

PRINCE GEORGE'S COUNTY HEALTH DEPARTMENT



HEALTH ENTERPRISE ZONE



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Building a Healthier Prince George's County

Summary For First 2 Years - PGCHEZ

PGCHEZ Goals	Activities
Reduce health disparities	<p>Culturally & linguistically appropriate training started</p> <p>Health Literacy Campaign – See slides 6 & 7</p> <p>Launched CHW Care Coordination & patient navigation</p>
Improve health care access and health outcomes	<p>Opened 3 of 5 patient centered medical homes – over 18,000 visits – see Slide 4, leverage EDI funds for construction</p> <p>Finalizing contracts for the 4th – Specialty/ behavioral health integration with Dimensions Health System and Health Dept..</p> <p>Challenge: Lack of fund for initial PCMH start up operation expenses</p>
Reduce healthcare costs and hospital admissions/readmissions	<p>Care Coordination Service for High Utilizers - Average number of active clients on a weekly basis range from 100 to 110 – see slide 5</p> <p>Challenge: finding addition funds for Care management for example clinical manager only funded for ½ time or need for additional CHWs,</p>
Enhance care communication and coordination	<p>Established and registered PGCHEZ Health Information Exchange, connection to CRISP, DCPCA, labs, etc.</p> <p>Consent2Share project</p>
Provide chronic disease management, with the assistance of specialized care coordinators	<p>Established of Community Care Coordination Team (CCCT) – a public/private partnership to improve care coordination with over 40 members from critical service areas.</p>

Summary of HEZ Year to Date

Patient Visits 2013-2014

- 18,780 total number of patient visits in HEZ Patient Centered Medical Homes.
- 11,563 people were seen (unduplicated visits).
- Patients seen are from 20743 and surrounding zip codes.
- 4,793 people seen from zip code 20743

CHW Report YTD 2015

- 66 new clients were enrolled since January 1, 2015
- Average number of active clients on a weekly basis range from 100 to 110
- Total number of completed client contacts = 1076
 - 137 in person contacts
 - 833 phone contacts
 - 107 other contacts
- Total number of Client Connections = 276
 - Majority of CHW connections are for transportation
 - 23 for linkage to a medical home
- Number of Resource Contacts Made on Behalf of Clients = 482
 - 80 bulk were made for transportation
- Total of 228 clients have been served by the HEZ program.
 - 43 clients or almost 20% live in 20743

Health Literacy Campaign Year 2

- Steering Committee created and meetings held monthly, of residents (6), faith-based representatives (4), and local businesses and non-profits (3)
- Focus groups (3) of residents (16) to design health messages
- Random household survey through multiple waves, with final response rate 20%
- Convenience resident-driven survey completed (158)
- HEZ Promotional Flier distributed (661)
- Teen Video produced by teens (11) and promoted throughout community
- Health literacy exhibiting at health fairs across neighborhoods (5)
- Draft health literacy fact sheets (4)
- Draft health literacy workbook to use in communication with providers

High Impact Objective #1 - Increase Provider Workforce

Objective: Establish four PCMHs and one specialty practice open to patients in ZIP code 20743.

Expected Outcomes: Practices open with 8 providers who will see 7,000 patients in Year 3.

Metrics: Anticipated 13,000 patients visits for the 7,000 patients

Key Strategies: Developed the RFA and provided TA to providers, liaised with County agencies and other funders to complete the build out of sites, utilized state tax, hiring tax credits, and loan repayments to recruit primary care providers to Zone, provided TA to ensure successful opening of practices, established CHW referral to providers

Activities: Complete lease negotiations and provider agreements signed, manage practice openings and community stakeholder holder engagement events, finalize site build out and provider reporting and compliance, and ongoing monitoring of patient enrollment and visits in the PCMHs



High Impact Objective #2 – Decrease High Utilizers

Objective: Reduce hospitalization and ED visits and associated charges for complex patients enrolled in the CHW program.

Expected Outcomes: Reduce hospital admissions and ED visits and charges among complex patients by 10% . Anticipated enrollment for year 3 is 240 patients.

