The Coordinating Center &

Jennifer Sulin-Stair, MS, Program Coordinator, Get Well Services
Jalisa Bell, Quality & Outcomes Management Specialist

All Zone HEZ Data Meeting
September 11, 2015
The mission of The Coordinating Center is to partner with people of all ages and abilities and those who support them in the community to achieve their aspirations for independence, health and meaningful community life.
The Coordinating Center...

- Is the largest independent community care coordination organization in Maryland and serves 10,000 individuals annually
- Has been rooted in the community for more than three decades
- Employs more than 250 highly qualified registered nurses, licensed social workers, community health coaches, housing specialists and supports planners
The Center’s Comprehensive Services

- Community Care Coordination
- Housing & Supportive Services
- Transitions of Care
- Hospital Readmission Reduction Programs
- Managed Care Case Management
- Life Care Planning
- Population Health
Today’s Objectives

- HEZ CARE COORDINATION OVERVIEW
  - Program Partners
  - Care Transition Intervention
  - Key Program Elements
  - Data Collection
Program Partners

- West Baltimore CARE
  15 organizations including 5 Hospitals
- The Coordinating Center
- Bon Secours Hospital
- Sinai Hospital Center
- St. Agnes Hospital
- University of Maryland, Main Campus
- University of Maryland, Midtown
- Care at Hand
## Community Demographics

<table>
<thead>
<tr>
<th></th>
<th>Southwest Baltimore</th>
<th>Baltimore City</th>
<th>Maryland</th>
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<tbody>
<tr>
<td><strong>Unemployment</strong></td>
<td>43%</td>
<td>34%</td>
<td>23%</td>
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<tr>
<td><strong>Median HH Income</strong></td>
<td>$23,070</td>
<td>$30,078</td>
<td>$56,250</td>
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<tr>
<td><strong>Infant Mortality Rate</strong></td>
<td>18.0</td>
<td>11.7</td>
<td>7.9</td>
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<tr>
<td><strong>Life Expectancy</strong></td>
<td>64.2</td>
<td>70.9</td>
<td>77.5</td>
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Sources: U.S Census Bureau, Maryland Department of Planning, Maryland Department of Health and Mental Hygiene, Baltimore City Health Department
Mortality Rate Comparison (per 10,000)

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<tr>
<th></th>
<th>Southwest Baltimore</th>
<th>Baltimore City</th>
<th>Maryland</th>
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<tbody>
<tr>
<td>Heart Disease</td>
<td>39.1</td>
<td>28.9</td>
<td>21.9</td>
</tr>
<tr>
<td>Cancer</td>
<td>27.7</td>
<td>23.4</td>
<td>19.2</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>9.8</td>
<td>5.2</td>
<td>0.96</td>
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<tr>
<td>Stroke</td>
<td>6.5</td>
<td>5.8</td>
<td>4.9</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5.8</td>
<td>3.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Chronic Lower Respiratory Disease</td>
<td>4.9</td>
<td>3.9</td>
<td>4.0</td>
</tr>
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</table>

CLRD includes COPD, emphysema, bronchitis, and asthma.

Sources: U.S Census Bureau, Maryland Department of Planning, Maryland Department of Health and Mental Hygiene, Baltimore City Health Department
Hospital Root Cause Analysis

• Identified all factors that contribute to readmissions
  ▪ Diagnoses related to readmissions
  ▪ Processes around discharge planning
  ▪ Individual experience
At Risk Target Population Identified

- High Risk Diagnoses
  - Congestive Heart Failure (CHF)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Acute Myocardial Infarction (AMI)
  - Septicemia (often related to Pneumonia)
  - End Stage Renal Disease (ESRD)
  - Bipolar
  - Major Depression
  - Cellulitis*
  - History of frequent readmissions*
  - Diabetes*

*Added additional diagnoses based on hospital input
Get Well Services Overview
Get Well Intervention

- 30-day intervention
  - based on an enhanced Coleman Model
  - Modified and incorporated BOOST to front load education prior to discharge
- Pre-discharge visit and personal goal
- Post-discharge visit within 3 days
  - Emphasis on physician follow-up 7-14 days
  - Emphasis on Red Flags (early symptoms)
  - Medication review
  - Personal health record
- Minimum of 3 follow-up phone calls
- 60-day intervention for a subset of individuals
Four Pillars of Focus

