Howard Health Partnership Overview

Mission

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

Target Population

- Howard County Resident
- At least 18 years old
- Medicare or dually eligible for Medicare and Medicaid

Some interventions are designed to reach a broader population including patients who come to HCGH (Patient Access Line, Peer Recovery Support Specialists, etc.) and people who live, work, or worship in Howard County (wellness screenings, health education, Advance Care Planning, etc.). These interventions have a green outline on strategic framework diagram.

Partners

Assisted Living Facilities
CRISP
Foreign-Born Information and Referral Network (FIRN)
Gilchrist Services
Horizon Foundation
HC Local Health Improvement Coalition
HC Health Department
HC Office on Aging and Independence
Johns Hopkins Health System
Johns Hopkins Home Care Group
Primary Care Practices
Lorien Health Systems
Ellicott City Healthcare Center
Waystation, Inc.

Overarching Goals (Triple Aim)

↑ Experience of Care	↑ Health Outcomes	↓ Health Care Costs
✓ Improve the patient experience	✓Reduce readmissions ✓Reduce potentially avoidable utilization (PAU) ✓Improve care coordination	✓Reduce total cost of care ✓Generate financial savings

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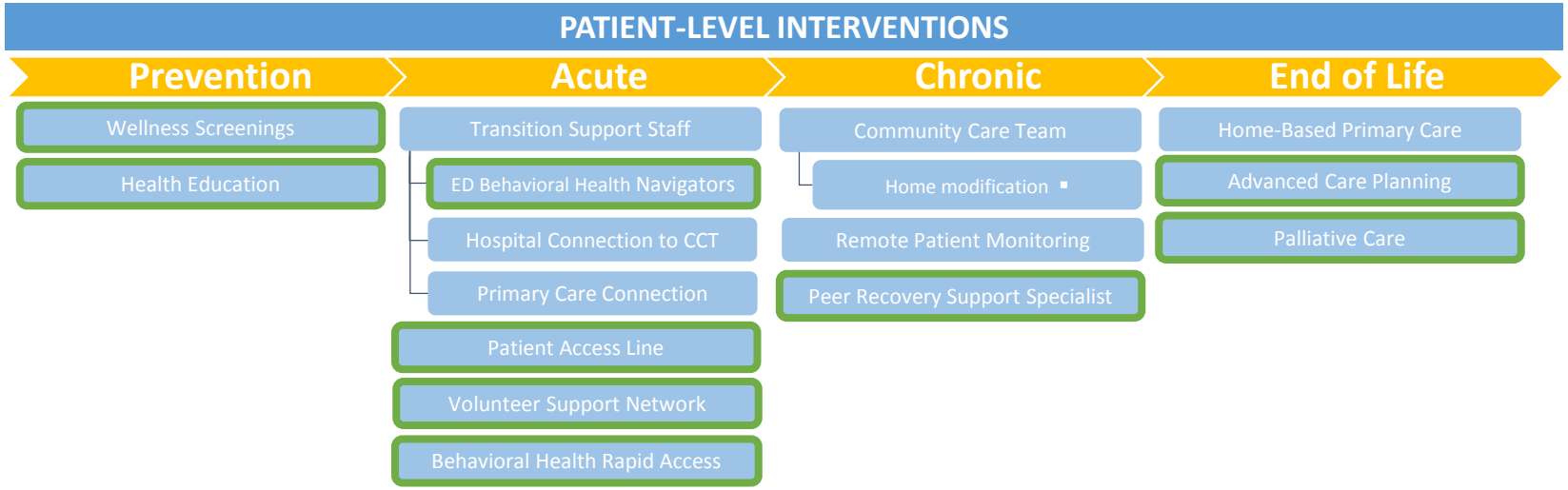
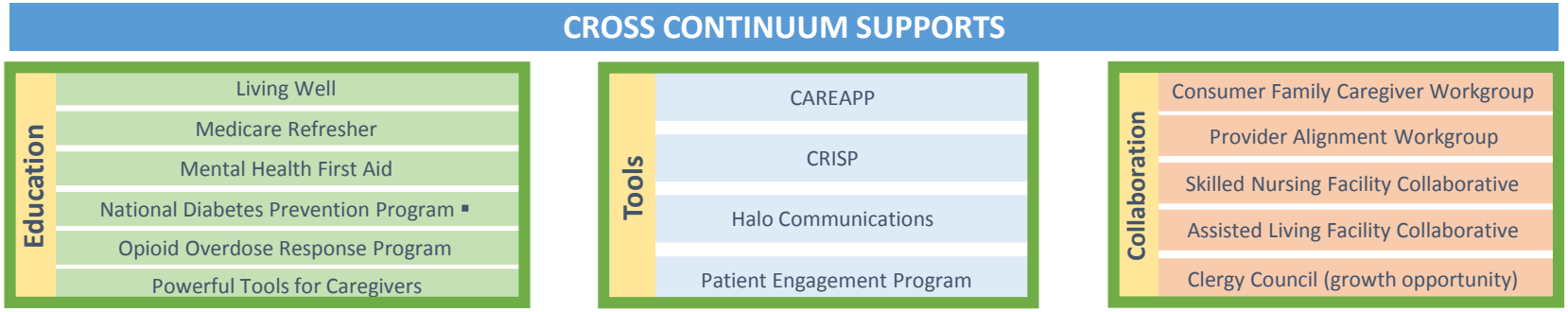
FY19 Howard Health Partnership Strategic Framework





