HOWARD COUNTY GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE

Howard Health Partnership

LHIC Forum: Transforming Healthcare in Howard County

October 27,2016

Discussion Agenda

- Developing the Howard Health Partnership (HHP)

- Intervention Spotlight
  - Community Care Team
  - Journey to Better Health

Maryland's Vision for Transformation

HOWARD COUNTY GENERAL HOSPITAL
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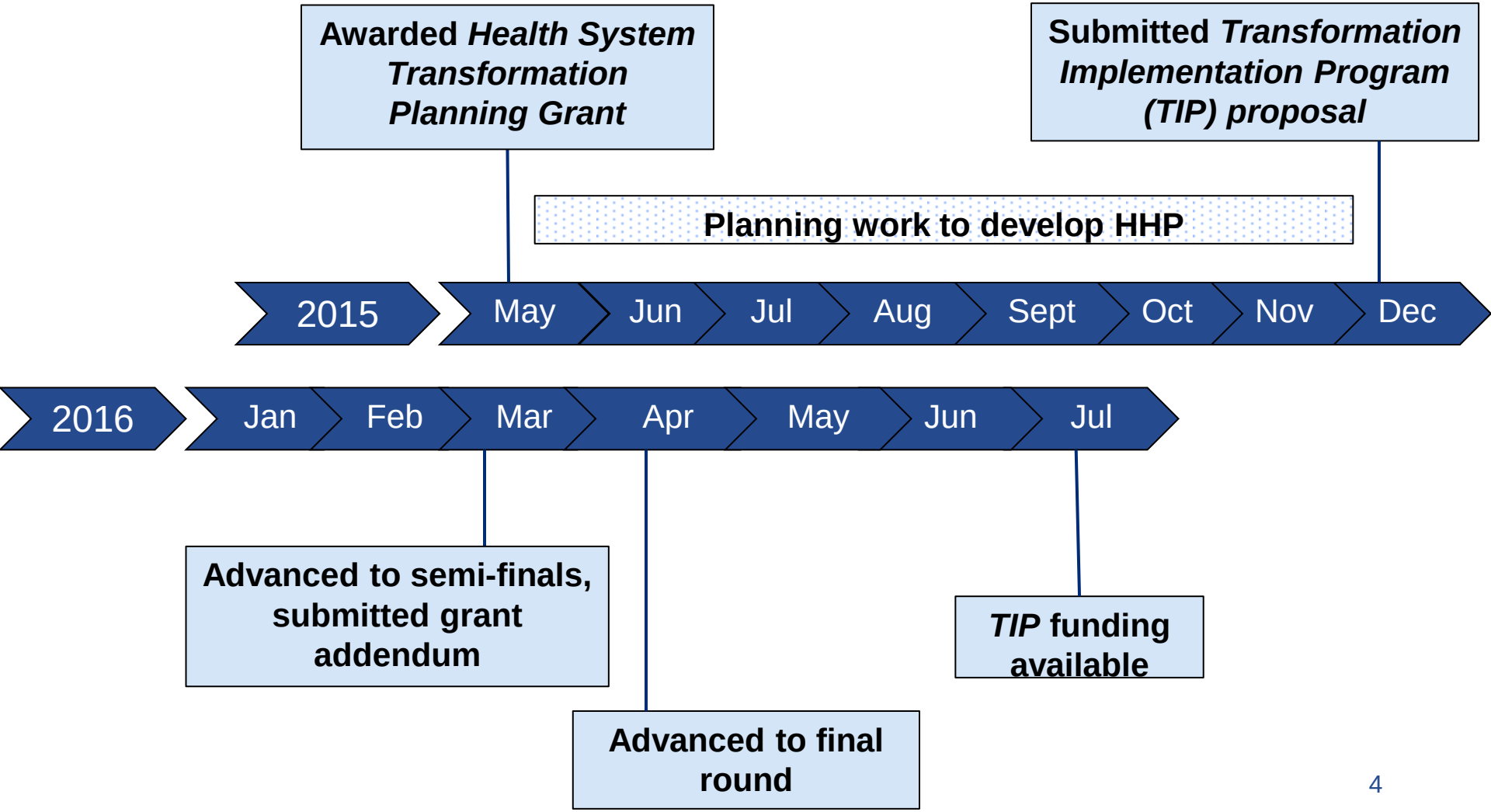
- Realize the "Triple Aim"
  1. Improve the health of the population;
  2. Enhance the patient experience of care;
  3. Reduce the per capita cost of care.
- Focus on multidisciplinary care teams, coordination across settings, patient-centered care
- Establish Regional Partnerships to manage health of a defined community (initial focus on Medicare)

HHP Timeline



HHP Mission

To deliver an effective, community-based & financially sustainable model of care that improves health, achieves cost savings & offers an enhanced patient experience for our target population.

