

# West Baltimore Health Enterprise Zone

Maha Sampath, *Chief of Staff*

Bon Secours Baltimore Health System

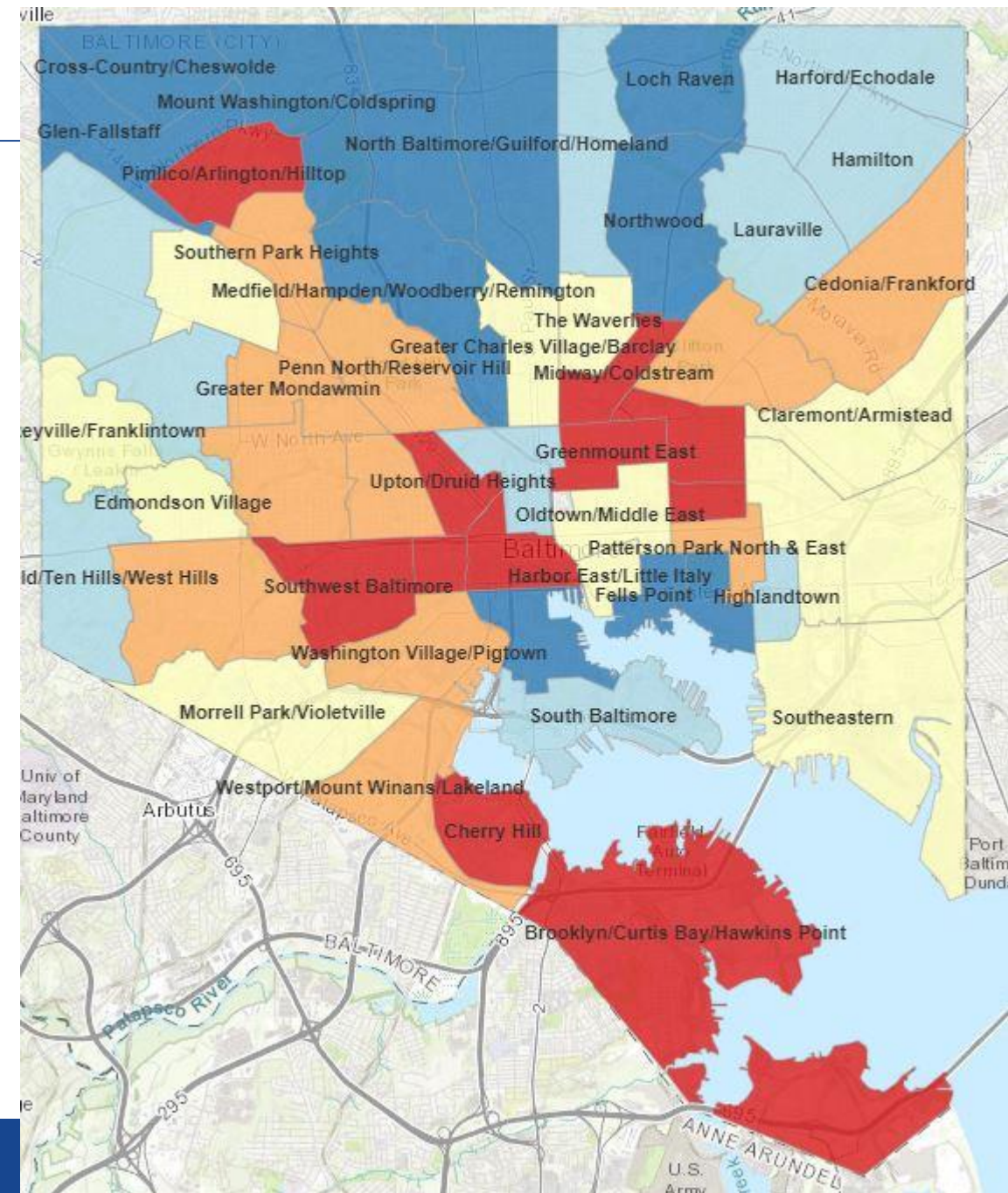
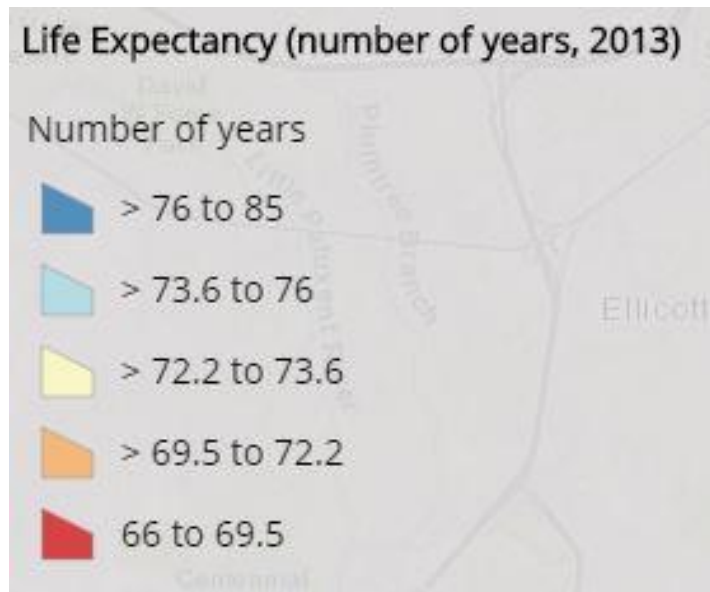
# West Baltimore Community Profile

