West Baltimore
Health Enterprise Zone
HEZ Sustainability Summit

November 3, 2016

Prepared By: Maha Sampath, WBCARE HEZ Director

Our Call to Action

West Baltimore Community Profile

- Approximately 86,000 Residents
- African-Americans comprise more than 76%
- Average median income in this area is $27,158
- **Highest disease burden and worst indicators of social determinates of health than any other community in Maryland**

West Baltimore Patient Profile

- Often unemployed or “working poor”
- Living in and out of crisis
- Frequently on the edge of homelessness
- Three times more likely to have cardiovascular disease than in any other area in the state of Maryland

Our Partners

FQHCs

- Baltimore Medical System
- Park West Health System, Inc.
- Total Health Care, Inc.

Hospitals

- Bon Secours Baltimore Health System
- University of Maryland - Midtown
- St. Agnes Hospital
- Sinai Hospital of Baltimore
- University of Maryland Medical Center

Community-Based Organizations

- Equity Matters
- Light Health and Wellness Comprehensive Services, Inc.
- Mosaic Community Services

Academic Institutions

- University of Maryland
- Coppin State University
- Baltimore City Community College

City and State

- Senator Verna Jones-Rodwell
- Baltimore City Health Department

Our Goals and Strategies for Building a Healthy Community

West Baltimore Health Enterprise Zone (HEZ) Focus

Geographic and Target Population:

- **86,000** West Baltimore residents within the 21216, 21217, 21223, and 21229 zip codes
- **1,200** High Utilizers

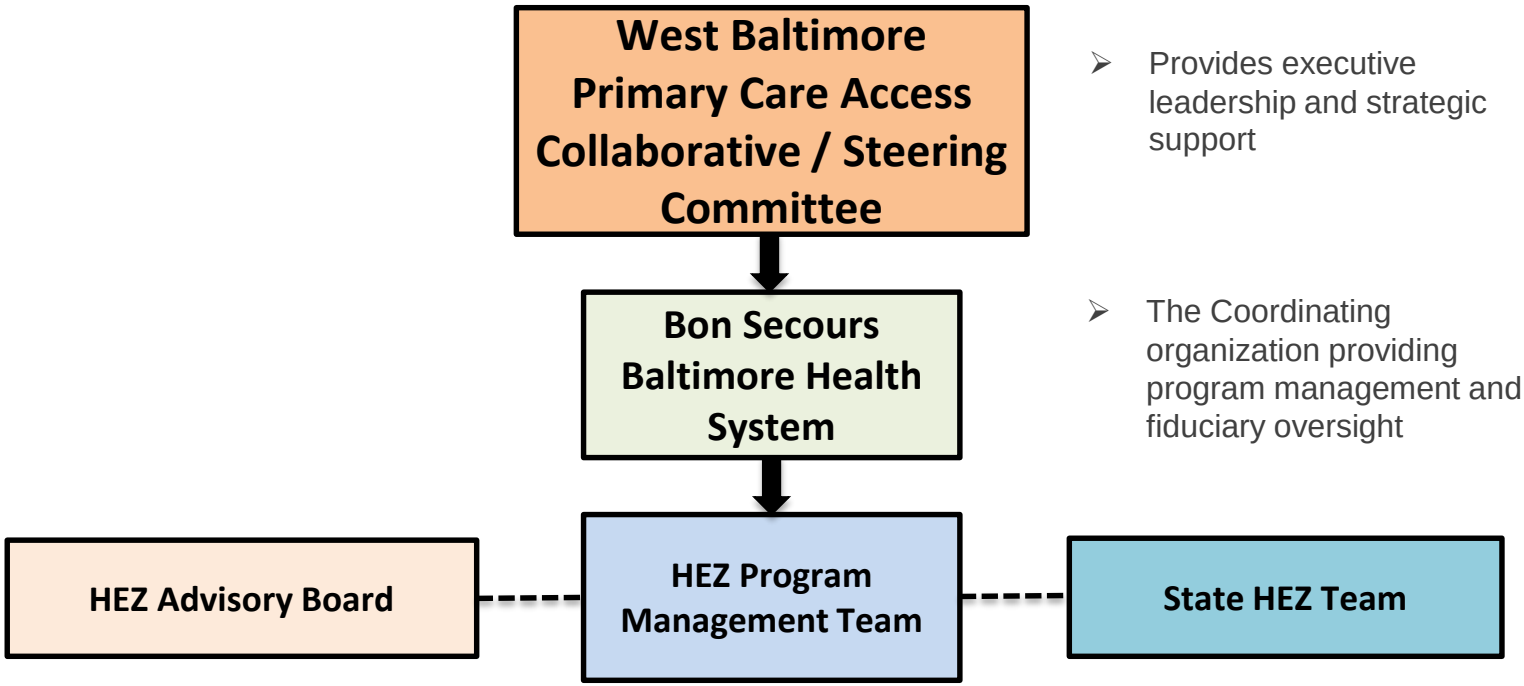
Core Disease and Target Conditions:

- Cardiovascular Disease (CVD)
- CVD Risk Factors (i.e., Diabetes and Hypertension)

Overarching Strategies:

- Care Coordination (Hospital High-Utilizers)
- Community-Based Risk Factor Reduction

HEZ Management Structure

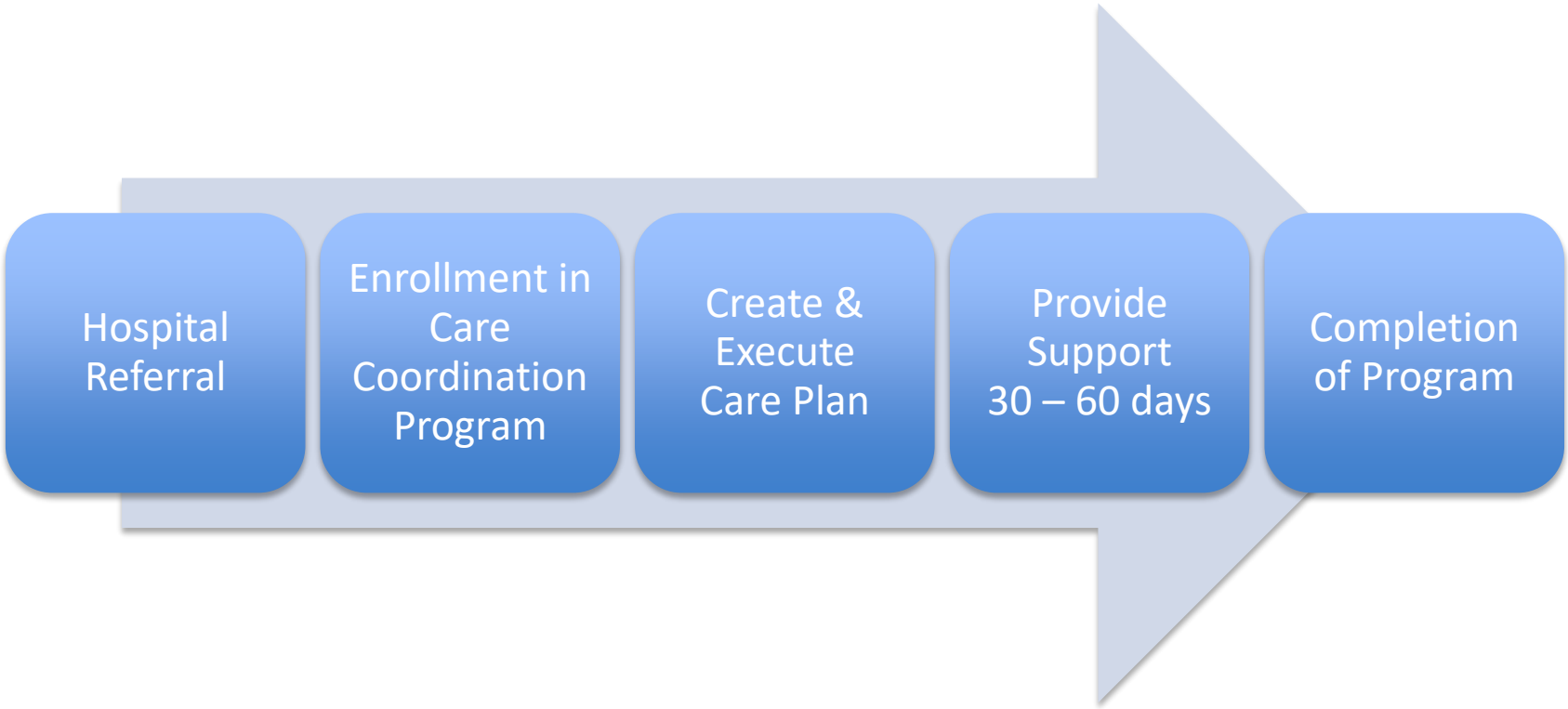


- Provides executive leadership and strategic support
- The Coordinating organization providing program management and fiduciary oversight
- Ensures programs and services are responsive to the health and social services needs and desires of West Baltimore residents
- Responsible for program planning, day-to-day management and oversight
- Provides technical assistance to all HEZ