Metrics: Comparison of hospitalization and ED visit rates and charges prior to the PGCHEZ CHW intervention with rates and charges post intervention

Key Strategies: Direct referral from Hospital Case Managers to Community Health Worker intervention. Utilization of CHW Pathways to manage patient issues

Activities: 1) identify high utilizers 2) assess patient needs, 3) develop an individual plans (pathways) for each patient, 4) collaborate with the patient to put the pathways into action, and 5) monitor the results.

Care Coordination is the Key!

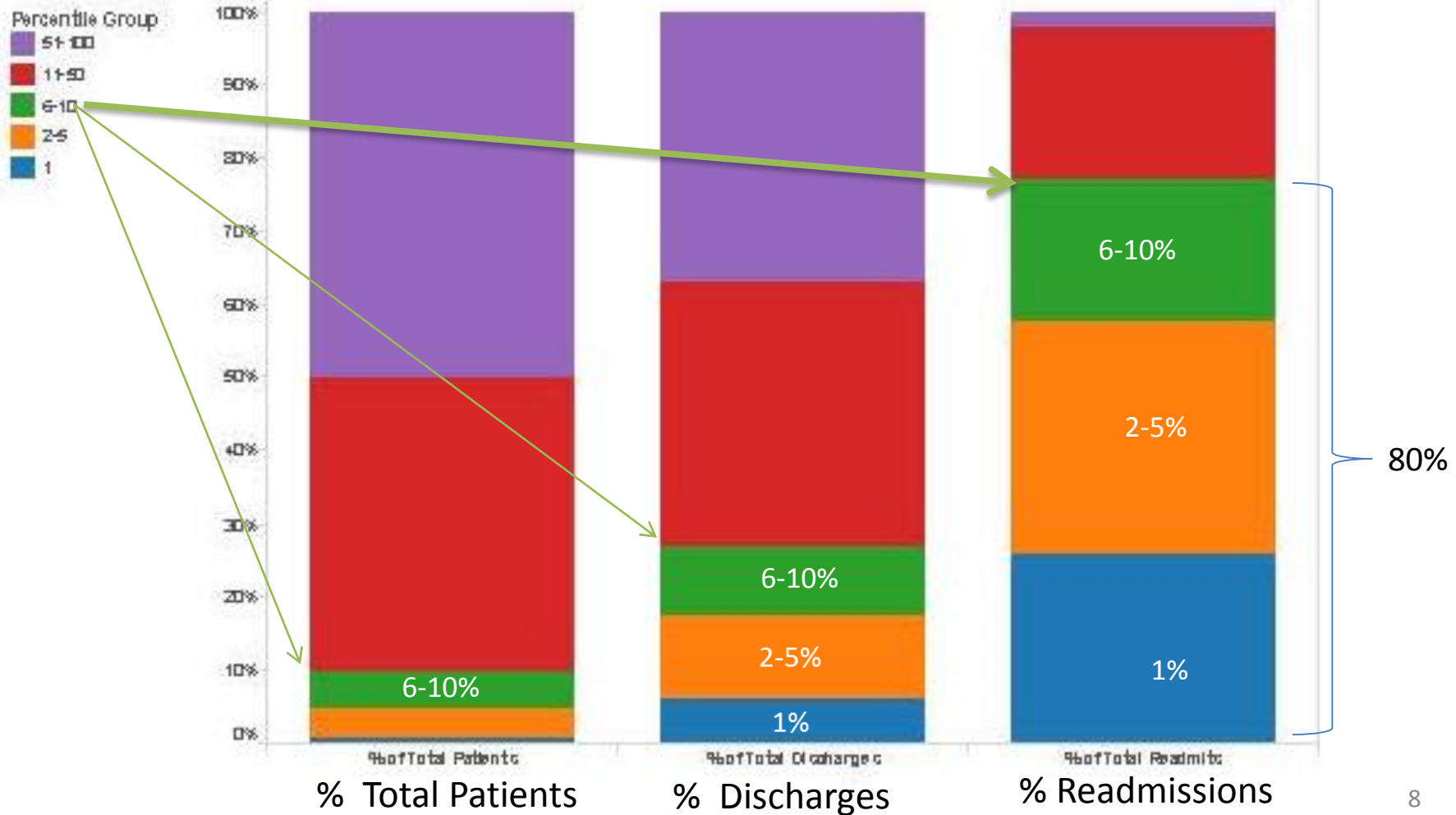
- Care coordination is a key strategy that has the potential to improve the effectiveness, safety, and efficiency of the American health care system.
- Well-designed, **targeted** care coordination that is delivered to the right people can improve outcomes for everyone: patients, providers, and payers.
- Must obtain data to identify your targeted population.
- Prince George's County HEZ statistics: (from CRISP data)
 - 10% PGC HEZ residents represent 80% of readmissions
 - Approximately 270 patients
 - In need of multiple services, i.e. social services, primary care, behavioral health, etc.

