HSCRC
Health Services Cost Review Commission

Regional Partnership Program Summary

August 2019 Update

The following information is being collected to ensure public reporting about the Regional Partnerships is accurate. The information provided will be posted on the HSCRC website and included in periodic reports about the status of the Regional Partnership Grant Program.
Please complete and email the form to hscrc.rfp-implement@maryland.gov by Friday, September 6th.

Please ensure only one form per partnership is submitted.

Regional Partnership Information
Regional Partnership Name: Community Health Partnership of Baltimore
Participating Hospitals: 1. The Johns Hopkins Hospital 2. Johns Hopkins Bayview Medical Center 3. LifeBridge Sinai Hospital 4. Mercy Medical Center
Participating Community Based Organizations: 1. Sisters Together and Reaching, Inc. 2. The Men & Families Center 3. Health Care for the Homeless 4. Helping Up Mission
Geographic Service Area Covered by Regional Partnership (e.g., counties or zip codes): Baltimore City (all zip codes)
Primary Point of Contact (Name, address, telephone, email): Linda Dunbar, PhD, RN, Vice President, Population Health Johns Hopkins HealthCare LLC ldunbar1@jhmi.edu

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Program #1
Intervention Program Name: Community Care Team
Category of Intervention: • Behavioral Health Integration • Care Transition • Patient Engagement & Community Education
Short description of intervention: The Community Care Teams (CCTs) expand upon existing services of primary care providers to coordinate care for a high-cost, high-need, Medicare population. Each team consists of a minimum of one Nurse/Social Worker Care Manager, two Community Health Workers (CHWs), and one Health Behavior Specialist. The teams assess social influencers of health, medical, and behavioral health needs of patients. The teams connect patients to primary care, resources to abate social barriers, and other medical and behavioral health resources. Teams utilize a variety of strategies to identify patients for outreach. These include receiving direct referrals from inpatient and primary care providers and outreaching patients who have recently had low-acuity ED visits. In some cases, patients request assistance with activities related to social barriers to care, and may only need assistance from a CHW at that time. CHWs are employed by Sisters Together and Reaching, Inc.

Program #2
Intervention Program Name: Home-Based Primary Care / JHOME
Category of Intervention: • Home-Based Care
Short description of intervention: Home-Based Primary Care (JHOME) is 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. The multi-disciplinary team consists of a Program Director, Geriatrician, Certified Registered Nurse Practitioner, Social Worker, Registered Nurse, Practice Manager, Patient Service Coordinator, and a Licensed Practical Nurse.

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Program #3
Intervention Program Name: Behavioral Health Bridge Team
Category of Intervention: • Behavioral Health Integration
Short description of intervention: The Bridge Team is a 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. The primary goal of the Bridge Team is to facilitate a successful transition to a medical home and engage patients in behavioral health services. The team consists of a Psychiatrist, a Health Behavior Specialist Team Lead, a Health Behavior Specialist, and two behavioral health Community Health Workers.

Program #4
Intervention Program Name: Convalescent Care
Category of Intervention: • Care Transition
Short description of intervention: Convalescent Care, administered by Health Care for the Homeless, provides people experiencing homelessness who are discharged from a partner hospital a place to stay, rest, and recuperate from an acute illness or surgery. On the Convalescent Care unit, patients receive 12-hour-a-day nursing services (medication education, care coordination, and wound care) and social work services (to link patients to housing resources, income, mental health, and addiction services).

Program #5
Intervention Program Name: MFC Neighborhood Navigators and Case Coordinators
Category of Intervention: • Patient Engagement & Community Education
Short description of intervention: The Men and Families Center (MFC) in East Baltimore hires and trains Neighborhood Navigators and Case Coordinators. Neighborhood Navigators (NNs) are present in/around the 21205 zip code, serving people they encounter regardless of whether or not the individual's address is in 21205. The majority of their clients reside in the 21202, 21205, 21213, and 21231 zip codes. NNs engage them in discussions about available healthcare and social service resources that might help meet their needs. Case Coordinators, located at MFC, are available to provide more direct assistance to clients (e.g., helping them enroll in health insurance, helping them to find employment, etc.).

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Program #6
Intervention Program Name: Patient Engagement Program
Category of Intervention: • Patient Engagement & Community Education
Short description of intervention: The Patient Engagement Program (PEP) is a comprehensive, in-person, skills-based training program that teaches nurses, physicians, social workers, and other providers how to change their team's culture, engage their patients as partners in health care, and communicate in a way that motivates patients to engage in healthier behaviors.

Program #7
Intervention Program Name: Helping Up Mission
Category of Intervention: • Behavioral Health Integration • Care Transition
Short description of intervention: Helping Up Mission provides hope to people experiencing homelessness, poverty, or addiction by addressing their physical, psychological, social, and spiritual needs. The goal of this initiative is to provide safe, stable shelter to homeless men and women who are waiting to be admitted into a treatment program. This initiative is specific to patients who are being discharged from Johns Hopkins Bayview Medical Center.