Key: ▪ Pending funds | Serves a broader population than HHP Target

FY19 Summary of Howard Health Partnership (HHP) Interventions Patient- Level Interventions				
	Intervention	**Description**	**Partner**	**Care Setting**
Prevention	Wellness Screenings	Free screenings to support self-management and identify and monitor conditions like high blood pressure, diabetes and obesity. Hosted by the Journey to Better Health (J2BH) program at various faith communities, the hospital and community spaces.	HCGH	Faith based centers, Community
	Health Education	Health Promotion services and classes provided under Howard Health Partnership teach practical skills to help patients and family members to manage chronic conditions. Classes include: Living Well, Medicare overviews, Mental Health First Aid, Opioid Overdose Response Program, Powerful Tools for Caregivers, etc.	HCGH, HC Health Dept.	Community
Acute	Transition Support Staff: ED Behavioral Health Navigators	HCGH received funding from the county to hire new staff for the ED to work with behavioral health patients. Behavioral Health Navigators will assist patients and families with addressing psychosocial barriers to participating in treatment and provide them with referrals for community services that will assist them in more successfully engaging in treatment. The navigators will provide telephonic follow-up with patients post-discharge to provide additional support and assistance regarding referrals made during the ED visit.	HCGH Emergency Dept.	Hospital
	Transition Support Staff: Hospital Connection to the Community Care Team (CCT)	A community health nurse embedded in the hospital inpatient setting identifies, screens, engages and enrolls patients who are eligible for the CCT while they are in the hospital. They work with the inpatient care teams including physicians, nurses, and case managers to coordinate services pre and post discharge. The embedded community health worker helps to identify eligible patients with social barriers to care, and helps those patients address barriers through care coordination, referrals to community resources (including CCT) and connection to primary care.	HCGH	Hospital
	Transition Support Staff: Primary Care Connection	A community health worker works to improve communication across care settings, focusing on specific strategies to strengthen care coordination efforts for the HHP target population between primary care, specialty care, and HCGH. Facilitates referrals to HHP interventions, communicates initiatives, shares information on community resources, and conducts quality improvement projects.	HCGH	Primary Care
	Patient Access Line (PAL)	Within 24 hours from being discharged from the hospital, a Johns Hopkins nurse calls the patient. Using information the electronic medical records the nurse makes sure that each patient understands the care directions and will also answer any questions caregivers might have.	HCGH	Telephone
	Volunteer Support Network	Free volunteer-driven support system and an innovative approach to addressing health concerns in the community. Volunteers provide a variety of non-medical support services that help patients heal at home. Volunteers work with members for a limited time, and some supportive services include social support, spiritual care, home management, transportation and information sharing. This program is coordinated by the Journey to Better Health (J2BH) program.	HCGH	Faith based centers, Community
	Behavioral Health Rapid Access Program (RAP)	Designed to provide access to urgent, outpatient, crisis stabilization services within 1-2 business days of referral for adult residents of Howard County who are in need of immediate access to short term, psychiatric, problem-focused interventions, regardless of ability to pay. The length of the RAP intervention program is 9 sessions.	Way Station	Community Provider
Chronic	Community Care Team (CCT)	CCT is the primary care coordination program in the Howard Health Partnership (HHP) by a team based at Howard County General Hospital (HCGH). Patients and their caregivers receive benefits from the program for 30-90 days after a hospitalization or emergency department (ED) visit with frequent home visits and/or phone contact from a multi-disciplinary care team including a community health worker (CHW), community health nurse (RN) and a social worker. Patients are assisted with connection to primary care, behavioral and specialty care; medication reconciliation, coordination of home care; and addressing of social needs with linkages to appropriate community resources.	HCGH	Home, Telephone

