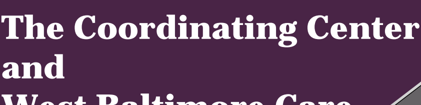

The Coordinating Center and West Baltimore Care

Jennifer Sulin-Stair, MS
Program Coordinator, Get Well Services
Chris Parsons, RN, CCM
RN, Get Well Services

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

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We Provide Comprehensive Services

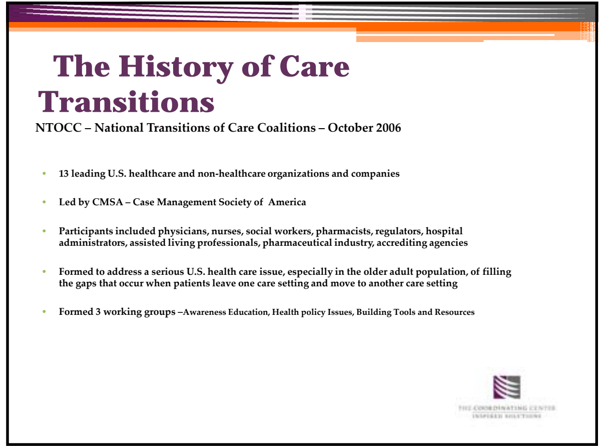
- The Coordinating Center
- Community Care Coordination
- Housing & Supportive Services
- Transitions of Care
- Hospital Readmission Reduction Programs
- Managed Care Case Management
- Life Care Planning
- Population Health

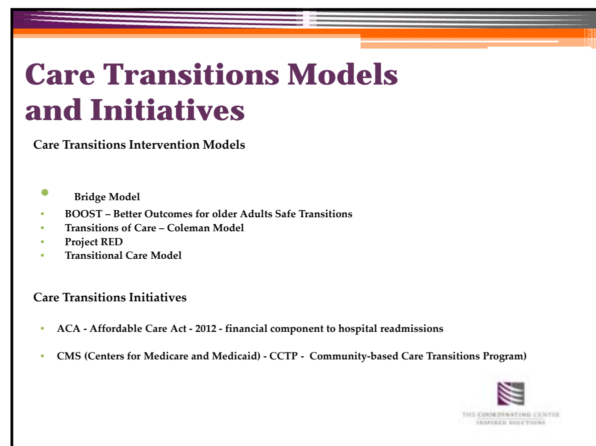
Today's Objectives

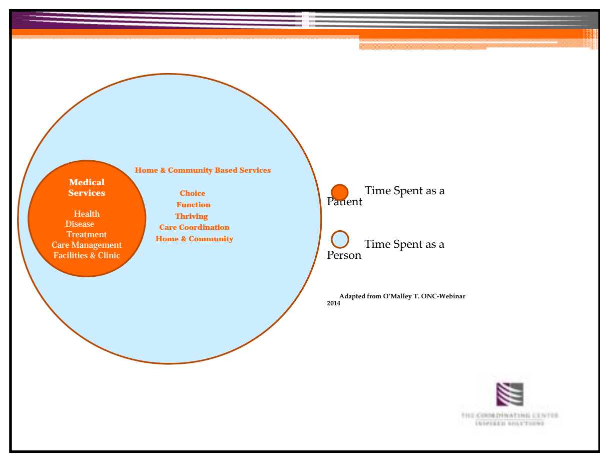
- Defining Care Transitions
- HEZ OVERVIEW
  - Program Partners
  - Care Transition Intervention
  - Key Program Elements
  - Care at Hand
  - Data Collection
  - Return on Investment
  - Patient Success Story

