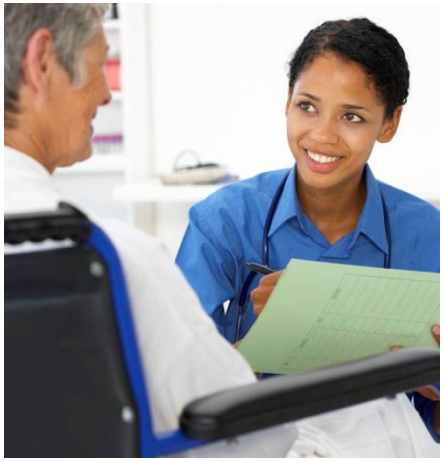
PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT

HEALTH ENTERPRISE ZONE

Pamela B. Creekmur
Health Officer

Dr. Ernest L. Carter
Deputy Health Officer

SELECTION OF HEZ PROVIDERS

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

ENGAGMENT:

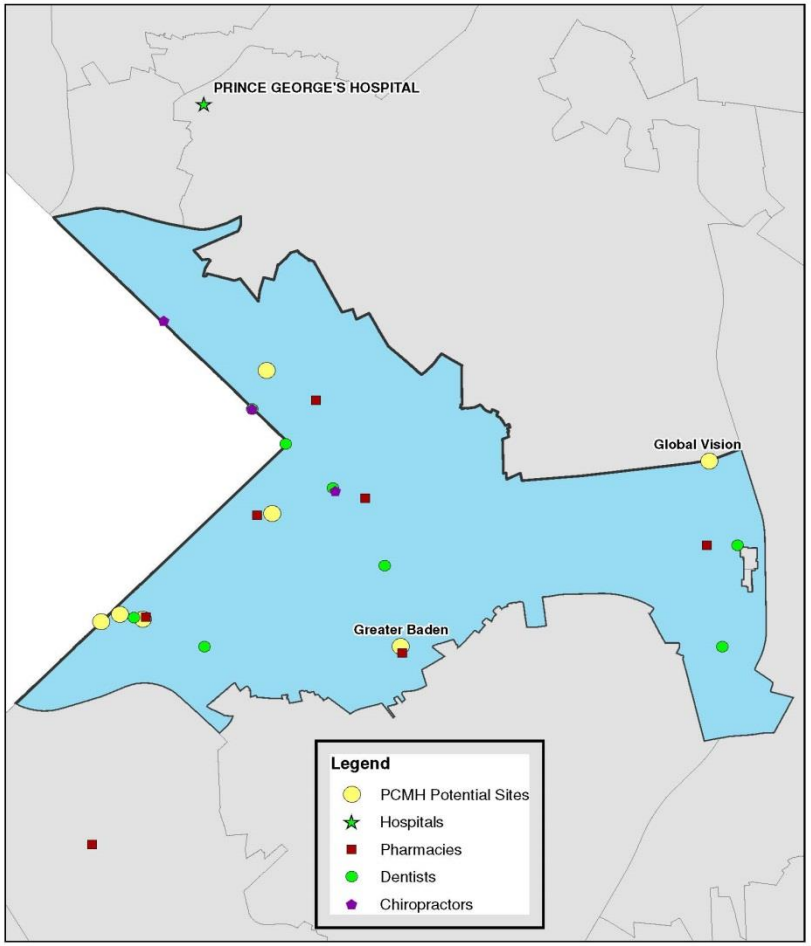
- Engaged medical practices through a direct approach
- Presented package of incentives and benefits
- Helped to secure funds outside of HEZ for build out

DESIGNATION:

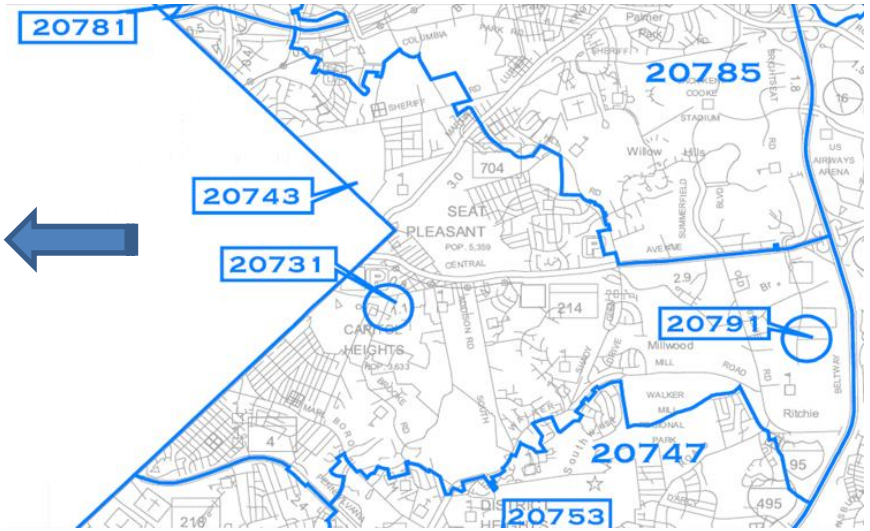
- Conducted an environmental scan. Matched need with available space
- Engaged members of the community to identify their needs e.g. our HEZ Coalition
- Collaborated with practice representative: i.e. Global' s business developer, Gerald's COO, Greater Baden's CEO, etc.

