The Coordinating Center &

West Baltimore CARE

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All Zone HEZ Data Meeting
September 11, 2015

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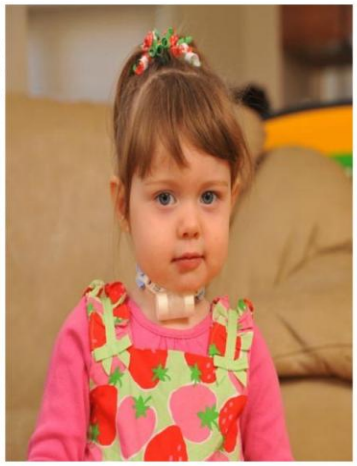
The mission of The Coordinating Center is to partner with people of all ages and abilities and those who support them in the community to achieve their aspirations for independence, health and meaningful community life.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The Coordinating Center…

- 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

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The Center's Comprehensive Services

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Today's Objectives

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

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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

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Community Demographics

	Southwest Baltimore	Baltimore City	Maryland
Unemployment	43%	34%	23%
Median HH Income	$23,070	$30,078	$56, 250
Infant Mortality Rate (per 1,000 live births)	18.0	11.7	7.9
Life Expectancy	64.2	70.9	77.5

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

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Mortality Rate Comparison (per 10,000)

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

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

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Hospital Root Cause Analysis

- Identified all factors that contribute to readmissions
  - Diagnoses related to readmissions
  - Processes around discharge planning
  - Individual experience

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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

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Get Well Services Overview

GET WELL

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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

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Four Pillars of Focus

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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

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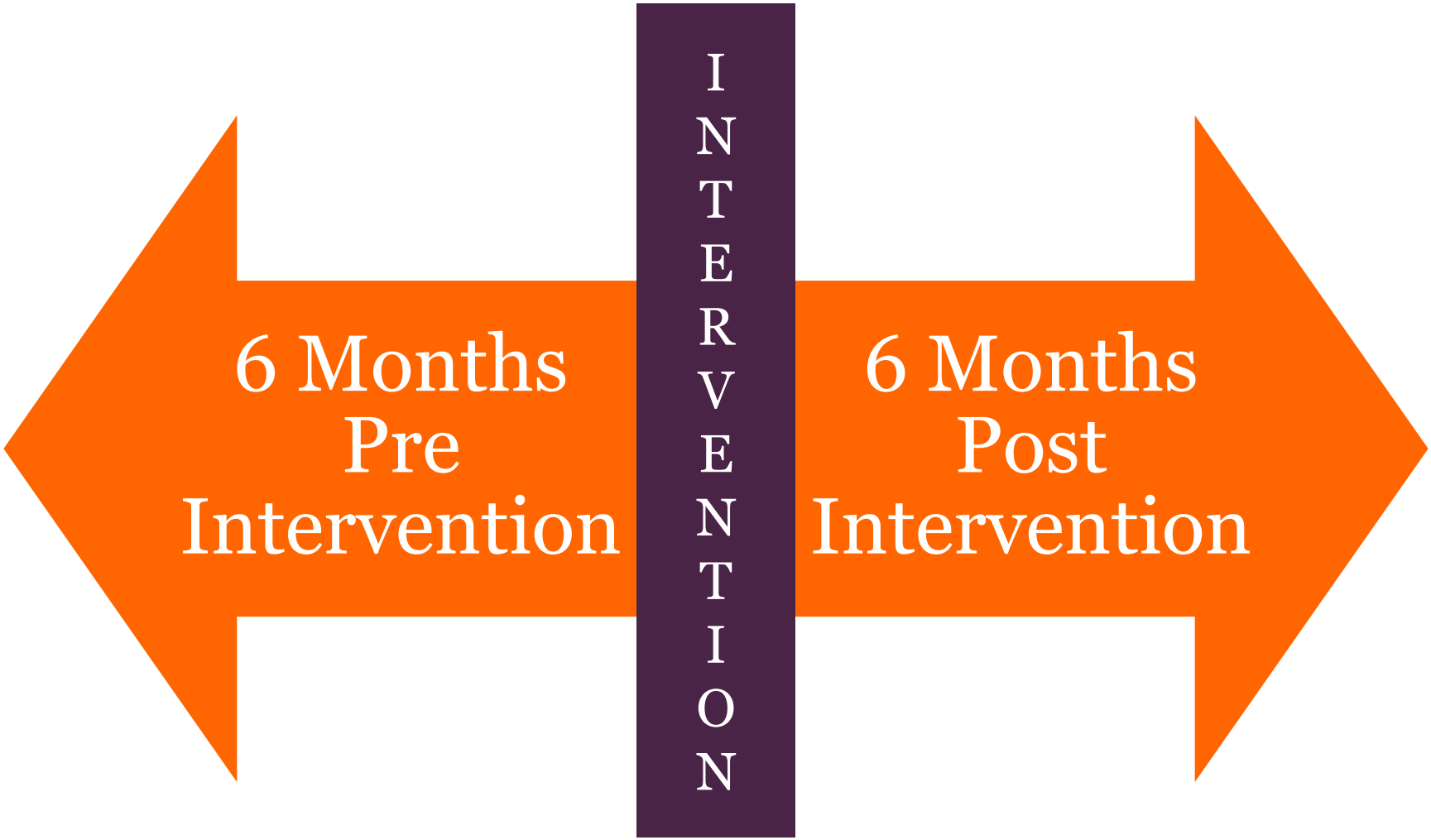