Care Coordination

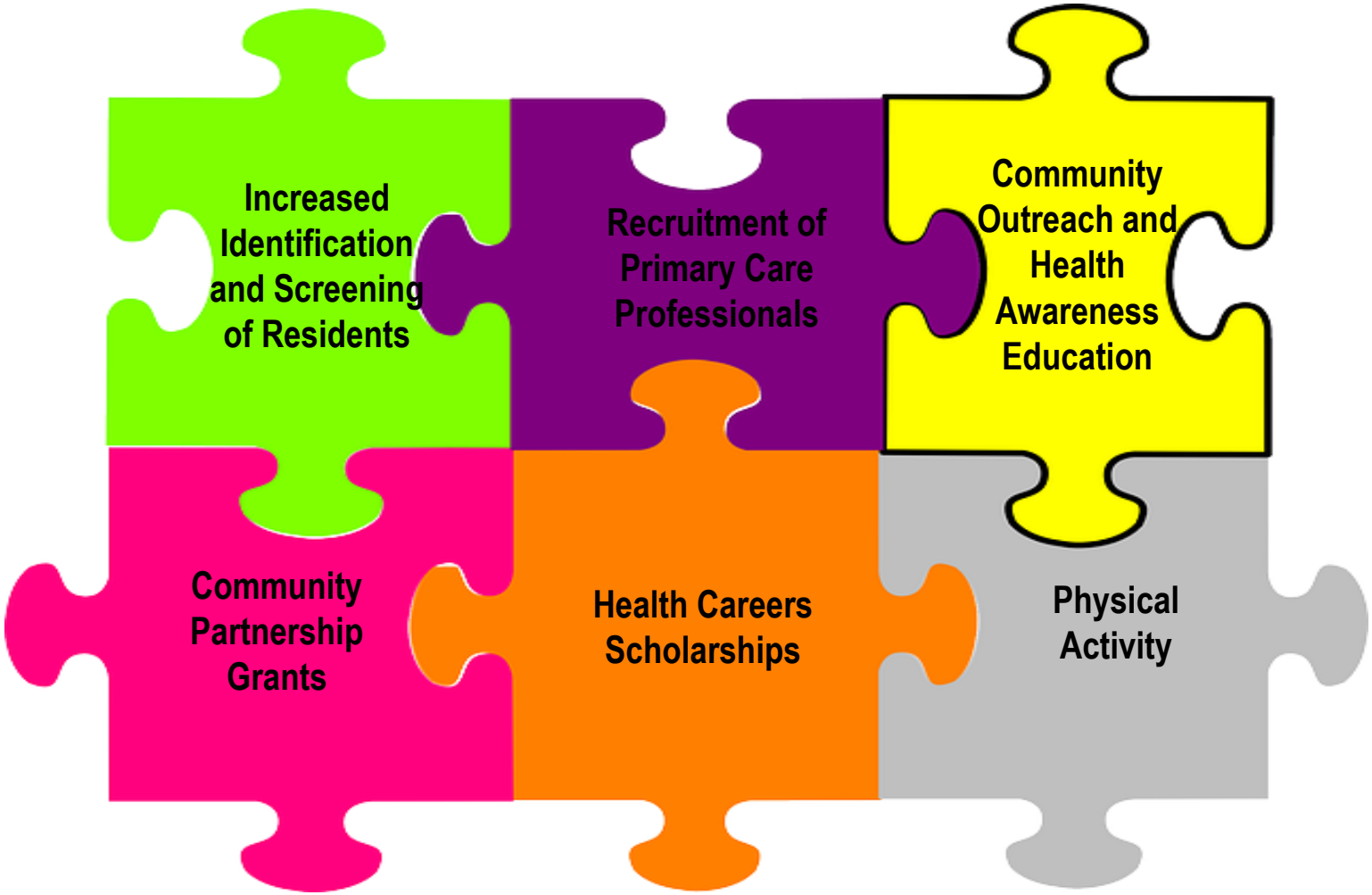
Program Component	Description
Target Population	High Utilizers
Referral Source	HEZ Hospitals (5)
Staffing Model	Includes Program Coordinator, Scheduler, Nurse Care Coordinator, Community Health Workers/Health Coaches
Program Elements	Two-Tier System • 30 Day Intervention – All High Utilizers • 60 Day Intervention – Subset of High Utilizers requiring additional support post 30 day intervention
Tools and Technology	Three complimentary technology systems: CARMA, Care at Hand and CRISP
Evaluation	6 Months Pre-Intervention and 6 Months Post-Intervention using CRISP Reporting

