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# The Community Health Partnership of Baltimore

**Linda Dunbar, Ph.D., R.N.**
**Vice President , Population Health**
**Johns Hopkins HealthCare**

# Maryland's Vision for Health Care Transformation

- Transform Maryland's health care system to be ***highly reliable, highly efficient, and patient-centered***. HSCRC and MDH envision a health care system in which ***multi-disciplinary teams can work with high need/high-resource patients to manage chronic conditions in order to improve outcomes, lower costs, and enhance patient experience***. Through aligned collaboration at the regional and state levels, the state and **regional partnerships** can work together to ***improve the health and well-being of the population***.
- In June 2016, HSCRC awarded ***14 Regional Partnerships*** across Maryland to enable partnerships amongst communities, hospitals, and healthcare providers and to address the physical, behavioral, and social needs of complex Medicare patients and to support the overall performance goals of the Maryland All-Payer Medicare Model Contract.

# The Maryland Health Services Cost Review Commission

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JOHNS HOPKINS MEDICINE — JOHNS HOPKINS BAYVIEW MEDICAL CENTER

JOHNS HOPKINS MEDICINE — THE JOHNS HOPKINS HOSPITAL

SINAI HOSPITAL — a LifeBridge Health center

Mercy MEDICAL CENTER

Johns Hopkins HealthCare LLC
Management Services Organization

Sisters Together and Reaching, Inc. (STAR)
"Advocating and Providing Optimal Health and Wellness"

M&FC The Men and Families Center

HEALTH CARE for the HOMELESS

- Community Care Teams
- Neighborhood Navigators
- Convalescent Care
- Mental Health Bridge
- Patient Engagement Program
- JHOME (Home-based Primary Care)

# CHPB Goals

Our goal is to coordinate care for patients with complex medical, behavioral,  and / or social challenges to improve their health outcomes.

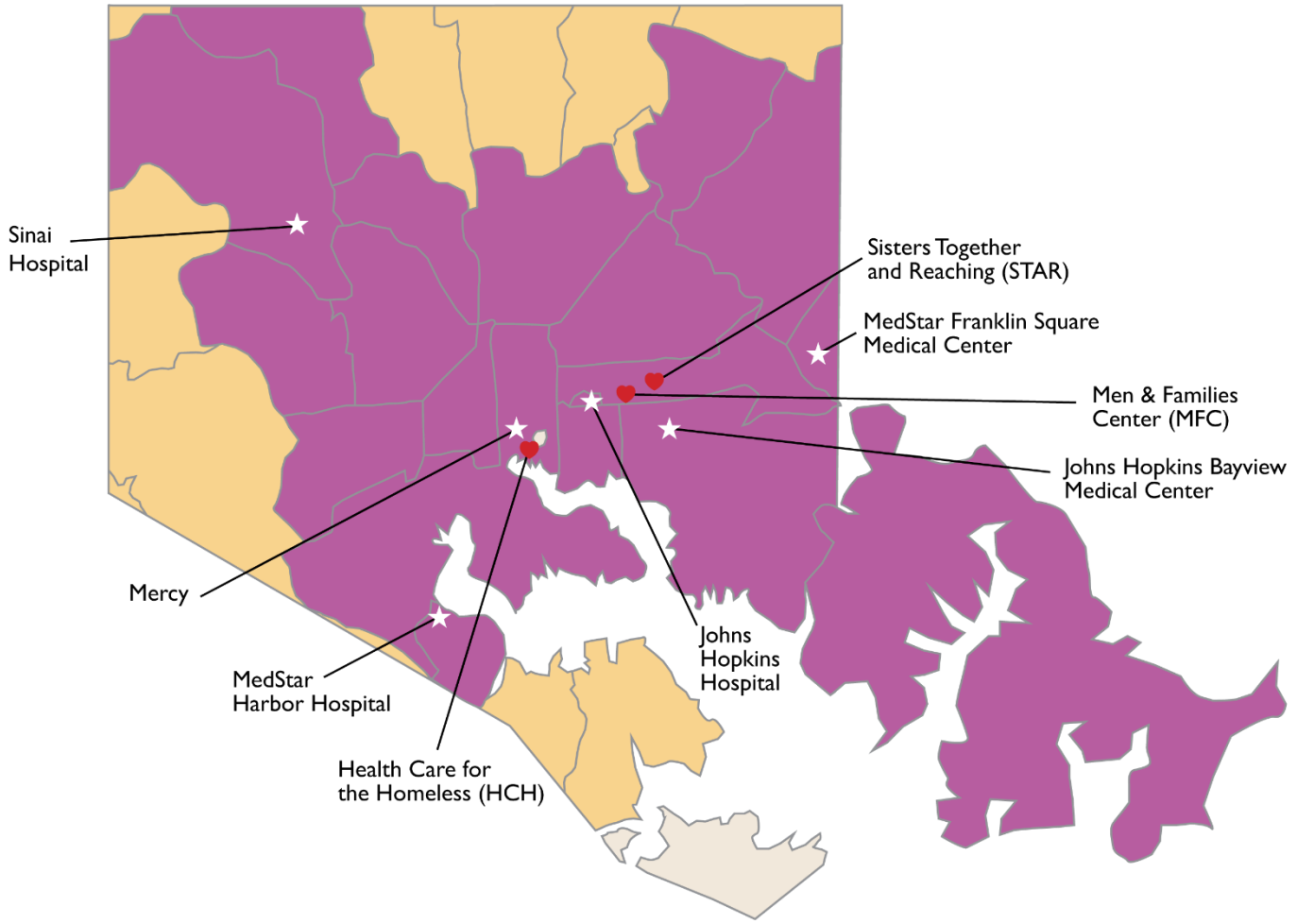
We focus on addressing current gaps in the delivery of healthcare services that lead to poor health outcomes and high utilization of inpatient and ED services.