- Approximately 86,000 Residents in four zip codes
- African-Americans comprise more than 76%
- Average median income in this area is \$27,158



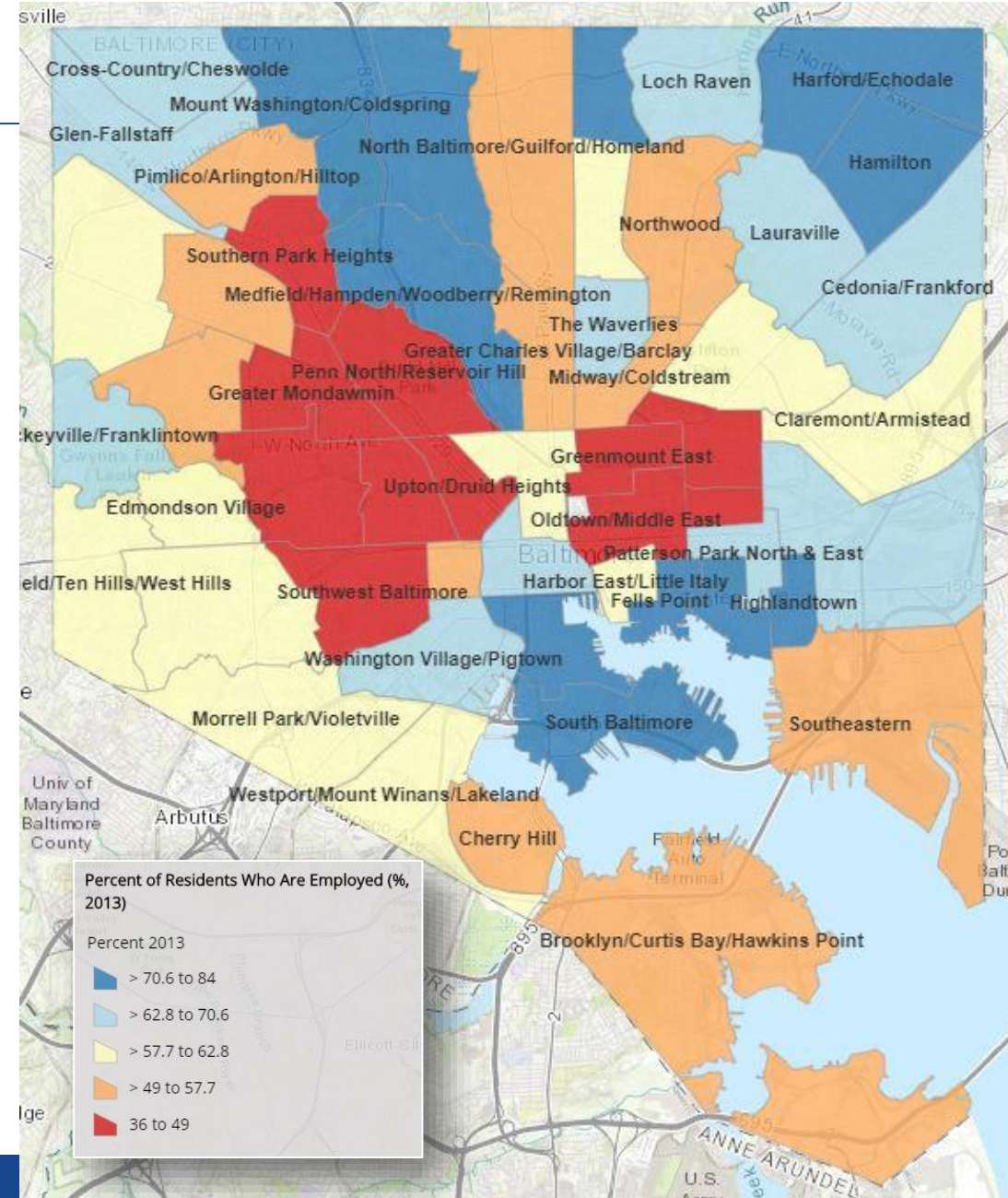
# West Baltimore Life Expectancy

- Highest disease burden and worst indicators of social determinates of health than any other community in Maryland



# Patient Profile

- Often unemployed or “working poor”
- Living in and out of crisis
- Frequently on the edge of homelessness
- Three times more likely to have cardiovascular disease than in any other area in the state of Maryland



# Our Partners

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## **FQHCs**

- Baltimore Medical System
- Park West Health System, Inc.
- Total Health Care, Inc.

## **Hospitals**

- Bon Secours Baltimore Health System
- University of Maryland - Midtown
- St. Agnes Hospital
- Sinai Hospital of Baltimore
- University of Maryland Medical Center

## **Community-Based Organizations**

- Equity Matters
- Light Health and Wellness Comprehensive Services, Inc.
- Mosaic Community Services

## **Academic Institutions**

- University of Maryland
- Coppin State University
