Community Health Partnership Baltimore

National Academy of Medicine
Care Culture and Decision-Making Innovation Collaborative

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Maryland Health Reform Landscape

Maryland Waiver Performance Dashboard
Cumulative Performance – Years 1, 2 and 3

- **ALL-PAYER HOSPITAL SPENDING GROWTH PER CAPITA**
  - Maryland Performance: 4.14%
  - Cumulative Target: 11.13%
  - Period: Jan '14 - Dec '16 vs. 2016 ceiling
  - Data: HCRC monthly financial data

- **MEDICARE HOSPITAL SPENDING GROWTH PER BENEFICIARY**
  - Maryland Performance: $538 million in savings
  - Cumulative Target: $132 cumulative savings at year 3
  - Period: Jan '14 - Dec '16 vs. 2016 target
  - Data: CMS data

- **MEDICARE ALL PROVIDER SPENDING GROWTH PER BENEFICIARY**
  - Maryland Performance: -1.63%
  - Cumulative Target: 0%
  - Period: Jan '14 - Dec '16 vs. 2016 target
  - Data: CMS data

- **MEDICARE READMISSION RATE**
  - Maryland Performance: -6.08%
  - Cumulative Target: -4.90%
  - Period: Jan '14 - Dec '16 vs. 2013 Base Year
  - Data: CMS data, V. 6

- **MARYLAND HOSPITAL ACQUIRED CONDITIONS RATE**
  - Maryland Performance: -43.33%
  - Cumulative Target: -19.28%
  - Period: Jan '16 - Dec '16 vs. Jan '13 - Dec '13
  - Data: HCRC data

Data contain summaries provided by the federal government that have been prepared for Maryland, but are not official federal data. Data are preliminary and contain lags in claims. There may be material differences in results when final data are received.
Maryland Health Reform Landscape

- Health Information Exchange (HIE): Enabling healthcare providers to transfer data through electronic networks among disparate health systems
- In 2009, the Maryland Health Care Commission and the Maryland Health Services Cost Review Commission designated Chesapeake Regional Information Exchange System for Patients (CRISP) as the Maryland state-wide HIE
- All Maryland hospitals have CRISP connectivity
Background

• Maryland Health Services Cost Review Commission (HSCRC) released RFAs in 2015 to establish regional based partnership programs

• Regional Partnerships (RPs) were designed to address the physical, behavioral, and social needs of complex Medicare FFS patients through enhanced care coordination

• RPs support the overall performance goals of the Maryland Waiver

• CHPB is 1 of 9 Maryland Regional Partnerships

• CHPB is funded through 6 Partner Hospitals in Baltimore

• CHPB established operational infrastructure in 2016

• CHPB launched it’s population health programs in 2017
Community Health Partnership Baltimore: Hospital Partners
Community Health Partnership Baltimore: Community Based Organization Partners
Presentation Outline

• CHPB Governance
• Patient Identification
• Individual Interventions
  • Descriptions
  • Dashboard Summaries
Community Health Partnership of Baltimore

Health Services Cost Review Commission (HSCRC)

- Johns Hopkins Hospital
- Johns Hopkins Bayview Medical Center
- Sinai Hospital
- Mercy Medical Center
- MedStar Franklin Square Medical Center
- MedStar Harbor Hospital

CRISP

- Sisters Together & Reaching
- Men & Families
- Health Care for the Homeless

Matrix

Community Based Organizations

- MSO Johns Hopkins HealthCare

Interventions invested in by all 6 Hospital Partners

- Community Care Team: JHH, JHBMHC, Sinai, Mercy, MedStar FS, MedStar Harbor
- Bridge Team: JHH, JHBMHC, Mercy, Sinai, MedStar FS, MedStar Harbor
- Convalescent Care: JHH, JHBMHC, Mercy, Sinai, MedStar FS, MedStar Harbor
- Home-Based Primary Care: JHH, JHBMHC, Sinai
- Neighborhood Navigators: JHH, JHBMHC, MedStar FS, MedStar Harbor
Community Health Partnership of Baltimore
Governance & Meeting Structure

Committee Structure

- Steering Committee
  - Operating Committee
    - CQI Subcommittee
    - Finance Subcommittee
    - Analytics Subcommittee

Intervention Workgroups
- Bridge Team
- Community Care Teams
- Home Based Primary Care
- Convalescent Care
- Patient Engagement Training
- Neighborhood Navigators
Intervention Eligibility