*Resource: Institute of Medicine of the National Academies**

Targeted Population

Inpatient Utilization Data for HEZ - zip code 20743 from CRISP

Prince George's County High Utilizers Q2 2012 - Q1 2013



Case Examples

Simple Case

- 52 y.o. AA male
- ER readmit < 30 days
- Needs
 - PCMH
- Outcomes
 - Uses PCMH
 - No further ER visits

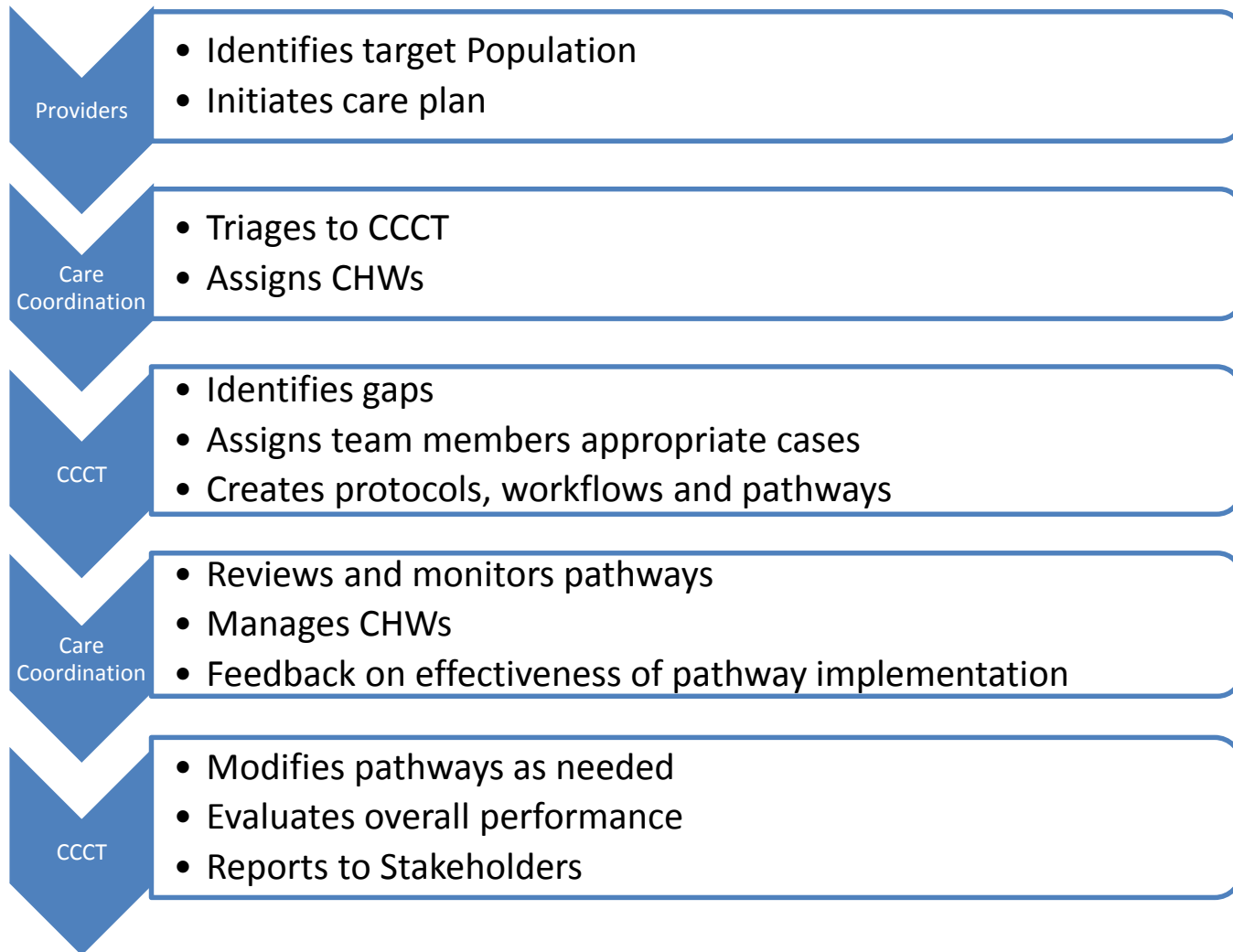
Complex Case

- 26 y.o. C female
- 43 AC admits in past year
- Needs
 - Health literacy
 - Transportation
 - Care coordination