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	Intervention	**Description**	**Partner**	**Care Setting**
Chronic	CCT: Home modification *(pending)*	CAPABLE uses an interdisciplinary team including the patient, a registered nurse (RN), an occupational therapist (OT), a pharmacist, and a home improvement specialist, to assist seniors with increasing their functional ability by assessing home safety and providing necessary modifications such as grab bars, repairs and other equipment. While CCT already employs RNs and works with a pharmacist, the additional funding would support the efforts of an OT, a home improvement specialist and the home repair equipment.	*Pending*	Home, Telephone
	Remote Patient Monitoring (RPM)	Home-based program for patients with heart failure or COPD with daily monitoring by RN case manager of biometric & symptom data. This allows for immediate feedback to patient & care team as needed, and provides an opportunity for disease education. Nurse case manager monitors data and interacts with patient and care team.	Johns Hopkins Home Care Group	Home
	Peer Recovery Support Specialist (PRSS)	PRSS are former addicts who have a minimum of 2 years of sustained recovery, and have completed specialized training in the area of addictions and behavioral health. They are employed by the Howard County Health Department and meet with patients in the hospital or community to assist with enrolling and participating in treatment or support services that address the patient's substance abuse condition. PRSS can also assist in addressing social determinants such as homelessness, unemployment, lack of health insurance, etc.	Howard County Health Department	Hospital, Community
End of Life	Elder Medical Care (formerly Support our Elders)	Provided through Gilchrist Services, the program is led by a physician, Certified Registered Nurse Practitioner (CRNP) in collaboration with a social worker to provide in-home medical care for home-bound elderly with advanced illnesses or conditions. It offers guidance on advance care planning and navigating the health care system as well as emotional support, education on living with serious illness and respite for caregivers.	Gilchrist Services	Home, Primary Care Office, Telephone
	Advanced Care Planning	HCGH committed to ensuring that patients have an Advance Directive (AD) that has a designated Health Care Agent and expresses their end of life wishes because these are important components for providing patient-centered care. To do this, HCGH received grant funding to establish an Advance Care Planning Coordinator who meets patients at the bedside to do education, along with collecting ADs post-discharge.	Horizon Foundation	Hospital, Community
	Palliative Care	Palliative Medicine is a sub-specialty of Internal Medicine that focuses on improving the quality of life for those with chronic, debilitating and life-limiting illnesses. The goal of HHP is to help identify more patients who are appropriate for Palliative/Hospice Care. At HCGH, care is provided by a multidisciplinary team consisting of a palliative medicine physician who provides medication and treatment to reduce pain and other symptoms; a nurse practitioner who provides symptom management for patients with advanced chronic illness; and a social worker and chaplain who provide emotional and spiritual support for patients and families.	Gilchrist Services	Hospital

