

# West Baltimore Health Enterprise Zone



A Project of the West Baltimore Primary Care Access Collaborative

**Community Health Resources Commission**

April 2, 2015

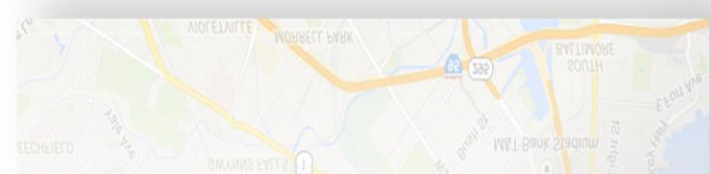
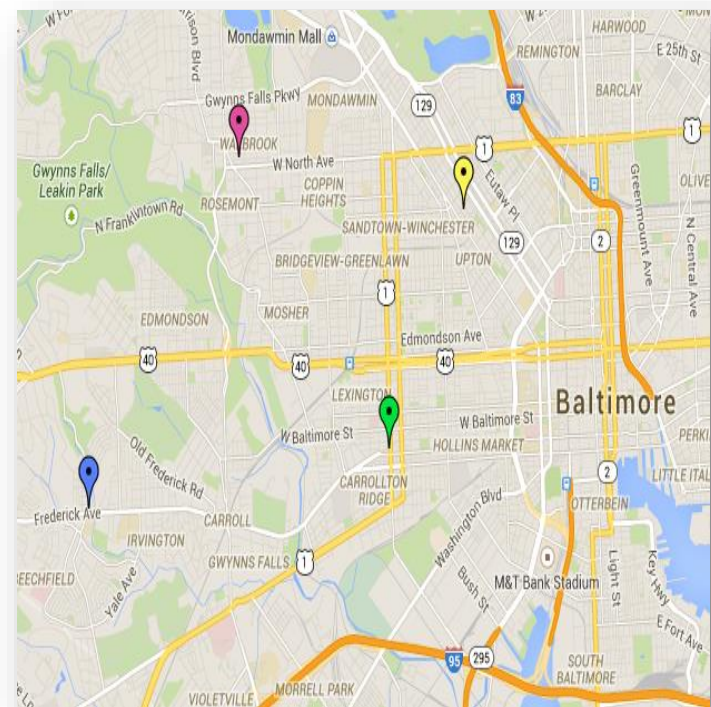
## West Baltimore CARE: Year 3 Focus

- Leverage and build upon the collaborative partnerships, infrastructure, performance data and lessons learned from Years 1 and 2 to:
  - 1) Strengthen and ensure alignment of West Baltimore CARE with the legislative intent of the HEZ Program:
    - ✓ Reduce health disparities among racial and ethnic minority populations and among geographic areas;
    - ✓ Improve health care access and health outcomes in underserved communities; and,
    - ✓ Reduce health care costs and hospital admissions and re-admissions.
  - 2) Ensure the sustainability of the West Baltimore CARE post 2016.

