IDENTIFICATION: (initial identification criteria)
• Medical Practices established practices that have the ability to extend their practice into the Zone
  • Start up practice with promising business plan and initial start up capital
  • Practices willing to:
    • provide services to the underserved population
    • become a Patient Centered Medical Home
• FQHC s—CCI, Mary Center and Greater Baden
• Hospital Based Practices – Not approached initially

ENGAGEMENT:
• Engaged medical practices through a direct approach
• Presented package of incentives and benefits
• Helped to secure funds outside of HEZ for build out

DESIGNATION:
• Conducted an environmental scan. Matched need with available space
• Engaged members of the community to identify their needs e.g. our HEZ Coalition
• Collaborated with practice representative: i.e. Global’s business developer, Gerald’s COO, Greater Baden’s CEO, etc.
Designation Assignments

- Kingdom Square: Capitol Heights
- Southern Capitol Heights
- Coral Hills
- Seat Pleasant
- Fairmount Heights
Provider agreements are executed with medical providers who received or will receive HEZ funding dollars, incentives, and benefits. Additional providers with no HEZ funding dollars will be required to enter into similar PGCHEZ agreement excluding terms and language for funding dollars.

Prince George’s County on behalf of the Prince George’s Health Department has four partnering agreements with providers:

- Memorandum of Understanding
- Party Specific Agreement
- Business Associate Agreement
- Data Exchange (Sharing) Agreement
Memorandum of Understanding (MOU)
- Standard language for requirements of all HEZ medical providers as designated by the grant
- Details the scope of work for both parties

Party Specific Agreement (PSA)
- Detailed provider language for requirements of all HEZ medical providers as designated by the grant
  - Overview and Effective Date
  - Grant Compensation to Medical Provider (installment payment terms based on HEZ year)
  - Management of hiring and state tax credits, loan repayment assistance managed by State
  - Reporting requirements (quarterly)
- Compliance with terms, conditions, and all administrative requirements and laws
Data Exchange (Sharing) Agreement
- Detailed, mandatory security measures and requirements that govern the electronic transmission and exchange of Protected Health Information (PHI) through parties of use of the EHN in accordance with applicable State and federal laws
- Agreement executed with all HEZ medical providers, hospitals, and other vendor exchanging health information
- Agreement between PGCHD and Each Individual Medical Provider

Business Associate Agreement (BAA) Agreement
- Detailed compliance agreement that outlines the business relationship in which each entity is considered a “business associate” of covered entity as defined in Health Insurance Portability and Accountability Act of 1996 (HIPPAA)
- Definitions, Use or Disclosure and Duties Business Associate relative to PHI
Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. The patient's needs and preferences are known ahead of time and communicated:

- at the right time
- to the right people

This information is used to provide safe, appropriate, and effective care to the patient.

Resource: Agency for Healthcare Research and Quality (AHRQ)
Department of Health and Mental Hygiene
Care Coordination Model

Hospital
- Inpatient Clinical Coordinator
- Hospitalist

At Home
- Patient
- Community Health Worker

Patient Centered Medical Home
- Patient's Doctor
- Outpatient Clinical Coordinator
Patient-Centered Medical Home

CONTINUOUS RELATIONSHIP

PATIENT-CENTERED CARE

PERSONAL PHYSICIANS

Access to Care

Team-Based Healthcare Delivery

Follow Standards for Care Coordination

Patient & Physician Feedback

Advanced IT Systems

Population Health

Whole Person Orientation

Decision Support Tool
Care Coordination Takes....

- Teamwork
- Care management plans specific to each patient
- Care transition workflows
- Medication assessment and management
- Data and information sharing
- Health information technology
- Services wrapped around the patient-centered medical home (PCP)

Resource: Agency for Healthcare Research and Quality (AHRQ)
Department of Health and Mental Hygiene
Examples of specific care coordination activities include:

- Establishing accountability and agreed upon responsibility of each member of the care team.
- Communicating/sharing knowledge about the patients’ needs.
- Helping with transitions of care: hospitalizations, emergency visits.
- Assessing patient needs and goals.
- Creating a proactive, comprehensive and coordinated care plan.
- Monitoring and scheduling follow-up with the patient, including responding to changes in patients' needs.
- Supporting patients' self-management goals.
- Linking to community resources.
- Working to align resources with patient and population needs.