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Quality Measures

- 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

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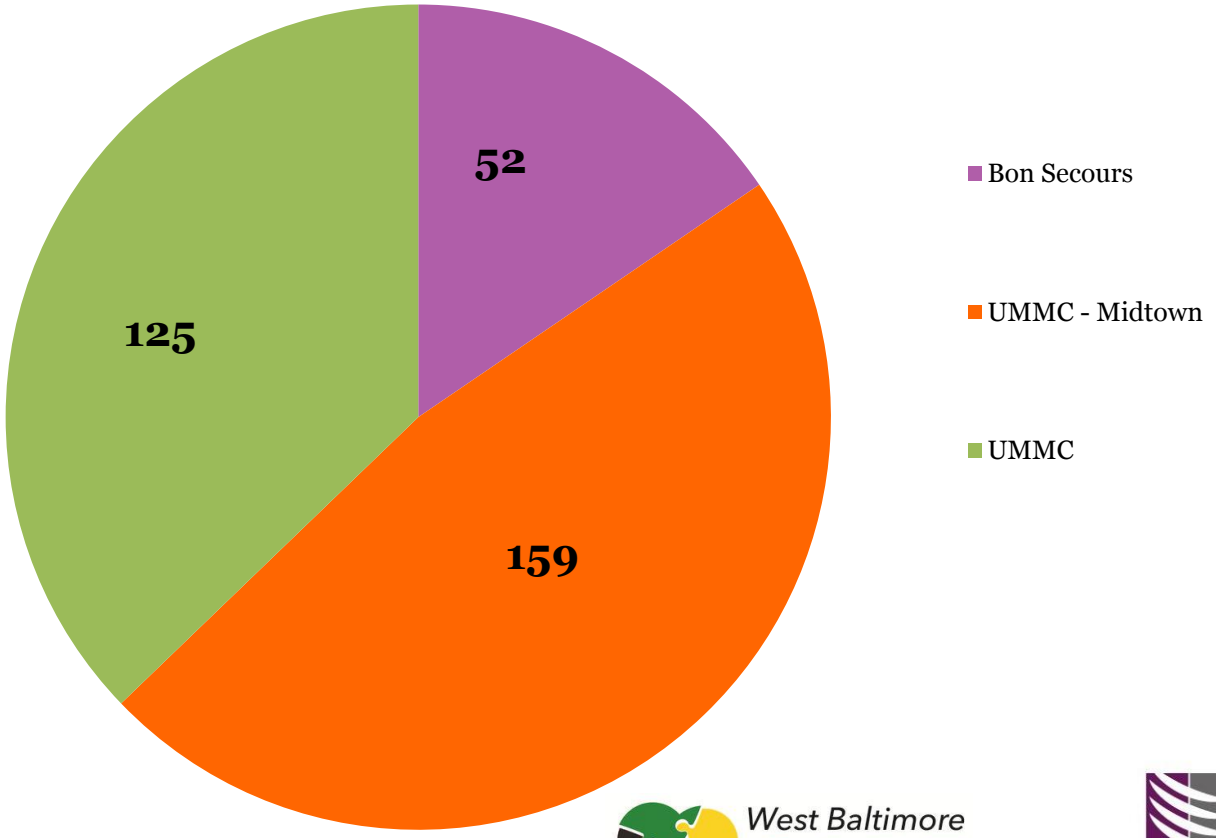
HEZ Monthly Care Coordination Enrollment by Hospital June – August 2015



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Hospital	2015 - 2016									
	June	July	August	September	October	November	December	January	February	March
University of Maryland										
# of patients coach assigned										
# readmissions during month										
% of readmits in high risk population										
University of Maryland - Midtown Campus										
# of patients coach assigned										
# readmissions during month										
% of readmits in high risk population										
Bon Secours Hospital										
# of patients coach assigned										
# readmissions during month										
% of readmits in high risk population										
Sinai Hospital										
# of patients coach assigned										
# readmissions during month										
% of readmits in high risk population										
St. Agnes										
# of patients coach assigned										
# readmissions during month										
% of readmits in high risk population										
Get Well Average:										