# West Baltimore CARE Overview

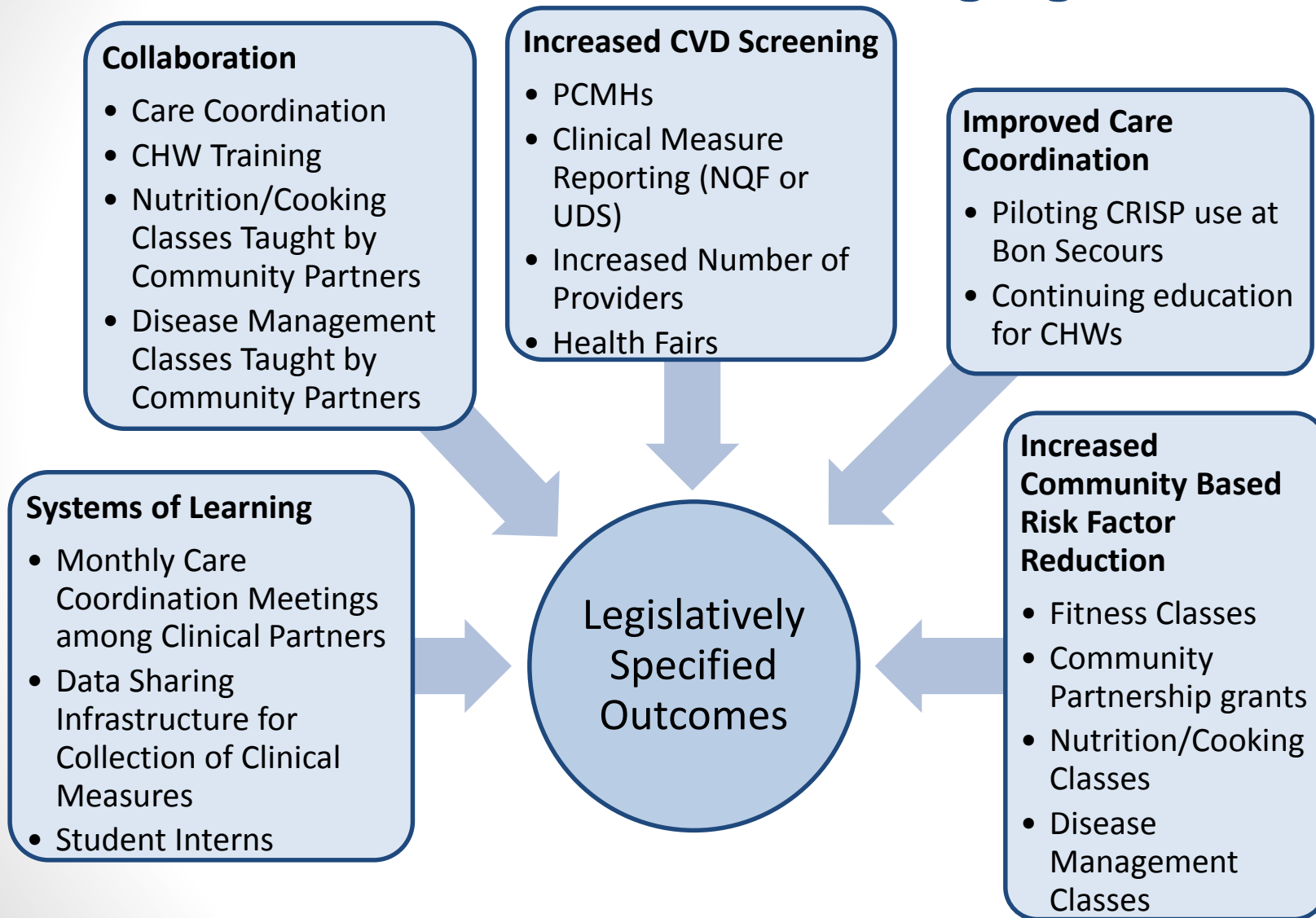
- **HEZ Geographic and Target Population:** 86,000 West Baltimore residents within the 21216, 21217, 21223, and 21220 zip codes
- **Core Disease and Target Conditions:** Cardiovascular disease (CVD) and CVD risk factors (i.e., diabetes and hypertension)
- **Overarching Strategies:** Care Coordination and Community-Based Risk Factor Reduction
- **Year 3 Budget Request:** \$1,188,522
  - Year 3: \$1,041,887
  - Year 2 Funds not expended (carried over into Year 3): \$146,635

**Figure 1. WB HEZ Geographic Area**



**WEST BALTIMORE CARE YEARS 1-2:  
ACCOMPLISHMENTS, CHALLENGES  
AND LESSONS LEARNED**

# Collective Impact Accomplishments: Partners Across the Zone Working Together



# Goal: Improved Risk Factor Prevalence Strategies and Outcomes\*

## Strategy

## Outcomes

### Health Promotion Courses

- Conducted 14 disease self-management classes with a total of 84 participants
  - Stanford Chronic Disease Self Management Program
- Conducted 24 nutrition/cooking classes with 223 participants

### Community Health Outreach

- Community Health Workers engaged 4,612 community members and patients
  - Health Screenings, Education, Emergency Department, Home and Clinic Visits

### Incentivizing Risk Reduction

- Leveraged 4 grants to community partners to reach 4,300 community members
- Enrolled 859 participants in our 'Passport To Health' Program
  - Points are given for healthy behaviors

\***Note:** All numbers are through December 2014.