Care Coordination Model



Weekly and Monthly Reporting - # of Referrals, Program Completion, Readmissions

Community-Based Risk Factor Reduction

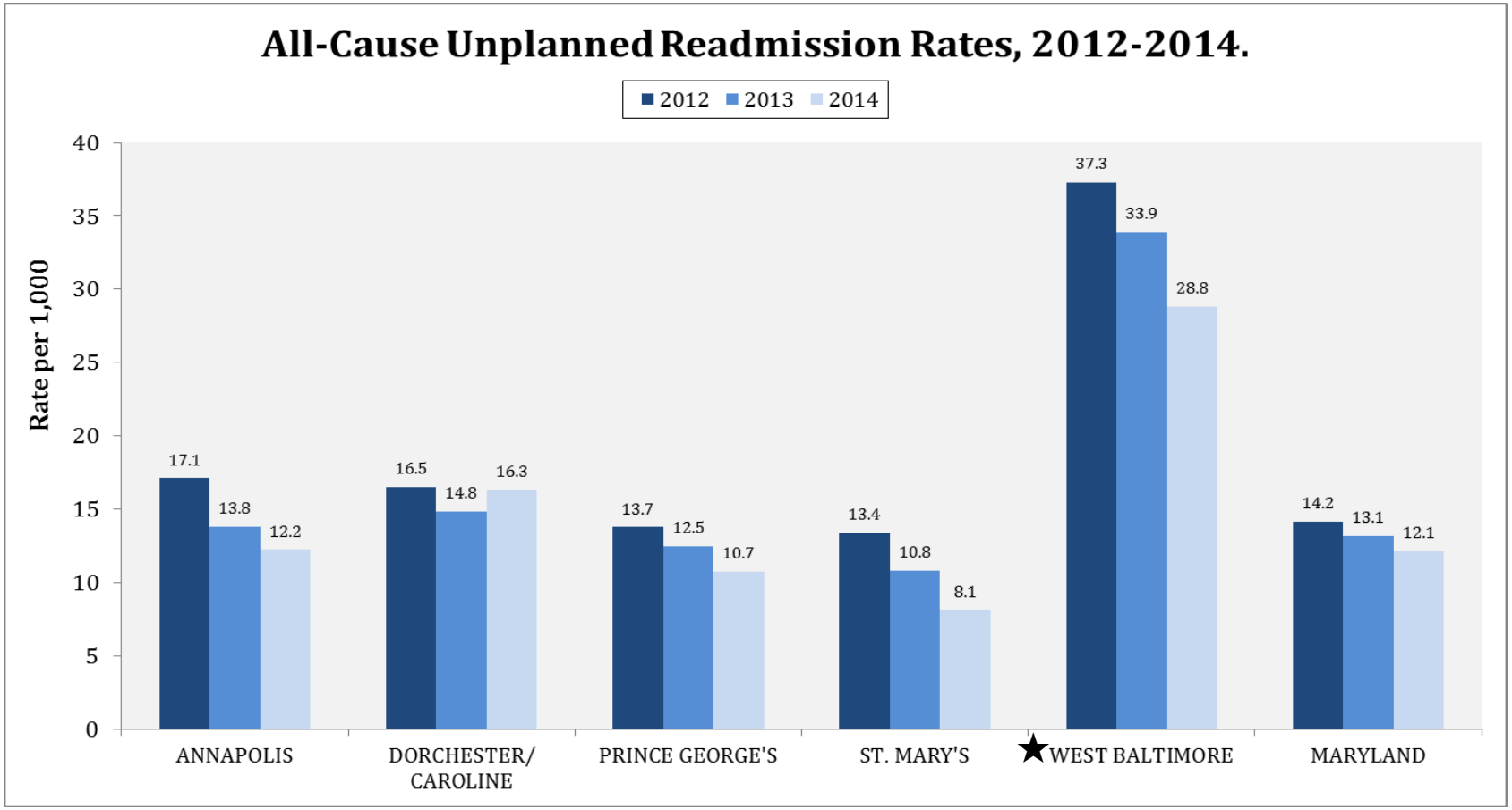


Key Impacts and Outcomes

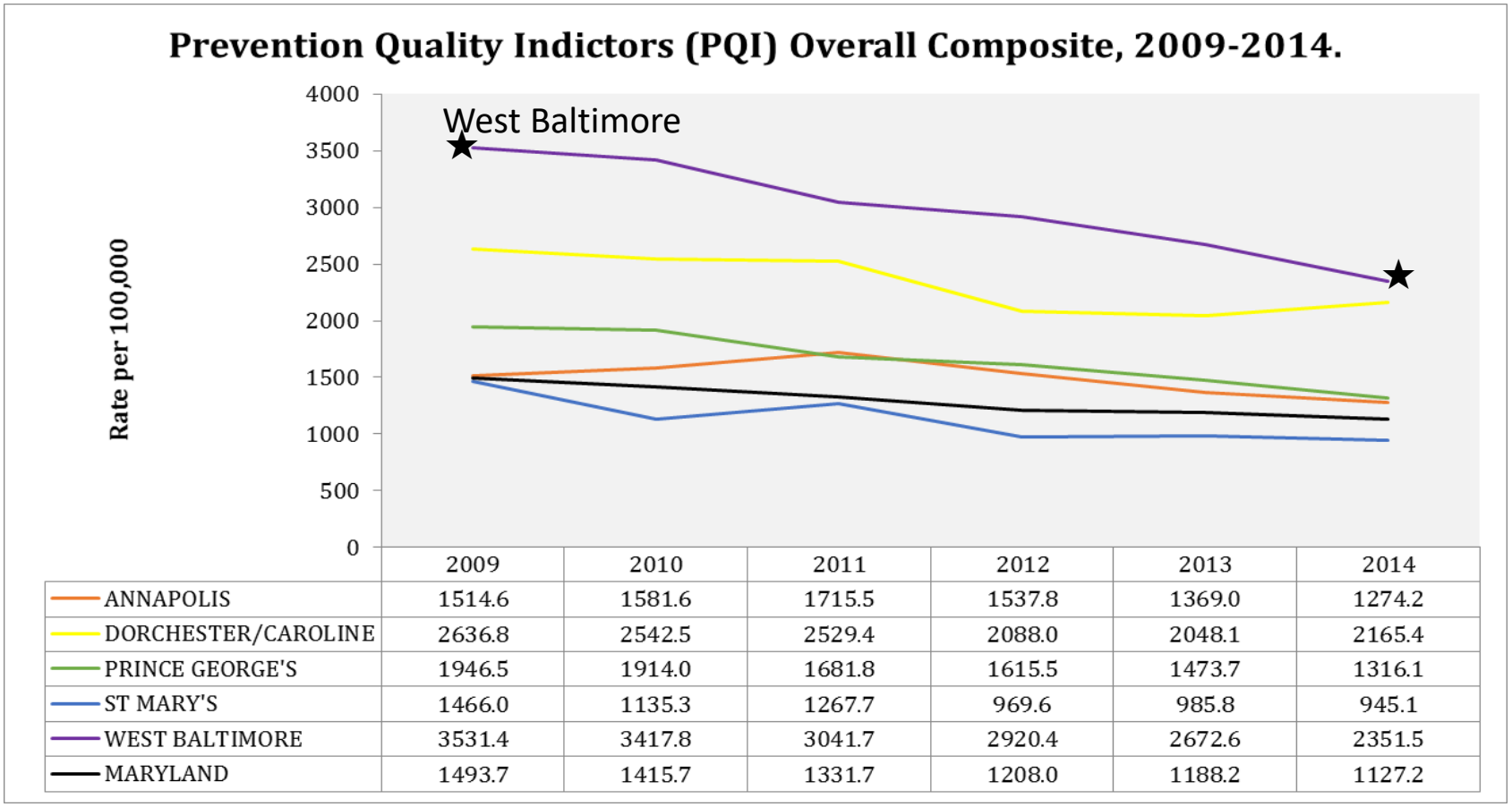
Key Impacts

- Successfully connected 7,200+ high utilizers to a Community Health Worker (CHW)
- Our CHWs completed 7,400+ encounters with high utilizers via home visits, phone, health screenings and clinic visits
- Successfully connected high utilizers to a Primary Care Provider
- Provided State tax credits and loan repayments in the amount of $116K to 17 retain HEZ providers
- Awarded 16 community–based organizations with a total of $130K in to support community CVD programs serving 2500+ residents
- Awarded 85 scholarships totaling more than $250K to HEZ residents to pursue health careers
- Offered free fitness classes for the community in partnership with neighborhood Recreation Centers and Churches
  - From 2015-2016, avg. wt. decrease ~15lbs, avg. BMI decreased ~1.5
- Provided 25 CHW and 1 trauma informed care training(s) and planning in progress for a cultural competency training

Outcome – Readmission Rate Reduction



Outcome – Improved Quality of Care



	2009	2010	2011	2012	2013	2014
ANNAPOLIS	1514.6	1581.6	1715.5	1537.8	1369.0	1274.2