- Baltimore City Community College

## **City and State**

- Senator Verna Jones-Rodwell
- Baltimore City Health Department

# West Baltimore Health Enterprise Zone Focus

## ■ Geographic and Target Population:

- 86,000 West Baltimore residents within the 21216, 21217, 21223, and 21229 zip codes
- 1,200 High Utilizers

## ■ Core Disease and Target Conditions:

- Cardiovascular Disease (CVD)
- CVD Risk Factors (i.e., Diabetes and Hypertension)

## ■ Overarching Strategies:

- Care Coordination (Hospital High-Utilizers)
- Community-Based Risk Factor Reduction



# Care Coordination

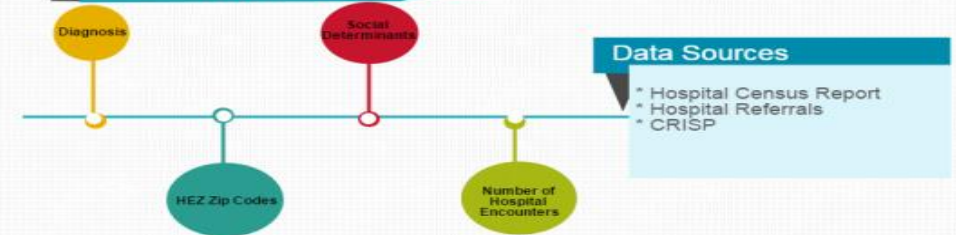


- Partnered with The Coordinating Center
- Hospitals: University of Maryland Medical Center, University of Maryland Midtown, St. Agnes, Bon Secours, and Sinai
- Provided Care Coordination services to **1,194** HEZ residents as of March 2017 with **2500+** encounters
- Average Readmission Rate is **14%** for high utilizers
  - Baseline 17%
  - Prior Year 15%
- CRISP Pre/Post Analysis shows reduction in ED visits and Hospital charges
- Successfully connected high utilizers to a CHW and a Primary Care Provided

