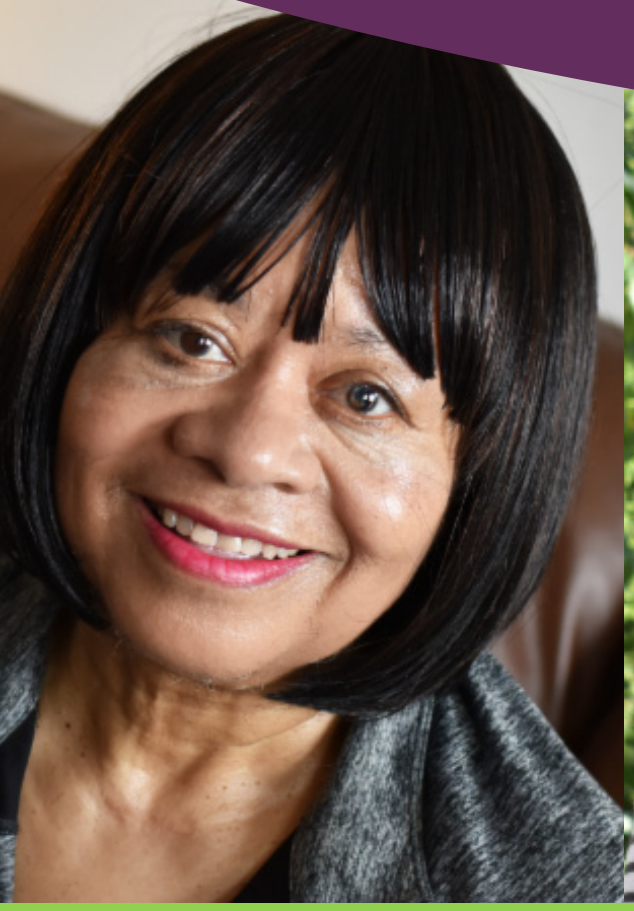

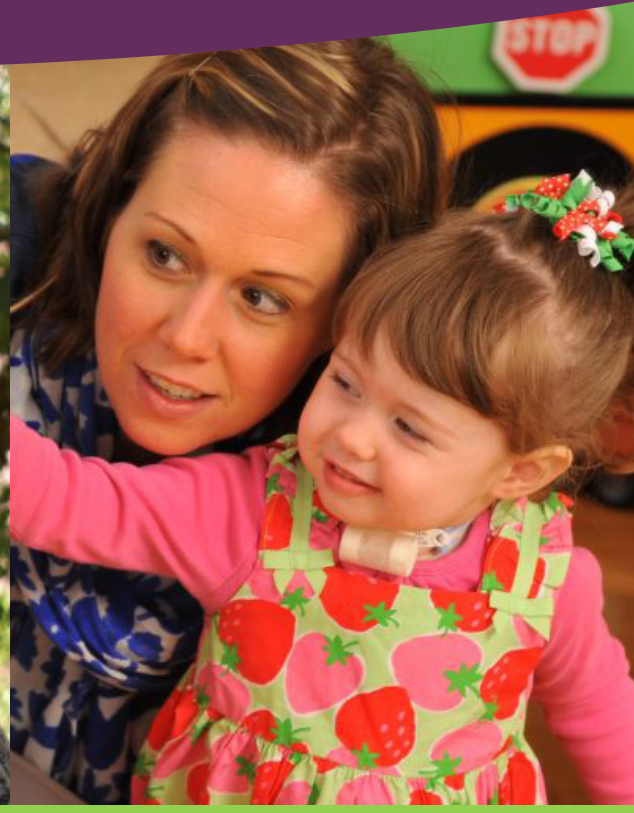

Hospital Services

THE COORDINATING CENTER

INSPIRED SOLUTIONS

CoordinatingCenter.org | The Coordinating Center 8531 Veterans Highway, 3rd Floor, Millersville, MD 21108 | (410) 987-1048

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.

THE COORDINATING CENTER

INSPIRED SOLUTIONS

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 Coordinating 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.

HOSPITAL SERVICES

Get Well is The Coordinating Center's signature coaching and care coordination program, designed with evidenced-based practices for people with a history of frequent hospital encounters and social correlates. **Get Well** is your solution to reducing readmissions and avoiding hospital encounters.

OUR IMPACT

The **Get Well** team has a proven track record of improving care transitions among individuals at high risk for hospital care and targets specific interventions to mitigate potential adverse events. **Get Well** increases communication between providers and individuals, offering tools and support that encourage individuals and their caregivers to more actively participate in the transition from hospital-to-home.

