Health Care Integration at Hopkins: Challenges & Progress in J-CHiP

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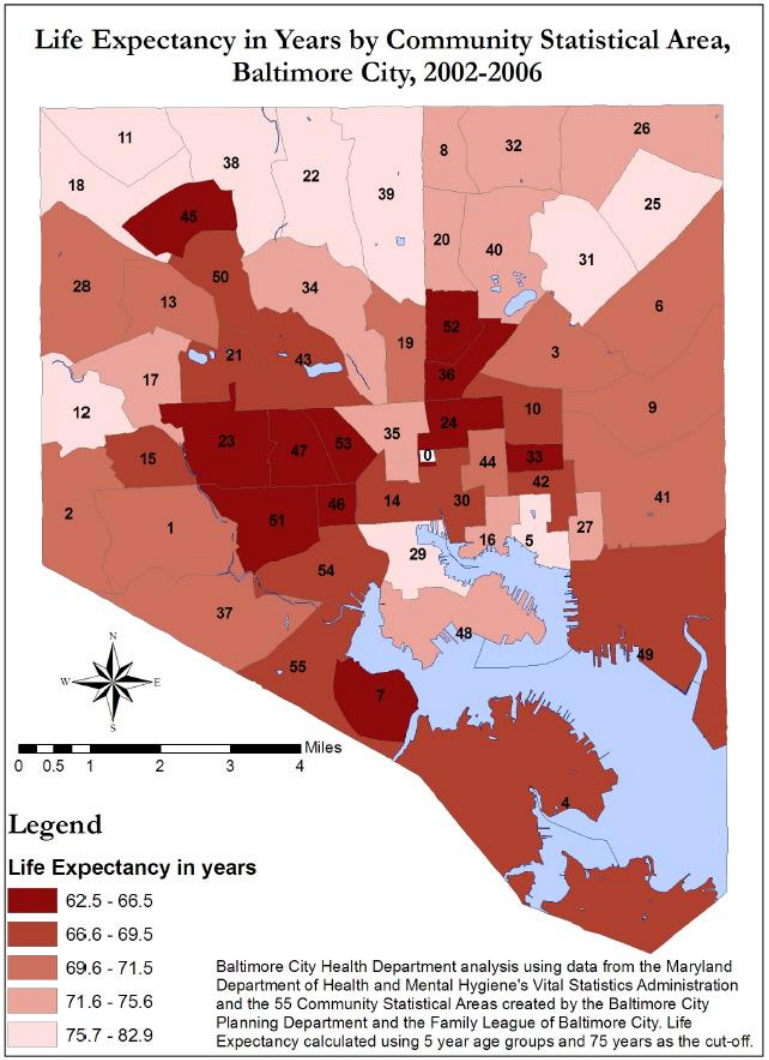
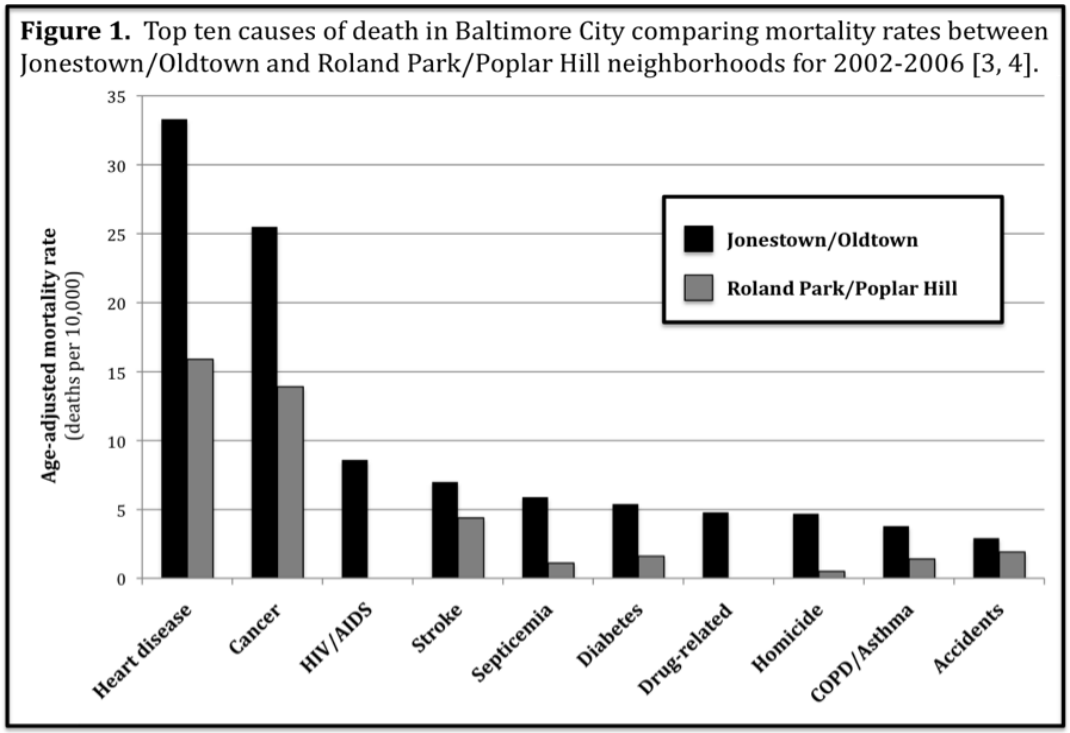
East Baltimore Community