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Care Transition Model

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Staffing Model

- Program Director
- Hospital Transitional Liaisons
- Community Health Coaches
- Clinical Care RNs
- Coordination Specialist
- Corporate Support
  - Quality Management
  - Finance
  - Human Resources

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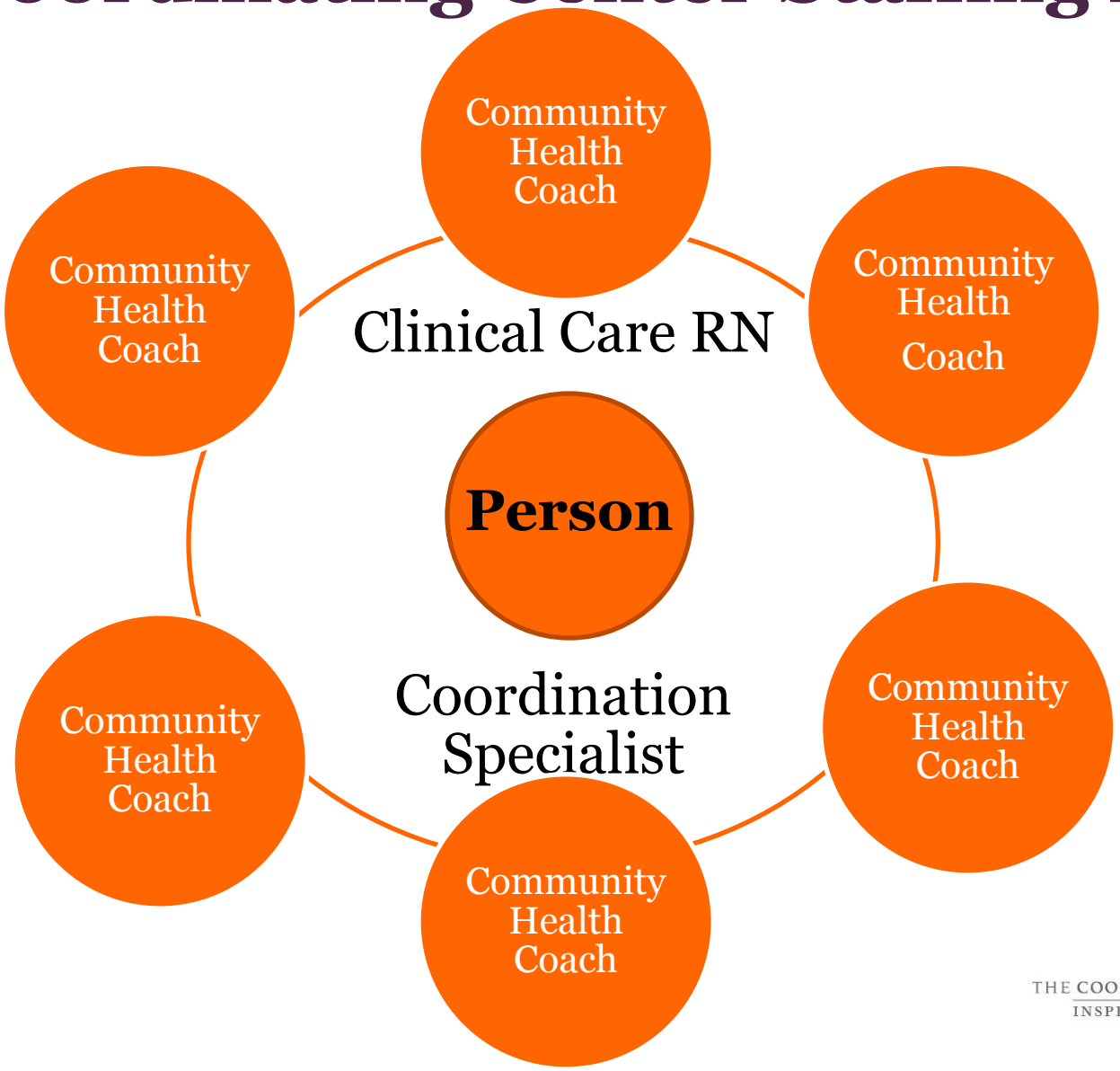
The Coordinating Center Staffing Model