FY19 Summary of Howard Health Partnership Interventions Cross-Continuum Supports				
	Intervention	**Program Description**	**Partner**	**Care Setting**
Education	Living Well	Free six-week evidence-based workshop to help individuals with chronic conditions learn how to manage and improve their own health, while reducing health care costs. The program focuses on problems that are common to individuals suffering from any chronic condition. Class is held for six weeks and co-led by trained facilitators. Hosted by the Journey to Better Health (J2BH) program.	J2BH	Community
	Medicare Refresher	Hosted by the Howard County Office on Aging and Independence, this course explains Medicare coverage and teaches participants how to become more active participants in their health care, along with key resources and assistance programs.	Howard County Office on Aging and Independence	Community
	Mental Health First Aid	8-hour education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports. Also teaches the common risk factors and warning signs of specific types of illnesses and teaches participants a five-step action plan to support someone developing signs and symptoms of a mental illness or emotional crisis.	HCGH	Community
	National Diabetes Prevention Program (NDPP) *(Pending)*	NDPP is a Centers for Disease Control and Prevention program for people with prediabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health.	*Pending*	Community
	Opioid Overdose Response Program	The Howard County Health Department offers free Opioid Overdose Response Program training for Howard County residents 18 years of age and older. Participants learn how to recognize, respond, and prevent an opioid overdose by administering Naloxone, a prescription medicine that reverses an opioid overdose.	Howard County Health Department	Community
	Powerful Tools for Caregivers	A 6-week evidence-based education program that teaches caregivers tools and strategies to better handle caregiver challenges. Curriculum includes self-care behaviors, management of emotions, self-efficacy and use of community resources.	Howard County Office on Aging and Independence	Community
Tools	CAREAPP	CAREAPP is a web-based tool that offers a risk assessment screening, and then provides a database of applicable community programs to which individuals can be referred to electronically using a bi-directional referral tracking system.	Howard County Health Department	Cloud-Based
	CRISP	CRISP is a regional health information exchange (HIE). HIEs allow clinical information to move electronically among disparate health information systems. The goal is to deliver the right health information to the right place at the right time - providing safer, timelier, efficient, effective, equitable, patient centered care. In doing so, CRISP offers a suite of tools aimed at improving the facilitation of care for regional providers.	CRISP	Cloud-Based
	Halo Communications	Mobile health platform for healthcare organizations. The Doc Halo mobile app and online system provides a secure texting and HIPAA-compliant environment for the transmission of ePHI (electronic personal health information) over an encrypted platform. The innovative physician-driven system allows for the sharing of critical health information via text-messaging.	CRISP	Cloud-Based
	Patient Engagement Program (PEP)	The PEP is a comprehensive, skills-based program to help health care providers and health care organizations realize the goal of patient-centered care by providing teams the skills to engage patients as active partners in their care. PEP uses evidence-based principles and skills of motivational interviewing to achieve behavior change by providers and patients. In order to develop and maintain skills, initial training must be combined with support and maintenance activities that includes regular engagement of PEP team champions.	Johns Hopkins Medicine (based at HCGH)	Hospital, Community

FY19 Summary of Howard Health Partnership Interventions Cross-Continuum Supports				
	Intervention	**Program Description**	**Partner**	**Care Setting**
Collaboration	Consumer Family Caregiver Workgroup	The objective of this HHP workgroup is to ensure all HHP interventions and initiatives are patient- and family-centered. Members provide feedback on educational materials developed for patients and families, and review intervention models, protocols and processes to ensure that patient and family preferences are kept front of mind. They also make recommendations regarding patient, family and caregiver education and engagement strategies and coordinate with existing Howard County General Hospital Patient and Family Advisory Councils (PFAC) to identify opportunities for collaboration.	Patient and Family representatives across Howard County	Community
	Provider Workgroup	Collaboration with other providers provided under Howard Health Partnership, this group includes primary care and specialty physicians to improve communication, coordination and transitions of patients across care settings to achieve the triple aim with a focus on the total cost care.	Physician reps across Howard County and	Community
	Skilled Nursing Facility Collaborative	HCGH collaborates with Lorien Health Services and other SNFs to better manage patients discharged from the hospital to skilled nursing facilities by standardizing the discharge process, implementing care pathways for the top causes of readmissions and supporting specialists to round/consult on these patients. A hospitalist physician, who is also a geriatrician, leads regular meeting to identify new areas for improvement, communication and collaboration.	Lorien Health Services, Ellicott City Healthcare	Community
	Assisted Living Facility (ALF) Collaborative	The Local Assisted Living Facility Collaborative aims to improve collaboration for patients transferred between hospital, ALF and home by focusing on transitions/communication, share lessons learned, etc.	ALF reps across Howard County	Community
	Clergy Council (growth opportunity)	Faith leaders in the community have advocated for this as an opportunity for better collaboration and coordination across Howard County.	Pending	Community