Tumaini (Hope) for Health

Organizing A Neighborhood Health Resource Workforce Block-by-Block to Support Care and Improve Health in East Baltimore, MD

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Presentation Overview

- Brief History of East Baltimore
- Tumaini – The Convergence of Two Responses:
  - The Johns Hopkins Community Health Partnership (J-CHiP)
  - The East Baltimore Health Enterprise Zone Collaborative
- Tumaini’s Multi-level Approach to Neighborhood-based Case Management
  - Community Health Worker-Case Managers
  - Neighborhood Navigators
- Focus on Neighborhood Navigators:
  - Meet Clarence Howard and Ida Hopkins
- Monitoring and Evaluation:
  - A mixed methods approach to inform implementation fidelity, quality improvement and sustainability
The Johns Hopkins Community Health Partnership (J-CHiP)

• Launched in July of 2012
• A multi-intervention systems change demonstration project funded by the Centers for Medicaid and Medicare Innovations (CMMI) Center
• Targets two populations:
  ○ All hospitalized patients discharged from Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center in East Baltimore
  ○ Medicare and Medicaid beneficiaries with multiple comorbidities receiving primary care in 21202, 21205, 21213, 21224, and 21231
• Composed, primarily, of two main interventions
  ○ Inpatient setting: Multidisciplinary inpatient teams who coordinate a patient’s care from hospital admission thru 30 days after discharge from hospital
  ○ Outpatient setting: 3000 high risk/high cost Medicare and Medicaid patients who receive multidisciplinary care through teams made up of primary care providers, nurse case managers, health behavior specialists, and community health worker
• In outpatient setting, care teams embedded and organized by clinic
The Johns Hopkins Community Health Partnership (J-CHiP)

• Barriers to engagement
  – Historically, low-income African American communities in East Baltimore have felt marginalized and were reluctant to engage with Hopkins because of perceptions of:
    • Racism
    • Unfair housing and urban development practices
    • Extensive research on neighborhood residents with perception by residents of little to no tangible benefit
    • Limited access to care for decades
  – Poverty
  – Staffing ratios: determining the right caseloads
  – Locating services in clinic poses challenges when getting patients to the clinic is itself a barrier
Community Advocacy

- Through an extended series of community meetings with Hopkins, J-CHiP’s East Baltimore residents and advocates suggested that two CBOs could help address barriers and extend the programs reach into the community.

- CBOs have decades of experience working in East Baltimore.

- These CBOs recently helped to lead a neighborhood-wide effort to develop a “block by block” care delivery model: the East Baltimore Health Enterprise Zone Collaborative
The East Baltimore Health Enterprise Zone Collaborative

- Organized by neighborhood leaders, CBOs, and health care providers
  - More than 30 organizational partners in total
- Aimed to leverage existing community assets and relations to support community organizing around health care and social service delivery
- “Block-by-block” approach to supporting neighborhood residents’ care-seeking and care-giving
- Initially:
  - Targeted the disproportionate burden of cardiovascular disparities in East Baltimore neighborhood
  - Focused on applying for funding from the State of Maryland for designation as a “Health Enterprise Zone”
- Now: committed broadly to building a resident-driven community health network
• Collaborative effort between J-CHiP, Sisters Together and Reaching (STAR), and the Men and Families Center, Inc. (MFC)

• Intervention design based on the multi-level community health workforce model created by the East Baltimore Health Enterprise Zone Collaborative, adapted in partnership with J-CHiP over a one year period.