The Community Health Partnership of Baltimore (the “Partnership”) is *an effective way to transition Medicare and Dual Eligible patients into reliable, neighborhood care.*

# Our Patients

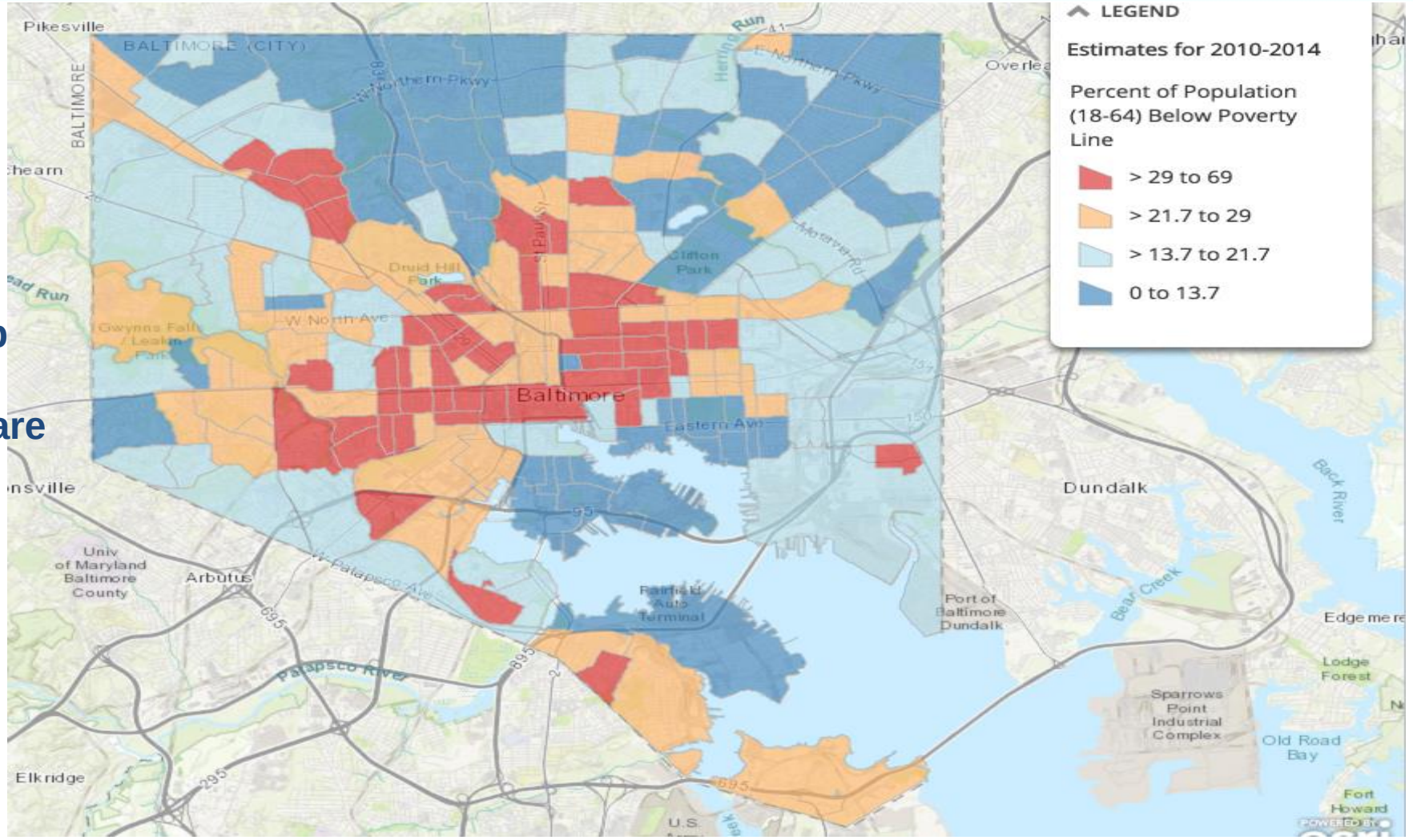
Our patients are prioritized with the following eligibility criteria:

1. High-risk: 3+ hospital bedded events over 12 months;
2. Medicare FFS and/or dual eligible; and
3. Residing within 19 Baltimore zip codes / Partner Hospital catchment areas

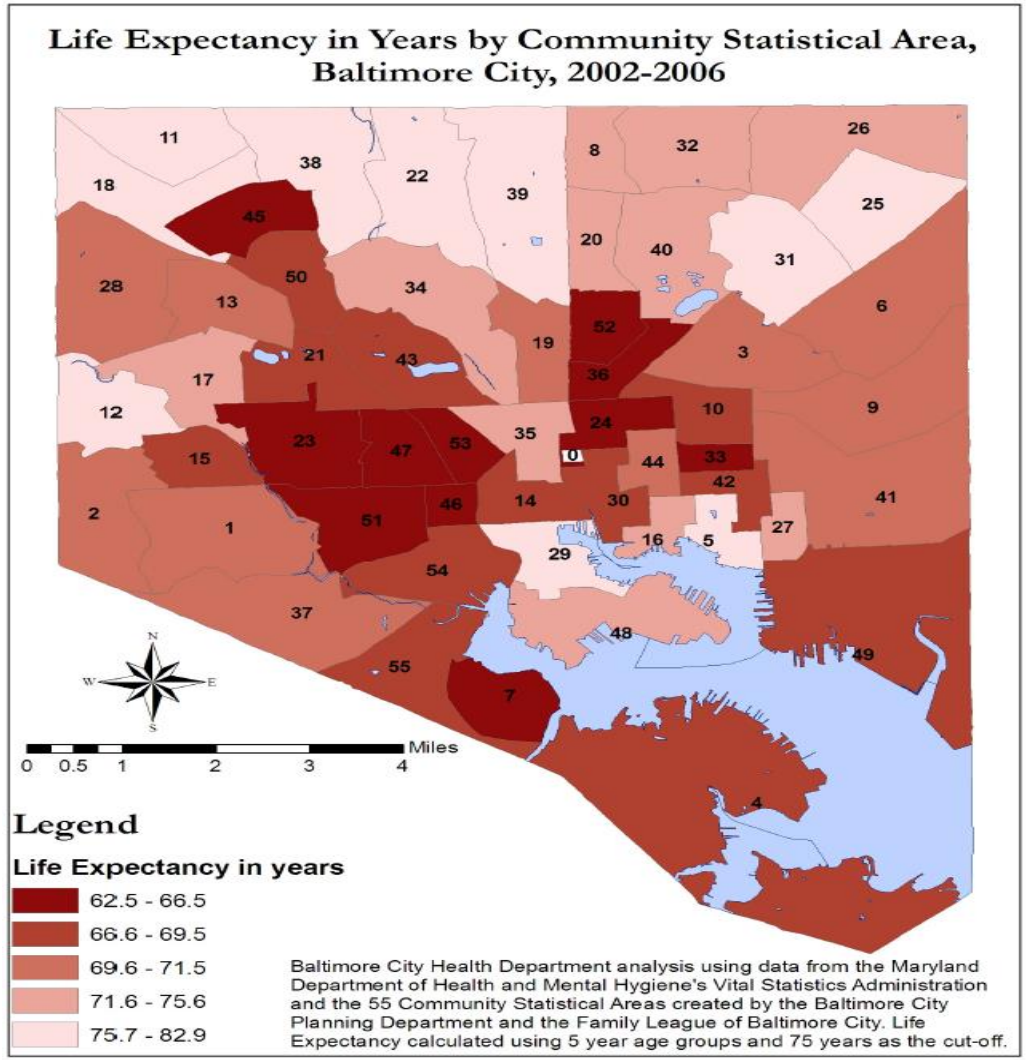


