained an upbeat and positive attitude, and was able to seek out assistance and follow up with my recommendations.

Once the power was restored, M.D. and her family moved back into the family home but were quickly faced with the threat of eviction because the rent was nearly three

months behind. M.D. was barely able to make regular payments because she was no longer working. Yet again, she persevered and accepted my recommendations and resources. HCAM provides items needed for her home including home appliances, and she was able to get financial assistance to pay off the rent balance. M.D is now working full-time as an IEP aide subcontracted by Baltimore City Public Schools.

Niger Alibi, Recovery Care Services Pregnancy, Post Partum Case Manager



GOING FURTHER TO PROVIDE QUALITY SERVICE

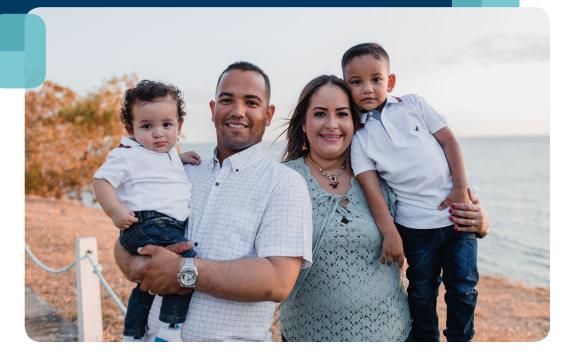


CONSUMER SPOTLIGHT

Kristi S. and her husband were self-employed and had purchased insurance in the private market before the Affordable Care Act. Her family's rates rose dramatically over the years and they had to forgo insurance for a period of time.

When the exchange started in 2013, Kristi went on the website to enroll, but the family's self-employment income made the process cumbersome. With the help of Pat Gussio, Navigator, in Howard County, Kristi was delighted to learn that her family was eligible for a subsidy to make their insurance affordable. Shortly after, Kristi was able to once again have comprehensive coverage for her family. When the S's re-enrolled for 2018, the Healthy Howard staff had become HCAM employees, but the transition was so seamless that Kristi wasn't even aware of the change!

"I was just happy to see Pat's familiar face - she walked me through every step of the process and helped me choose the best plan for my family. There is just no substitute for the in-person assistance that she provides."





GOING FURTHER

TO EDUCATE AND PROVIDE PERSONALIZED CARE

A 66-year-old client was in and out of the hospital due to Chronic Obstructive Pulmonary Disease (COPD) exacerbations. Though she had a Primary Care Physician, she would often visit the Emergency Department because she believed that she could not go to the doctor every time she needed something and that she could continue smoking without consequence.

This client has been widowed for 10 years but has great family support including a sister-in-law, a son who moved in, and helpful neighbors. The client doesn't drive, has an education level of 10th grade, and is a heavy smoker. She has a history of COPD, Congestive Heart Failure (CHF), Hypertension (HTN), fibroids and heavy bleeding with an impending total hysterectomy.

Upon enrollment in our program, I set her up with initial goals including staying out of the hospital, medication assistance and transportation assistance.

Through my work, our client was approved for Maryland Transportation Administration Mobility Service which allows two trips daily with the cost of \$2/per trip. She was more recently connected to the taxi card program in which she can pay \$12/month and ride any cab service unlimited.

She is now taking four medications regularly and has consistently stayed out of the hospital for the past 90 days. She was provided a pharmacy drug discount card and instructed on its use, and she now uses RX outreach to order 90-day supply of medications.

Due to my client having reliable transportation while in the program, she is able to attend almost all appointments and makes the effort to reschedule those she cannot attend. Toward the end of her case management, she was calling to inform me of appointments and the results.

In addition to meeting basic medical needs, I provided my client with personalized education on the importance of paying attention to signs/triggers of declining health and alternative ways to improve it, such as increasing inhaler use, attending appointments in the earlier part of the day during hotter months and keeping hard candy around when feeling an urge to smoke.

She has become a conscious thinker of her health, having reported that she went from smoking 3-4 cigarettes a day to 1 cigarette every 3-4 days. She calls her doctor during after-hours and thinks first before visiting the ER. Because she is healthier at this time, I am helping her with a new goal of becoming more social.

Genevieve Clinton, RN Care Manager, West Baltimore Collaborative

In FY18, the HCAM leadership team made significant advancements towards our strategic goals of supporting effective and efficient operations and investing in our people.

Established Core Values and Core Service Excellence Awards

Implemented new Performance Review process that includes our core values

Trained front line managers on employee relations and management

Established the Diversity & Inclusion Committee and Program

Provided LGBTQ Sensitivity Training to Managers and Supervisors

Established processes and programs to improve recruitment efforts and employee retention

Established employee Health & Wellness Committee

Updated policies and procedures to improve compliance with laws and regulations



HCAM'S COMMITMENT TO OUR STAFF AND WORK

HCAM CORE VALUES

IN ALL THAT WE DO, WE BELIEVE IN:

HELPING OTHERS

At our core, we are driven to serve and help people in need.

SUPERIOR QUALITY & SERVICE

We go above and beyond to deliver our best. We respect each client as we respond to their individual needs.

COLLABORATION MAKES US BETTER

Teamwork strengthens our foundation and allows us to produce superior results.

