




The Coordinating Center and West Baltimore Care

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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.

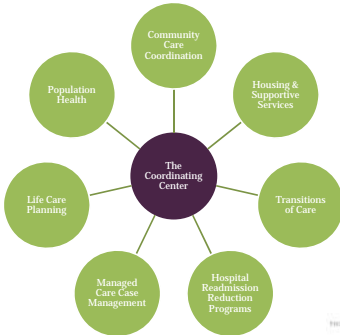




The Coordinating Center...

- 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 nurses, social workers, housing specialists and supports planners





We Provide Comprehensive Services


Today's Objectives

- Defining Care Transitions
- HEZ OVERVIEW
 - Program Partners
 - Care Transition Intervention
 - Key Program Elements
 - Care at Hand
 - Data Collection
 - Return on Investment
 - Patient Success Story



What is Care Transitions?


- Refers to the movement of patients (clients) across the health care spectrum
- Emphasizes the importance of communication to include all parties
- Recognizes the importance of including the patient (client) and caregiver(s)
- Promotes accountability and collaboration



The History of Care Transitions

NTOCC – National Transitions of Care Coalitions – October 2006

- 13 leading U.S. healthcare and non-healthcare organizations and companies
- Led by CMSA – Case Management Society of America
- Participants included physicians, nurses, social workers, pharmacists, regulators, hospital administrators, assisted living professionals, pharmaceutical industry, accrediting agencies
- Formed to address a serious U.S. health care issue, especially in the older adult population, of filling the gaps that occur when patients leave one care setting and move to another care setting
- Formed 3 working groups – Awareness Education, Health Policy Issues, Building Tools and Resources




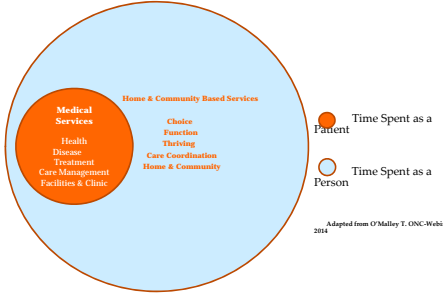
Care Transitions Models and Initiatives

Care Transitions Intervention Models


- Bridge Model
- BOOST – Better Outcomes for older Adults Safe Transitions
- Transitions of Care – Coleman Model
- Project RED
- Transitional Care Model

Care Transitions Initiatives

- ACA - Affordable Care Act - 2012 - financial component to hospital readmissions
- CMS (Centers for Medicare and Medicaid) - CCTP - Community-based Care Transitions Program

Adapted from O'Malley T. ONC-Webinar 2014




Get Well Services Overview





Program Partners


- West Baltimore HEZ – West Baltimore Care
- 16 organizations and 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

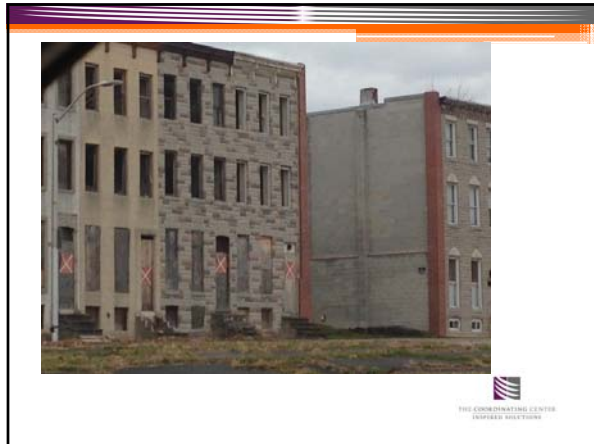


Community Demographics

	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





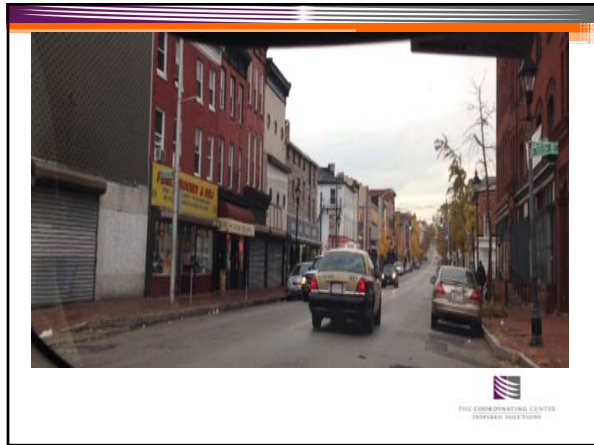
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Mortality Rate Comparison (per 10,000)