Get Well's 30-day intervention focuses on four pillars based on CTI®:
1) Medication Self-Management
2) Use of a Dynamic Patient-Centered Record
3) Primary Care and Specialist Follow-Up
4) Knowledge of Red Flags and Early Symptoms

For individuals with continued high risk of hospital encounters beyond the 30-day intervention, the Get Well team is available to provide an additional 30-day intervention. If additional services are needed beyond 60-days, comprehensive ongoing care coordination, inclusive of re-assessment of needs, is available.

STAFFING

Our **Get Well Team** is comprised of **Community Health Workers** who are supervised and supported by a l**icensed R.N.**, who help members avoid unnecessary hospital use, adhere to preventative health schedules and access vital clinical and community resources.

- Care Teams can be enhanced to include a **Program Liaison** who facilitates enrollment in Get Well pre-discharge and/or a **Program Support Specialist** to assist with administrative and scheduling support, as well as coordination of resources to address social determinants of health.
- To better support individuals, Care Teams generally live in the communities they serve.
- Our staffing ratio is one Community Health Worker to 25-30 individuals (i.e., patients).

TECHNOLOGY

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

- Care Teams use a proprietary client management information system designed to capture activities related to coaching, care management, care coordination and care transition. This system, known as CARMA has interoperability with CRISP, Maryland's designated Health Information Exchange (HIE), enabling The Coordinating Center to respond to Electronic Notification System (ENS) alerts in real time through Doc Halo secure texting.
- Our Care Teams also have experience documenting in other Electronic Medical Health Record Systems, such as Epic.

QUALITY

In addition to a full-service Information Systems Department, The Coordinating Center has 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.

The Coordinating Center is certified by URAC case management accreditation, and has successfully participated in the NCQA Health Plan certification process three times over the past 14 years, meeting all requirements and standards. Additionally, The Coordinating Center recently achieved 100% passing score for MCO annual Delegation Audit.

WE HELP INDIVIDUALS BY

- Meeting them **face-to-face** in the hospital, their home and in the community
- Supporting individuals post-discharge in accessing health and community-based services
- Utilizing **Motivational Interviewing** to identify personal motivators and goals to adhere to health maintenance plans
- Focusing on the four pillars based on CTI®
- Ensuring communication with and among the medical home team is clear, frequent and timely
- Helping individuals handle issues that may keep them from getting **the right care, at the right time and in the right place**
- Assisting with coordination and participation in medical appointments, as well as access to durable medical equipment and disposable medical supplies
- Helping individuals understand when to see their doctor rather than using the Emergency Department (ED)
- Explaining services, supports and options available through **Medical Assistance** (Maryland Medicaid), Medicaid policies and procedures, as well as locating other non-Medicaid/community resources to address Social Determinants of Health (SDOH)
- Guiding and facilitating enrollment into supportive and **long-term support systems** within the State of Maryland
- Anticipating, planning and facilitating **transitions** (e.g., hospital to home, nursing facility to home, school-based services to adult services, including health care transition)
- Locating affordable and accessible housing, providing housing supports and training individuals in the area of good tenancy topics
- Helping coordinate personal attendant care providers to assist with activities of daily living (ADLs) or instrumental activities of daily living (IADLs)

Sample of Get Well Program Work Flow at The Coordinating Center

(Note: Can be customized to meet hospital's requirements)

Referral

Hospital referral is sent to The Coordinating Center via Doc Halo

Outreach

Get Well Team Member meets the individual (i.e., patient) at the hospital pre-discharge to enroll in Get Well and begin to identify potential transition needs and barriers to care.

Evaluation

An evaluation is completed within one week post-discharge, preferably in their home.

- Review discharge summary, current medications, follow up needs and SDOH
- Identify personal motivators and goals
- Develop a plan to address the individual's needs

30 Days

- Avoid immediate rehospitaliziation and Emergency Department Encounters
- Focus on the four pillars and identify and address barriers to care
- Begin to coach and coordinate care by addressing the individual's most acute needs and resolving barriers to care

60 Days

- Following re-evaluation, continue to support the individual who is a Persistent Risk for Hospital Encounters (e.g., due to Advanced Complex Illness, behavioral/mental health, multi-faceted SDOH)
- Continue to identify and address barriers to care and facilitate additional resource supports to address the risks

90+ Days

- Following re-evaluation, continue to support the individual who is a Persistent Risk for Hospital Encounters (e.g., due to Advanced Complex Illness, behavioral/mental health, multi-faceted SDOH)
- Facilitate additional resource supports to address the risks and guide enrollment into supportive and long-term support systems within the State of Maryland

Ongoing

- Focus on medication self-management, physician follow-up, early symptoms and personal health record
- Avoid immediate rehospitalization and ED encounters
- Respond promptly to ENS Alerts generated by CRISP
- Facilitate and participate in case management rounds with hospital

PARTNER WITH US

The Coordinating Center is well positioned to partner with health care systems* in achieving positive health outcomes for their members. 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 management services including care coordination and care transition services that meet the specific needs. 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.