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







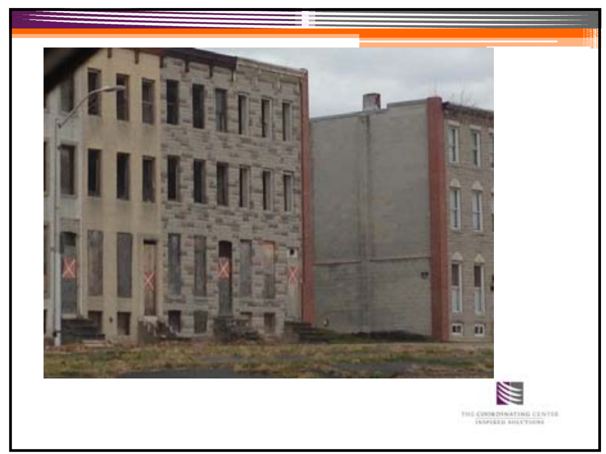
Program Partners

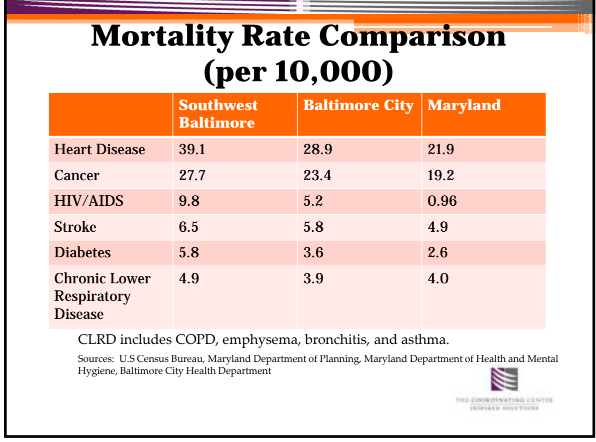
- West Baltimore HEZ – West Baltimore Care
- 16 organizations and 5 Hospitals
- The Coordinating Center
- Bon Secours Hosptial
- Sinai Hospital Center
- St. Agnes Hospital
- University of Maryland, Main Campus
- University of Maryland, Midtown
- Care at Hand

Community Demographics

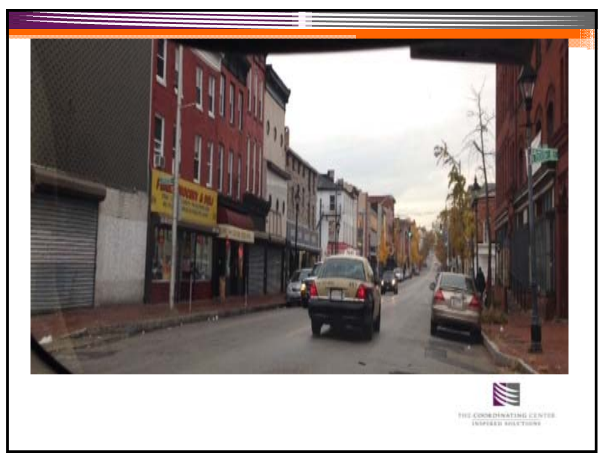
	Southwest Baltimore	Baltimore City	Maryland
Unemployment	43%	34%	23%
Median HH Income	$23,070	$30,078	$56, 250
Infant Mortality Rate (per 1,000 live births)	18.0	11.7	7.9
Life Expectancy	64.2	70.9	77.5

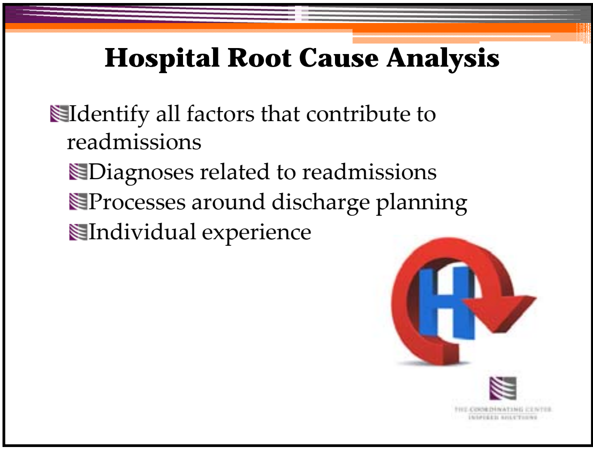
Sources: U.S Census Bureau, Maryland Department of Planning, Maryland Department of Health and Mental Hygiene, Baltimore City Health Department