GUIDING PRINCIPLES

1. Design and formalize care management activities to help mitigate the long-term medical and financial risks from poorly controlled chronic diseases.
2. Utilize local community care networks and care managers to work in partnership with primary care providers to identify high risk and at-risk patients who will benefit from targeted care management interventions.
3. Target high risk and at-risk residents to receive care transition, care coordination and linkages to services.
4. Address the gaps that adversely impact social determinants of health.
5. Involve the patient and family in planning activities, and develop care plans that are customized to meet their needs.
6. Share knowledge and information freely between and among patients, care partners, physicians, and other care givers.
7. Measure, report and monitor outcomes to ensure that the patient benefits from services and support.

High Level CCCT Workflow



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 (45 current members)

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



Improved Data to Measure High Utilizers

- Dimensions and Doctor's Community
Hospitals are providing pre- and post- CHW intervention patient-level data
- Partnering with EMS to determine associated costs for High Utilizers
- Working to establish partnership with health insurance to have more complete picture of associated costs

Evaluation



Satisfaction Surveys

- Clients of HEZ providers
- Clients of Community Health Workers (CHW)

CHW Activities

- Weekly Report
 - Client enrollment and discharges
 - Client contacts
 - Pathways started and completed
 - Resource Connections made

Emergency/Inpatient Healthcare Utilization

- Analysis of HSCRC data for HEZ area (20743)
- Analysis of DC data for HEZ residents

Evaluation

Utilized new data website to analyze and share combined Maryland and DC hospitalization data, as well as other common health metrics

www.pgchealthzone.org

PGC HealthZone
HEALTH DEPARTMENT
Prince George's County

Facts & Figures Promising Practices Resources & Funding Tools & Wizards Topic Centers

Explore data for Health Enterprise Zone 20743

Select from a variety of indicators for zip code 20743

Families in Poverty 9.4 PERCENT

What is this indicator?
This indicator shows the percentage of families living below the federal poverty level.
[Learn more](#)

Zip Code: 20743

Map labels: Sterling, Reston, Centreville, Washington, Dale City, Annapolis, Easton

Age-Adjusted Hospitalization Rate due to Diabetes

This indicator shows the average annual age-adjusted hospitalization rate due to diabetes per 10,000 population aged 18 years and older. Cases of gestational diabetes were excluded.

Zip Code



Comparison: MD Counties

59.9
hospitalizations/10,000 population
18+ years

Measurement Period: 2010-2012

Zip Code: 20743

[View Every Zip Code](#)

Data Source: The Maryland Health Services Cost Review Commission (HSCRC) & Maryland Health Care Commission (MHCC)

Categories: Health / Diabetes

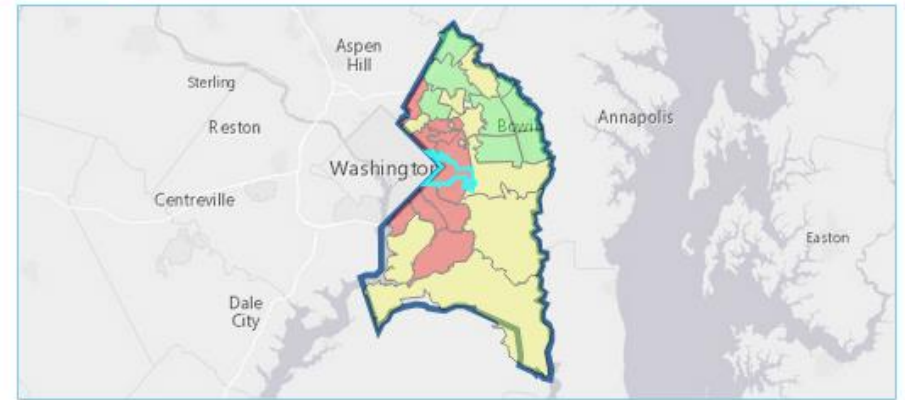
Technical Note: The distribution is based on data from 24 Maryland counties.