# Goal: Expanded Primary Care Workforce\*

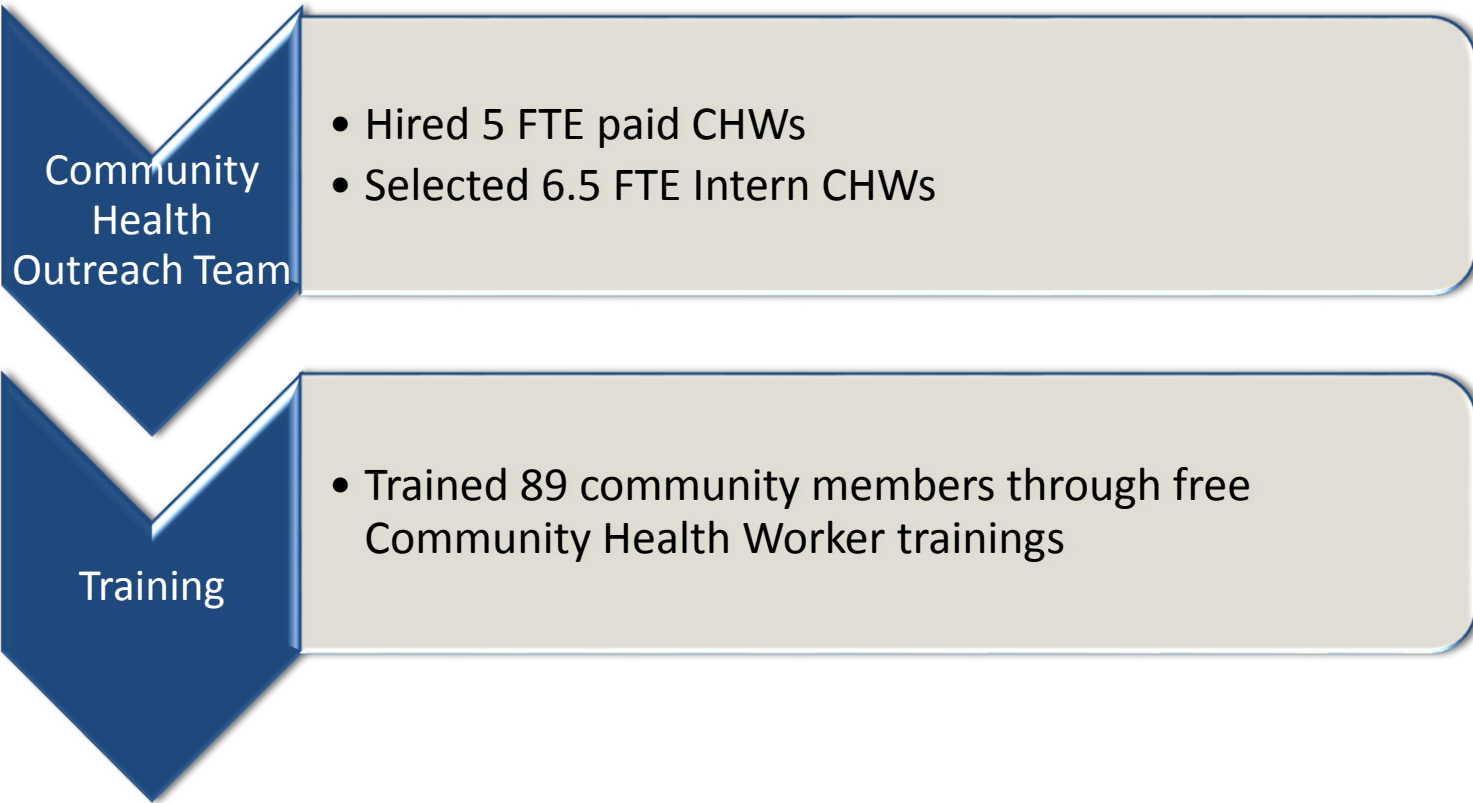
<u>Strategy</u>	<u>Outcomes</u>
Tax Credits and Loan Repayment	<ul style="list-style-type: none"><li>• 5 Qualifying providers received \$26,205 in State tax credits</li></ul>
Health Career Scholarships	<ul style="list-style-type: none"><li>• Awarded 29 scholarships averaging \$2,500</li><li>• Predominantly for entry level health professional programs (8wk-24month in length)</li><li>• Anticipate 30 FTEs will be filled by scholars by April 2016</li></ul>
PCMH	<ul style="list-style-type: none"><li>• Conducted a Zone wide PCMH training by a contractor for Clinical Partners</li><li>• Purchased online self-study curriculum for use by practices</li></ul>

