Caroline – Dorchester
Competent Care Connections
Health Enterprise Zone

HEALTH EQUITY

Caroline–Dorchester HEZ

LOGIC MODEL

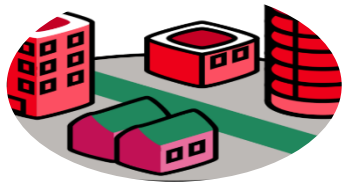
Investment - HEZ Resources

Actions

- Care Coordination somatic & behavioral
- Access to Care somatic & behavioral
- Peer Support
- Access to Community Health and Social Supports

RESULTS = improved health - reduced disparities - reduced costs

PROGRESS YEARS 1 & 2



Expanding and Filling Service Capacity

Maryland Healthy Weighs (MHW)

114 individuals averaged 14.2% reduction in BMI
36 DM patients averaged 15.2% decrease A1c

Shore Wellness Partners (SWP)

91 high utilizers of hospital care served
year 1 - ED visits after 6 months enrollment = 26
year 2 to date - ED visits after 6 months enrollment = 11 (57.7% decrease)

Federalsburg Mental Health Clinic

Anticipated opening April 2015
Increased access for 159 clients in Federalsburg zip code

Progress Continued

School Based Wellness Centers (SBWC)

Dorchester - Maces Lane SBWC **-** 221 students/970 visits

Caroline SBWC - 54 students/653 visits

Associated Black Charities

256 participants received 1-1 health coaching

658 participants received community based health education

300 participants received health screenings

DRI-Dock/Chesapeake Voyagers Peer Recovery

Drop-in center open Monday-Friday 8 AM to 6 PM

157 participants/539 visits

9.7 points average increase of the Quality of Life Self-Assessment tool

Progress Continued

Affiliated Santé Mobile Crisis Team

809 dispatches
167 hospital diversions with calculated savings of $398,963
(average cost for ED visit is $2,389 – Healthcare Blue Book)

Eastern Shore Area Health Education Center

14 CHWs trained and deployed in the region
provide navigation and education services

MED-CHI

Opening of Chesapeake Women's Health
(3 FTE providers - 528 patient encounters)
Recruitment of 2 new SBWC providers (1.2 FTE)
4 tax credit applicants

Progress Continued

Total participants served – 1922
Total number of HEZ partner participant visits -7662
+ Chesapeake Women's Health visits – 528

Licensed Practitioners – 3.6 FTE
Licensed/Certified Healthcare Practitioners – 5.93 FTE
Other Staff – 12.58 FTE
Total Jobs Added – 22.11 FTE

Challenge - Care Coordination

Improve connections to assure we are -

"doing enough of the right things for the right people".

Year 3 Focus

Partners Linking

ALL

Care Coordination efforts especially among "high utilizers".

Solution

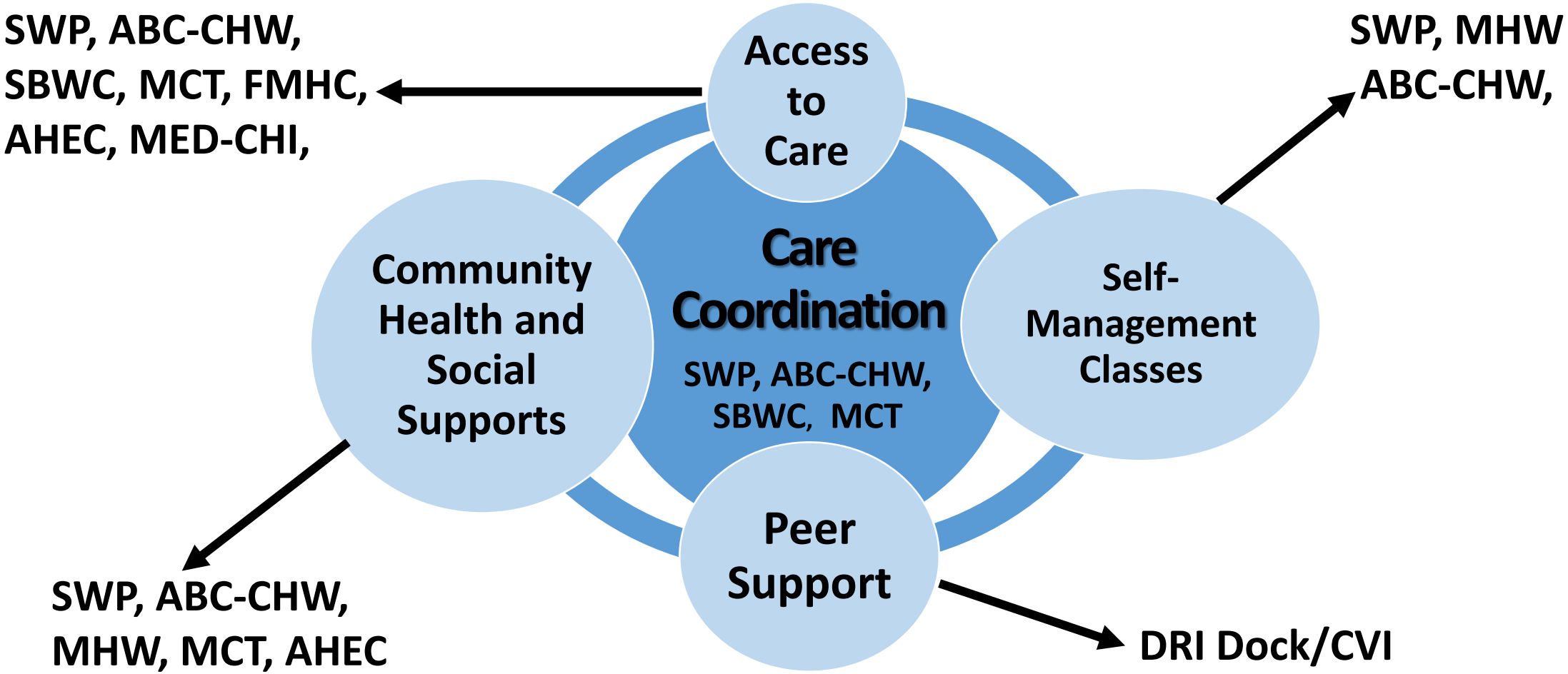
Partners working to develop a formal referral criteria.