Resource: Agency for Healthcare Research and Quality (AHRQ)
Department of Health and Mental Hygiene
PGC HEZ Care Coordination Structure

Program Manager

Nursing Manager
- Community Health Workers

Partner Services Coordinator
- Coalition of Elected Officials
- Patient Center Medical Homes
- Partners Agencies, Hospitals, Health Systems, Beh. Health, Non-Profits
- Community Advisory Board and Health Literacy

Supervises CHWs, and provides clinical oversight, monitoring and measuring of CHW activities

Organizes and manages PGCHEZ partnership activities, identifies gaps in health and social services, and assures that coordination of care services needed by the PCMHs are made available
Care coordination is a key strategy that has the potential to improve the effectiveness, safety, and efficiency of the American health care system.

Well-designed, targeted care coordination that is delivered to the right people can improve outcomes for everyone: patients, providers, and payers.

Must obtain data to identify your targeted population.

Prince George’s County HEZ statistics:
- 10% PGC HEZ residents represent 80% of readmissions
- Approximately 270 patients
- In need of health and social services
• Patients readmitted to the hospital for the same condition within 30-60 days.
• Frequent ED utilizers.
• At-risk patients not adhering to the PCP’s treatment plan for many reason:
  – Non-adherence to prescribed medications
  – Poor nutrition resulting in elevated LDL, HgAlc and blood pressure
  – Smoking with the presence of chronic illness
  – Non-adherence to prenatal appointment schedule, proper nutrition and/or prenatal vitamins. Exhibiting at-risk behaviors
• At-risk patients diagnosed with:
  – Asthma, moderate to severe
  – Diabetes with HgAlc >8.0 and/or LDL > 100 mg/dL after medication is administered
  – Hypertension with BP>120/80 after medication is administered
  – Obesity - BMI between > 34
  – High risk pregnant women needing prenatal appointment adherence
High Utilizers/Targeted Populations

Inpatient Utilization Data for HEZ - zip code 20743 from CRISP
Plan:

- Ensure the development care plans for *Frequent Flyers* and High Utilizers.
- Monitor to ensure that care plans are followed.
- Targeted conditions:
  - Diabetes
  - Hypertension
  - Overweight/Obesity
  - Smoking
  - Depression

Outcome:

- Reduce Re-Admissions
- Reduce ED Visits
- Improve low birth weight infants
Hospital transition for high utilizers
ED transition for frequent utilizers
Community Health Worker (CHW)
Community Care Coordination Team (CCCT)
Transition

- High risk patients with a hospital readmission within 30-days for the same condition
- High risk patients with overuse of ED visits:
  - Inappropriate ED visit for non-emergency care
  - 3 ED visits within 12 months
  - ED Revisit within 30-days of the 1st visit
- Patients with no PCP

Coordination

- High risk patients in poor control of their chronic illness
- High risk patients needing connections to social services
Hospital Transition Workflow

**Patient Admitted to Hospital**: Medical Mall staff alerts Patient Centered Medical Home (PCMH) of hospital admission or ER Visit. If no PCMH, link patient to a Patient Centered Medical Home (PCMH). Census is categorized by insurance, diagnosis and zip code. High risk patients living in Prince Georges County are identified.

**Alert Sent to PCMH**: Nurse sends Patient Information to PCMH. Medical Mall staff receives information that patient will be discharged within 48 hours.

**Discharge Plan Developed**: Medical Mall nurse develops treatment plan with established goals and forwards copy of treatment plan to the PCMH/PCP.

**30 Day Follow-up Plan**: Medical Mall staff follows patient for 30 days post discharge. Medical Mall staff provides PCMH/PCP with documentation of each follow up contact.

**PCMH CHW Referral**: Medical Mall staff refers high risk PCMH patient who meets protocol to the PCMH CHW.

**CHW Introduction to Patient**: Medical Mall staff introduces CHW to patient and family.

**Discharge Plan Shared with CHW**: Medical Mall staff provides patient contact to release PHI to CHW.

**Documentation of Contacts**: CHW documents outcome of each contact and resources needed by the patient. CHW assists patient with obtaining resources.