\***Note:** All numbers are through December 2014.

# Goal: Increased Community Health Workforce\*

## Strategy

## Outcomes



\***Note:** All numbers are through December 2014.



# Goal: Increased Community Resources for Health\*

## Strategy

## Outcomes

### Fitness Classes

- Hosted 11 Free Weekly Fitness Classes with a total of 678 participants
- Yoga, Line Dancing, Zumba, Kick-boxing

### Nutrition Support

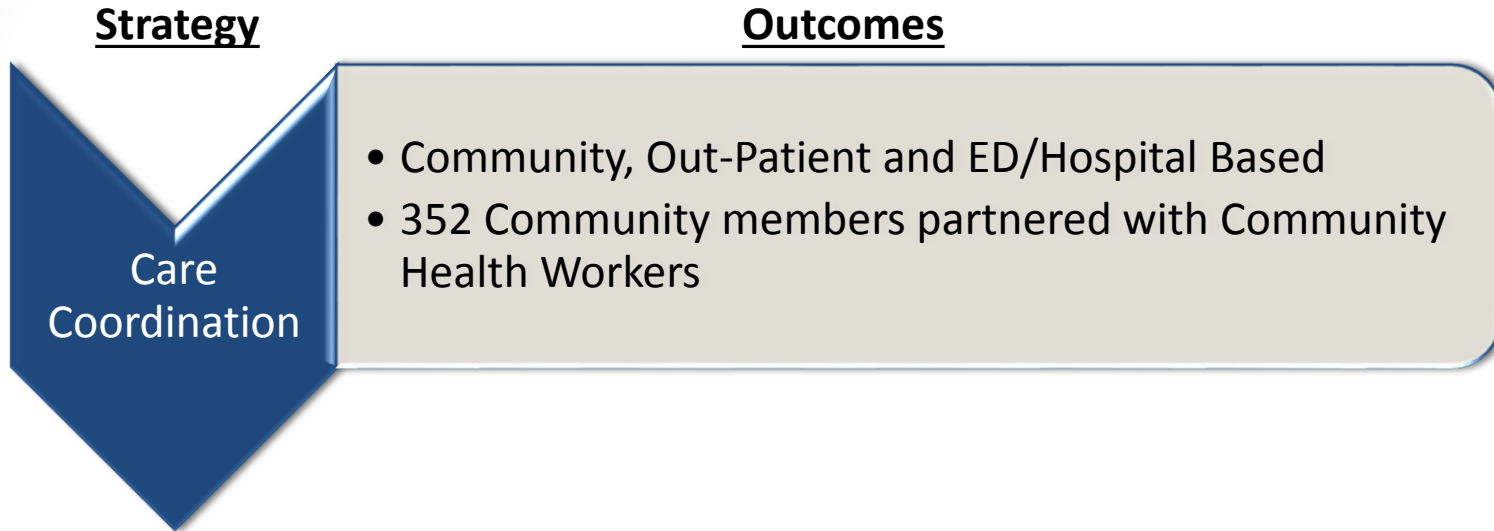
- Promoted and modified DinnerTime for our population
- Web based meal planning platform to aid implementation of medical dietary instruction
- Modified for smart phone use and health literacy level
- Advertised a twice a month Produce Market (collaboration with Bon Secours)

### Engagement

- Awarded \$70,000 to seven community partners for CVD programming
- Held 7 Capacity Building Workshops with a total of 73 participants

\***Note:** All numbers are through December 2014.