HHP Target Population

- Howard County Resident, ≥ 18 yrs
- Medicare or dual eligible
- At least 2 HCGH encounters in past 365 days (inpatient, observation or ED visit)

Initial focus on high utilizers. Population health improvement is long term goal.

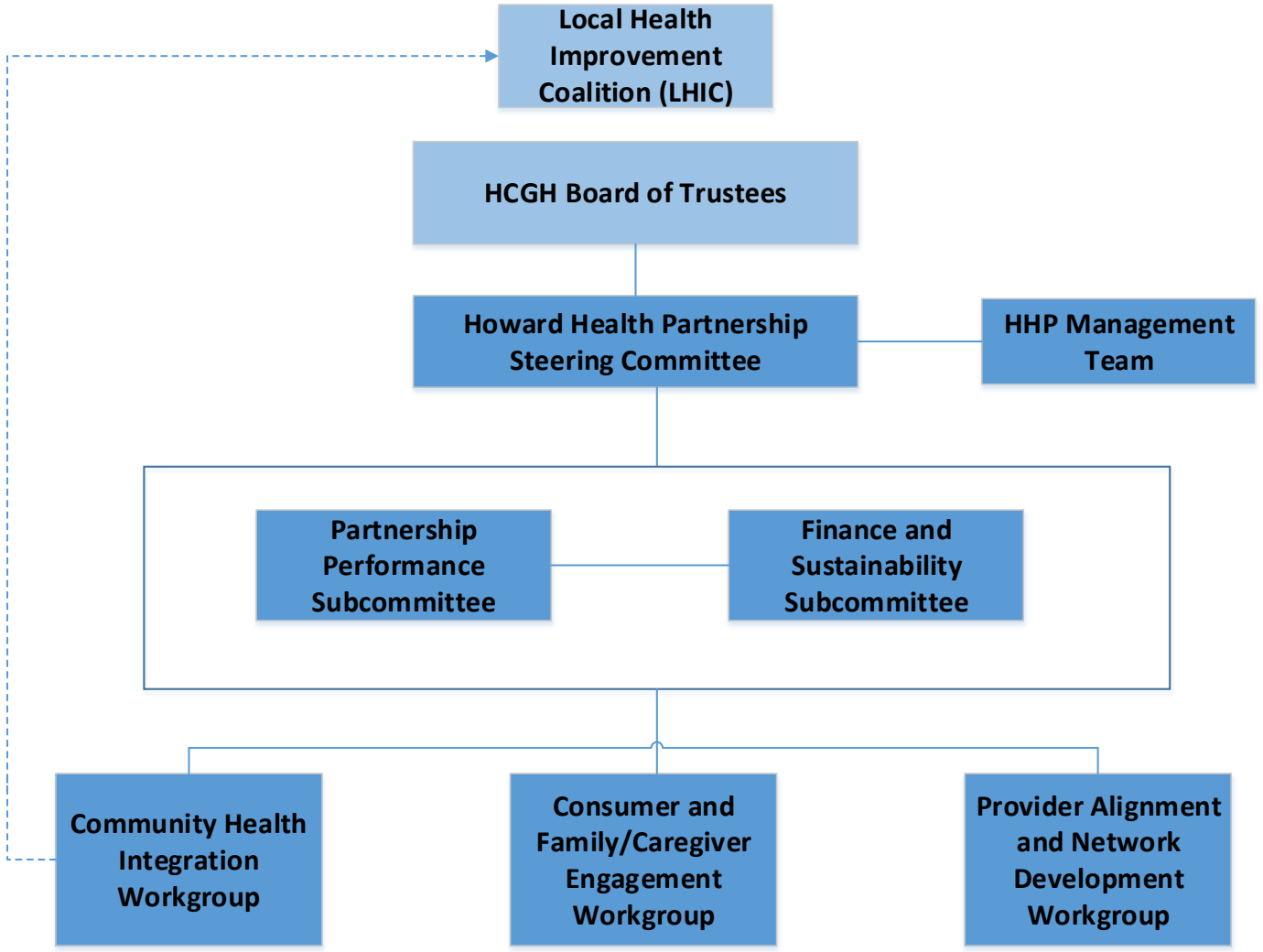
Target Population Snapshot

- Clustered in 5 zips: 21044, 21045, 21043, 21042 & 21075
- 80% are ≥ 65yrs + (51% are ≥ 80yrs)
- 66% have multiple chronic conditions
- 42% of hospital visits are for conditions that could be managed outside of a hospital

HHP Interventions

Complex Care Management	• Community Care Team (CCT) • Support Our Elders (Gilchrist) • Remote Patient Monitoring (Johns Hopkins Home Care Group)
Seamless Care Transitions	• Community Health Workers embedded in Emergency Dept & Primary Care Offices • Skilled Nursing Facility Collaborative (Lorien) • Rapid Access Program for Behavioral Health (Way Station) • Transitions & Care Choices programs (Gilchrist)
Self Management Supports	• Journey to Better Health (J2BH) • Powerful Tools for Caregivers (Office on Aging & Independence) • CAREApp (Health Dept)