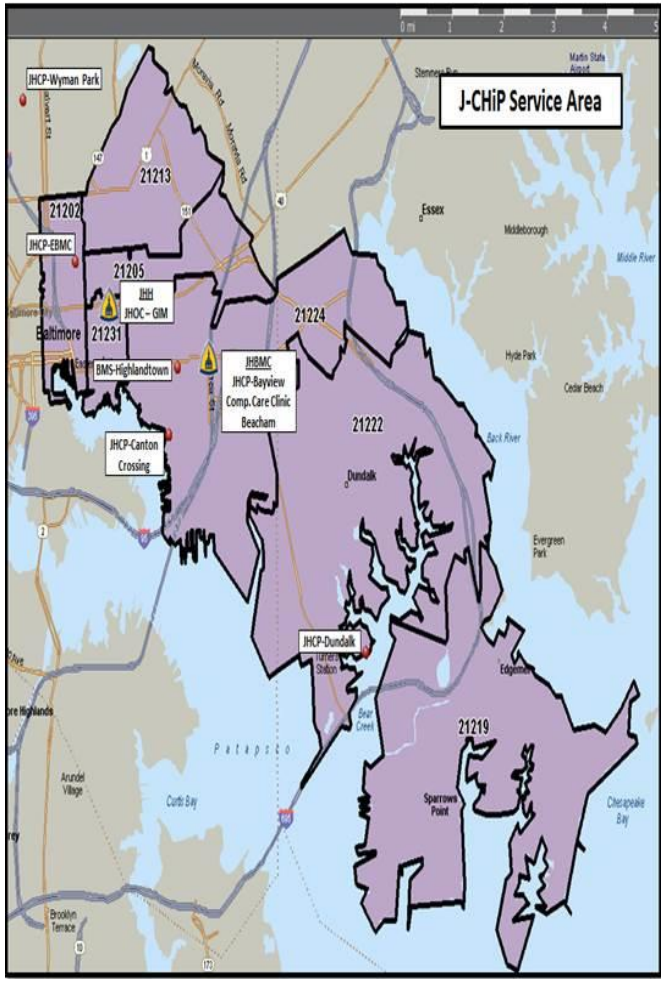


- 20 year difference in life expectancy
- Major portion of mortality difference due to treatable conditions



Community Health Partnership

- Health Care Innovation Award launched in 2012 and built on existing programs
- **Transforms across continuum**: ***clinics, SNFs, hospitals, home, community and EDs***
- Acute care/SNF largely completed June 2015, extension through June 2016 for community component
- **East Baltimore Community is "Core"**



The Community Health Partnership

1..2..3

1 Program focused on care coordination across continuum.

2 Target Populations:

a. By year 3, **nearly all 40,000 adult patients** discharged annually from **JHH and JHBMC** and **thousands of ED visits**.

b. Underserved, **high risk** East Baltimore population → ***≈ 1000 PPMCO*** *and* ***2000 Medicare patients****.*