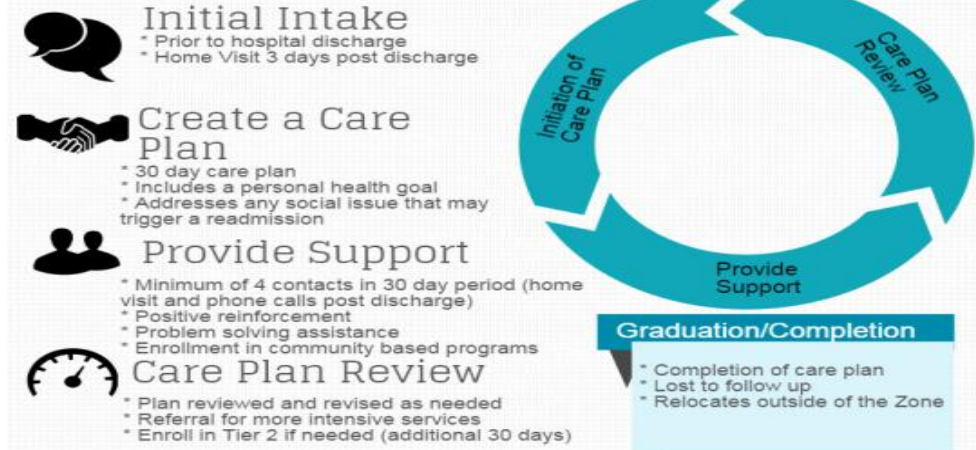
## West Baltimore CARE and Get Well Care Coordination Process