# Percent living in Poverty by Census Block

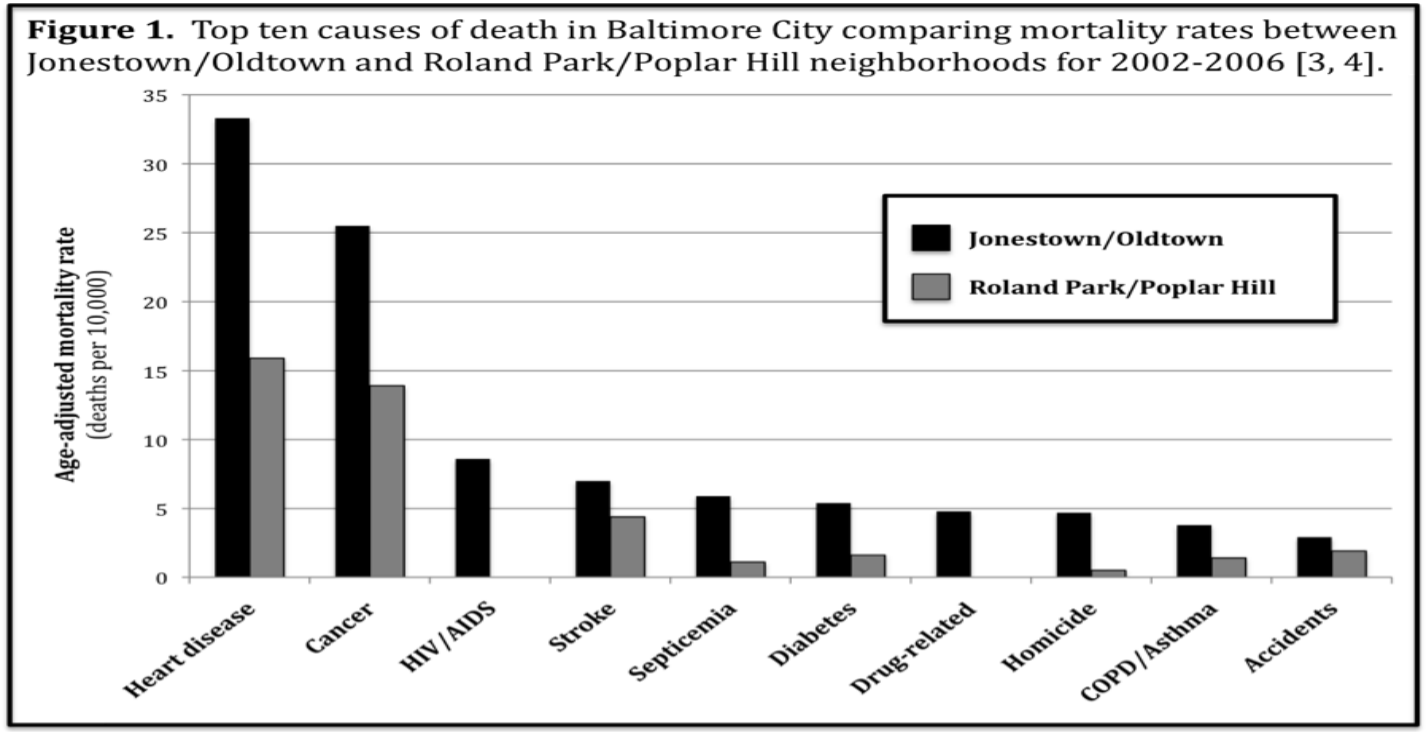
**High percentage of poverty in the Community Health Partnership catchment areas; High-cost and high-need Medicare patients with multiple social determinants of health**



