**PROFILES IN INNOVATION**

**Linda Dunbar, PhD,** is vice president of care management and population health at Johns Hopkins HealthCare in Baltimore, Maryland. She currently oversees the community-based aspects of the Johns Hopkins Community Health Partnership, a program funded by a Center for Medicare & Medicaid Innovation award. She has a PhD in nursing and health policy, and is also an adjunct professor at the Johns Hopkins University School of Nursing and Bloomberg School of Public Health.

**ABOUT THE INNOVATOR**

Growing up alongside a sister with cerebral palsy, and having witnessed the successes and failures of the health care system to meet her family’s needs, Dr. Linda Dunbar knew from age six that she wanted to help individuals with complex health issues. Starting her career on the front lines as a pediatric nurse and rising through the ranks to become a hospital administrator and managed care plan executive, her focus today is on strengthening community partnerships and building robust systems to support Baltimore’s neediest populations.

Dr. Dunbar began her health care career as a nurse in the neonatal intensive care unit at Mt. Washington Pediatric Hospital in Baltimore. She remembers being “drawn to the patients and families with very complex, long-term needs—especially those arising from things like premature births and lung conditions,” and she has continued to work with this population throughout her clinical career. Appointed as the director of nursing and patient services at Mt. Washington in 1984, Dr. Dunbar oversaw services there for 13 years.

In 1997, Maryland began mandating enrollment in managed care for all Medicaid beneficiaries. Concerned that these plans could not adequately meet the needs of children with disabilities, Dr. Dunbar originally advocated that this population be excluded from mandatory enrollment. These efforts led Johns Hopkins to recruit her to join its own managed care plan, Priority Partners, and strengthen its capacity to serve children with special health care needs.

During her tenure with Johns Hopkins HealthCare (JHHC), Dr. Dunbar has led efforts to develop care management programs for individuals with chronic conditions. Her current focus at JHHC is on better serving patients whose medical conditions are compounded by behavioral health needs, substance use disorders, and other social challenges.

She is now deeply involved in the Johns Hopkins Community Partnership (J-CHiP), a new initiative funded by the Centers for Medicare & Medicaid Innovation that is bringing together community-based partners to provide care in one of the Baltimore’s highest-needs areas. With its ambitious scale and scope, innovative use of technologies, and strong network of partnerships, J-CHiP promises to yield important insights into the field of complex care as it moves forward.

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*The Center for Health Care Strategies’ Complex Care Innovation Lab, made possible by Kaiser Permanente Community Benefit, is bringing together leading innovators working to improve care for vulnerable populations with complex medical and social needs. Participants will explore new ways to advance complex care delivery at the local, state and national level. These profiles highlight Innovation Lab participants. For more information, visit www.chcs.org.*
## ABOUT THE INNOVATION

### The Johns Hopkins Community Partnership

**Program Description:** The Johns Hopkins Community Partnership (J-ChiP) is a care coordination and management program for residents of East Baltimore. The program is a partnership between Johns Hopkins University’s Schools of Medicine, Nursing, and Public Health; its primary care physician network; its home care service; and its managed care organization. Other partners include five skilled nursing facilities, two acute care facilities, a number of federally qualified health centers, and a variety of community-based organizations. J-ChiP focuses on strengthening patients’ linkages to primary care, improving transitions in care, and ultimately improving the quality of services delivered while reducing costs and unnecessary readmissions. The program officially launched in July 2012.

**Population:** The two target populations for J-ChiP are: (1) patients who already use the two large hospitals in the area – Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center – and need assistance with transitions from hospital to community; and (2) underserved Medicare and Medicaid beneficiaries residing in East Baltimore and identified through a predictive algorithm as being at high-risk for future inpatient hospitalization. Johns Hopkins has set the goal of serving 50,000 patients through J-ChiP by its third year of operation.

**Delivery Model:** Community health workers (CHWs) locate and engage eligible patients in their home or community and conduct an assessment to identify barriers to care. The patient is assigned to a clinic-based team (CBT), which consists of nurses, primary care physicians and behavioral health specialists, among others. After an initial comprehensive clinical assessment, the CBT lead works with the patient and team to create a care plan. Other team members may include a health behavior specialist, who focuses on mental health and substance abuse needs, and a volunteer navigation support specialist, who is recruited from the community and is paid a stipend to help patients access health and social supports.

**Financing:** Johns Hopkins received a $19.9 million Center for Medicare & Medicaid Innovation (CMMI) award to fund the three-year J-ChiP program, and is contributing an additional $12 million of in-kind resources, including 10 nurses and CHWs. Once the CMMI grant ends, the project aims to support itself through a shared savings model.

**KEYS TO SUCCESS**

1. **Multidisciplinary care teams** that maintain a coordinated, patient-centered approach to care;
2. **Information technology** that allows for real-time team communication, comprehensive data gathering and analysis, and seamless interaction with providers’ electronic medical record systems;
3. **Comprehensive patient data analyses conducted** before and after engagement to get a clear picture of patients’ needs; and
4. **Strong continuous quality improvement processes** that reveal best practices and ensure fidelity to the program model across all care sites.

### Spotlight: Harnessing the Power of Technology

Baltimore has long been one of America’s most troubled cities, and within it, East Baltimore is one of its most challenging neighborhoods. Urban decay, poverty, drugs, food deserts and high unemployment rates are just a few of the challenges facing the residents. To tackle these issues, J-ChiP is investing in technologies that facilitate care coordination; enhance continuous quality improvement efforts; and ensure staff safety, productivity, and ease of communication.

J-ChiP has purchased iPads with GPS software for all CHWs. This software allows supervisors to monitor staff locations at all times, which helps to ensure safety. It also provides insight into where staff are spending their time, allowing teams to better understand neighborhood needs, and to track staff productivity. Using their iPads, CHWs can immediately send initial assessment data to the clinic-based team, allowing teams to be looped into care from the moment the patient is engaged.

Another technology that the project is testing is its web-based case management platform, developed through Salesforce.com. Key features include integration with Johns Hopkins’ electronic medical record system and a live-chat function. This instant messaging feature promotes staff safety by allowing field-based staff to communicate with supervisors instantaneously and inconspicuously, and allows team members to communicate about their patients from any location in real-time. Dr. Dunbar believes that leveraging opportunities created by these emerging technologies will help ensure J-ChiP’s success in both clinical and community settings.