Designation Assignments

Health Enterprise Zone
ZIP Code 20743



Density Map of HEZ



- Kingdom Square: Capitol Heights
- Southern Capitol Heights
- Coral Hills
- Seat Pleasant
- Fairmount Heights

PGCHEZ Partnership Agreements

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**

PGCHEZ Partnership Agreements

- **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

PGCHEZ Partnership Agreements

- **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

What is Care Coordination?

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

Care Transition

At Home

Patient

Community Health Worker

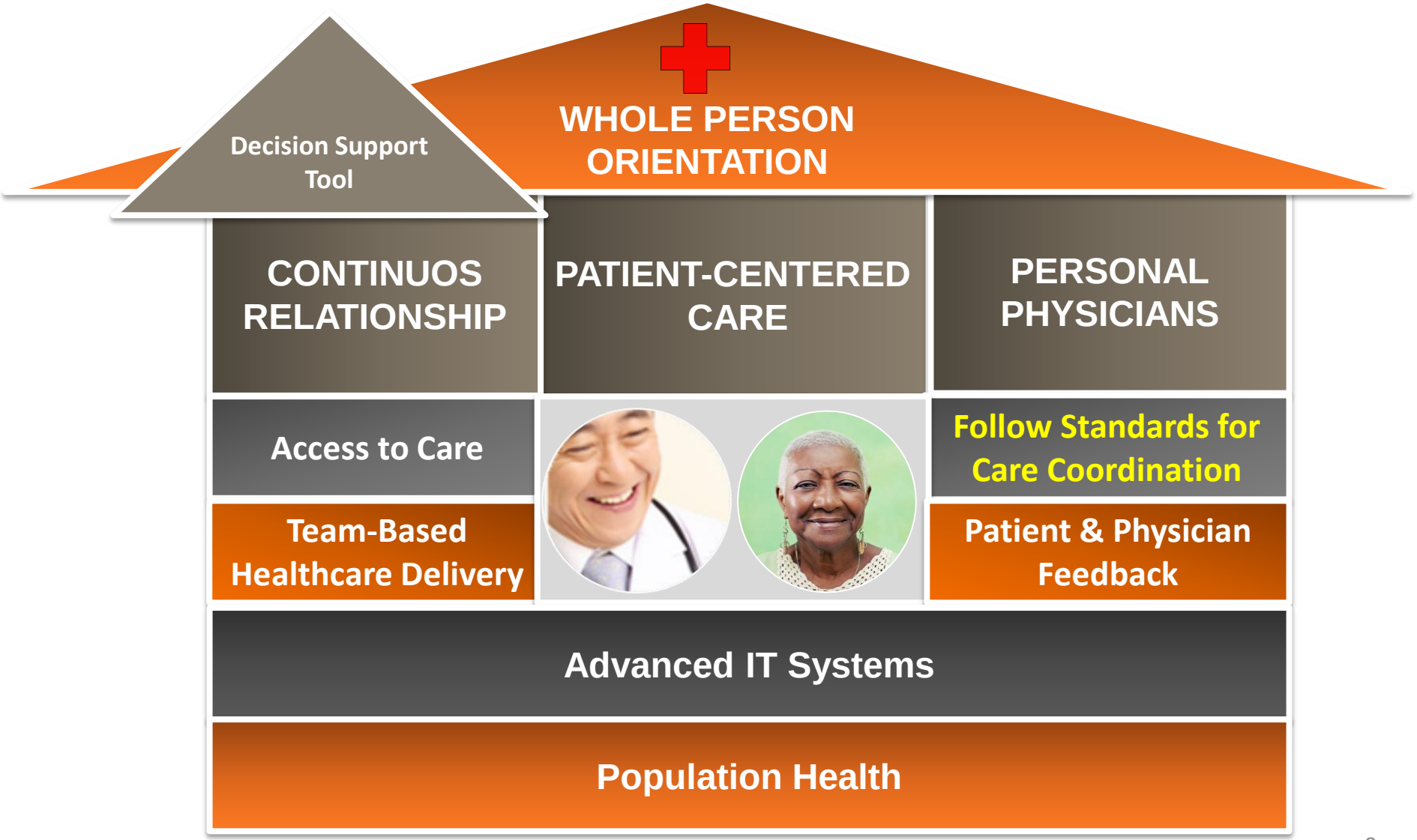
Care Coordination

Patient Centered Medical Home

Patient's Doctor

Outpatient Clinical Coordinator

Patient-Centered Medical Home



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

Care Coordination : Examples

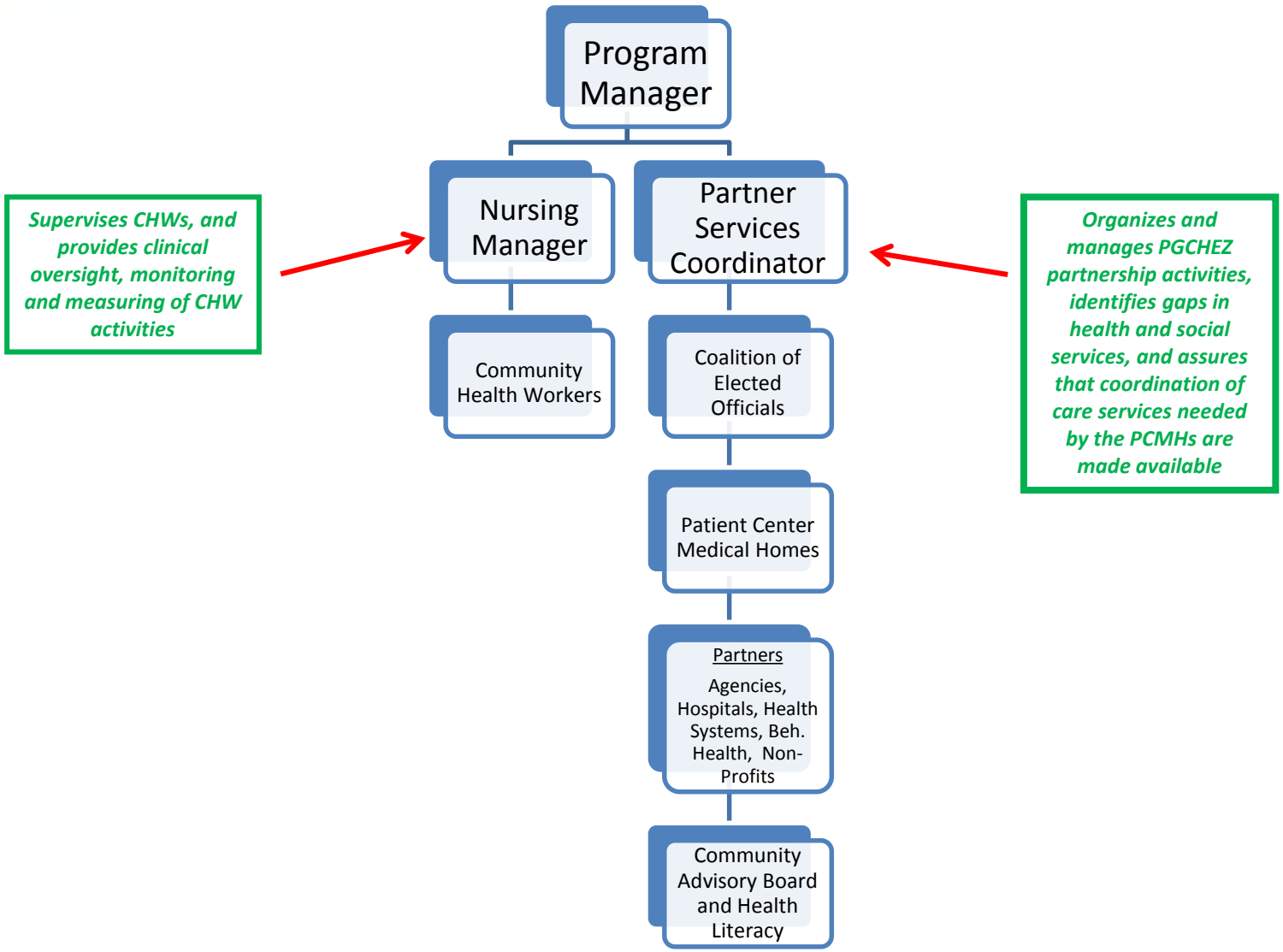
Examples of specific care coordination activities include:

