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
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

Access to Care

Community Health and Social Supports
SWP, ABC-CHW, SBWC, MCT, FMHC, AHEC, MED-CHI,

Peer Support
SWP, ABC-CHW, MHW, MCT, AHEC

Self-Management Classes
SWP, MHW ABC-CHW,

DRI Dock/CVI
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

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Average Age</th>
<th>Gender</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients</td>
<td>57</td>
<td>65.8% F, 34.2% M</td>
<td>87.7% W, 12.3% B</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Factor All Patients</th>
<th>Initial Average Value</th>
<th>Latest Average Value</th>
<th>Change from Initial to Latest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>256.3 lbs.</td>
<td>218.1 lbs.</td>
<td>↓ 38.2 lbs.</td>
</tr>
<tr>
<td>BMI</td>
<td>41.4</td>
<td>35.5</td>
<td>↓ 14.2%</td>
</tr>
</tbody>
</table>
### Demographics

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<th>Gender</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEZ – Total (34)</td>
<td>50</td>
<td>88.2% F</td>
<td>67.6% W</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11.8% M</td>
<td>32.4% B</td>
</tr>
</tbody>
</table>

### Risk Factor All Patients

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<th>Latest Average Value</th>
<th>Change from Initial to Latest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight – Total HEZ</td>
<td>268.2 lbs.</td>
<td>237 lbs.</td>
<td>↓ 31.2 lbs.</td>
</tr>
<tr>
<td>BMI – Total HEZ</td>
<td>46</td>
<td>40.9</td>
<td>↓ 11%</td>
</tr>
</tbody>
</table>
# Medical Risk Factor Changes

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

<table>
<thead>
<tr>
<th>Risk Factors – Diabetic Patients (43%) of Total</th>
<th>Initial Average Value</th>
<th>Latest Average Value</th>
<th>Change from Initial to Latest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>272 lbs.</td>
<td>229 lbs.</td>
<td>↓ 43 lbs.</td>
</tr>
<tr>
<td>BMI</td>
<td>42.9</td>
<td>36.6</td>
<td>↓ 14.5%</td>
</tr>
<tr>
<td>A1c</td>
<td>8.1</td>
<td>6.9</td>
<td>↓ 15.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meaningful Use of Risk Factors</th>
<th>Initial Compliance with Measure</th>
<th>Latest Compliance with Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL</td>
<td>67% &lt; 100</td>
<td>83% &lt; 100</td>
</tr>
<tr>
<td>BP</td>
<td>71% &lt; 140/90</td>
<td>91.6% &lt; 140/90</td>
</tr>
</tbody>
</table>

86% of these patients reduced or discontinued their diabetic medications.
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

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