Community Provider Services

THE COORDINATING CENTER

INSPIRED SOLUTIONS

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VISION

People of all ages and abilities have equitable access to achieve optimal quality health, affordable housing and meaningful community life.

MISSION

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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ABOUT US

The Coordinating Center is Maryland's premier, nonprofit care coordination organization, with vast experience in delivering community-based care coordination for people with disabilities, and the most complex medical and social needs. The Center holds URAC Accreditation in Case Management and is certified by Maryland Nonprofits Standards for Excellence.

Since 1983, The Coordinating Center has translated national movements into ground level, community-based programs centered on: population health, Medicaid rebalancing initiatives, aging in place, reducing avoidable hospital encounters and homelessness. The Coodinating Center has expertise in partnering to resolve complicated, intractable and costly social and health challenges for some of the state's most vulnerable populations. Working with people who have low incomes, high health utilization rates and/or disabilities, The Coordinating Center locates, coordinates and navigates services for more than 9,200 children and adults. Our innovative programs
improve the health and quality of life for people transitioning from institutions, nursing facilities and hospitals to homes in the community of their choice, while reducing costs to the system and citizens of Maryland.

COMMUNITY PROVIDER SERVICES

The Coordinating Center partners with providers to deliver care coordination services to improve population health. VIPhysicians&Kids is The Coordinating Center's community provider service for pediatric providers. Our VIPhysicians&Kids Care Coordination Team partners with pediatric practices, the patient, and their family to deliver culturally-effective, care coordination services, within a synchronous telehealth patient-centered medical home, for children and youth with special health care needs (CYSHCN), birth – age 22, and their families.

STAFFING

VIPhysicians&Kids interdisciplinary Care Coordination Team includes R.N. Care Coordinators and Certified Community Health Workers who work side-by-side to support CYSHCN and their families.

- R.N. Care Coordinators play a critical role in managing the Shared Care Plan process, responding to ENS alerts generated by CRISP and supporting referrals to services and supports that address medical needs of participants.
- Certified Community Health Workers collaborate with R.N. Care Coordinators and participants by serving as the main point of contact for families, linking CYSHCN and their families to resources that address social determinants of health and transitioning youth services and supports.

OUR IMPACT

- Pediatric providers and families continuously report being highly satisfied with the VIPhyscicians&Kids Care Coordination Team.
- Pediatricians report a reduction between 25-50% of time spent on non-reimbursable time, and more time focused on chronic care management for CYSHCN enrolled in VIPhysicians&Kids. At the same time families are reporting a reduction in time spent on coordinating services and more time focused on chronic health care management and preventative care.
- VIPhysicians&Kids also excels at helping youth with the transition to adulthood, including linking youth and families to adult health care providers and other long-term services and supports.

TARGET POPULATION

VIPhysicians&Kids supports Children and Youth with Special Health Care Needs (CYSHCN). The Federal Maternal Child Health Bureau defines CYSHCN as those who "have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally."

Examples of conditions include, but are not limited to:

Anxiety Disorder
Asthma
Attention Deficit Disorder
Attention Deficit Hyperactivity Disorder
Autism Spectrum Disorder
Behavior Issues(s)
Cancer
Cardiovascular System Disorder
Cerebral Palsy
Cleft Lip/Palate
Cognitive/Developmental Delay
Congenital Disorders
Connective Tissue Disorder
Craniofacial Disorder
Cystic Fibrosis
Dental Conditions
Diabetes Type I and II
Digestive Disorders
Down Syndrome
Dyslexia
Dyscalculia
Eating Disorder
Emotional Disturbance
Endocrine Disorder
Epilepsy/Seizure Disorder
Failure to Thrive/Malnutrition Disorder
Fetal Alcohol Spectrum Disorder
Fragile X Syndrome
Functioning Sensory Processing Disorders
Gastro/Intestinal Issues
Genetic Disorder
Genitourinary Impairments
Hearing Impairment/Deafness
Hematological Disorders
Hepatitis C
HIV
Intellectual Disability
Learning Disability
Mental Illness
Mood Disorder
Motor Delay
Neonatal Abstinence Syndrome
Sickle Cell Disease
Speech or Language Impairment
Spina Bifida
Traumatic Brain Injury
Visual Impairment/Blindness

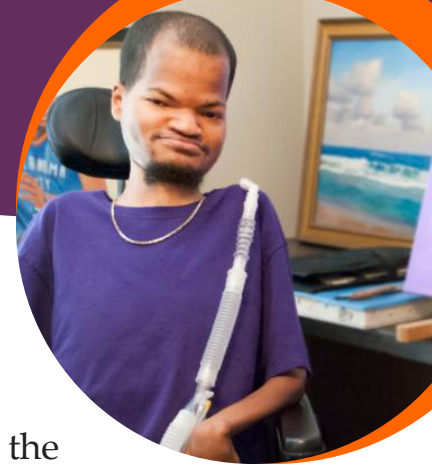
TECHNOLOGY

The Coordinating Center embraces the integration of new technology and care coordination, which are essential in better meeting client outcomes.

- VIPhysicians&Kids Care Coordination Team use a proprietary client management information system designed to capture care coordination and care transition activities. This system, known as CARMA, has interoperability with CRISP, Maryland's regional Health Information Exchange, enabling The Coordinating Center to respond to Encounter Notification System (ENS) alerts.
- The Coordinating Center has a full-service Information Systems Department, a Quality, Improvement and Outcomes Management Department and staff trained in Health Informatics, which enable Care Teams to improve care, ensuring high quality and efficiency.