July 2015

### Risk Stratification



### Care Plan Life Cycle



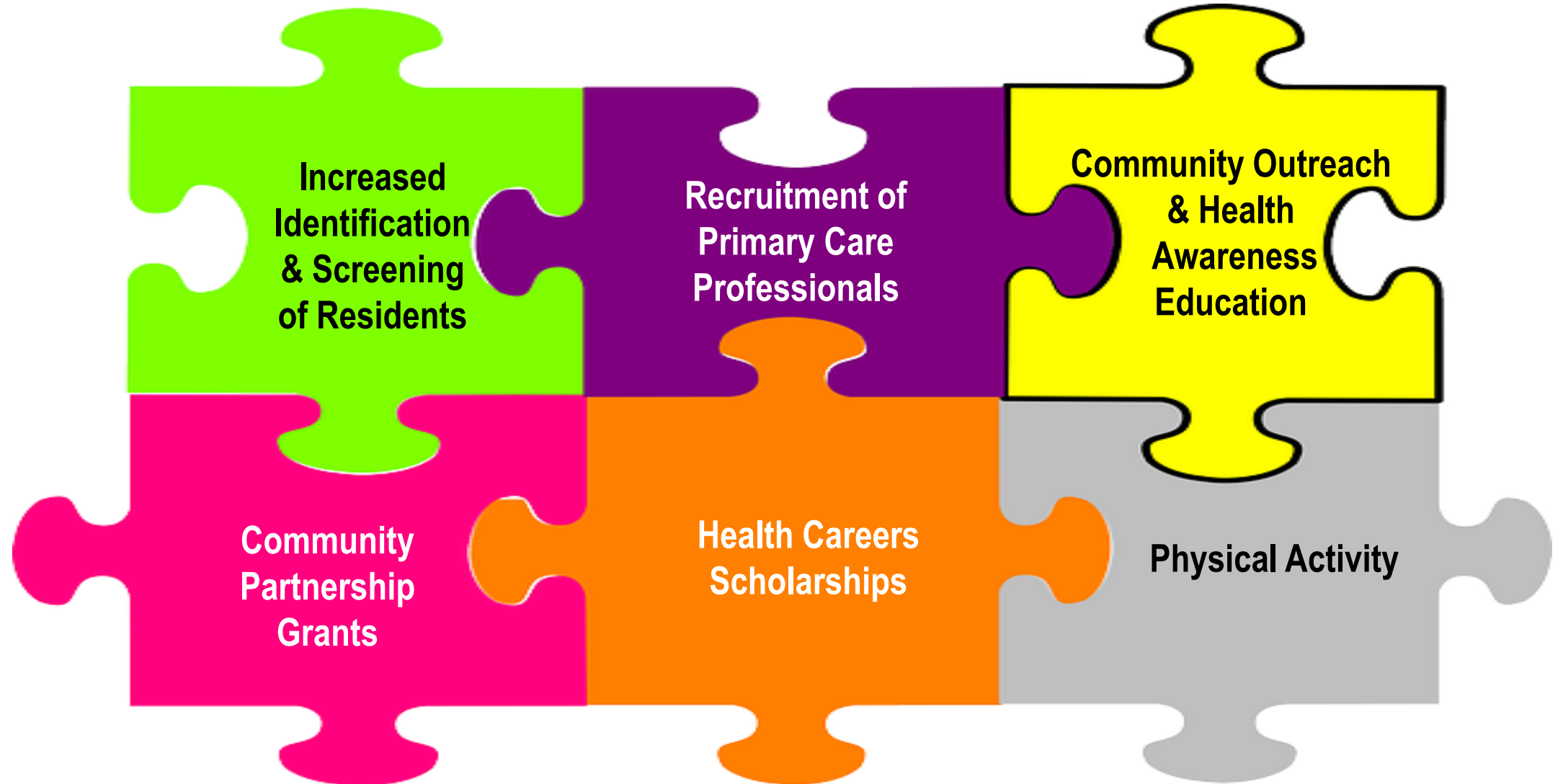
### Reporting Requirements



“I was unable to get back and forth to see my doctor and infectious disease specialist because Johns Hopkins is too far. I preferred to have care at St. Agnes Hospital. I am much happier now. Ms. Quiana taught me how to change my main doctor on my medical assistance card to the doctor she helped me find at St. Agnes Hospital. She helped me set up a new patient appointment with my new doctor, Dr. Bajaj and he was then able to refer me to an infectious disease specialist at St. Agnes as well. I had a visit from Mr. David from the Health Department and I was very nervous because he made me feel like I was doing something wrong and that I was putting other people’s lives at risk because of my HIV. I know I have HIV and I would never do anything to hurt other people. Ms. Quiana spoke to Mr. David and he was able to see that I was in the process of getting a new doctor and infectious disease specialist at a different hospital. He was satisfied so all I had to do is call him once I got my new appointment. Thanks to Ms. Quiana I now have a new doctor, a new infectious disease doctor and I am compliant with the health department. I also get my prescriptions from the pharmacy at St. Agnes. I won’t have any problems now going to see my doctor. The Get Well program is very helpful. I always wanted a new doctor closer to me but I didn’t know how to do it.”



# Community-Based Risk Factor Reduction



# Increased Identification and Screening of Residents

- HEZ Providers reported on NQF and UDS quality measures (Diabetes, Hypertension, Smoking Screening, BMI) to track their identification, screening, and management efforts of individuals with risk factors for CVD



# Recruitment of Primary Care Professionals

- To date we have spent \$170k in tax credits for 25 providers in the Zone
- Provided 4 Community Health Worker (CHW) training sessions



# Community Outreach and Health Awareness Education

- Offered free CVD health promotion courses on nutrition, physical activity, smoking cessation, and stress relief
- Provide care coordination and community health outreach services at the public and senior housing sites
- In conjunction with community partners, sponsored community outreach activities focused on health and wellness