Maintained By: Healthy Communities Institute

Last Updated: November 2014

[View Full Map](#)

[Maps FAQ](#)





High Impact Objective #3 – Improve Health Literacy

Objective: To engage residents as health literacy advocates that sustain efficacy and wise use of PGCHEZ medical homes.

Expected Outcomes: In Year 3, fifty (50) residents in PGCHEZ will be trained as health literacy advocates and can educate other about health literacy.

Metrics: The number of PGCHEZ residents who completed the training in health literacy.

Key Strategies: Recruit residents, create the health literacy messages and curriculum, conduct training sessions for residents, and evaluate training competency through pre and post testing.

Activities: UMSPH Center for Health Literacy conducted a health literacy survey to develop tailored training and messaging materials (123 surveys randomly collected and 156 surveys collected through the Steering Committee)

Health Literacy Campaign Year 3

- Create and disseminate evidence-based health messages
 - Use channels for campaign that are culturally and linguistically appropriate for community
 - Address awareness (60%), knowledge (50%), self efficacy (30%), and intent to use HEZ (25%) by target audience
- Neighborhood-based “Advocate” initiative, to train 50 residents and CHWs in health literacy.
 - Advocates inform circle of friends and neighbors (1,000) about health literacy and HEZ, using materials developed for campaign.
- Create and assess 100% campaign materials that are health literate and culturally sensitive.
 - Draft 4 fliers (8,000) and 1 Workbook (1,000) to raise awareness and knowledge about health literacy
 - 40% HEZ patients use workbook when meeting with practitioner.