**CHW ensures patient attends follow up visits**.

**PCP provides PCP with routine updates**.

**72 Hours post-discharge**: Conduct home visit or phone call. Assess patient adherence to disease management plan. Access home environment and care support system. Review/update action plan.

**7 Days post-discharge**: Ensure patient kept F/U appointment with PCP.

**3 Weeks post-discharge AND 4 weeks post-discharge**: Home visit or phone call. Assess adherence to plan. Review/update care plan.
ED Transition Workflow

1. **Patient Seen in Emergency Department**
   - Medical Mall staff identifies high risk patients with the following criteria:
     - Inappropriate emergency department visit for non-emergent care
     - 3 or more emergency department visits within 12 months
     - 2 emergency department visits within 30 days

2. **Medical Mall Obtains ED Patient List and Refers High Risk Patients to CHW**
   - Community Health Worker (CHW) conducts assessment to identify:
     - Barriers to accessing care
     - Medical needs
     - Behavioral health needs
     - Medicine management or pharmacy assistance
     - Social service needs
       - Housing
       - Transportation
       - Food
     - Understanding provider instructions
     - Need for insurance coverage

3. **Community Health Worker Conducts Needs Assessment**
   - Link patient to PCP and schedule appointment
   - Link patient to resources to address social and financial needs
   - Provide patient with assistance in obtaining official documents
   - For patients with non-urgent ED visits, provide information and resource list for:
     - Urgent care locations
     - 24 hour medical advice lines
     - Preventive care tools for their chronic condition
     - PCMH evening and weekend hours

4. **CHW Develops Care Assistance Plan**
   - Conduct phone call 48 hours after initial visit
   - Conduct home visit 7 days after initial visit
   - At each contact, review the patient's Pathway Goals and care assistance plans
   - Document progress and revise as needed

5. **CHW Plans Follow-up Contacts and Timeline**
Community Health Worker

- Are members of the community.
- Help patients identify and implement self-help strategies.
- Link patients to primary care physicians.
- Promote patient adherence with the physician’s treatment plan.
- Provide information on available resources.
- Help patients understand provider recommended treatment.
- Advocate for individuals and community health needs.
- Help patients improve their health literacy and provide resources for patient education.
- Link patients to community and support services such as transportation, food assistance, patient education classes and other services as needed.
- Follow up with patients to help with reminders for appointments and follow up on referrals.
- Educate the community about CHW services.
CHW Workflow

- Receive referral
- Engage client
- Obtain consent
- Enroll client
- Conduct initial assessment
- Identify barriers
- Select pathway
- Track and document pathway steps
- Report to care coordinators/PCP
- Ongoing monitoring and tracking
**CHW Pathways**

- Evidence-based
- Visual, logical work management tools
- Guides for CHWs to track, document and report services delivered
- Facilitate measurement of outcomes

Resource: Agency for Healthcare Research and Quality (AHRQ) 
Department of Health and Mental Hygiene
### CHW: Initial Assessment

**CHW Pathway: Care Planning Checklist**

#### INITIAL ADULT CHECKLIST

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#### OVERALL HEALTH

**What is your greatest health concern?**

**What is the greatest barrier to your having good health?**

### CLIENT INFORMATION

- Are you single? [ ] Yes [ ] No
- If no: [ ] Significant other [ ] Married [ ] Separated [ ] Divorced [ ] Widowed
- Do you rent your home or apartment? [ ] Yes [ ] No
- If not: [ ] Own [ ] Live with relatives [ ] Live with friends [ ] Not from the area
- [ ] Homeless [ ] Other
- Do you speak another language besides English at home? [ ] Yes [ ] No
- If yes, do you need a translator for appointments? [ ] Yes [ ] No
- Are you in school now? [ ] Yes [ ] No
- If not: [ ] College graduate [ ] High school diploma [ ] GED [ ] Dropped out of high school [ ] Other
- Are you interested in finding a job? [ ] Yes [ ] No
- If no: [ ] Employed [ ] Disability Insurance [ ] Enrolled in a training program
- [ ] Other
- If disabled, what is the reason? [ ] Yes [ ] No
- Do you need help with transportation to appointments? [ ] Yes [ ] No
- Do you have children? [ ] Yes [ ] No
- If yes, how many? [ ]
- How many children live with you? [ ]
- Do any of your children have special needs? [ ] Yes [ ] No
- Do you need help with child care? [ ] Yes [ ] No
- Do you have any problems providing: [ ] Housing [ ] Food [ ] Utilities [ ] Other [ ]
- Do you have any legal issues? [ ] Yes [ ] No