# Community Partnership Grants

- Partnered with and awarded grants to community-based organizations to support community programs that align with WB CARE goals and strategies to improve cardiovascular health and to reduce CVD risk factors
- Awarded a total of 16 grants to date totaling \$130k



# Health Careers Scholarships

- Offered scholarships and career readiness trainings to community members to support enrollment in technical professional programs for health and social service careers (e.g., Cardiovascular Technician, Nursing Assistant, Social Worker, Phlebotomist, etc.)
- Awarded a total of 105 scholarships to date totaling \$338k



## Scholarship Recipient Story

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“Hello Everyone my name is Rodney Butler and I am a recipient of the west Baltimore cares scholarship program. I would like to express my gratitude and pleasure to the HEZ department and everyone involved with the scholarship program because it has benefited me in a way that I believe will make my future as a college graduate so much more gainful. I am currently in school to become a respiratory therapist, the curriculum and the journey so far has been tasking, tedious and challenging but worth every minute. While attending college I am able to not only help myself but inspire my children to always seek higher education and strive to be as productive as possible. Becoming a college graduate has always been a goal that I wanted to accomplish and with the help of the scholarship program my goal is coming to fruition.”



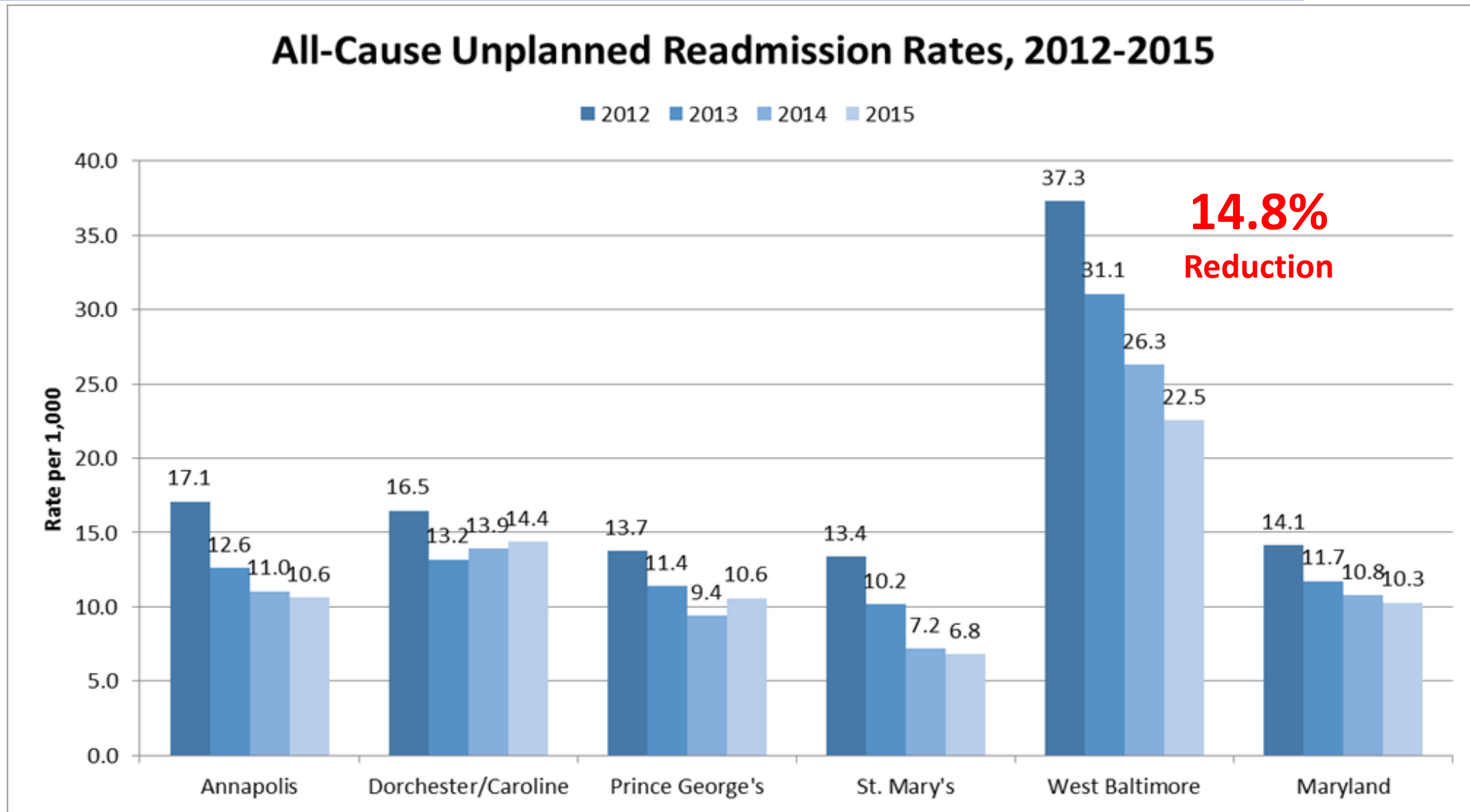
# Physical Activity

- Partnered with neighborhood Recreation Centers and churches to offer free fitness classes (11 one hour weekly classes for 12 weeks)
- Provided Biometric Assessments to all fitness participants
  - From 2015-2016, avg. wt. decrease ~15lbs, avg. BMI decreased ~1.5
- Over 4,700 fitness class encounters