HHP Governance



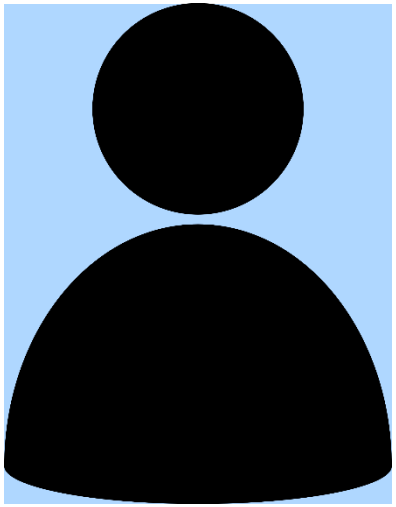
Intervention Spotlight

COMMUNITY CARE TEAM (CCT)

CCT

- Multidisciplinary team: Community Health Nurse (CHN), Community Health Worker (CHW), Licensed Clinical Social Worker (LCSW)
- Referral pathways: acute, post acute, primary care & home care
- Address social determinants in addition to health care needs
- Client-led care plan development; progress shared with care team

CCT Patient Profile

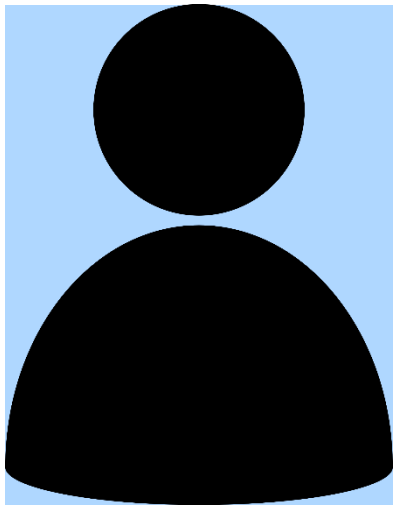


Profile	• M, 65yrs • Lives with wife & extended family • 4 chronic conditions, history of stroke & heart attack • 10 ER visits + 4 inpatient admissions in past yr
Getting Connected	• Met patient at bedside during hospital stay (identified by Home Care Coordinator) • 1st home visit w/ CHN & CHW 6 days post discharge

From Assessment to Care Plan

Assessment Findings	Care Plan
✓ *Medical Home*: Good relationship w/ PCP & specialists ! *Health Literacy:* symptom management & use of ED ! *Access:* Difficult to make urgent appointments due to out of county providers	• Enroll in Remote Patient Monitoring Program • Teaching – how/when to report symptoms to PCP or cardiologist & appropriate use of ER visits.
✓ *Health Literacy:* Wanted to learn how to cook meals to meet diet restrictions	• Recipes & grocery lists for meals & snacks to meet low-salt & low-carb diet

Life after CCT



- Length of CCT intervention: 60 days
- Hospital utilization:
  - 1 ER visit w/in 2 weeks of starting w/ CCT (teachable moment)
  - 0 inpatient admissions during time w/ CCT or in 6 weeks post graduation.
- Patient continues w/ RPM to track daily vitals & on schedule for regular follow up (every 3 mos) w/ providers

Intervention Spotlight

JOURNEY TO BETTER HEALTH (J2BH)

J2BH

- Funded by Howard County Health Department
- ***Aim 1:*** **Empower self-management of chronic disease**
  - Focus on pre-diabetes/ diabetes, pre-hypertension/ hypertension & obesity
  - Screenings & onsite chronic disease self-management programs (e.g. Living Well)
- ***Aim 2:*** **Provide social support through Member Care Support Network (MCSN)**
  - Congregation members volunteer to serve as Community Companions & receive special training
  - Residents sign up to be part of MCSN, consent for Community Companion to be contacted if in hospital

Value of J2BH

- Fits with existing goals of many congregations, especially those with established health ministries
- Community-based – screenings & classes delivered in locations where residents already come together
- MCSN - Enhances congregations' ability to minister to members
- Potential to reduce social isolation & address low-level social support needs for residents

Contact Us!

Elizabeth Edsall Kromm VP, Pop Health & Advancement	Ph: 410-740-7734 Email: ekromm@jhmi.edu
Tracy Novak Director, Population Health (Oversees HHP)	Ph: 410-720-8762 Email: tnovak2@jhmi.edu
Kate Talbert Manager, Complex Care Management (Oversees CCT & J2BH)	Ph: 410-720-8789 Email: ktalbert@jhmi.edu
CCT	Ph: 410-720-8788 Email: HCGH-CCT@jhmi.edu
J2BH	410-720-8788 Email: HCGH-J2BH@jhmi.edu