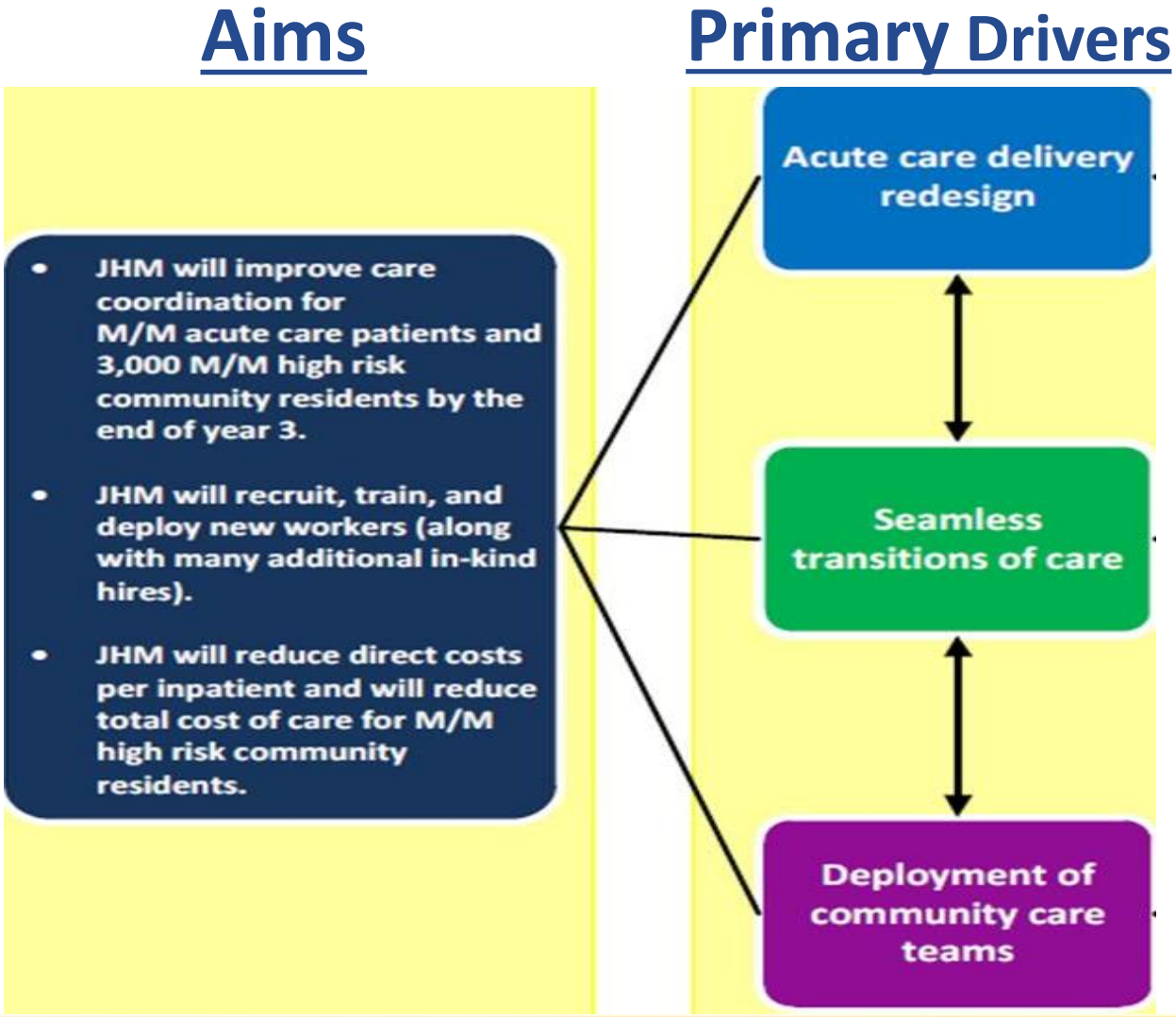
3 Primary Intervention Components:

a. Acute/Post-Acute/ED: As above.

b. Ambulatory/Community Care: JHM clinic sites and 1 BMS site within or near the 7 zip codes surrounding JHH/JHBMC.

c. Skilled Nursing Facilities (SNFs): Includes all JHH/JHBMC discharges to 5 neighboring SNFs as well as JHBMC Care Center.