- **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.**

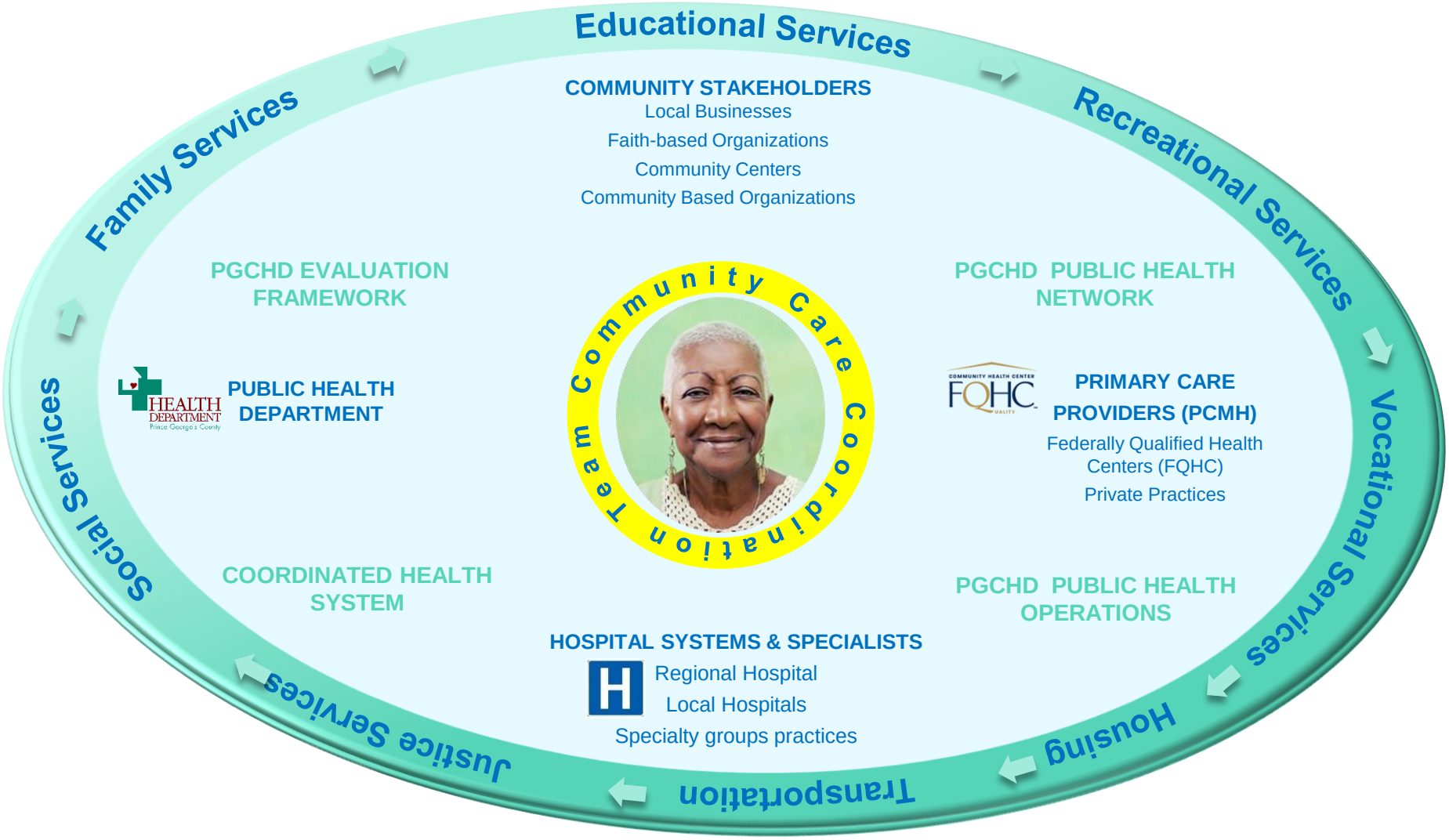
Resource: Agency for Healthcare Research and Quality (AHRQ)