**Notes:**

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Lessons Learned

- Need a formal structure
- Must understand the social determinants of health in the community
- Access to care must be accessible
- Develop partnerships with community resources
- Integrate CHWs into the care team
- CHWs: not a threat but a support to medical professionals
- Cultural competency training
- Core competencies for problem solving
Promoting our Community Health Workers

The Prince George’s County Health Enterprise Zone (HEZ) is bringing quality, affordable healthcare that will serve more than 10,000 residents in areas surrounding the 20743 zip code. Do you have ideas or suggestions on how to make HEZ better? Join our Community Advisory Board!

Call 301-883-7879 or visit www.mypgchealthyrevolution.org for more information!

New Medical Providers in Capitol Heights

Gerald Family Care, 
Primary Care
4744 Marlboro Pike
Capitol Heights, MD 20743
Phone: 301-364-3200

Hours of Operation:
Monday – Friday,
8:00 a.m. – 5:00 p.m.

Services:
- General/Executive Physical Examinations
- Commercial Driver’s License Exams
- Emergency Care
- Pediatric & Geriatric Care
- Laboratory Studies
- Hearing Evaluation and Visual Examinations
- Dermatology Care
- EKG, Pulmonary & X-ray Studies
- Nutritional Consulting

Greater Baden at Capitol Heights: Health Center for Adult Primary Care
1458 Addison Road, South Capitol Heights, MD 20743
Phone: 301-324-1500

Hours of Operation:
Monday – Friday,
8:00 a.m. – 4:00 p.m.

Services:
- Family Health Care
- Family and individual case management
- Health Promotion (HIV testing, sexually transmitted disease prevention)
- Health education and outreach
- Tuberculosis control, diabetes, cardiovascular disease, and obesity

Global Vision Community Health Center
9171 Central Avenue
Suite B11 and B12
Capitol Heights MD 20743
Phone: 301-499-2270

Hours of Operation:
Monday – Friday,
9:00 a.m. – 5:30 p.m.

Insurance:
All insurances accepted, including Medicare and Medicaid.

Services:
- Primary Care for Infants, Children and Adults
- Infectious Disease Treatment
- Addictions Medicine
- Endocrinology

Your Community Health Workers

HEZ’s Community Health Workers (CHWs) will assist you with locating medical facilities, understanding the healthcare system, and connecting you with other supportive services.

Elaine Williams
Mobile: (240) 800-5020
Email: elainewilliams@co.pg.md.us

Everette D. Bradford
Mobile: (240) 690-5203
Email: edbradford@co.pg.md.us

Zaneta Crawford
Mobile: (301) 332-4517
Email: zanetacrawford@co.pg.md.us

Marcia D. Murphy
Mobile: (301) 390-4216
Email: mdmurphy@co.pg.md.us

Angelina Chappell
Mobile: (301) 390-4216
Email: achappell@co.pg.md.us
Phase 2: Prince George’s County Community Care Coordination Team Model

Community Stakeholders
- Local Businesses
- Faith-based Organizations
- Community Centers
- Community Based Organizations

Primary Care Providers (PCMH)
- FQHC
- Private Practices

Public Health Department

Multi-disciplinary team from several health and social service organizations working together to meet the needs of at-risk patients

The Team identifies gaps in processes across organizations; creates workflows and protocols to address gaps

CCCT workflows focus on linkages to care and services

CCCT pathways ensure quality, evidence based practices

Family Nurse Coordinator
Community Health Workers
Social Workers
Care Coordinators
Dieticians
Pharmacists
Behavioral Health
Sister Circles
Health Literacy

Hospital Systems & Specialists
- Regional Hospital
- Local Hospitals
- Specialty groups practices

The Team identifies gaps in processes across organizations; creates workflows and protocols to address gaps

CCCT pathways ensure quality, evidence based practices
Questions