# Baltimore: Health and Social Disparities

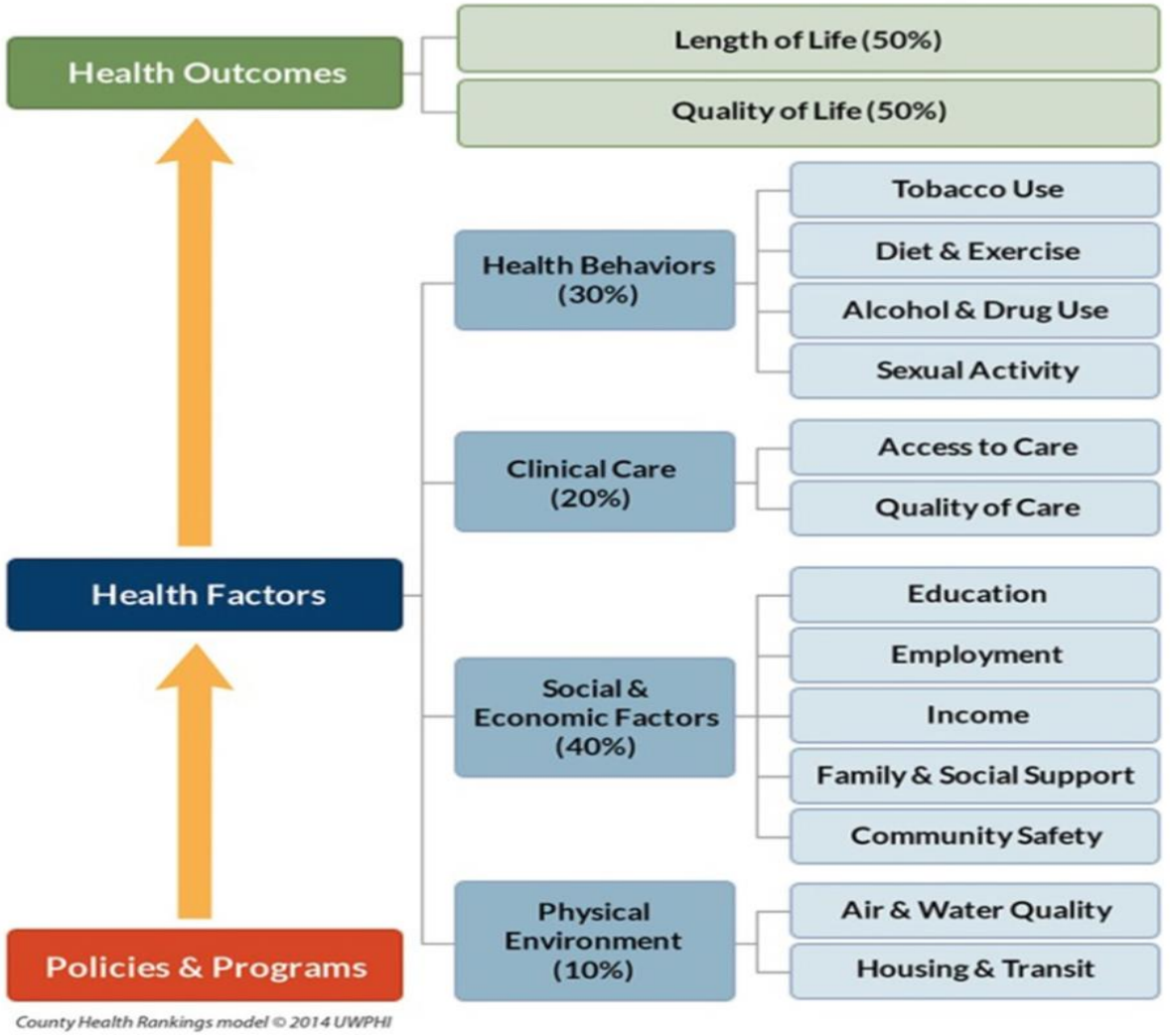



- 20 year difference in life expectancy
- Major portion of mortality difference due to treatable conditions



# What Drives Health Outcomes?

- Studies demonstrate that social and economic factors may contribute most to health outcomes (40%)
- Health behaviors, including substance abuse, diet and exercise contribute 30% to these outcomes
- Key: Changing health outcomes requires a focus beyond just “clinical care and coordination”




Source: University of Wisconsin Population Health Institute: County Health Rankings 2013. Accessible at www.countyhealthrankings.org.