Department of Health and Mental Hygiene

PGC HEZ Care Coordination Structure



HEZ Partners



Care Coordination Put into Action

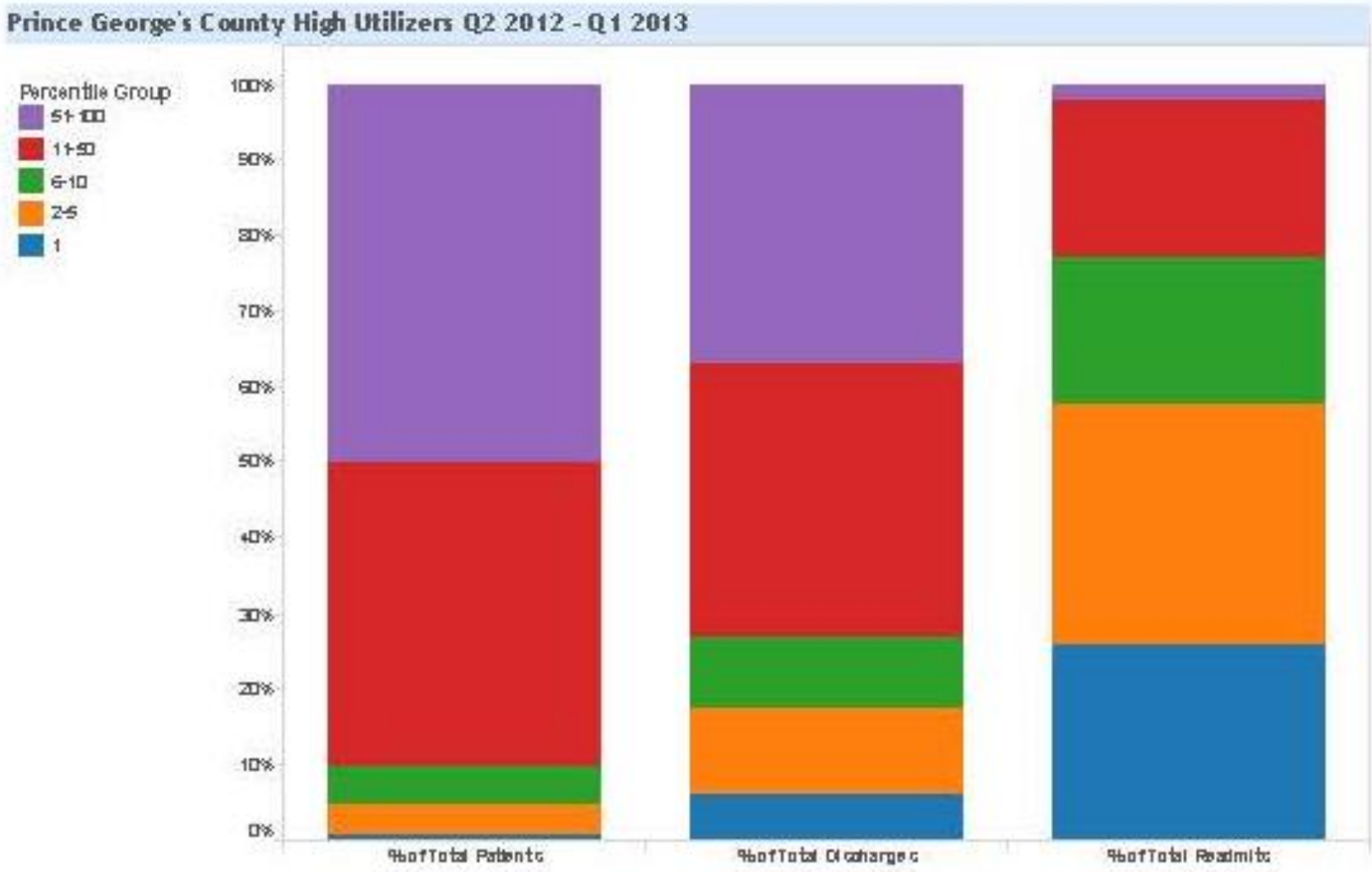
- **Care coordination is a key strategy that has the potential to improve the effectiveness, safety, and efficiency of the American health care system.**
- **Well-designed, targeted care coordination that is delivered to the right people can improve outcomes for everyone: patients, providers, and payers.**
- **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**

High Utilizers/Targeted Populations

- 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



PGCHEZ Care Coordination: Goals and Objectives

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**

Care Coordination Plan

- Hospital transition for high utilizers
- ED transition for frequent utilizers
- Community Health Worker (CHW)
- Community Care Coordination Team (CCCT)