Re-purpose funds **($40,250)**

Increasing SWP Community Case Specialist, R.N.

Coalition is exploring expansion of SWP nurse's role to include some level of oversight.

Care Coordination



Challenge - Data Vulnerabilities

Personal Health Information (PHI) – HIPAA Compliance

Improved tracking of participants, services, outcomes, within/across partners over time.

Evaluation Partner – UMES – School of Pharmacy researched EHR/PHR vendors to find a HIPAA compliant, cloud-based, user-friendly, affordable data system.

Selected Vendor – will provide custom designed, secure real-time data entry at point of service, for all providers. This HIPAA compliant EHR/PHR portal, will enhance coordination of care and collection of outcome measures.

Re-purposing ($50,000) to implement new system.

Increased Access to Weight Management

Goal 1: To improve health outcomes corresponding to diabetes and hypertension.

Objective 1.1. Year 3: Improve BMI by 10%, in 35 patients per quarter served by MHW.

Strategy - Maryland Healthy Weighs, LLC (MHW) implements the HMR Program for Weight Management™

- successful, research-based medical weight loss program
- improves long term health
- focused on making and sustaining healthy lifestyle changes
- prevent/reduce the incidence of the major chronic diseases

MHW - Medical Risk Factor Changes

N = 114 patients who completed at least 8 weeks of Phase 1, 2014

Demographics	Average Age	Gender	Race
All Patients	57	65.8% F 34.2% M	87.7% W 12.3% B

Risk Factor All Patients	Initial Average Value	Latest Average Value	Change from Initial to Latest
Weight	256.3 lbs.	218.1 lbs.	↓ 38.2 lbs.
BMI	41.4	35.5	↓ 14.2%

MHW - Medical Risk Factor Changes

N = 114 patients who completed at least 8 weeks of Phase 1, 2014

Demographics	Average Age	Gender	Race
HEZ – Total (34)	50	88.2% F 11.8% M	67.6% W 32.4% B

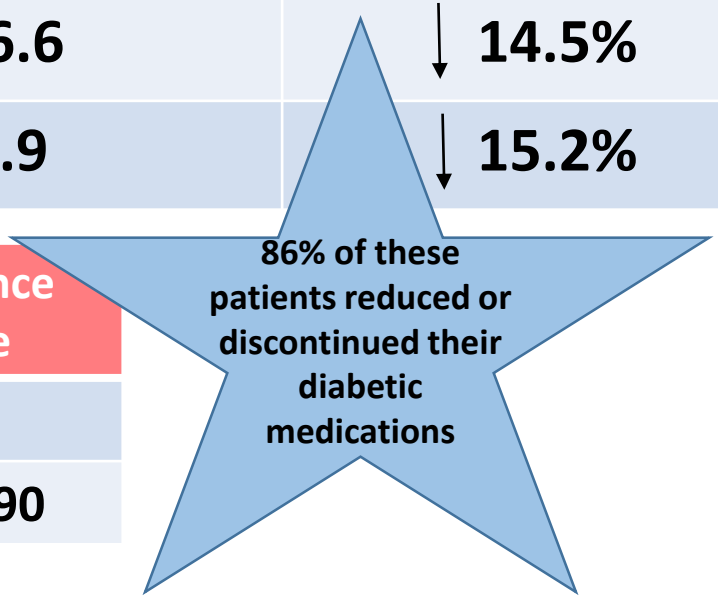
Risk Factor All Patients	Initial Average Value	Latest Average Value	Change from Initial to Latest
Weight – Total HEZ	268.2 lbs.	237 lbs.	↓ 31.2 lbs.
BMI – Total HEZ	46	40.9	↓ 11%

