Enhancing Self-Management through Community-Based Intervention







Dan Hale, Ph.D.

Special Advisor to the President & Director of Healthy Community Partnerships Johns Hopkins Bayview Medical Center <u>whale5@jhmi.edu</u>

Panagis Galiatsatos, MD, MHS Assistant Professor, Division of Pulmonary & Critical Care Medicine; Interim Director Health Equity Steering Committee of Johns Hopkins Health System

Stephanie Archer-Smith, MS Executive Director Meals on Wheels of Central Maryland, Inc. archersmith@mowcm.org





Health Care Overview

Aging of the population: Chronic disease epidemic

Rising cost of care: Health Care Reform

Focus on population health

Nutrition and food security

Isolation Housing Johns Hopkins Bayview Medical Center History as a community hospital

Home to the Johns Hopkins Division of Geriatric Medicine and Gerontology

Community Benefits – IRS requirement for non-profit hospitals

Benefits to the Patient



Meals on Wheels is a known and trusted provider



Offers easy access to healthy food



Acts as an extra set of 'eyes and ears'



Brings additional services into the home

Benefits to the Medical Center

G

Ideal for patients at high risk of readmission

0

Ability to uncover issues and concerns missed in the hospital



Can supplement what the hospital & other agencies offer



Can tailor services to the needs of the community



Good for community relations



Good story

Future Considerations

Baby boomers and life expectancy gains continue to feed rising number of seniors

More communitybased treatment will be necessary

Payors are beginning to recognize the value in the service

"The right thing to do becomes the smart thing to do"

Eliminating Disparities is the Pathway to Equity



This is Disparity

This is Equality This is Equity

Baltimore's Health Disparities



Baltimore's Health Disparities







Website produced by the Applied Population Lab, UW-Madison • Privacy Statement • Contact Us

To overcome health disparities, can a 21st hospital and healthcare system act alone to achieve health equity for all populations?

Eliminating Disparities is the Pathway to Equity



This is Disparity

This is Equality This is Equity

The Framework

Make health equity a strategic priority. Organizational leadership must make a strategic commitment to improving equity, to signal that advancing equity is critical to the mission and vision of the organization.

How?

Identify equity as a priority in the organization 's strategic plan

Demonstrate leadership ownership, behaviors, accountability and vision for health equity Increase awareness of health equity throughout the organization

Identify a reliable partner & secure sustainable funding

Novel Health Care Services

 Establish <u>trust</u> between providers and patients, particularly when co-designing new processes and care designs in partnership with patients

• Provide <u>accessible services</u> focused on meeting the needs of vulnerable individuals in the community

- Nutrition
- Home safety
- Social Isolation/Engagement

Meals on Wheels of Central Maryland



More than a Meal philosophy and approach to service



Affinity Group on Aging Called to Care HUBS

Project Overview

Together In Care

Designed as a randomized controlled trial

IRB approval

Pre-post screenings

90 days of service

3 years; 200 people per year

Currently engaged in grant funded one year pilot study

Together In Care

No Cost Home Delivered Meals

Care Coordination Services

- Health and safety checks via daily and weekly surveys
- Nutrition and health education
- Medication monitoring and support
- Minor home repairs and modifications
- Links to other benefits and services
- Response in real time through technology

Daily Survey





Daily Survey



Dashboard Report

Project Coordinator Dashboard	× +										- 0	a x	
← → C a cxm.servtracker.com/Dashboards/ProjectCoordinator/ProjectCoordinator#											\$	Θ:	
III Apps 📀 RD Web Access 🔳 U	Uber Health: Past Ri 🔳 U	Jber Health: Today'											
	Search for s	something								B	P Logo	out 🕫	
	Project Coordinator Dashboard Total Pending Actions Clients Escalated Successful Deliveries Delive								es In Progress Failed Deliveries				
Plintervention c	1 0 3 0								0				
🐴 Contacts	Open Interventions												
🗃 Mailbox	All routes are selected									Today +			
🗱 Setup	Client ID	▼ Name	Y Weig	Escalation	Escalation ×				Case Manager	▼ Site ▼			
	▲ 33480	Tic Sawyer Coruzzi	1	First Name	Last Name	Email	Route Group Description	11/18/2019	Margo Coruzzi	TEST99	Escalate		
	Negative Survey Responses					coruzzi@mowcm.org	Undefined		Project Coordinator Notes				
	Question					kirley@mowcm.org	Undefined		Called client and pre	Called client and prescription had arrived			
	Did you take your medicine today? Is the client unusually confused? Was the home clean and free from obvious safety hazards?					brown@mowcm.org	Undefined	expected this afternoon.					
						hurd@mowcm.org	Undefined						
						pitts@mowcm.org	Undefined						
	Do you have a no	H 1 2 3 H 1 -5 of 11 items											
		Escalate				Sive							
	8 8 1 8 8								1-1 of Litems 🗿				

Results to Date

Better medication management

Fewer reported falls

30 day re-admission rate @ 17%

Reduction in ICU rate

Improved overall health

Case Examples: Joseph & Debra



Joseph is 77 years and was referred to the Together In Care project in January after he was hospitalized due to a back injury that left him unable to walk. He was also diagnosed with hypertension and diabetes.

He has no family and, in fact, was an orphan living on the streets in Puerto Rico before he earned enough as a teenager money to come to the United States to work as a migrant worker. Benefits to Meals on Wheels of Central Maryland Affiliation with a highly regarded institution

Builds confidence in capabilities through demonstrated quality service and results

Creative and sustainable funding opportunities

Impetus for innovations organization wide

Pipeline for referrals: hard to reach clients

Knowledge and evidence base