CHW Referral Protocols

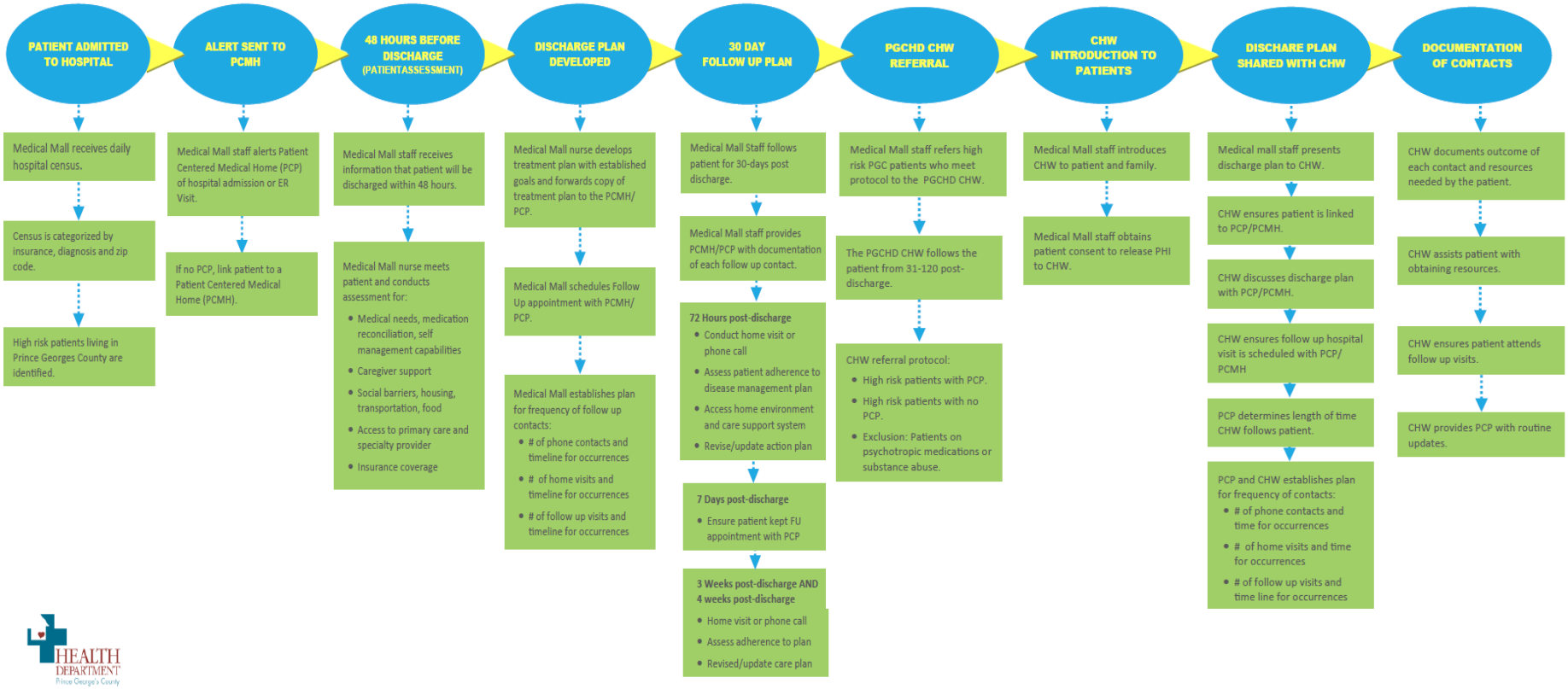
Transition

- 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

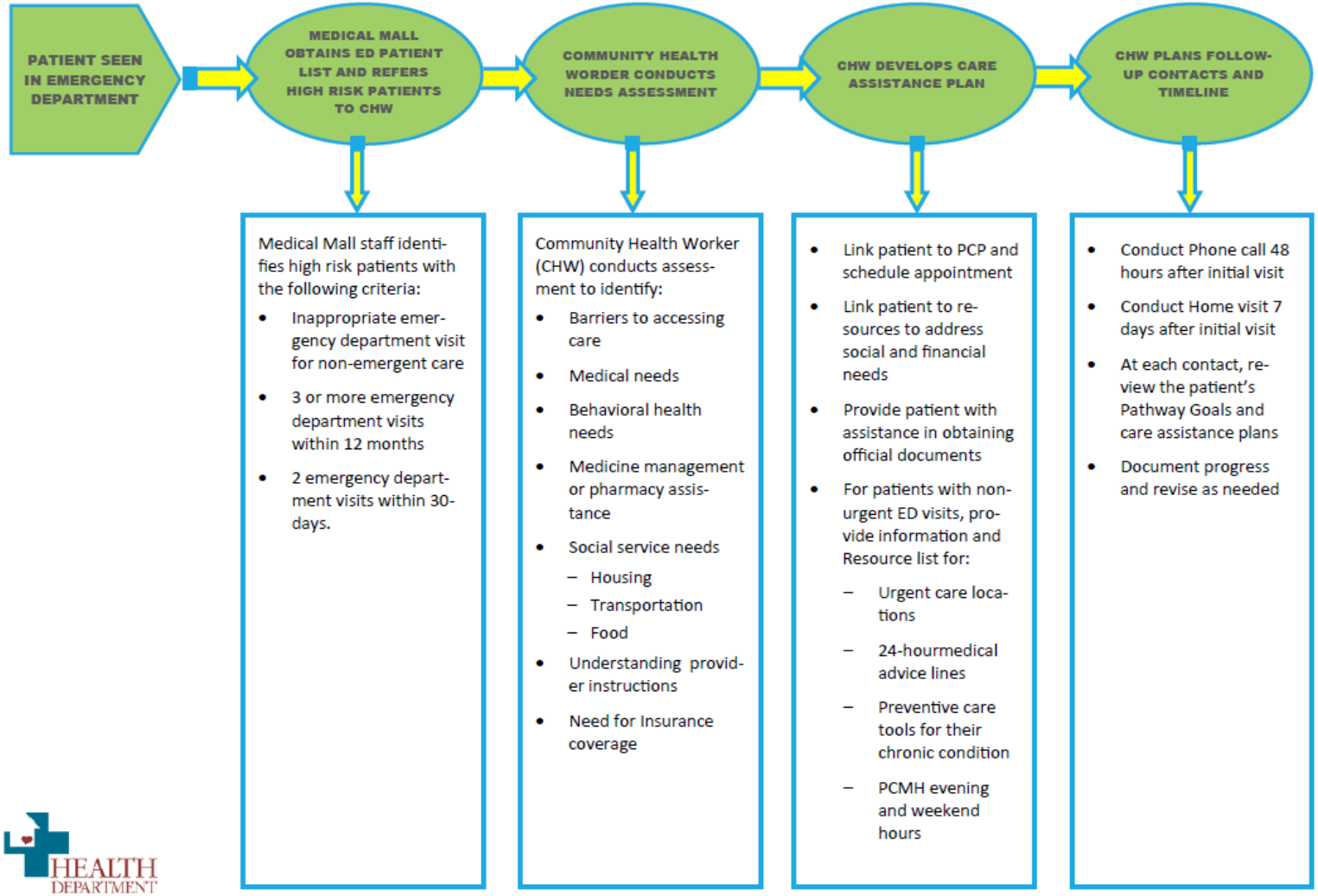
- High risk patients in poor control of their chronic illness
- High risk patients needing connections to social services