# Readmission Rates

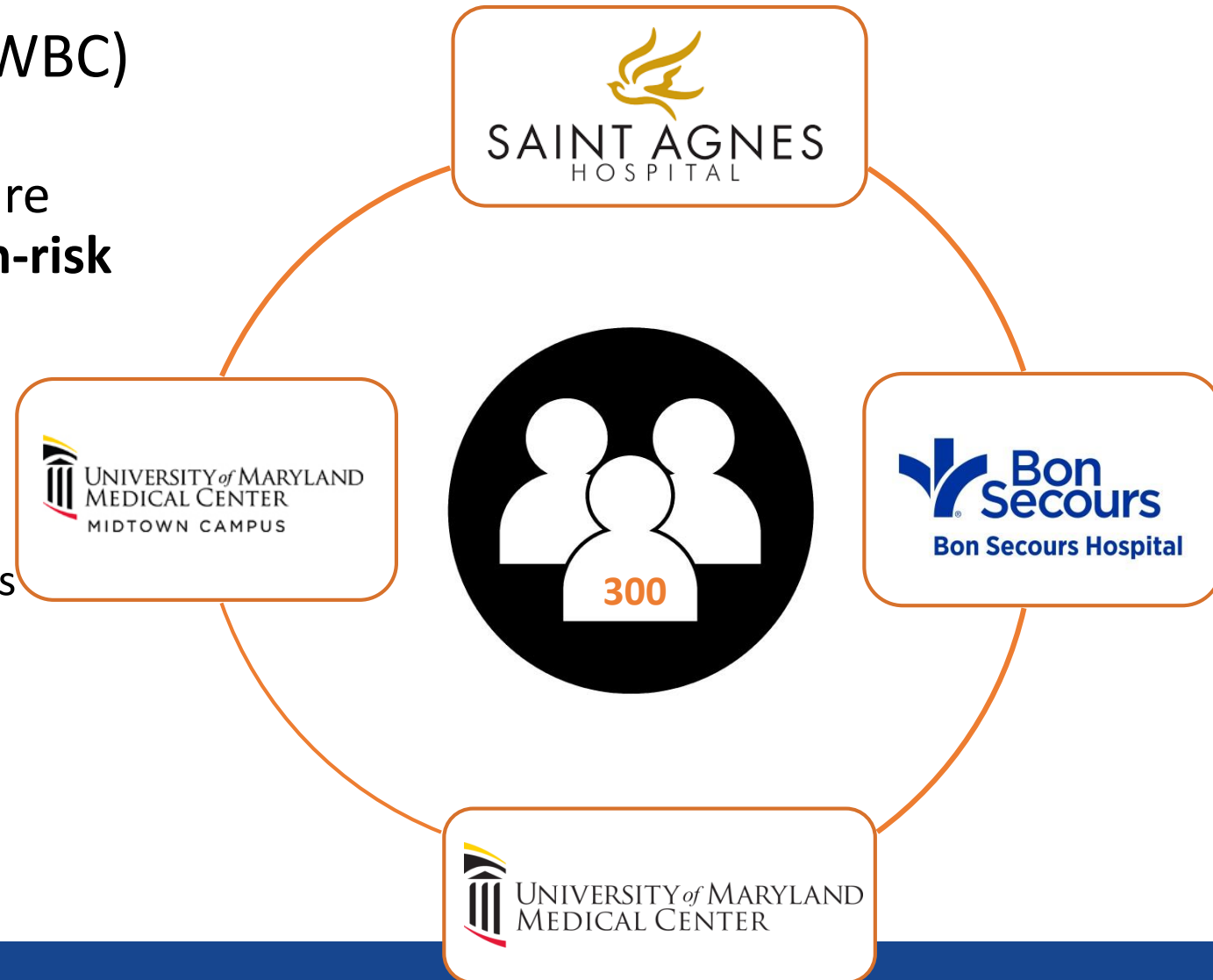


Source: HSCRC data prepared by the CRISP and the DHMH VDU.

- Partners/Model Complexity
  - Clear roles and responsibilities
  - Ongoing engagement and dialogue
- Patient Population Challenges (trust, transient, basic resources)
  - Ongoing communication and dialogue
  - Flexibility and agility
- Access to Impact and Outcome Data
  - Identify and confirm sources of program data and access upfront
- Leadership Turnover

- West Baltimore Collaborative (WBC)

- Partnership between four West Baltimore hospitals to provide care coordination services to **300 high-risk patients** a year
- Program Challenges
  - Care coordination vendor staff turnover
  - Different case management models at the four hospitals



- Future Baltimore
  - Partnership between Bon Secours Baltimore, Kaiser Permanente, and the residents from three communities in the 21223 zip code.

**“Nothing about me,  
without me.”**



### Education

**Program Name:** Returning Citizens  
CNA/GNA Training

**Partners:** Baltimore City State Attorney's  
Office

#### *Two Year Outcomes*

- 100 clients receive CNA/GNA training
- 72% placement rate in allied health professions
- 60 returning citizens receive case management support and GED training
- < 22% recidivism rate of program participants
- 50% of participants receive job training, placement, or education

### Economic Wellbeing

**Program Name:** Baltimore Works! Incubator Program  
Last Mile Urban Co.  
Baltimore Economic Assessment

**Partners:** Chesapeake Food to Table  
Southwest Partnership\*  
Enterprise Community Partners\*

#### *Two Year Outcomes*

- > 8 new job-generating businesses identified for incubation
- Address the critical dearth of healthy food options in 21223 for 75 families per week

### Mental Health & Wellbeing

**Program Name:** First Responder Mental Health  
Frederick Elementary School Sponsorship  
Community Health Worker  
BH-Works Onsite Assessment

**Partners:** Bon Secours Department of  
Behavioral Health, BH-Works

#### *Two Year Outcomes*

- 100 first responders receive training
- 10 tailored programs developed to meet mental health needs of students
- Mental health referral process for local residents established

### Partnership

**Program Name:** West Baltimore Neighborhood  
Revitalization Project

**Partners:** Baltimore Mayor's Office of  
Employment Development,  
Baltimore City Public Schools

#### *Two Year Outcomes*

- Achieve \$5.5M fundraising goal
- Build community resource center
- Leverage assets knowledge and trust through shared ownership of initiative, agenda, and metrics

# Questions?

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