• Composed of two intersecting interventions:
  - Neighborhood Navigators, trained and overseen by the Men and Families Center, Inc.
  - Community Health Worker-Case Managers, trained and employed by Sisters Together and Reaching, Inc.
Tumaini (Hope) for Health – Community Health Worker-Case Managers (CHW-CM)

- **Intensive, longitudinal community-based case management to mitigate barriers to access, engagement, and adherence**

- **Community-based and community-placed**
  - Care activities in patients’ homes and community centers
  - Regular home visitation and accompaniment to appointments for health and social needs

- **5 CHW-CMs**
  - All reside in East Baltimore neighborhoods where their patients live
  - Caseload of approximately 50 patients each, assigned based on where patient lives and complexity of needs

- **Dual clinical and operational supervision**
  - Clinical: RN nurse case manager
  - Operational: supervisor with extensive experience as CHW

- **Document work in cloud-based case management database shared with J-CHiP**

- **Coordinate care activities with Neighborhood Navigators (NNs) for patients residing in NN neighborhoods**
Tumaini (Hope) for Health – Neighborhood Navigators

• “Block-by-Block”
  – Organizing for health one block at a time.
• Reside and work in specific neighborhoods
  – Middle East, McElderry Park, Madison/East End, Broadway East, Berea
• Model draws on geographically- and census-based approaches to community health delivery in resource-poor settings
  – Ex: Census Based Impact Oriented (CBIO) approach, the Care Group model, and histories of community organizing in East Baltimore.
• Combines features of community health worker and peer advocate/mentor models
• NNs receive a stipend and in-kind compensation
  – Approximately equivalent to a living wage for an individual for 10 hours per week.
• Document work through a telephone data entry tool developed by JHHC and adapted for use for the NNs with a de novo needs screening tool
Tumaini (Hope) for Health – Neighborhood Navigators (cont.)

- Deployed officially in April 2014
- Trained and overseen by the Men and Families Center
  - 40 residents were trained, 30 chosen and deployed
- Serve four primary roles:
  - General neighborhood education and outreach (neighborhood-wide)
  - Informal monitoring and surveillance of unmet needs related to access to health care and social services (neighborhood-wide)
  - Regular home visits to provide social support and promote engagement with care among a small caseload of high-risk patients (including, but not exclusive to patients identified by J-CHiP)
  - Capacity-building and mobilization of neighborhood residents through regular participation in and presentation to neighborhood association meetings
Geographic Focus on Neighborhoods
Meet the Neighborhood Navigators

- Ida Hopkins
- Eugene Brown
Evaluation Design and Approach: Community-based Participatory Research

- Draws on principles of community-based Participatory Research (CBPR)
- All research questions, aims, outcomes, and methods were agreed upon by all partners involved in the collaboration
Study Aims

• **Study Aim 1:** To evaluate the overarching feasibility of implementing a multilevel community-based intervention

• **Study Aim 2:** To explore the experience of implementing this program from the perspectives of program planners, deliverers (i.e., CHWs and NNs), recipients, and other neighborhood stakeholders
• **Study Aim 3:** To begin to qualitatively track the effects on experiences of care-giving and care-seeking among East Baltimore residents

• **Study Aim 4:** To begin to track the metrics related to health, utilization, and cost outcomes for J-CHiP patients and residents of the target 3 zip code area who are not J-CHiP patients as a critical part of ongoing program monitoring
Study Questions

• What factors affect the development and implementation of a geographic care delivery model/community-based model with respect to its perceived acceptability (for patients and staff alike) and implementation fidelity?

• What are the experiences of deploying the program from the perspectives of program planners, deliverers, and recipients?
  - What are the experiences of J-CHiP patients residing in Neighborhood Navigator neighborhoods?
  - What are the experiences of J-CHiP patients residing in zip codes 21202, 21205, and 21213 who receive CHW services?
  - What are the experiences of residents living in the targeted neighborhoods who are not J-CHiP patients?
  - What are the experiences of CHWs?
  - What are the experiences of NNs?
Study Questions (cont.)

• Are there characteristics of the patients themselves that may predict the extent to which they engage in the program?

• What methods can we employ to track health, utilization, and cost outcomes for community residents who are not J-CHiP patients and for whom such data is not readily available?