Hospital Transition Workflow



HEALTH DEPARTMENT
Prince George's County

ED Transition Workflow



HEALTH DEPARTMENT
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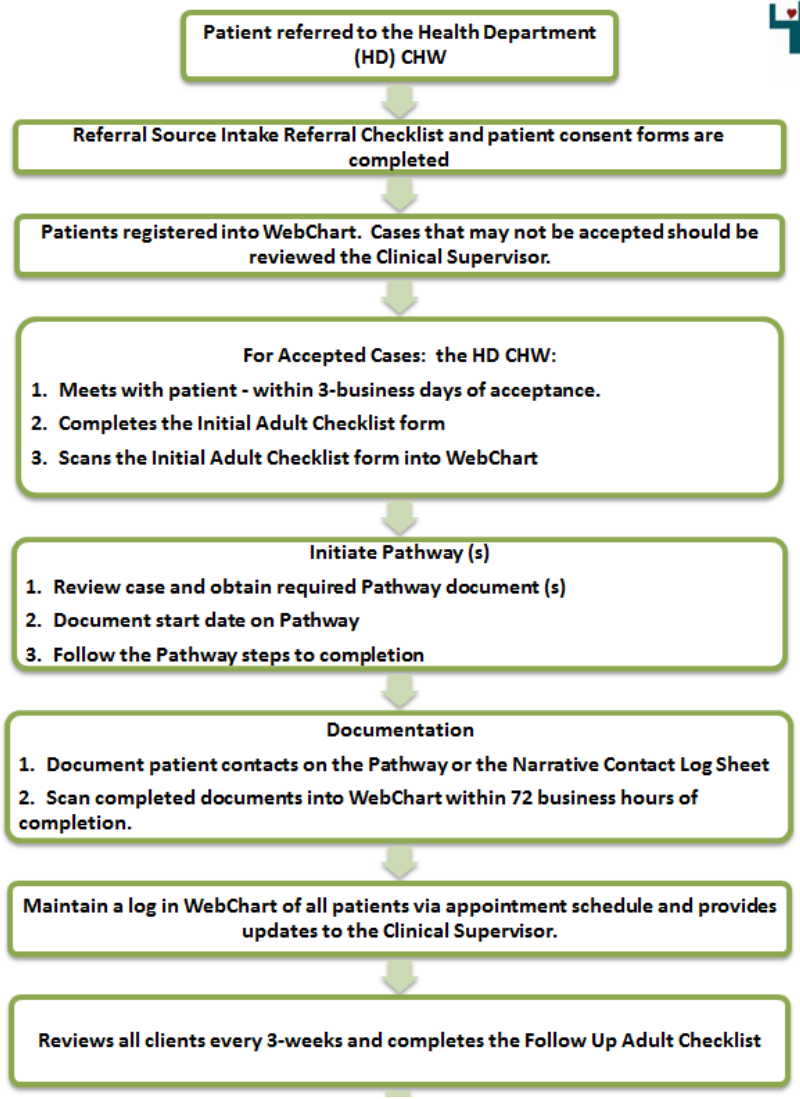
Community Health Worker

- 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 Pathway: Medical Home

Client Name	
Date of Birth	
Community Health Worker	
Primary Diagnosis	
Pathway Start Date	
INITIATION	Client needs a primary care physician or medical home
Payment Source	☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Self-Pay
Find appropriate primary care office that fits the needs of the client	☐ Accepts payment source ☐ Easily accessible to client's home or work ☐ Speaks language of client ☐ Near public transportation ☐ Sub-specialty services available
Primary Care Information	Physician Assigned to Client: Contact Number:
Initial Appointment	Date of Initial Appointment:
Client Contact	Date client informed of Appointment Details:
Client Education	Date client/family educated about the importance of: ☐ Keeping the appointment ☐ Making regular follow up appointments with PCP ☐ Preparing for the appointment: o Prepare a list of Medication o Write questions you have for the doctor o Write a description of your symptoms or any concerns
Steps Taken with Client	☐ Appointment arrangements made ☐ Previous medical records obtained ☐ Transportation assistance arranged
Appointments kept	☐ Did client keep the appointment ☐ Yes ☐ No How was appointment compliance verified ☐ Informed by client ☐ Informed by referral provider/service ☐ Informed by family member

CHW: Initial Assessment

CHW Pathway: Care Planning Checklist

INITIAL ADULT CHECKLIST

Visit Date:_____ Time: _____ (Start) - _____ (End) Visit Type: _____

Community Health Worker: _____

Patient Name: _____ (Last) _____ (First) _____ (Middle/Initial)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Social Security Number: _____ (###-##-####) DOB: _____ (mm/dd/yyyy) Age: _____

Race: _____ Ethnicity: _____ Gender: ❑ Female ❑ Male

Insurance: _____ Medicaid Number: _____

Referral Date: _____ (mm/dd/yyyy) Emergency Contact Number: _____ (###) ###-####

Primary Diagnosis: _____

OVERALL HEALTH

What is your greatest health concern?

