The Prince George’s Healthcare Alliance, Inc. is an award-winning 501 (c)(3), non-profit organization whose mission is to decrease over utilization of health system resources and to maximize the quality of care coordination for high need, high utilizers of healthcare resources.

Our vision is to help patients change their health behaviors and to achieve their best health by addressing the social factors adversely impacting their health. Social factors represent 70% of the determinants impacting population health in our community.

Who We Serve
The Healthcare Alliance serves high risk, underserved patients in poor control of their chronic illnesses with high medical costs, needing family and social service resource connections. We help:

- High risk patients with frequent hospital readmissions for the same condition
- Patients with multiple emergency room visits
- Patients with multiple 9-1-1 calls
- Patients with no health insurance
- Patients with no Primary Care Physician (PCP) or who have not seen their PCP in over 12 months
- High risk patients with unmet behavioral health needs and care gaps with no access to preventive care services

Care Coordination
The Healthcare Alliance provides care coordination services to high risk, high-need, high-utilizers of healthcare resources with a focus on helping residents address the social issues adversely impacting their health.

- We conduct home visits and individualized assessments.
- We identify patient and family barriers, set goals and develop individualized intervention plans.
- We collaborate with county agencies, non-profits and behavioral health providers, and connect residents to needed resources.
- We assist patients with obtaining health insurance coverage, selecting a primary care provider, scheduling appointments and transportation.
- We educate patients on becoming self-advocates and active participants in their own healthcare.

Case Example
A 29 year old homeless female was referred to the Prince George’s Healthcare Alliance, Inc. by UMCRH Prince George’s Hospital Center with 17 medical conditions, 18 doctors, 20 medications. She had 8 ED visits and 1 hospitalization in 2 months before referred to the Healthcare Alliance. She was living behind the Walmart in Laurel, MD with no income, no food, no transportation and no family support. Her community health worker (CHW) conducted her assessment in an open field behind Walmart.

- Her CHW connected her to resources for food, clothing, social security disability, insurance, transportation to doctor’s appointments, behavioral health treatment, medication reconciliation and housing.
- Outcome: no ED visits, no hospitalizations, health stabilized.

Patient’s Testimony: “Thank you for everything you have done for me. I have a roof over my head, food to eat, and now I’m making my doctor’s appointments. I am not good with communicating or expressing myself with people…but you have saved my life and you gave me a second chance to do better and I will always be grateful for that.”
Positive Impact on High Risk Patient Populations

Reductions in Hospital Utilization and Hospital Costs for Medicare and Dual Eligible Beneficiaries

Summary:
Hospital Use and Charges Data calculated for 111 Medicare/Dual Eligible Beneficiaries referred by UMCRH Prince George’s Hospital Center to the Healthcare Alliance for CHW Care Coordination Services.

Utilization (visits) and costs were calculated 6-months before referral and then compared to 6-months after CHW intervention, demonstrating an average of $11,615 reduction in hospital charges for a total savings of $1.2 million dollars.

Change in Total Patient Visits and Costs

<table>
<thead>
<tr>
<th></th>
<th>Before CHW Referral</th>
<th>After CHW Intervention</th>
<th>Visit Reduction and Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Visits</td>
<td>718.17</td>
<td>532.80</td>
<td>(185.37)</td>
</tr>
<tr>
<td>Hospital Costs</td>
<td>$3,293,148</td>
<td>$2,003,883</td>
<td>($1,289,265)</td>
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</tbody>
</table>

Data Source: CMS Medicare Part A Claims
Patient referrals July 2018 – December 2018
Prepared by Health Quality Innovators (HQI)

Per Patient Utilization and Cost Reductions Achieved

<table>
<thead>
<tr>
<th></th>
<th>Reduction in Hospital Use</th>
<th>Reduction in Hospital Cost</th>
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</thead>
<tbody>
<tr>
<td>Inpatient Admissions</td>
<td>26.45%</td>
<td>34.73%</td>
</tr>
<tr>
<td>ED Visits</td>
<td>27.17%</td>
<td>42.25%</td>
</tr>
<tr>
<td>Observation Stays</td>
<td>24.13%</td>
<td>41.42%</td>
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</tbody>
</table>

Definitions:
Inpatient Admissions – overnight hospital stay
ED Visits – emergency room/department visits
Observations Stays – hospital stay to determine an inpatient admission

Social Determinants of Health