J-CHiP Aims


Aims
Primary Drivers
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.
Acute care delivery redesign
Seamless transitions of care
Deployment of community care teams

J-CHiP Vital Statistics

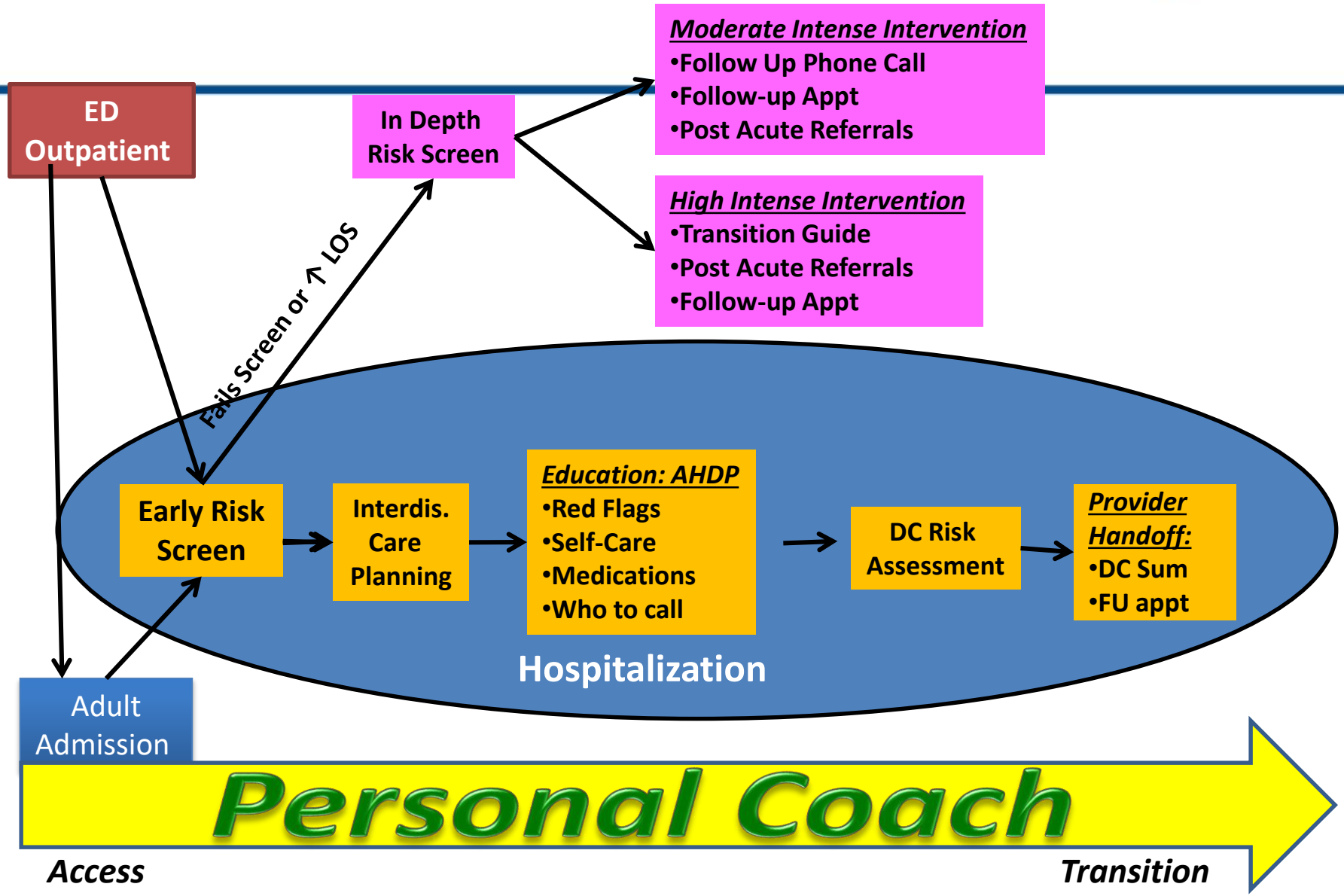
- **Total Program Participants:** 80,257
  - (including 3,000+ high risk community residents, 40% residing in the 7-zipcodes surrounding JHH and JHBMC)
- **Total Training Hours:** 2,568 staff (not unique) and 19,200+ hours
- **Total New Workers Hired and Trained:** 106
- **Program Participants from 7-zip code area**: 25,116 (31%)
- **Number (%) Medicare/Duals/Medicaid:**
  - 23,047 (29%); 4,843 (6%); 16,399 (20%)
- **Inpatient Units:** 35 (14 JHBMC; 21 JHH)
- **Ambulatory Clinics:** 7
- **SNF Sites:** 5