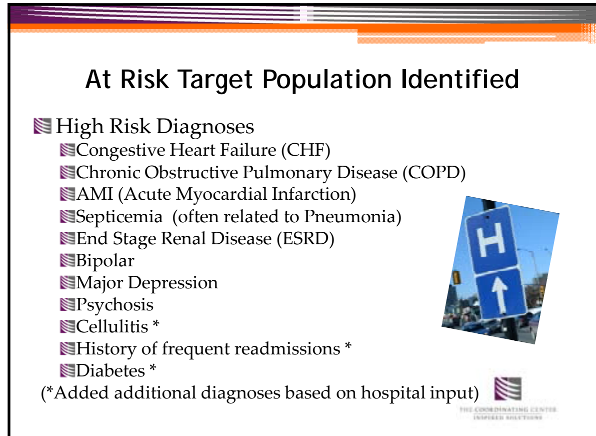


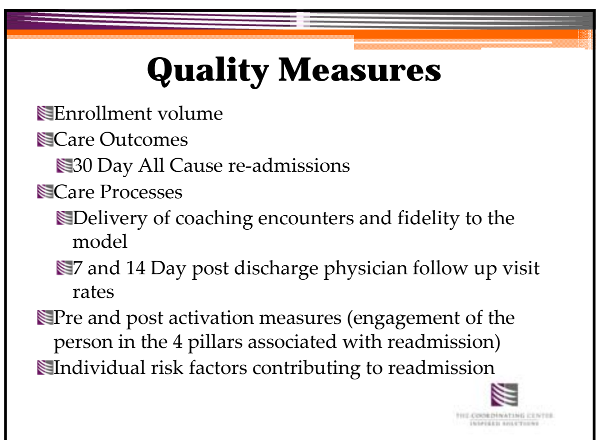


	Southwest Baltimore	Baltimore City	Maryland
Heart Disease	39.1	28.9	21.9
Cancer	27.7	23.4	19.2
HIV/AIDS	9.8	5.2	0.96
Stroke	6.5	5.8	4.9
Diabetes	5.8	3.6	2.6
Chronic Lower Respiratory Disease	4.9	3.9	4.0