HOW WE HELP

Our VIPhysicians&Kids Care Coordination Team offers providers the opportunity to reduce time spent on non-medical tasks, and offers participants (CYSHCN and their families) exceptional care coordination services. VIPhysicians&Kids is a one-stop shop for medical and non-medical resources for CYSHCN and their families. The program was developed to help participants address healthcare resources access and coordination barriers, while guiding them along a path of health and wellness promotion. VIPhysicians&Kids participants receive family-centered, coordinated care within a medical home.



Our Care Coordination Team:

- Ensures communication with and among the medical home team is clear, frequent and timely.
- Provides education and tools that promote self-management skills, patient advocacy and health care transition readiness.
- Engages participants in development of Shared Care Plans to address active and high priority needs of participants.
- Anticipates, plans and facilitates transitions (e.g., hospital to home, nursing facility to home in the community, school-based services to adult services, including health care transition).
- Guides and facilitates participant's enrollment into Medicaid Programs and Waivers that support CYSHCN, including the Governor's Transitioning Youth Initiative under the Maryland Developmental Disabilities Administration (DDA).
- Helps participants understand when to see their doctor rather than using the Emergency Department (ED).
- Responds to Encounter Notification System (ENS) Alerts generated by CRISP, Maryland's Health Information Exchange.
- Facilitates access to services and supports such as: assistive technology, behavioral health services, caregiver support/ respite, durable medical equipment, food/nutritional needs, healthcare transition, medical day programs, transportation assistance, assistance with discharge, planning from hospital to home, and other community services.
- Leads collaborative care coordination huddles with pediatric practices to support Shared Care Plans. Huddles are tailored to each practice's preference for method and frequency.

Sample of VIPhysicians&Kids Work Flow at The Coordinating Center

Referral

Provider referral is sent to The Coordinating Center

Outreach

Contact family within two business days of referral to conduct enrollment call.

Enrollment

To be completed during an enrollment call with referred families:

- **Discuss barriers to care and issues identified on the provider referral form**
- **Identify gaps in care, current medical needs, and social determinants of health**
- **Determine short- and long-term goals**

Shared Care Plan

- **R.N. Care Coordinator develops a Shared Care Plan, incorporating short- and long-term goals identified during enrollment discussion**
- **Distribute Shared Care Plan to the referring Provider**
- **Implement Shared Care Plan with family**

Tier 1: Active Participants

Newly enrolled participants (CYSHCN and their families) receive:

- Weekly phone calls during the first month from their Care Coordination Team.
- Continued support through care coordination services

Tier 2: Passive Engaged

Participants who have completed short-term goals in Shared Care Plan receive:

- Contact with their Care Coordination Team as needed (participant determines frequency)
- Support for long-term goals and new care coordination needs
- Additional resource supports

Tier 3: Passive Disengaged

Participants who have not completed short-term goals or have become unable to contact are disenrolled from the program

Ongoing

- Respond to ENS Alerts generated by CRISP
- Ongoing communication with providers regarding participant's progress towards meeting goals in Shared Care Plan
- Participants receive The Coordinating Center's quarterly e-newsletter on advocacy and community resources, including advocacy training

PARTNER WITH US

The Coordinating Center is well positioned to compliment health care systems* community providers as partners to achieve positive health outcomes in the community. In addition to healthcare priorities, our experienced Care Coordinators help people access a wide variety of public and private services and community resources while providing strategies to address the totality of a person's needs.

We deliver customized care coordination and care transition services that meet the specific needs of the population identified as high risk or "at risk" with the goal of improving quality of care and reducing overall healthcare costs. The Center has the experience and expertise needed to quickly and effectively roll out and implement a program that meets the needs of your organization.

OUR PARTNERS

- *Health Care Systems: Hospitals, Physicians/Providers and Managed Care Organizations
- Long-term Services and Supports: Medicaid and Medicare
- Community Organizations and Providers
- Government and Policy Makers

WHY CHOOSE THE COORDINATING CENTER?

Person-Centered
Personal goals drive The Coordinating Center's approach to helping individuals and caregivers achieve optimal health and independence.

Inspires Change
The Coordinating Center advocates for policy and system change that positively affects the lives of people with the most complex needs.

Rich History of Innovation
Since 1983, The Coordinating Center has translated national movements into ground-level, community-based programs including Transitions of Care, Hospital Encounters including Readmission Reduction, Aging in Place and addressing homelessness.

Leaders in Change
Team members are sought out to serve on national, regional and local initiatives that address disabilities, care coordination, transitions of care, older adults and affordable housing.

Qualified Professionals
The Coordinating Center employs over 250 highly qualified individuals including certified case managers, licensed social workers and nurses, community health workers, housing specialists and supports planners who live in the communities we serve.

Driven By Results
The Coordinating Center is a data driven organization using best practices and evidence-based models to achieve quality outcomes and proven return on investment.

Experts in the Field
The Coordinating Center has been rooted in the community for more than three decades and has access to a wide network of resources.

Commitment to Excellence
The Coordinating Center is accredited by URAC, an independent organization that promotes healthcare quality standards and by the Maryland Nonprofits Standards for Excellence, which ensures accountability and high ethical standards.

Widely-Known and Well Respected
The Coordinating Center is the largest independent, nonprofit community care coordination organization in Maryland and an active leader in healthcare transformation.

Partner with Us
The Coordinating Center provides a customized approach for the most complex populations with public and private payers, hospitals, government and community providers.