# Goal: Reduced Preventable Emergency Department Visits and Hospitalizations\*



\***Note:** All numbers are through December 2014.

# Year 1 and 2 Challenges and Lessons Learned

Challenge	Lesson Learned
1) Data Integrity Due to Multiple Systems used across Partner Organizations and Program Activities	Consolidating data collection mechanisms and responsibilities as much as possible limits errors.
2) Staff Turnover	Choosing individuals who can be flexible in order to work in a pilot program environment where change is constant.
3) Introduction of New Software	Creating a realistic plan for implementation and training improves adoption and creates clear expectations across stakeholders.
4) Ability to identify High Utilizers	The use of a single definition across Clinical Partners and ability to track high utilizers in our database increases our ability to impact legislatively defined outcomes.
5) Alignment of program strategies and budget with legislative intent	Increasing our use of metrics allows us to quickly determine if our strategies/activities work toward the legislative intent of the program.

# West Baltimore Care Year 3: Path Forward

Year 3 Program Change	Expected Benefit
1) Care coordination focus on high utilizers	Better alignment with legislatively specified outcomes and lays the groundwork for sustainability (potential capitated payments by insurance plans)
2) Adding clinical support to CHWs	Enhanced CHW role development and ability to manage day to day clinical aspects of the care coordination program
3) Increased measurement	Improved accountability and provide early notification to change workflow in order to achieve our goals
4) Provider quality incentives	Increased engagement across our HEZ providers to support change management that improves outcomes

# Care Coordination Priorities and Program Redesign Components

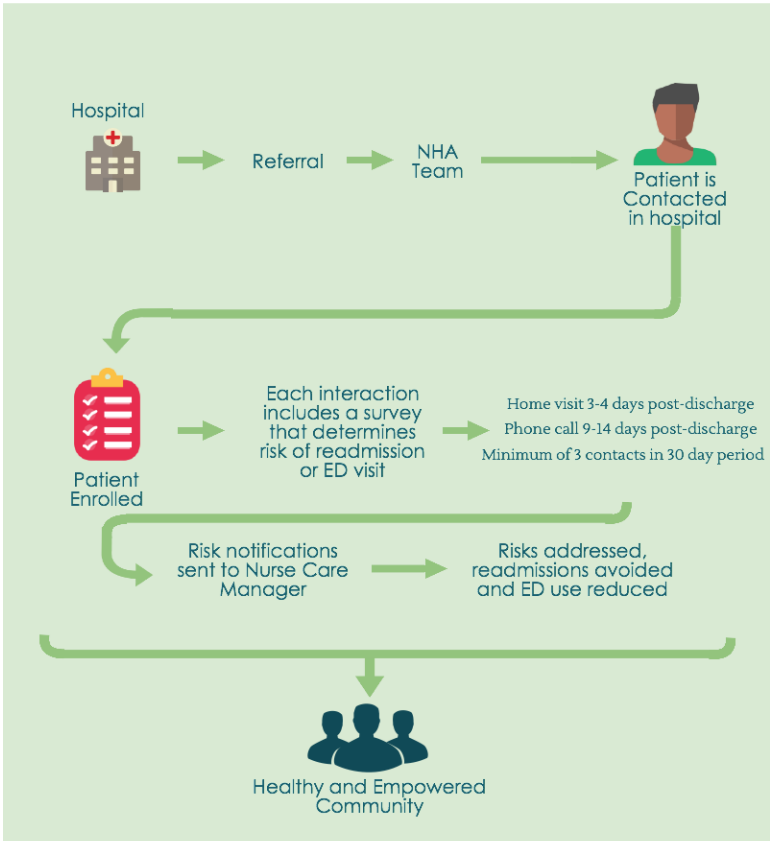
- Continue to target 86,000 West Baltimore residents
  - 1,575 high utilizers who are subset of the 86,000 residents
- Strengthen the connection between hard to reach, high cost populations and primary care providers.
- Address social determinants of health: utilities, housing, food access