Medical Risk Factor Changes

N = 36 diabetic patients who completed at least 8 weeks of Phase 1, 2014

Risk Factors – Diabetic Patients (43%) of Total	Initial Average Value	Latest Average Value	Change from Initial to Latest
Weight	272 lbs.	229 lbs.	↓ 43 lbs.
BMI	42.9	36.6	↓ 14.5%
A1c	8.1	6.9	↓ 15.2%

Meaningful Use of Risk Factors	Initial Compliance with Measure	Latest Compliance with Measure
LDL	67% < 100	83% < 100
BP	71% < 140/90	91.6% < 140/90



Care Coordination

Goal 1: To improve health outcomes corresponding to diabetes, hypertension, and asthma.

Objective 1.2. In Year 3: 25 % reduction in hospital readmissions within 30 days, for 80 high utilizers enrolled with SWP for at least 6 months.

Strategy: Model developed by the University of Colorado and implemented by University of Maryland Shore Regional Health, Shore Wellness Partners (SWP).

In-home program offers links connecting participants to improved:

- securing health insurance
- access via admission to primary care practice
- knowledge and self-management
- medication access, management and compliance
- nutrition via securing food and/or food stamps

Asthma Management at Maces Lane SBWC

Goal 1: To improve health outcomes corresponding to asthma.

Objective 1.4 Year 3: Decrease by 10% the number of asthma exacerbations in school.

Strategy - The NP at ML SBWC will implement "Breathe Easy a Comprehensive, Evidence-Based School Based Health Center Model for Asthma Improvement". This model follows six steps.

- Identify students
- Easy access to inhalers
- Protocol for handling worsening asthma
- Identify and reduce common triggers
- Enable students to participate in school activities
- Provide education to personnel, parent and students.

Year 3 Budget Request

$727,000 Year 3 funding
+ $233,785 Carry-over
= $960,785 Year 3 Request

Carry-over derived from

Dorchester HD - **greater collections**
Eastern Shore Area Health Education Center – **fewer trainings**
Shore Wellness Partners - **staff vacancies**
Caroline HD – **Federalsburg Mental Health Clinic opening April 2015** MED-CHI - **$60,500 – unobligated incentives**
Data Collection/Evaluation – **data collection re-focus**

Carry-Over Investment in Year 3 Enhancements

MHW + $54,000 Expand services to additional 20 low-income participants per quarter. Current waiting list 25 **(Goal 1)**

Dorchester HD + $25,000 Asthma Management **(Goal 1)**

ESAHEC + $23,000 – SBWC Residency **(Goal 2)**

SWP + $30,000 Increase Community Case Specialist, R.N. to 1 FTE, utilizing increase to improve linkages for enhanced care coordination between partners. **(Goal 1 & 4)**

ABC +15,000 Provides one additional .5 FTE. **(Goal 1 & 4)**

EHR & Improved Data Management - $50,000

Tax Credits - $25,000

Indirect Costs – $17,173 (2% - Year 3 only)

Program Partnerships Resources Leveraged

10 CHWs not supported by HEZ were trained & deployed in the region.

Community partnerships deploying CHWs to assist in implementing "Living Well" programing and the "Check. Change. and Control." American Heart Association's BP self-monitoring program.

DHMH Center for Chronic Disease Prevention and Control Funding for Caroline & Dorchester - over $1.6 million over 4 years for local health actions addressing Chronic Disease Prevention. Funding through Sept 2018 – 18 months beyond HEZ sustaining prevention efforts.

CWH increased capacity for women's healthcare by 270 visits per week

Potential - Residency Program Partnership with School Based Wellness Center (growing our own).

Contact

Dorchester County Health Department

http://www.dorchesterhealth.org

Roger Harrell, MHA – Health Officer
410-228-3223
roger.harrell@maryland.gov

Project Director

Sandy Wilson – 410-901-8126
sandra.wilson@maryland.gov

Project Coordinator

Terri Hughes R.N., B.S.N.– 410-901-8160
terri.hughes@maryland.gov