DORCHESTER/CAROLINE	2636.8	2542.5	2529.4	2088.0	2048.1	2165.4
PRINCE GEORGE'S	1946.5	1914.0	1681.8	1615.5	1473.7	1316.1
ST MARY'S	1466.0	1135.3	1267.7	969.6	985.8	945.1
WEST BALTIMORE	3531.4	3417.8	3041.7	2920.4	2672.6	2351.5
MARYLAND	1493.7	1415.7	1331.7	1208.0	1188.2	1127.2

Outcome – Care Coordination Program Specific

- Working with the Chesapeake Regional Information System for Our Patients (CRISP) to analyze and compare hospital ER visits and charges pre and post for patients who completed the HEZ Care Coordination program

- Initial Pre/Post Analysis Report provided specific to one participating hospital only; Preliminary results show some improvements in charges/visits for residents who received HEZ Care Coordination services

- Working with CRISP to refine the report and include data for other participating hospital partners

CRISP

Pre/Post Analysis - Summary

The analysis is based on discharges before and after the enrollment date.

Time Period	Pre-Engagement		Post-Engagement		% Change Pre to Post	
	Total Visits	Total Charges	Total Visits	Total Charges	Visits	Charges
1 Month						
3 Months						
6 Months						
12 Months						

Lessons Learned and Moving to Sustainability

Lessons Learned

- Partners/Model Complexity
  - Clear roles and responsibilities
  - Ongoing engagement and dialogue
  - Competing priorities and multiple care coordination efforts

- Patient Population Challenges (trust, transient, basic resources)
  - Ongoing communication and dialogue
  - Flexibility and agility with shift of focus/scope

- Sustainability
  - Plan for sustainability early on and have funding sources lined up

- Access to Impact and Outcome Data
  - Identify and confirm sources of program data and access upfront

Moving to Sustainability

- Working with Partners to Develop and Execute a Sustainability Plan

  - Reviewed progress against program goals ***(Completed)***
  - Identified critical activities and/or features that facilitated success – **Care Coordination and Scholarship Programs *(Completed)***
  - Identifying partners to support and promote selected programs ***(In Progress)***
    - Assessed ongoing engagement of current partners given competing priorities
    - Explored filing for a 501(c)3
    - Identifying new partners
  - Building a Business Case for Sustainability ***(In Progress)***
    - Programs identified for sustainment align with recently completed Bon Secours Community Health Needs Assessment
    - Finalizing CRISP reporting
  - Seeking funding sources ***(In Progress)***
    - Through a grant from the Kaiser Foundation, Scholarship Program recipients are connected with Bon Secours Community Works to assist with job readiness and placement

Patient Story