



Community Provider Services



THE COORDINATING CENTER

We Are Stronger Together.

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 a 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 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 10,000 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

VIP Connect, The Coordinating Center’s premier service for community providers, specializes in coaching and care coordination services for people with special health care needs (CYA-SHCN). This person-centered, telehealth medical home program is dedicated to advancing medical, oral, and behavioral health optimization by emphasizing preventative care, self-management skills, facilitating resource access, and addressing social determinants of health.

Staffing

VIP Connect’s interdisciplinary Care Coordination Team includes Certified Community Health Workers and R.N. Consultants who work side-by-side to support CYA-SHCN and their families.

- Certified Community Health Workers collaborate with providers and program participants to address social determinants of health and care coordination needs, providing linkages to resources and services.
- Certified Community Health Workers manage the short- and long-term goals, respond to ENS alerts generated by CRISP, Maryland’s regional health information exchange, in collaboration with a Registered Nurse Consultant, and facilitate referrals to services and supports that address medical needs of participants.

Our Impact

- Providers and families continuously report being highly satisfied with the VIP Connect Care Coordination Team.
- Providers report a reduction between 25-50% of time spent on non-reimbursable tasks, and more time focused on chronic care management for CYA-SHCN enrolled in VIP Connect. 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.
- VIP Connect 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

VIP Connect supports Children and Young Adults with Special Health Care Needs (CYA-SHCN). People with special health care needs are defined by the Council on Clinical Affairs as those with “physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs.”

Examples of conditions include, but are not limited to:

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

Technology

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

- VIP Connect Care Coordination Team use a proprietary information management 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 VIP Connect Care Coordination Team offers providers the opportunity to reduce time spent on non-medical tasks, and offers participants (CYA-SHCN and their families) exceptional care coordination services. VIP Connect is a one-stop-shop for medical and non-medical resources for CYA-SHCN and their families. The program was developed to help participants access health care resources, navigate care coordination barriers, and address social determinants of health needs, while guiding them along a path of health and wellness promotion. VIP Connect participants receive family-centered, coordinated care within a medical home.

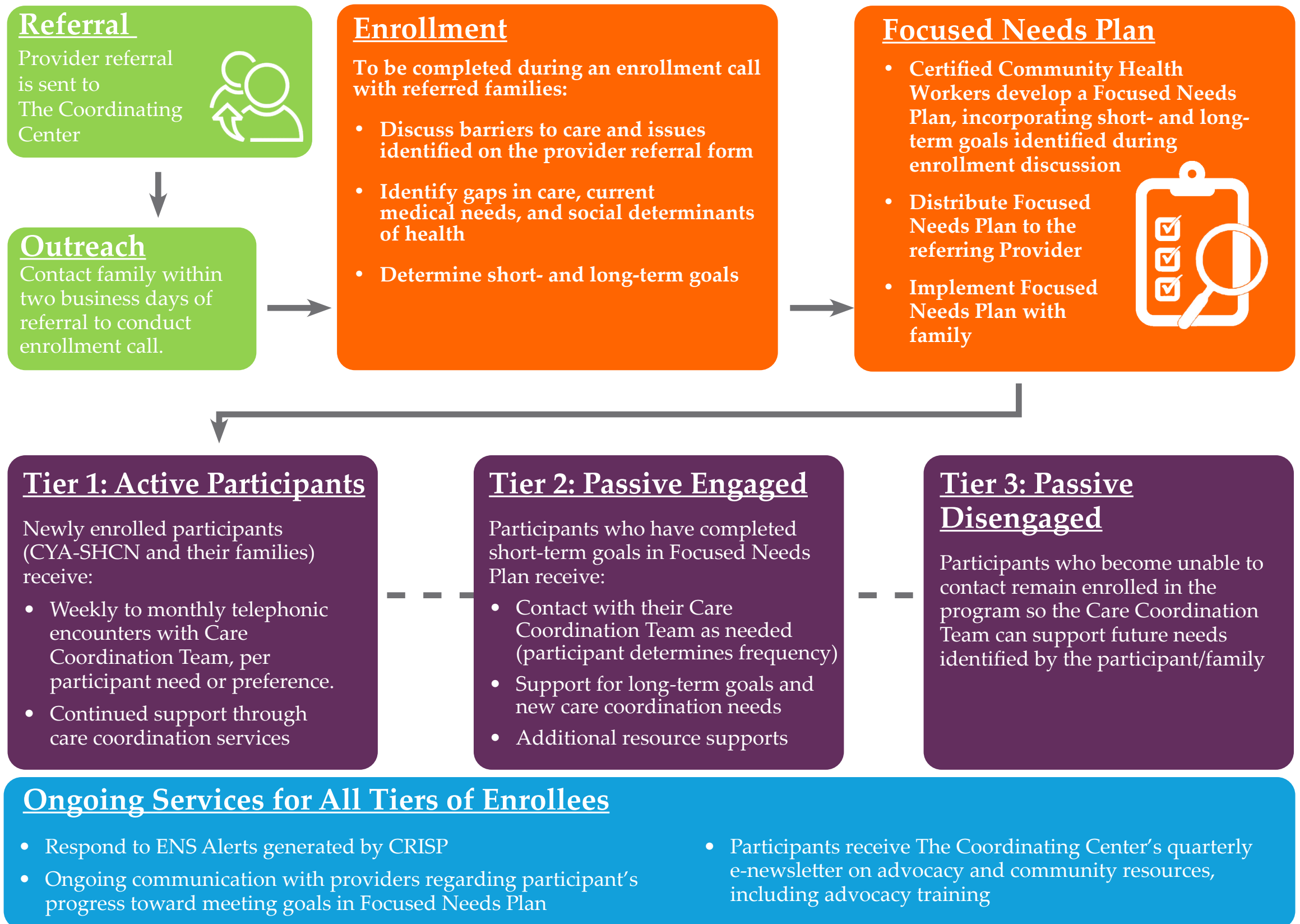


Our Care Coordination Team:

- Ensures communication with and among the medical home team is clear, frequent and timely.
- Provides education and tools that promote self-management competence, advocacy skills and health care transition readiness.
- Engages participants in development of Focused Needs 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 CYA-SHCN, 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, dental/oral health services, behavioral health services, caregiver support/respite, Durable Medical Equipment (DME), 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 Focused Needs Plans. Huddles are tailored to each practice's preference for method and frequency.



Sample of VIP Connect Work Flow at The Coordinating Center



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 Coordinating 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, Federally Qualified Health Centers (FQHC), and Managed Care Organizations (MCO)
- 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 four 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.