| **Baltimore HELPS (Health Eating Leading Partnerships for Seniors)** | | | | | |
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| **Using Data to Drive Dramatic Improvement in Baltimore City Community Work Plan**  **March 2013** | | | | | |
| **Task Description** | **Activity/Approach** | **Start Date** | **Completion Date** | **Status** | **Expected Outcome** |
| DFMC will use Medicare Claims Data to identify and select target areas | DFMC works with CFMC to drill down Medicare claims data by chronic condition by zip code to identify locations that have Medicare beneficiaries with chronic disease and available resources that can be pooled to implement a short-term, rapid cycle improvement project. Consideration will also be given to areas in need with less existing attention and/or activities. | September 27, 2012 | February 28, 2013 | Completed | Two areas with low life expectancy, high mortality and high chronic disease burden were selected (Oliver and Sandtown/Poppleton) |
| DFMC will work with coalition partners to share data as a means for strengthening community collaboration around addressing senior health. | DFMC will develop data use agreements with coalition partners to share relevant Medicare data. | September 27, 2012 | August 31, 2013 | Ongoing | Formation of engaged, activated, and self-sustaining coalition. |
| *PDSA CYCLE #1:*  Coalition partners will convene to identify areas of greatest need in terms of addressing senior health and health outcomes around diabetes and hypertension. | Baltimore City Health Department, as well as local businesses, public health groups, care providers, community activists, and seniors are convened and provided a brief overview of the SIP project. Community identifies existing programs and services that could address the scope of the SIP project. | September 27, 2012 | January 16, 2013 | Completed | Existing programs are identified and commitment made by coalition partners to make them available. |
| Coalition partners will identify and engage seniors with the highest need. | The Baltimore City Health Department’s Neighborhood Health Initiative and Senior Care Services will use community feedback, asset mapping, CFMCs community characterization report, and shared data to determine the areas that should receive assistance.  DFMC works with coalition partners to identify and recruit sites within these communities to host the project  DFMC seeks approval from senior community to offer programs and services. | September 27, 2012  September 27, 2012  September 27, 2012 | January 6, 2013  March 22, 2013  March 20, 2013 | Completed  Completed  Completed | High need, high-risk areas are identified and targeted by coalition partners.    Physical locations for service delivery are identified based on available resources among coalition partners.  Seniors and senior advocates at physical locations approve package of programs and services offered by coalition partners. |
| DFMC and coalition partners will develop a strategy for sustaining. | DFMC will facilitate monthly meetings and one-on-ones to ensure the sustainability of the project | September 27, 2012 | September 1, 2013 | Ongoing | Baltimore HELPS project becomes a self-sustaining coalition. |
| Coalition partners will develop a package of programs and services to serve as a “one-stop service center” at two locations. | DFMC works closely with coalition of partners to develop a strategy for addressing senior health and health outcomes around hypertension and diabetes that includes:   1. Improved access to healthy, affordable food 2. Physical Activities 3. Nutrition education 4. Assistance with insurance and available benefits 5. Wellness Visits | September 27, 2012 | May 1, 2013 | Ongoing | Two different demonstration sites were selected: one senior center and one residential tower.  Seniors are engaged in both the programs offered on-site and actively engaged in promoting the HELPS project. |
| *PDSA CYCLE #2:*  DFMC works with local health clinic partner to establish a clinical correlation for the impact of this project. | DFMC assists People’s Community Health Centers to create a process for identifying and administering AWV to all eligible seniors entering their clinic.  AWV will then be expanded to both off-site locations for eligible senior as well.  Each senior will receive a personal wellness plan at the end of their visit and a small sample of seniors (20%) will be contacted prior to the conclusion of the project to determine change in behavior or health status as a result of available programs. | September 27, 2012 | August 18, 2013 | In Planning Phase | Increased utilization of AWV  Improved health status of participating seniors. |