• Eligibility Criteria:
  • Payer: Medicare and/or Dual Eligible patients
  • Utilization: 3 or more hospital contacts over 12 months
  • Geography: 19 zip codes in Baltimore
    • Partner hospital catchment
CHPB PARTNERSHIP DATA FLOW FOR PATIENT IDENTIFICATION

Signed Agreements between Partners and MSO

- Johns Hopkins Hospital
- Johns Hopkins BMC
- Sinai Hospital
- Mercy Medical Center
- MedStar Franklin Square Hospital
- MedStar Harbor Hospital

MSO Analytics team

High Risk Patients Lists with Contact Info

CHPB Programs
CHPB ANALYTICS TEAM

• IDENTIFY HIGH-RISK PATIENTS FOR INTERVENTION
• GENERATE OPERATIONAL REPORTING DASHBOARDS
• CONSULT ON MEASURES, DATA CAPTURE, COMMUNITY PARTNER PROGRAMS
• SUPPORT CQI EFFORTS ACROSS CHPB PROGRAMS
INTERVENTIONS

• COMMUNITY CARE TEAMS
• BRIDGE
• CONVALESCENT CARE
• HOME BASED PRIMARY CARE
• NEIGHBORHOOD NAVIGATOR
• PATIENT ENGAGEMENT TRAINING
COMMUNITY CARE TEAMS
CCT OVERVIEW

• CCTs expand upon existing services of primary care providers to meet the needs of a high-risk population and coordinate care

• 10 regional teams consisting of:
  • Care Managers (CMs): Nurse or Social Worker
  • Community Health Workers (CHWs) from Sisters Together and Reaching (STAR)
  • Health Behavior Specialists (HBS): Social Workers

• Weekly rounding sessions and communication among providers
CCT REPORTING

• REPORTING SYSTEM: Epic and JCare
• CHPB DASHBOARD REPORTING
  • Patient Demographics
  • Utilization Status
  • CCT Enrollment
    • Risk / Referral -> Outreach -> Enrollment
  • Goal Success (CHW, CM, HBS)
  • Patient Case Closure
  • Intervention Capacity
BRIDGE TEAM
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 Peer Support Specialists

• **Referrals**: Hospital Partners’ Emergency Departments, Acute Care, PCP offices directly to Bridge Team
BRIDGE REPORTING

- REPORTING SYSTEM: Epic
- CHPB DASHBOARD REPORTING
  - Referrals
  - Enrollment
  - Patient Demographics
  - Length of Stay
  - Goal Success
  - Transition to Community Program
  - Intervention Capacity
CONVALESCENT CARE
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

• 12 beds (total 25 beds at HCH)

• Interdisciplinary care team: nurses, medical providers, social workers
CONVALESCENT CARE REPORTING

- **REPORTING SYSTEM**: HealthCare for the Homeless records
- **CHPB DASHBOARD REPORTING**
  - Referrals
  - Enrollment
  - Bed Census
  - Length of Stay
  - PCP Transition
  - BH Transition
  - ED Readmission
  - Successful Discharge
  - Intervention Capacity
HOME BASED PRIMARY CARE
HOME BASED PRIMARY CARE

• 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

• Referrals: Made directly to HBPC team
HOME BASED PRIMARY CARE REPORTING

• REPORTING SYSTEM: EPIC

• CHPB DASHBOARD REPORTING
  • Referrals
  • Enrollment
  • Patient Demographics
  • Home visits per month
  • ED Visits per month
  • Intervention capacity
  • Well visit completion
NEIGHBORHOOD NAVIGATORS
NEIGHBORHOOD NAVIGATOR

• The Neighborhood Navigators are trained volunteers from the Men and Families Center who outreach clients around the neighborhood (street level relationship) on which they live to let them know of available health care and social service resources

• Roles include: relationship building, social support, education, resource connection, linkage to care, informal monitoring, and surveillance of unmet needs
NEIGHBORHOOD NAVIGATOR REPORTING

• REPORTING SYSTEM: RedCap
• CHPB DASHBOARD REPORTING
  • Encounters
  • Clients Serviced
  • ED Visits
  • Hospitalizations
  • Homelessness
  • Insurance Status
  • Social Determinants of Health
PATIENT ENGAGEMENT TRAINING
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• Patient Engagement Training (PET) 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
PATIENT ENGAGEMENT TRAINING REPORTING

• REPORTING SYSTEM: Training Records
• CHPB DASHBOARD REPORTING
  • Number of trainings
  • Number of professionals trained
  • Learning Effectiveness
QUESTIONS?

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