- Medications Self-management
- Use of PHR
- Follow up with physician
- Knowledge of red flags
Three Complimentary Technology Systems

- **CARMA**
  - Robust customized client management information system
    - Care Transition encounters
    - Personal goals
    - Tracks coaches and performance
    - Reporting capabilities that incorporate CRISP info

- **Care at Hand**
  - Mobile technology to assess risk for readmission
  - Dashboards for risk trending and performance

- **CRISP**
  - Statewide Health Information Exchange
  - Use electronic notifications to track ED encounters and hospitalizations
6 Months Pre Intervention

INTERVENTION

6 Months Post Intervention
Quality Measures

- Enrollment volume
- Care outcomes
  - 30-day readmissions
- Care Processes
  - Delivery of coaching encounters
  - 7 and 14 day post discharge physician follow-up visit rates
- Pre and post activation measures (engagement of the person in the four pillars associated with readmission)
- Individual risk factors contributing to readmission
HEZ Monthly Care Coordination Enrollment by Hospital June – August 2015

- Bon Secours: 52
- UMMC - Midtown: 125
- UMMC: 159
<table>
<thead>
<tr>
<th>Hospital</th>
<th>2015 - 2016</th>
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<tr>
<td></td>
<td>June</td>
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<tr>
<td>University of Maryland</td>
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<tr>
<td># of patients coach assigned</td>
<td></td>
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<tr>
<td># readmissions during month</td>
<td></td>
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<tr>
<td>% of readmits in high risk pop.</td>
<td></td>
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<tr>
<td>University of Maryland - Midtown Campus</td>
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<tr>
<td># of patients coach assigned</td>
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<td>Bon Secours Hospital</td>
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<td>Sinai Hospital</td>
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<tr>
<td>St. Agnes</td>
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<td>% of readmits in high risk pop.</td>
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<tr>
<td>Get Well Average:</td>
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Care Transition Model
Staffing Model

• Program Director
• Hospital Transitional Liaisons
• Community Health Coaches
• Clinical Care RNs
• Coordination Specialist
• Corporate Support
  ▪ Quality Management
  ▪ Finance
  ▪ Human Resources
The Coordinating Center Staffing Model

- Community Health Coach
- Community Health Coach
- Community Health Coach
- Community Health Coach
- Community Health Coach

Clinical Care RN

Person

Coordination Specialist
Care Transitions in Action

Hospital Transition Liaison

Coordination Specialist

Community Health Coach
Using Mobile Technology in the Field

- Community Coaches survey person at each encounter
- Survey questions are based on the person’s active issue(s)
- Risk alerts of early health decline are sent to RN Care Coordinator
- Deployment of clinical staff as needed, driven by data
- Creation of dashboards for trending and performance
ROI – Return on Investment

- **Financial Impact**
  - Money saved by reducing hospital encounters
  - Cost-savings on staffing configurations

- **Partnership Impact**
  - Hospitals, providers of care Community-based organizations
  - Technology providers

- **Educational Impact**
  - Health disparities
  - In the hospital, in the community

- **Personal Impact**
  - Personal empowerment
  - Self-management skills - strategies for long term
Ms. S’s Story

Ms. S is a 53-year-old woman diagnosed with diabetes and has a history of substance abuse. She is a single mom, living in West Baltimore and receiving public assistance.

Personal Goal:
Ms. S wanted to write a will and be healthy enough to visit her granddaughter who lives in Pennsylvania with her godmother.
Goal Met:

- Ms. S learned to use her blood pressure cuff and follow her diabetes regiment.

- Ms. S was healthy enough to take a trip to Pennsylvania and visit her granddaughter.

- Ms. S expressed relief when PCP confirmed that her blood glucose and blood pressure numbers were within normal range.
In her own words

I cannot put into words how u have my life that now I want to live. If every hospital had u in it we could all live. When I had no hope you made me see other. I am blessed to have u in my life and my granddaughter now has her grandmother and I have u to thank. Love

My little way of saying “thanks.”

U showed me a way of life I am blessed.
For More Information Contact:

Jennifer Sulin-Stair, MS
Program Coordinator
jsulin-stair@coordinatingcenter.org
410-987-1048, ext. 134

Jalisa Bell
Quality and Outcomes Management Specialist
jbell@coordinatingcenter.org
410-987-1048, ext. 292