What is the greatest barrier to your having good health?

YES	NO	CLIENT INFORMATION
❑	❑	**Are you single?** If no: ❑ Significant other ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
❑	❑	**Do you rent your home or apartment?** If no: ❑ Own ❑ Live with relatives ❑ Live with friends ❑ Not from the area ❑ Homeless ❑ Other
❑	❑	**Do you speak another language besides English at home?** If yes, do you need a translator for appointments? ❑ Yes ❑ No
❑	❑	**Are you in school now?** If no: ❑ College graduate ❑ High school diploma ❑ GED ❑ Dropped out of high school ❑ other _____
❑	❑	**Are you interested in finding a job?** If no: ❑ Employed ❑ Disability insurance ❑ Enrolled in a training program ❑ Other _____ If disabled, what is the reason? _____
❑	❑	**Do you need help with transportation to appointments?** What are you using now for transportation? _____
❑	❑	**Do you have children?** 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?**
❑	❑	**Do you have any problems providing:** ❑ Housing ❑ Food ❑ Utilities ❑ Other _____
❑	❑	**Do you have any legal issues?** _____

Notes:

_____

_____

_____

_____

Pathway Goals

GOALS:

Select pathways for Care Coordination and tracking.

☐ Asthma Management	☐ Diabetes	☐ Domestic Violence
☐ Health Insurance	☐ Housing	☐ Medication Assessment
☐ Medical Home	☐ Medical Referral	☐ Smoking Cessation
☐ Social Service Referral		
☐ Other:		

TREATMENT PLAN GOALS/OBJECTIVES

GOAL TOPIC	GOAL DESCRIPTION	DATE SET	RESULTS

CHW Pathway: Social Services Referral

The Social Services Referral Pathway covers priorities such as housing, food, and other basic survival needs. Understanding and addressing these needs become a prerequisite to improving overall health. Complete one pathway per agency.

Client Name	
Date of Birth	
Community Health Worker	
Primary Diagnosis	
Pathway Start Date	
INITIATION	Client needs assistance with obtaining social services.
Type of Referral	☐ Child Assistance ☐ Family Assistance ☐ Food assistance/WIC ☐ Financial Assistance ☐ Transportation Assistance ☐ Job/Employment Assistance ☐ Education Assistance ☐ Legal Assistance ☐ Parenting Skills Assistance ☐ Clothing Assistance ☐ Utilities Assistance ☐ Translation Assistance ☐ Other (please specify) _____
Referral Information	Agency Name: Contact Person: Contact Number:
Initial Appointment	Date of Initial Appointment:
Client Contact	Date client informed of Appointment Details:
Client Education	Date client/family educated about the importance of keeping the appointment and making regular follow up appointments with PCP: _____
Steps Taken with Client	☐ Appointment arrangements made ☐ Enrollment Forms Received ☐ Application Received ☐ Assistance with completing forms ☐ Assistance with submitting forms ☐ Other: (please specify) _____
Appointments kept	☐ Did client keep the appointment ☐ Yes ☐ No How was appointment compliance verified ☐ Informed by client ☐ Informed by referral provider/services ☐ Informed by family member
Application	Date application received by client: Date application completed and submitted to Agency: Date services started:
COMPLETION Completion Criteria: Client connected to services Services started	Date of completion _____ OR [] Follow up needed ☐ Client needs being fully met ☐ Client needs being partially met. Specify: ☐ Client needs not being met. Specify:
Follow Up	Date and Status report:

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

20743 Prince George's County

HEALTH ENTERPRISE ZONE

QUICK SHEET

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!

5 Medical Practices will serve more than **10,000** Residents!

BRW • Coral Hills • Chapel Hills • Fairmount Park • Fairmount Heights • Jefferson Heights • Oak Crest • Pepper Mill • Pleasant Valley • Capitol Heights • Seat Pleasant •

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) 855-5369
ESWilliams@co.pg.md.us

Everette D. Bradford
Mobile: (240) 695-4203
E-mail: edbradford@co.pg.md.us

Zaneta Crawford
Mobile: (301) 332-4317
E-mail: zrcrawford@co.pg.md.us

Marcia D. Murphy
Mobile: (240) 695-4916
E-mail: mdmurphy@co.pg.md.us

Angelina Chappell
Mobile: (240) 691-8791
E-mail: achappell@co.pg.md.us

HEALTH DEPARTMENT Prince George's County

Health Enterprise Zones 11/14

Phase 2: Prince George's County Community Care Coordination Team Model

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

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

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

Public Health Department

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

Primary Care Providers (PCMH)
- FQHC
- Private Practices

CCCT workflows focus on linkages to care and services

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

CCCT pathways ensure quality, evidence based practices

Questions