Table 1

Baseline characteristics of community population enrolled in a multi-disciplinary health care collaboration to improve readmissions and heal

Characteristic	Priority Partners 1000 High-Risk Patients % (n)	Medicare 2000 High-Risk Patients % (n)
Age: Mean (Range)	49 (19–64)	74 (23–100)
Female:	73% (728)	62% (1248)
Medicaid Qualification Reason		
Disability (SSI)	83% (830)	N/A
Temporary Aid to Needy Families (TANF)	17% (170)	N/A
6+ Chronic Conditions	36% (361)	85% (1703)
Congestive Heart Failure	32% (319)	31% (620)
Hyperlipidemia	52% (521)	65% (1305)
Hypertension	84% (841)	92% (1846)
Peripheral Circulatory Disease	13% (127)	11% (213)
Diabetes	49% (491)	46% (925)
Kidney Disease	28% (283)	55% (1103)
Transplant	2% (20)	4% (72)
Neurological Condition	20% (195)	64% (1287)
Chronic Obstructive Pulmonary Disease	29% (291)	32% (636)
HIV/AIDS	9% (90)	3% (67)
Anxiety, Neuroses	15% (151)	18% (352)
Depression	31% (314)	33% (654)
Bipolar Disease	15% (151)	8% (167)
Schizophrenia or Affective Psychosis	8% (75)	8% (157)
Substance Abuse	45% (450)	N/A
At least 1 hospital admission in the last year	47% (469)	57% (1137)

Care Coordination



J-CHiP-B, aka “The B Team”

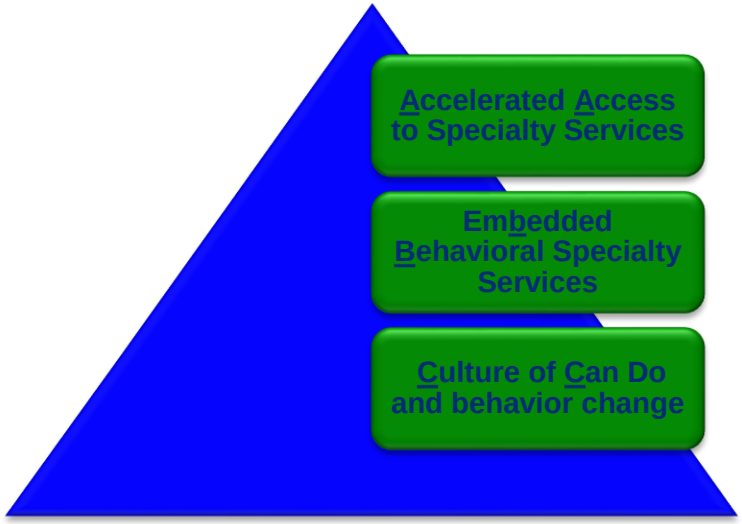
JOHNS HOPKINS MEDICINE

B = Behavioral Health (or B = Best)

Behavioral health
-Mental illness
-Addiction
-Health behavior

The Need
-70% smokers
-57% BMI > 30
-56% current psych
-45% SA
-29% EtOH

The Impact
-Shorter life span
-Worse life quality
-25% higher costs
-Delay 20% of discharges



The Team
-Community workers
-Care managers
-Health Behavior Spec.
-Physicians
-Psychologists
-Psychiatrists

Integration
-Uniform training
-Single HBS team
-In- and Out-reach
-Early detection
-Community engagement

Summary of Outcomes – NORC, external evaluator

JOHNS HOPKINS MEDICINE

OUTCOMES, Hospital Arm§§

COST

- Reduction in 90-day total cost of care (-$1,115 per beneficiary-episode, Medicare)
- Reduction in 90-day total cost of care (-$4,987 per beneficiary-episode, Medicaid)