• What methods can we employ to track how Tumaini influences household management of illness and dynamics of care-seeking and care-giving?
Methods

- **Quantitative:**
  - Data culled from administrative, claims, and program implementation
  - Descriptive and inferential statistics to conduct analyses assessing efficacy of Tumaini on health, utilization, and cost outcomes; as well as impact of program processes on outcomes

- **Qualitative**
  - Focus groups, in-depth interviews, and ethnographic studies to explore:
    - Patients’ responsiveness to STAR CHW and NN interventions
    - Impact of involvement on NNs themselves
    - Caregiving among neighborhood residents
Methods *(Qualitative)*

- Longitudinal prospective ethnographic case studies among households receiving services from CHWs
  - Goal: to understand the intersection between program activities and household caregiving practices
  - Conducted at regular intervals over the course of the intervention
  - Population to be made up of 2 households receiving support from:
    - NNs + CHWs
    - CHWs only
    - NNs only
Methods (Qualitative, cont.)

- Participant observation of NNs’ and CHWs’ outreach activities
  - Goal: to ascertain how specific factors related to program design and neighborhood characteristics shape the conditions and impact of NNs’ and CHWs’ interactions with patients
  - Accompaniment to occur for all 30 NNs and 5 CHWs
  - Study team members to maintain field notes, which will be coded and analyzed with Atlas.TI
Methods (Qualitative, cont.)

• Participant observation in, and content analysis of, community health workforce staff meetings
  ⊗ Goal: to monitor which patient, program and neighborhood-level concerns emerge week-to-week that are endorsed as affecting successful deployment and receipt of intervention activities
  ⊗ Study team members to maintain field notes, which will be coded and analyzed with Atlas.TI
Methods (Qualitative, cont.)

• Focus group discussions and semi-structured interviews of NNs and CHWs
  - Goal: to create a catalog of the barriers and facilitators of implementing Tumaini from the perspective of NNs and CHWs
  - Solicit feedback on the extent to which patients’ characteristics, familial dynamics, neighborhood socioeconomic environment, and program operations affect capacity to deliver program as intended
Methods (Qualitative, cont.)

- **Focus group discussions among neighborhood residents**
  - Goal: to develop a repository of community experiences that sheds light on how transformation, within their communities, has shaped health-seeking and maintenance behaviors
  - Will track awareness and acceptability of Tumaini at large and its components in particular; perceived concordance with CHWs and NNs; satisfaction with services received; and desire for CHWs or NNs in health
  - To be conducted at regular intervals throughout the course of the intervention (every 3 to 4 months)
## Outcomes of Interest

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<th>PROGRAM STAGE</th>
<th>FEASIBILITY QUESTION</th>
<th>POTENTIAL OUTCOMES</th>
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| Ramp-up       | What resources are needed to support full implementation of Tumaini? | - Time to fill CHW positions  
- Time to recruit for NN positions  
- Total # of applications for CHW positions  
- Total # of qualified applicants for CHW positions  
- Total # of NNs recruited  
- Total # of NNs retained  
- Total # of CHW training hours  
- Total # of NN training ours |
### Outcomes of Interest (cont.)

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| Implementation | To what extent are Tumaini's interventions judged as suitable, satisfying, or attractive to program deliverers? To program recipients? | - Patient satisfaction with CHWs and NNs  
- Community stakeholder satisfaction with CHWs and NNs  
- Patient engagement with Tumaini  
- CHWs and NNs’ satisfaction with Tumaini |
## Outcomes of Interest (cont.)

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<tr>
<td>Implementation</td>
<td>To what extent can Tumaini be successfully delivered to intended participants?</td>
<td><strong>Neighborhood Navigators</strong>&lt;br&gt; - # of residents outreached by NNs&lt;br&gt; - # of patients identified for J-CHiP by NNs&lt;br&gt; - # of face-to-face encounters with NNs&lt;br&gt; - # of referrals made to appropriate community, social, and health services&lt;br&gt;<strong>STAR Community Health Workers</strong>&lt;br&gt; - # of J-CHiP patients outreached by CHWs&lt;br&gt; - # of J-CHiP eligible patients found by CHWs&lt;br&gt; - # of face-to-face encounters with CHWs&lt;br&gt; - # of telephonic encounters with STAR CHWs&lt;br&gt; - # and type of barriers mitigated by STAR CHWs&lt;br&gt; - # of referrals made to appropriate community, social, and health services</td>
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