## Program Components

- ✓ Added Clinical Expertise Resource for CHWs
- ✓ Two-tiered Care Coordination to Meet High Utilizer Needs
- ✓ Expanded Patient Tracking Software
- ✓ 30-Day Care Plans and Behavior-Based Goals
- ✓ Streamlined Referrals
- ✓ Proactive, Structured Patient Contacts
- ✓ Improved Caseload Management

# Year 3 Care Coordination Redesign

## DRAFT 2015 West Baltimore CARE Care Coordination Workflow



<http://www.healthyywestbaltimore.org/>

## High Impact Objectives and Strategies

- By March 31, 2016, successfully connect 1,125 high utilizers to a Community Health Worker and provide prolonged support to 450 high utilizers.
- By March 31, 2016, Community Health Workers will provide 4,725 encounters via home visits, phone, health screenings and clinic visits.
- By March 31, 2016, successfully connect 100 high utilizers to a primary care provider (PCP).

### Strategies

- ✓ Care Coordination: Re-designed program
- ✓ Technology: Patient Tracking Platform and Care at Hand
- ✓ Referrals from WBPCAC Clinical Partner Hospitals: St. Agnes, Bon Secours, UM Midtown, UM Medical Center, Sinai of Baltimore

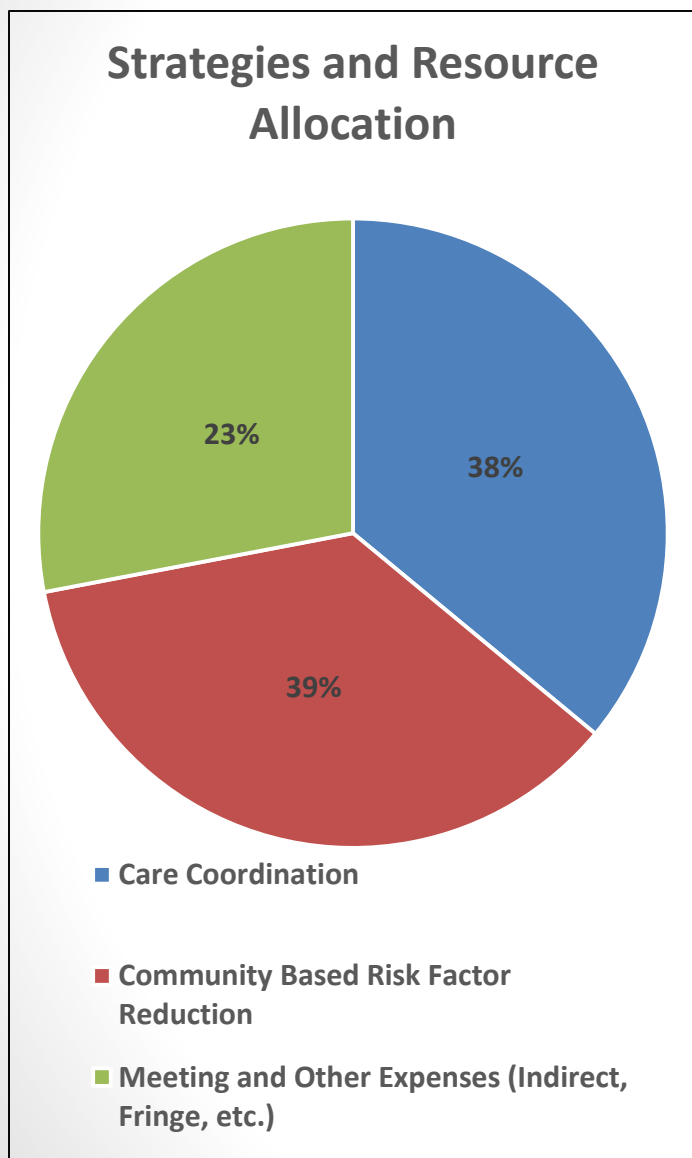
# High Impact Objectives Process Measures and Health Outcome Objectives

