Implementation of a comprehensive program to improve coordination of care in an urban academic health care system- Johns Hopkins Community Health Partnership (J-CHiP)

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Johns Hopkins Community Health Partnership in East Baltimore

- Launched in 2012 and built on existing programs
- Transforms across continuum: clinics, SNFs, hospitals, home, community and EDs
- Catalyzed by CMS HCIA Award $19.9 million for 3 years
- Increases in:
**Aims**

- JHM will improve care coordination for M/M acute care patients and 3,000 M/M high risk community residents by the end of year 3.
- JHM will recruit, train, and deploy new workers (along with many additional in-kind hires).
- JHM will reduce direct costs per inpatient and will reduce total cost of care for M/M high risk community residents.

**Primary Drivers**

- Acute care delivery redesign
- Seamless transitions of care
- Deployment of community care teams

**Secondary Drivers**

- Emergency department care coordination and use of protocols for common conditions
- Transdisciplinary care planning through daily rounds
- Pharmacist-driven medication management
- Preparation for self-management through targeted patient/family education
- Early and frequent risk screening for complex needs
- Creation of after-hospital personal health plan
- Primary provider-handoff and early follow-up
- Moderate and high intense post-acute intervention (Transition guides, Home Care, Skilled Nursing/Rehab Facilities)
- Patient Access Lines (PAL)
- Establish community partnerships (including Tamani (Hope) for Health)
- Predictive modeling to identify patients at high risk for utilization
- Care coordination teams with embedded case managers and behavioral specialists, and community-based community health workers, and Neighborhood Navigators
- Frequent surveillance of patients’ self-management, adherence, barriers to care, and engagement
- Integrated behavioral care based on risk
Four components of J-CHiP

**Acute Care**
- Early risk screening for complex needs
- Pharmacist-driven medication reconciliation
- Self-management training
- Multidisciplinary team

**Skilled Nursing Facilities**
- Standardized protocols for CHF and COPD patients
- Timely receipt of discharge notes from hospitals

**Community Care and Partnerships**
- Community health workers for follow-ups and home visits
- Assistance in social and health issues

**Behavioral Intervention**
- Trained LCSW to identify symptoms
- Referrals to community clinics through assessments
- Health educator

**Four components of J-CHiP**
Acute Care

- Implemented in selected pilot units, then expanded to a total of 35 units in JHH and Bayview
- The bundle of services include:
  - Early risk screening for complex needs
  - Pharmacist-driven medication reconciliation
  - Self management training
  - Multidisciplinary team
  - Early Screen for Discharge Planning (EDSP)
  - Patient/Family Education
  - Transition pharmacy extender (TPE)
  - Patient access line (PAL)
  - Transition Guides (TG)
Community Care

- Acute Care
  - Community health workers for follow ups and home visits
  - Assistance in social and health issues

- Skilled nursing facility
  - Behavioral Intervention

- J-CHIP Classic
  - Multi-disciplinary care coordination team
  - Team: 1 CHW, 0.5 health behavior specialist for 100 patients

- Sisters Together and Reaching (STAR)
  - Nurse Care manager to address care coordination and social needs
  - Serves 3 zip codes: 21202, 21205, 21213

- Tumaini (Hope) for Health
  - Collaborative effort between JHMI, Sisters Together and Reaching (STAR) and the Men and Families Center, Inc. (MFC)
  - Neighborhood Navigators: volunteers trained by MFC
  - CHW: trained and deployed by STAR
Behavioral Intervention

- Trained LCSW to identify symptoms
- Referrals to community clinics
- Health educator assessed for mental health conditions and substance abuse
- Health educator visited homes and assessed health knowledge
Skilled Nursing Facility

• Standardized protocols for CHF and COPD patients
• Timely receipt of discharge notes from hospitals

Collaboration with five participating SNFs

Implemented standardized CHF/COPD, discharge planning protocols to reduce rehospitalizations and LOS
Purpose: Documenting the process and implementation steps of the program.
Leadership interview results (the good.....)

Common goal

Buy-in from front line staff

Quick feedback and transparency

- Breaking down silos
- Facilitating two-way communication
- Improved discharge hand-offs
Leadership interview results (improvements needed.....)

- IT and data integration
- High staff turnover
- Complex interventions
  - Lack of incentives?
  - Culture change
  - Staff burnout
Implications of J-CHiP for other urban care settings

- Increased channels for communication reduce barriers for all the interventions
- Partnerships with the community and employing CHWs from the community is a strong strategy for acceptance of services
- A bundle of strategies facilitate improved care coordination for patient needs