# WHO: Social Determinants of Health

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The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

http://www.who.int/social_determinants/en/

# Defining Social Determinants of Health (SDH)

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| Economic Stability | Neighborhood and Physical Environment | Education | Food | Community and Social Context | Health Care System |
|---|---|---|---|---|---|
| Employment | Housing | Literacy | Hunger | Social integration | Health coverage |
| Income | Transportation | Language | Access to healthy options | Support systems | Provider availability |
| Expenses | Safety | Early childhood education | | Community engagement | Provider linguistic and cultural competency |
| Debt | Parks | Vocational training | | Discrimination | Quality of care |
| Medical bills | Playgrounds | Higher education | | | |
| Support | Walkability | | | | |

**Health Outcomes**
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

THE HENRY J. KAISER FAMILY FOUNDATION

# Improving health

Six population health interventions were developed to achieve the goals of reducing unnecessary health service utilization, decreasing costs, and improving health for patients in the zip codes represented. The interventions include:

- Community Care Teams (CCTs)
- Mental Health Bridge Team
- JHOME
- Neighborhood Navigator
- Patient Engagement Program
- Convalescent Care

Sisters Together and Reaching, Inc. (STAR)
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# Intervention: Community Care Teams

**CCTs expand upon existing services of primary care providers to meet the needs of a high-risk population and coordinate care. Weekly rounding sessions and communication among providers. 10 regional teams consisting of:**

1. **Care Managers (CMs): Nurse or Social Worker (n=10)**
2. **Community Health Workers (CHWs) from Sisters Together and Reaching (STAR) (n=20)**
3. **Health Behavior Specialists (HBS): Social Workers (n=5)**

M&FC
The Men and Families Center

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# Intervention: Neighborhood Navigator

**The Men and Families Center Neighborhood Navigators are trained volunteers (10 hours per week) who outreach clients around their neighborhood (street level relationship) to engage residents about available health care and social service resources.**

**Roles include: relationship building, social support, education, resource connection, linkage to care, employment/training connections, legal services, and surveillance of unmet social needs**

HEALTH CARE for the HOMELESS

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# Intervention: Convalescent Care

- Provide people experiencing homelessness who are discharged from a Partner hospital a place to stay, rest, and recuperate from an acute illness or surgery.
- Patients receive 12-hour-a-day nursing services (medication education, care coordination, and wound care) and social work services to link patients to housing, income, mental health, and addiction services
- CHPB funds 12 beds (total 25 beds at HCH)
- Interdisciplinary care team: nurses, medical providers, social workers

# Intervention: Mental Health Bridge Team

**Multi-disciplinary team that works with patients exhibiting complex psychiatric needs, Substance Use Disorder (SUD), and other complex case management needs associated with behavioral health.**

- **Goal: Facilitate a successful transition to a medical home and effectively engage these patients in behavioral health services**
- **Team: Psychiatrist, Health Behavior Specialist Team Lead, and 2 Behavioral Health Community Health Workers**
- **Referrals: Hospital Partners' Emergency Departments, Acute Care**

# Intervention:
# J-HOME

- **A community-based program that provides home-based medical care, care management, caregiver support, counseling, and acute inpatient continuity to high-need, high cost home-bound individuals on a longitudinal basis**
- **Builds on the foundation of the current Johns Hopkins Bayview Medical Center HBPC program to expand to JHH and Sinai Hospital (J-HOME)**
- **Team: Program Director, Geriatrician, NP, Social Worker, RN, Practice Manager, Patient Service Coordinator, LPN**

# Intervention: Patient Engagement Program

**Patient Engagement Program (PEP) initiative trains providers and staff on the tactics and skills needed to facilitate patient engagement, effect health behavior change, and promote patient satisfaction**

**This includes training staff and physicians utilizing a number of formats, including skill building and maintenance and learner evaluation**

# Community Health Partnership: Improving Population Health in Baltimore

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# Contact Information

Linda Dunbar, PhD, RN

Vice President, Population Health

ldunbar1@jhmi.edu

410-361-7910