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Care Transitions in Action

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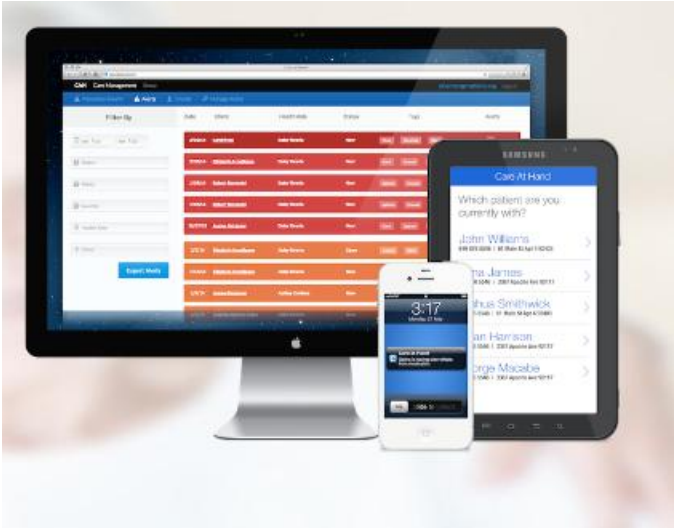
Using Mobile Technology in the Field

- 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

Care at Hand



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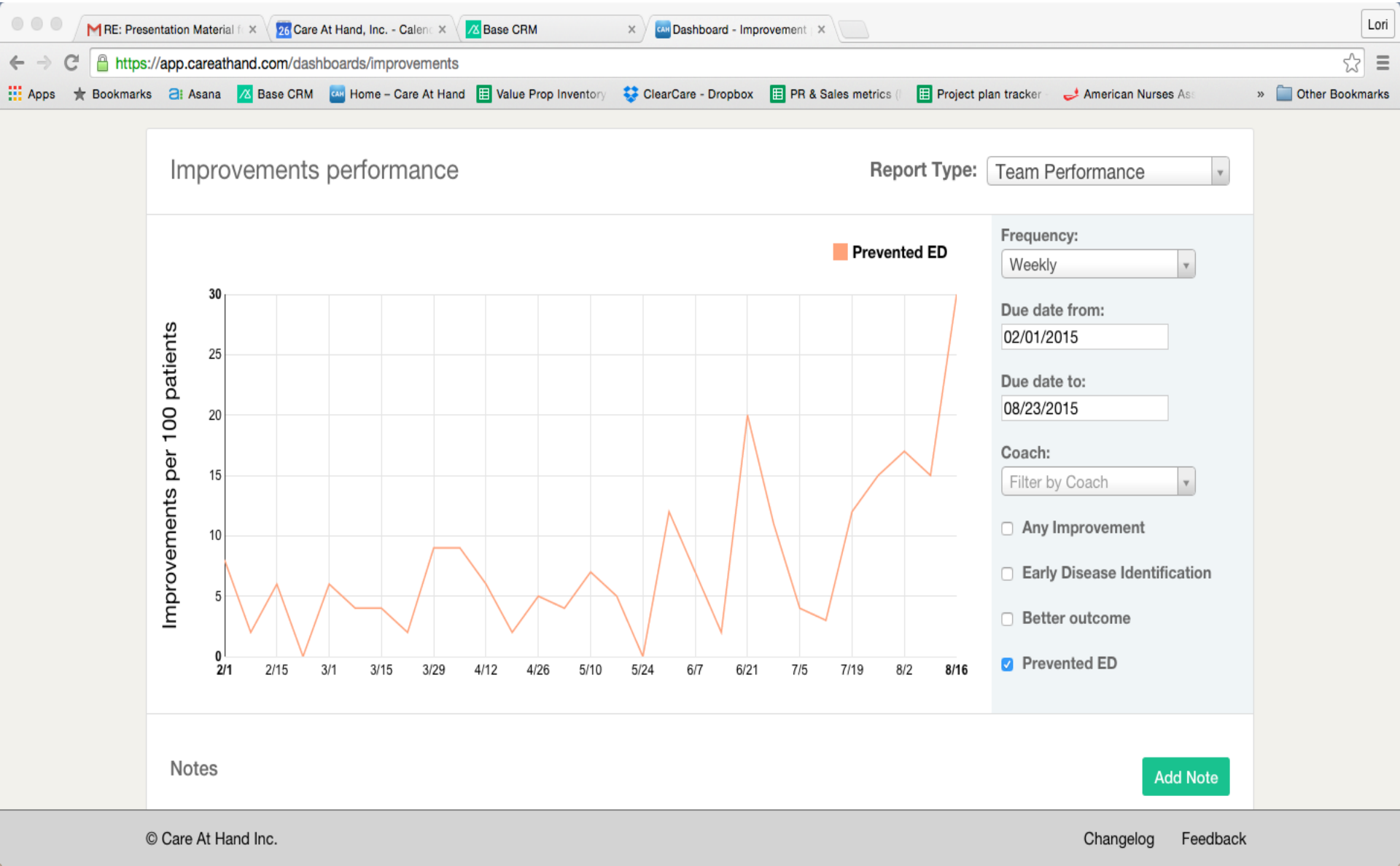
CAH Measures - Prevented ED Visits



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

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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.

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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 grandmom and I have u to thanks. Love [redacted]

My little way of saying "thanks."

U. Showed me a way of life I am blessed.

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