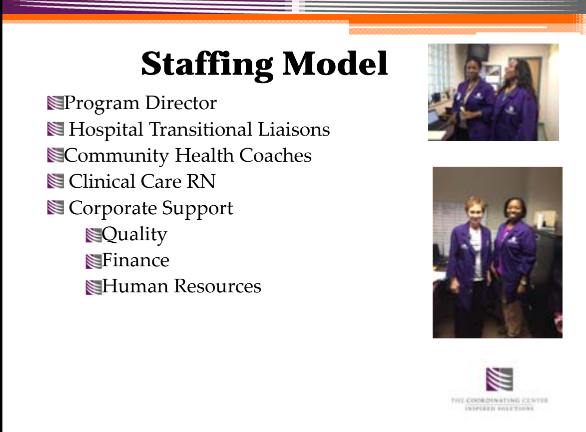


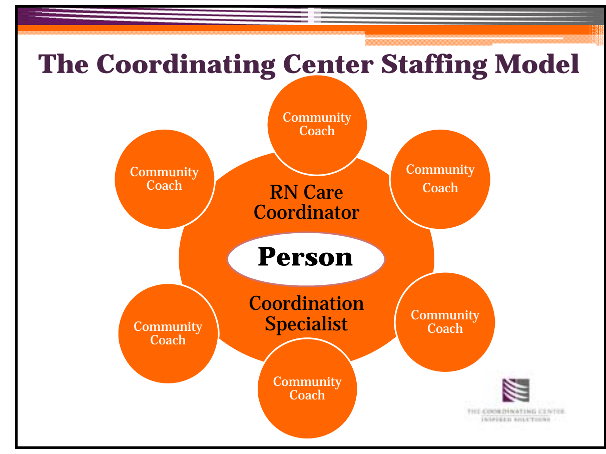


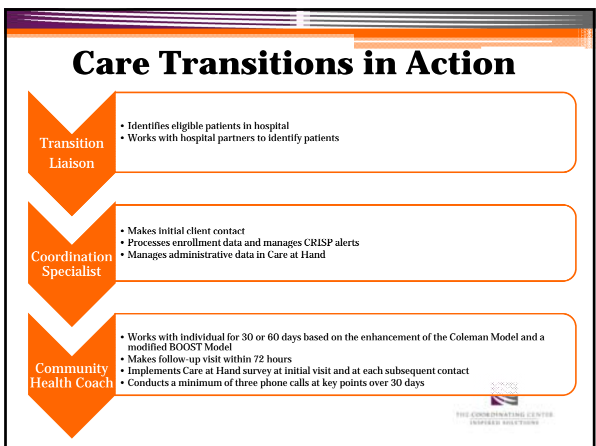


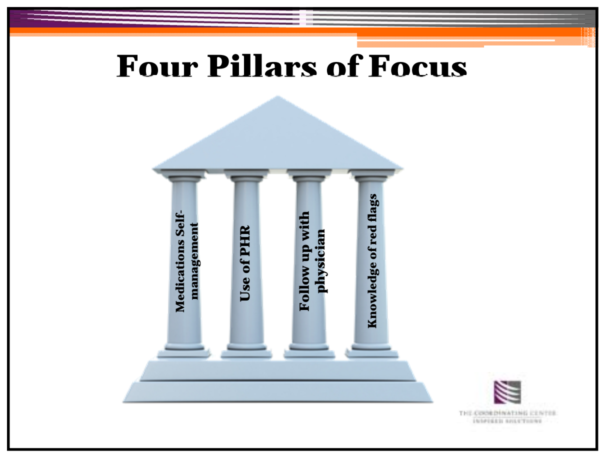

Quality Measures
Enrollment volume
Care Outcomes
30 Day All Cause re-admissions
Care Processes
Delivery of coaching encounters and fidelity to the model
7 and 14 Day post discharge physician follow up visit rates
Pre and post activation measures (engagement of the person in the 4 pillars associated with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

CARE TRANSITIONS MODEL

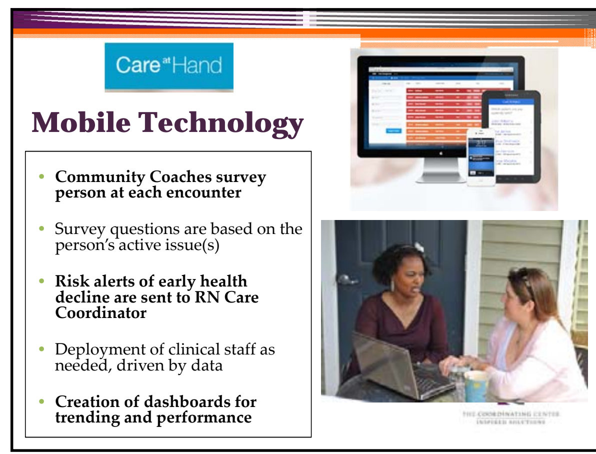

Staffing Model
Program Director
Hospital Transitional Liaisons
Community Health Coaches
Clinical Care RN
Corporate Support
Quality
Finance
Human Resources

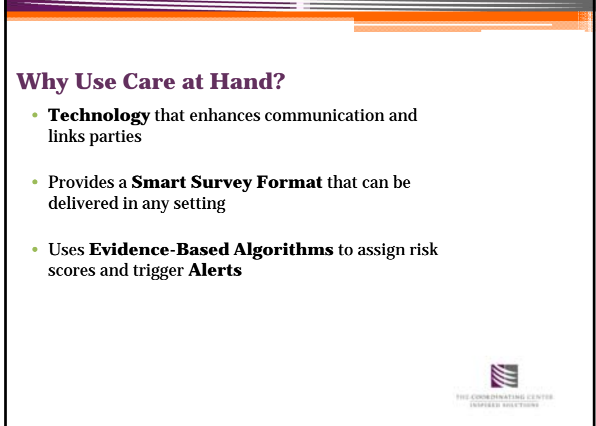

The Coordinating Center Staffing Model
Community Coach
Community Coach
Community Coach
RN Care Coordinator
Person
Coordination Specialist
Community Coach
Community Coach
Community Coach

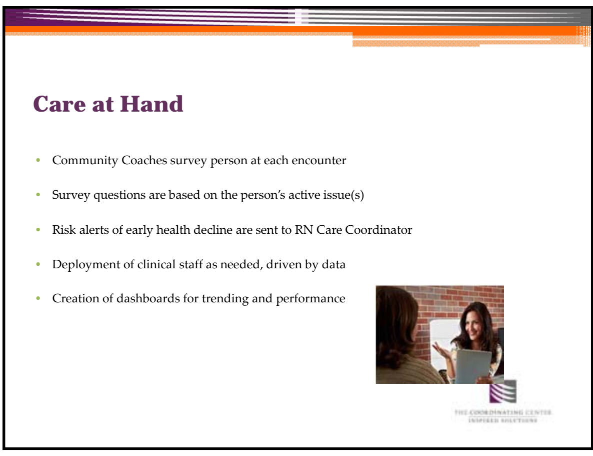

Care Transitions in Action
Transition Liaison
• Identifies eligible patients in hospital
• Works with hospital partners to identify patients
Coordination Specialist
• Makes initial client contact
• Processes enrollment data and manages CRISP alerts
• Manages administrative data in Care at Hand
Community Health Coach
• Works with individual for 30 or 60 days based on the enhancement of the Coleman Model and a modified BOOST 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
Medications Self-management
Use of PHR
Follow up with physician
Knowledge of red flags