UNWAVERING COMMITMENT

We stay focused on our mission by delivering exceptional service.

UNIFIED DIVERSITY

We embrace and leverage our differences to inclusively care for each other and ourselves so that we can positively impact our community.

HealthCare Access Maryland would like to thank all of its funders and donors who supported our programs and services during the Fiscal Year of 2018. We look forward to your continued support and collaboration.

HCAM Funders

(through contracts or grants)

Anne Arundel County Health Department Baltimore City Department of Social Services

Baltimore City Health Department
Baltimore City Fire Department
Baltimore City Mayor's Office of Human
Services
Baltimore County Health Department

Behavioral Health System Baltimore

France Merrick Foundation
Harry and Jeanette Weinberg Foundation
Maryland Community Health Resources
Commission
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St. Agnes Hospital
United Way of Central Maryland
West Baltimore Collaborative



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Kristin Maynard

Mosaic Group

Priority One Staffing Services

Rudolph Supply

Saint Agnes (Emergency Administration)

Saint Agnes/Ascension

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Sheila Mackertich

Tammi Fleming

The Annie E. Casey Foundation

The Goldin Group, LLC

The Hatcher Group

Total Health Care

Traci Kodeck

Tribridge Partners

George Jay Unick

William McLennan



YOUR CONTRIBUTIONS CAN HELP US GO FURTHER

\$10,000



Pays for **90 days** of case management services for **4 clients** who are overusing emergency department hospital services



Provides case management and engagement services to locate **5 pregnant women**, lost to care or unable to locate



Pays for 100 clients to receive prescription assistance for 6 months



Pays for 465 clients to get enrolled into health insurance benefits

\$5,000



Pays for rental assistance for a family for 6-9 months



Pays for **60 newborns** to receive a pack-n-play and to have a safe place to sleep



Pays for bus fare for 800 clients for a year

\$2,500



Pays for **50 staff members** to attend a professional development/core competency training course



Pays for 4 sessions of mindfulness training for a staff of 200



Provides 100 vulnerable newborns with pacifiers, onesies, and formula assistance as part of the Safe Sleep Initiative

\$1,000



Pays for move-in kits for **10 clients** in our Rapid Rehousing program



Pays for 1 staff member to have license/access to our case management and e-learning systems

\$500



Pays for **1,900 children** in MATCH program to receive an updated health passport at least **2 times a year**



Provides staffing for **2 navigators** to cover **6 outreach events** and provide education on Medicaid and private health insurance coverage

\$100



Provides Baby Basics books to **35 pregnant/parenting teens** in the MATCH program



Covers postage for **100 foster care families** to receive updated medical cards



Pays for incentive cards to engage 4 clients in services



Covers the cost of one move-in kit



Covers **one week of outreach work** in the Needle Exchange Program van



Covers cost of Information and Referral line staff for 8 calls



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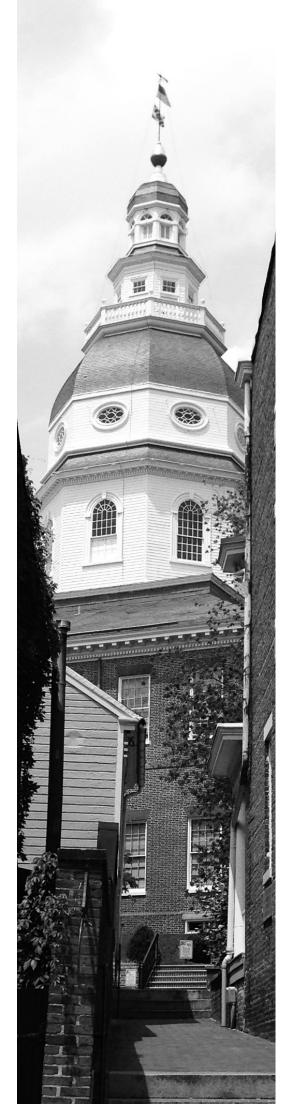
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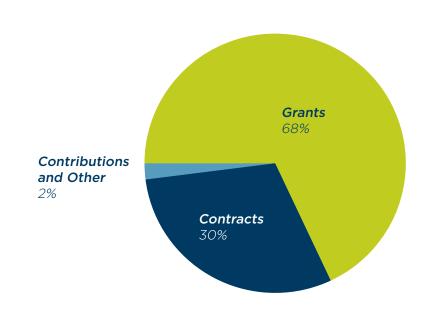




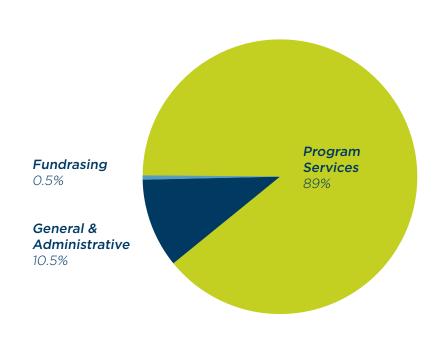
FINANCIAL DATA

as of June 30, 2018 (Audited)

Revenues - \$16,749,432



Operating Expenses - \$16,308,990





Celebrating 20 Years of Connecting Communities & Healthcare



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