UTILIZATION

- Increase in 90-day hospitalizations and 30-day readmissions and (11 and 14 per 1,000 beneficiary-episodes per quarter, respectively, Medicare)
- Decrease in 90-day ED visits (-134 per 1,000 beneficiary-episodes per quarter, Medicaid); increases in 90-day hospitalizations and 30-day readmissions (53 and 26 per 1,000 beneficiary-episodes per quarter, respectively, Medicaid)

QUALITY

- Decrease in 7-day and 30-day practitioner follow-up visits post-discharge (-41 and -29 per 1,000 beneficiary-episodes per quarter, respectively, Medicare)
- Decrease in 30-day and 7-day practitioner follow-up visits post-discharge (-70 and -184 per 1,000 beneficiary-episodes per quarter, respectively, Medicaid)

OUTCOMES, Community Arm§§

COST

- Reduction in total quarterly cost of care (-$495 per beneficiary, Medicare)
- Reduction in total quarterly cost of care (-$1,756 per beneficiary, Medicaid)

UTILIZATION

- Decrease in hospitalizations and ED visits (-17 and -16 per 1,000 Medicare beneficiaries per quarter, respectively)
- Decrease in hospitalizations and ED visits (-31 and -48 per 1,000 Medicaid beneficiaries per quarter, respectively)

QUALITY

- Decrease in avoidable hospitalizations (-7 per 1,000 Medicaid beneficiaries per quarter)

HEALTH

- 82% of respondents report that they spoke with clinic staff about how to take care of themselves
- Most respondents report that they trust their community health worker (CHW) and would recommend their provider to family and friends

Accomplishments

- CMS Triple Aim achieved
  - Better care for individuals
    - Improvements in HCAHPS scores, high patient satisfaction among community participants
  - Better health for populations
    - Acute: reductions in 30-day readmissions for Medicare and Medicaid (internal evaluation)
    - Community: reductions in ED visits for Medicare and Medicaid (internal and external evaluations)
  - Reductions in cost

- J-CHiP original project goals achieved
  - Improve care coordination across the continuum, including behavioral health integration across settings
  - Recruit and hire innovative workforce
  - Realize cost savings

Accomplishments (cont'd)

- Meaningful achievements in each of the six JHM Strategic Priorities
- Fostered strong relationship with community-based organizations
  - Sisters Together and Reaching (STAR)
  - Men and Families Center (MFC)

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

M&FC
THE MEN & FAMILIES CENTER
2222 Jefferson Street
Baltimore, Maryland 21205
410-614-5353

Challenges

- Patient and provider engagement
- Sustaining and expanding community partnerships in East Baltimore
- Imperfect data collection
- Optimizing Epic for care coordination
- Evolving state and federal policy landscape

Sustainability: What programs have been influenced by J-CHiP?

- Johns Hopkins' ACO, Johns Hopkins Medicine Alliance for Patients
- Baltimore City Regional Partnership
- JHH and JHBMC HSCRC Hospital Transformation Strategic Goals
- Advantage MD (Medicare Advantage)
- JHM SNF Collaborative
- Others

Incredible Talent and Teamwork

(including but not limited to…)

Project Directors

- Paul Rothman
- Patty Brown
- Scott Berkowitz

Acute Care

- Amy Deutschendorf
- Carol Sylvester
- Dan Brotman
- Eric Howell
- Diane Lepley
- Mary Myers
- Melissa Richardson
- Curtis Leung

Community

- Linda Dunbar
- Ray Zollinger
- Debra Hickman
- Leon Purnell
- Regina Richardson
- Tracy Novak
- Lindsay Hebert

Over 100 newly hired staff…

- Case Managers
- Transition Guides
- Community Health Workers
- Transition Pharmacy Extenders
- Neighborhood Navigators

…and many more!

SNF

- Michele Bellantoni
- Carol Sylvester
- Chris Durso
- Lisa Filbert
- Denise Kelly

Behavior

- Kostas Lyketsos
- Anita Everett
- Laura Torres
- Melissa Reuland
- Eric Strain
- Michael Fingerhood

Research/Evaluation

- Eric Bass
- Albert Wu
- Shannon Murphy
- Doug Hough
- Kevin Frick
- Larry Appel
- Felicia Hill-Briggs

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