	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

- Identify 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)
 - AMI (Acute Myocardial Infarction)
 - Septicemia (often related to Pneumonia)
 - End Stage Renal Disease (ESRD)
 - Bipolar
 - Major Depression
 - Psychosis
 - Cellulitis*
 - History of frequent readmissions*
 - Diabetes*

(*Added additional diagnoses based on hospital input)


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Quality Measures

- ▣ Enrollment volume
- ▣ Care Outcomes
 - ▣ 30 Day All Cause re-admissions
- ▣ Care Processes
 - ▣ Delivery of coaching encounters and fidelity to the model
 - ▣ 7 and 14 Day post discharge physician follow up visit rates
- ▣ Pre and post activation measures (engagement of the person in the 4 pillars associated with readmission)
- ▣ Individual risk factors contributing to readmission



CARE TRANSITIONS MODEL



Staffing Model

- ▣ Program Director
- ▣ Hospital Transitional Liaisons
- ▣ Community Health Coaches
- ▣ Clinical Care RN
- ▣ Corporate Support
 - ▣ Quality
 - ▣ Finance
 - ▣ Human Resources




The Coordinating Center Staffing Model




Care Transitions in Action

Transition Liaison


- Identifies eligible patients in hospital
- Works with hospital partners to identify patients

Coordination Specialist



- Makes initial client contact
- Processes enrollment data and manages CRISP alerts
- Manages administrative data in Care at Hand

Community Health Coach

- Works with individual for 30 or 60 days based on the enhancement of the Coleman Model and a modified BEST Model
- Makes follow-up visit within 72 hours
- Implements Care at Hand survey at initial visit and at each subsequent contact
- Conducts a minimum of three phone calls at key points over 30 days



Four Pillars of Focus





What is Care at Hand?

- It is an evidence-based smart survey and analytics platform that predicts and prevents hospitalizations using non-clinical workers






www.careathand.com



Care at Hand


Mobile Technology

- 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



Why Use Care at Hand?

- Technology** that enhances communication and links parties
- Provides a **Smart Survey Format** that can be delivered in any setting
- Uses **Evidence-Based Algorithms** to assign risk scores and trigger Alerts



Care at Hand

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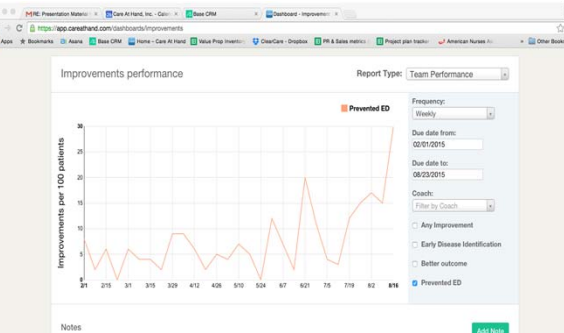



Client "Touches" - Prevented Hospital Encounters






CAH Measures - Prevented ED visits



Report Type: Team Performance

Frequency: Weekly

Due date from: 05/01/2015

Due date to: 06/23/2015

Coach: Filter by Coach

Any Improvement
 Early Disease Identification
 Better outcome
 Prevented ED

Notes

Add Note

© Care At Hand Inc. Changelog Feedback

ROI – Return on Investment

<ul style="list-style-type: none"> • Personal Impact <ul style="list-style-type: none"> - Consumer Engagement - Self-Management Skills - Long term strategies long term • Partnership Impact <ul style="list-style-type: none"> - Hospitals, providers of care - Community-based organizations - Technology providers 	<ul style="list-style-type: none"> • Educational Impact <ul style="list-style-type: none"> - Health Literacy - In the hospital, in the community • Financial Impact <ul style="list-style-type: none"> - Money saved by reducing hospital encounters - Cost-savings on staffing configurations
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Care at Hand Humor







Care at Hand, not to be confused with carrot hand or Karen-Ann!

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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:

- Client was healthy enough to take a trip to Pennsylvania and visit her granddaughter.
- She expressed relief when PCP confirmed that her blood glucose and blood pressure numbers are within normal range.

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In her own words...

I cannot put into words how u have my life that now I want to live. If every Hospital had us 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 thanks. Love

My little way of saying "thanks."

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

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Questions?

Add your name and contact information

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For More Information Contact:

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