What is Care at Hand?
It is an evidence-based smart survey and analytics platform that predicts and prevents hospitalizations using non-clinical workers
Care at Hand
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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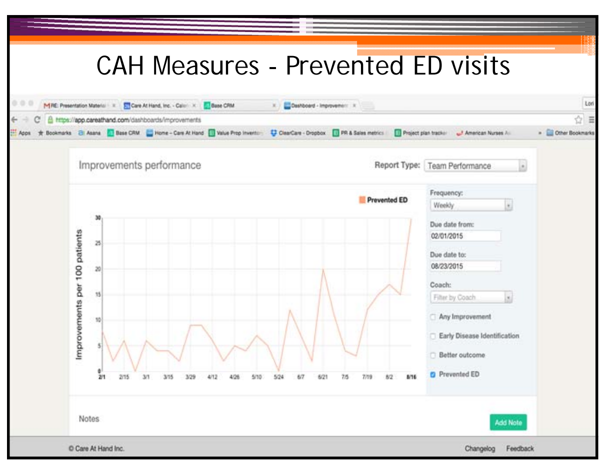
Client "Touches" - Prevented Hospital Encounters
Care at Hand
GET WELL
Coaching and Care Coordination


CAH Measures - Prevented ED visits
Improvements performance
Report Type: Team Performance
Prevented ED
Improvements per 100 patients
Frequency:
Weekly
Due date from:
02/01/2015
Due date to:
08/23/2015
Coach:
Any Improvement
Early Disease Identification
Better outcome
Prevented ED
Notes
Add Note
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Changelog
Feedback

ROI – Return on Investment

- **Personal Impact**
  - Consumer Engagement
  - Self-Management Skills
  - Long term strategies long term
- **Partnership Impact**
  - Hospitals, providers of care
  - Community-based organizations
  - Technology providers

- **Educational Impact**
  - Health Literacy
  - In the hospital, in the community
- **Financial Impact**
  - Money saved by reducing hospital encounters
  - Cost-savings on staffing configurations

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.

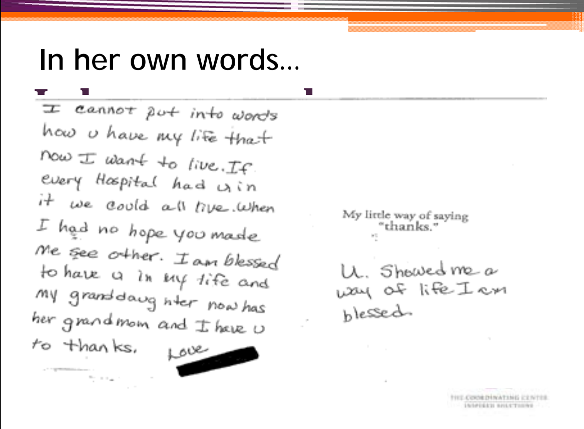
The Coordinating Center

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.

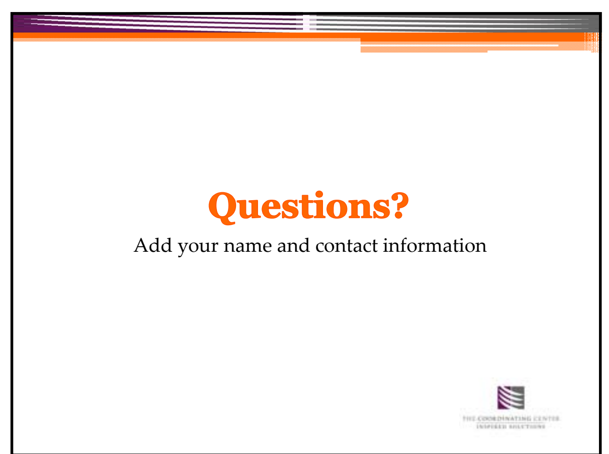
The Coordinating Center

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

My little way of saying "thanks."

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



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