Projected PGCHEZ Year 3 Expenditures

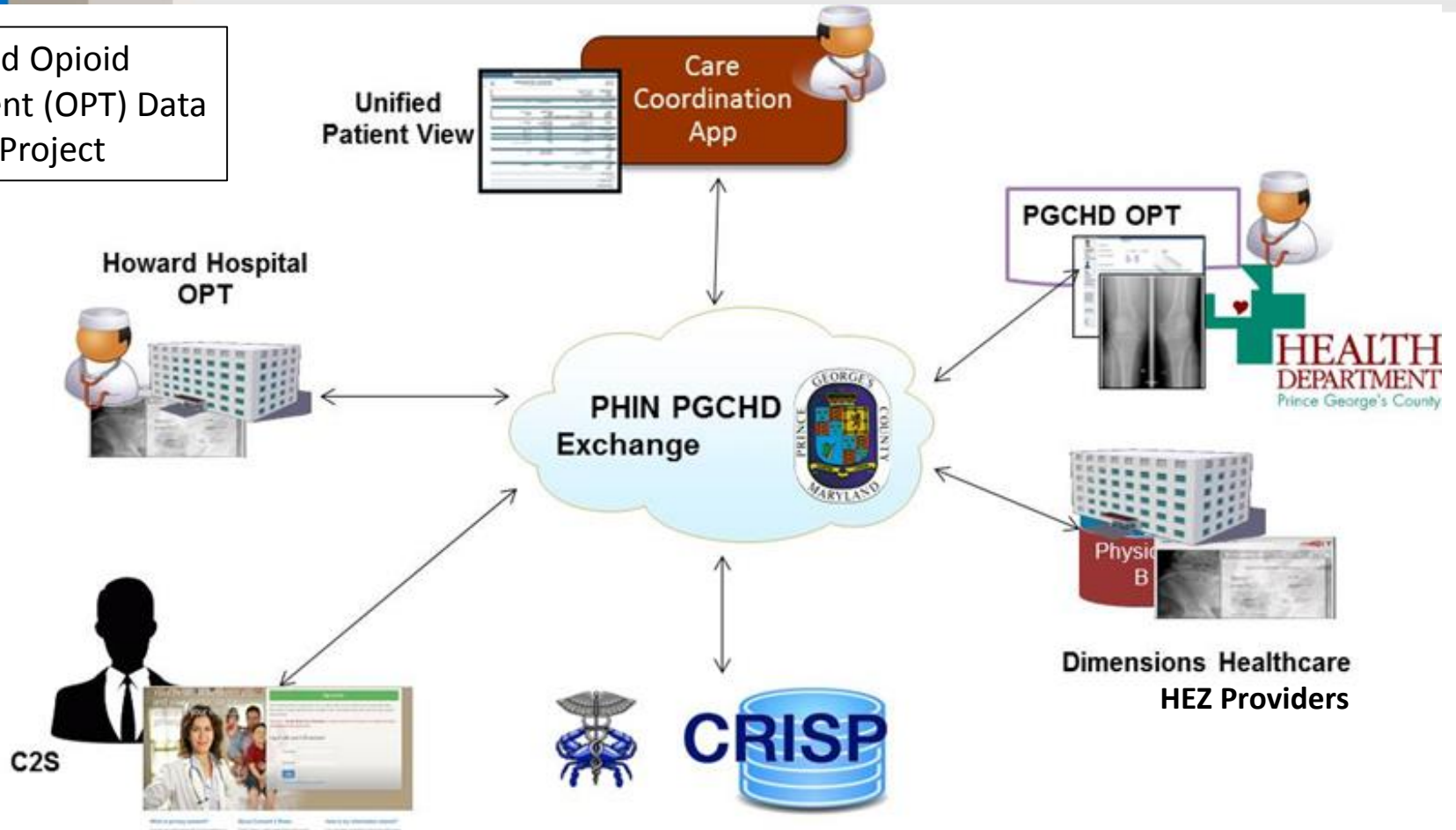
- Expenses for Program Management and PCMH Implementation Activities
 - Activities related to establishing practices, health interventions support/contractual vendors, and managing PCMH build out, project coordination efforts, completion of project deliverables in Year 3 budgeted costs \$130,632
 - Increase in Provider Capacity and Health Services in 20743 by adding 2 PCMHs and 1 Specialty Practice costs \$214,500
 - Addition of 3.5 primary care providers to increase PCP workforce by end of Year 3 for total of 8 providers by utilization of tax credits \$21,217.50 and hiring credits \$20,000 from budgeted funding (total \$41,217.50)
- Expenses for Clinical Management and Five (5) CHW Activities
 - Activities related to CHWs and Clinical Health Nurse Manager connecting high utilizers with no PCP to PCMH/medical practices, community-based, and social resources in Year 3 budgeted costs \$277,682

Projected PGCHEZ Year 3 Expenditures

- Expenses for Partner Services, Care Coordination and Community Care Coordination Team (CCCT), and Coalition/CAB Activities
 - Activities related to managing care coordination oversight and partner services with PCMH/practice providers, and community engagement through PGCHEZ Coalition and CAB/Steering Committee Efforts in Year 3 budgeted costs \$58,762
- Improvement in Health Outcomes and Services in 20743 through Health Intervention Support Vendors (total costs \$240,437)
 - Health Information Technology Service-Vendor: (Electronic Health Network) Public Health Information Exchange, Care Coordination Software, and PCMH Provider Integration and Connectivity costs \$120,000
 - Behavioral Health Intervention-Vendor: (Drs. Gaston and Porter) Sister Circles costs \$20,403
 - Health Literacy Campaign and Data Analysis Services-Vendor: University of Maryland, School of Public Health (UMSPH) and Center for Health Literacy costs total \$100,034
 - Zone-related Evaluation Activities, Patient Satisfaction, and Client Satisfaction Surveys costs \$33,400

Efforts, Programs, Partnerships

Proposed Opioid Treatment (OPT) Data Sharing Project



\$425,000 Sub contract enables PHIN to connect to DCPCA's Washington DC Exchange as part of George Washington's School of Public Health's CMS funded Prevention@Home Project

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Please Note: This site is for demonstration purposes only. Please DO NOT enter any personal data or personal health information.

Log in with your C2S account

Username: Jack.Doe

Password: [masked]

Login

Trouble accessing your account?

Wellness on Wheels (W.O.W.)

- W.O.W. is a partnership between Doctors Community Hospital and Prince George's County Health Department
- Walmart & Walmart Foundation provided \$100,000 award
- Funding will support the 1st year of W.O.W. operations



Questions