Process Measure	Annual Goal*
1) High Utilizers to CHWs (Tier 1)	1,125
2) High Utilizers to CHWs who need prolonged support (Tier 2)	450
3) Home visits	1,125
4) Phone contact	3,150
5) Clinic Visits	150
6) Health Screenings (done at each encounter)	4,725
7) Number of medically homeless participants referred to a PCP	100
8) By March 31, 2016, increase by 3% the percentage of WBPCAC hypertensive adult patients with blood pressures lower than 140/90mmHg.	224**
9) By March 31, 2016, increase by 3% the percentage of WBPCAC diabetic adult patients with LDL-C <100 mg/dL.	272***
10) By March 31, 2016, increase by 3% the percentage of WBPCAC diabetic adult patients with HbA1c under control.	260****

\*Note: Goals are calculated with planned start of program to start in June 2015. \*\* based off of a targeted population of 7,481 (denominator for quality measure ) in calendar year 2013; \*\*\*based off of targeted population of 9,075 in calendar year 2013\*\*\*\*based off of targeted population of 8,650 (denominator for quality measure) in calendar year 2013



# Budget Priorities and Key Interventions



- **Overarching Strategy #1 – Care Coordination (\$453,629- 38% of funding total)**
  - Technology: \$78,800
  - Evaluation: \$23,870
  - Implantation Support: \$350,959
    - \$20,000 (Pilot Implementation, Training, Continuing Education) +
    - \$330,959 (6.5 FTE Assignment)
- **Overarching Strategy #2 – Community-Based Risk Factor Reduction (\$460,500 39% of funding total)**
  - **Strategy 2.1** - Increased Identification and Screening of Individuals with CVD or at risk for CVD: \$118,640
    - \$58,000 (Provider quality incentives) + \$23,870 (clinical measure evaluation) + \$36,770 (biometric assessment vendor)
  - **Strategy 2.2** - Recruitment of Primary Care Professionals and Paraprofessionals: \$20,000
    - \$20,000 State Tax Incentives

# Budget Priorities and Key Interventions

- **Overarching Strategy #2 – Community-Based Risk Factor Reduction (\$456,630- 39% of funding total)**
  - **Strategy 2.3** - Scholarships to Expand Care Teams with Community Members: \$117,878
    - \$97,878 (*scholarships*) + \$20,000 (4 student stipends)
  - **Strategy 2.4** - Patient Education: \$25,000
    - \$25,000 (Nutrition, cooking, disease management and capacity building classes)
  - **Strategy 2.5** - Physical Activity: \$22,000
    - \$22,000 (Fitness classes and incentives)
  - **Strategy 2.6** - Community Partnership Grants: \$50,000
    - \$50,000 (Community Partnership Grants)
  - Implementation Support 2.5 FTE: \$106,982
    - \$10,000 (Training, Facilitation)
    - \$96,982 (FTE assignment)

## Partnerships and Sustainability

- During the past two program years, we leveraged partnerships with 25 organizations across the Zone to provide in-kind and paid activities.
- WB CARE successfully acquired \$132,610 in additional grant dollars to directly support HEZ activities enabling us to provide disease management classes, purchase incentives to promote resident participation in Passport to Health activities, and expand our efforts to aid in meal planning from several granting organizations including PNC Bank, Baltimore City Health Department, and the Family League of Baltimore.
- We have the support of multiple WBPCAC members with fundraising resources committed to expanding these funding relationships in addition to other funding resources such as insurance carriers.
- We plan to evaluate our care coordination model to see if there is a business case for additional funding (i.e., capitated payments) by public or private entities.

# Questions

