Shorter Hospital Stays *(continued from page 2)*

After implementing the checklist for six months, the researchers compared how many patients had received an early discharge—defined as discharged by 2 p.m. on the day physicians had selected as the goal—with the number of patients who received an early discharge before the checklist was developed. While only 12 percent of patients met this target before the checklist, about 40 percent did after the checklist was put in place—a nearly threefold increase.

The researchers hope to study the effects of implementing similar checklists to streamline care for other groups of patients, such as those admitted for intravenous immunoglobulin and plasmapheresis. If results are promising, they say, other hospital departments may consider implementing similar checklists for their patients to streamline hospital stays.

"We've shown that it's truly possible," says Puttgen, "to increase the value of care by maintaining quality and increasing efficiency." ■

Bits, Bytes & Briefs

Smarter Ordering of Breast Biomarker Tests Could Save Millions in Health Care Dollars

A review of medical records for almost 200 patients with breast cancer suggests that more selective use of biomarker tests for such patients has the potential to save millions of dollars in health care spending without compromising care, according to Johns Hopkins researchers. Specifically, waiting to perform these tests until a patient has a full excisional biopsy instead of "reflexively" or automatically testing for them on initial small "core" biopsies could save as much as $117 million, according to a report on the study published in the July issue of *The American Journal of Surgical Pathology*.

Better Continuity of Care May Significantly Reduce Overuse of Medical Tests

A "look back" study of Medicare fee-for-service claims for more than 1.2 million patients over age 65 has directly affirmed and quantified a long-suspected link between lower rates of coordinated health care services and higher rates of unnecessary medical tests and procedures. In a report on the study published online May 18 in *JAMA Internal Medicine*, a trio of Johns Hopkins researchers say they analyzed 5 percent of Medicare claims using a previously validated set of 19 overused procedures and a measure of so-called continuity of care.

Hopkins in the News

Johns Hopkins and All Children's Hospital Leaders Recognized as Top Experts in Patient Safety

Two leaders from the Johns Hopkins Health System were named to *Becker's Hospital Review*'s list of 50 Experts Leading the Field of Patient Safety: Peter Pronovost, director of the Armstrong Institute for Patient Safety and Quality and senior vice president for patient safety and quality at Johns Hopkins Medicine, and Brigitta Mueller, vice president of medical affairs and chief patient safety officer at All Children's Hospital Johns Hopkins Medicine.

Infection Expert Tapped by White House for Antibiotic Initiative

Johns Hopkins infectious disease researcher Sara Cosgrove was recently tapped by the White House to help address solutions to the ever-growing problem of antibiotic-resistant bacteria. Cosgrove, along with more than 150 others in the field, outlined current and future contributions to antibiotic stewardship as part of the initiative. This work will be part of a federal plan to make changes over the next five years to slow the emergence of antibiotic-resistant bacteria, detect resistant strains, preserve the efficacy of our existing antibiotics and prevent the spread of resistant infections.

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Marketing and Communications:
901 S. Bond St., Suite 550
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Dalal Haldeman, Ph.D., M.B.A., *senior vice president*
Justin Kovalsky, *managing editor*
Karen Blum, *writer*
Lori Kirkpatrick, *designer*
Keith Weller, *photographer*

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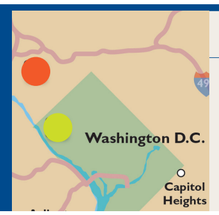
Inside MCP



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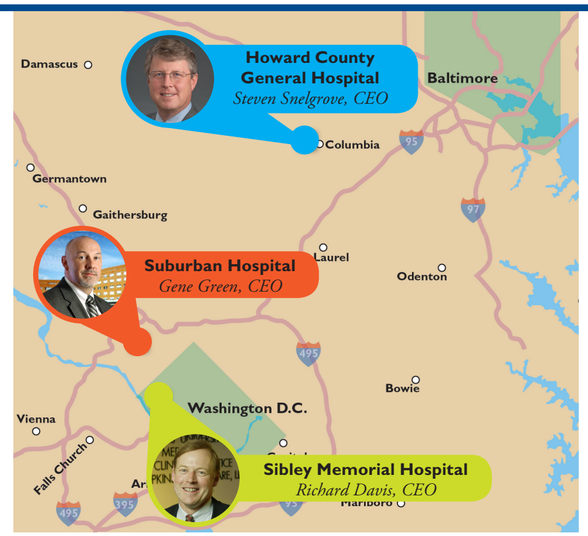
Community Hospitals in a Shifting Climate



Community hospitals were long viewed as a place to go only when you became ill or injured. But changing market forces are requiring these medical centers to embrace a new role that encompasses not just acute care but also overall prevention and wellness. *Managed Care Partners* sat down with Johns Hopkins Medicine's three community hospital presidents to find out more.

What are some of the biggest challenges facing community hospitals today?

Steven Snelgrove, Howard County General Hospital: One is the global revenue cap in Maryland, which clearly put us in the population health business overnight. We don't think about ourselves as just hospital administrators worried about business coming into the hospital. We think about addressing the needs of the community we serve to ensure health and wellness. We partner with other community providers, such as physicians, skilled nursing facilities, assisted living facilities and home health agencies, to ensure that patients are not just cared for in the hospital but also when they're discharged so they don't have to be readmitted.

We're also now focused on the social determinants of health that create disease or illness in the first place: poverty, transportation, access to affordable housing, good nutrition, exercise, smoking status. We're now partnering with the Health Department and other community agencies to improve access to services and help people do the right things for their health.

Richard Davis, Sibley Memorial Hospital: One major challenge is maintaining the balance between continuing the high-quality, efficient care our community expects while also meeting the needs of community physicians in the midst of a rapidly shifting marketplace. One of the new models of care we must look at is providing patients a full continuum of care within and without the traditional hospital walls. We're preparing for population health, which requires that patients receive the right care in the right place and at the right time for the right cost. It's a very service-oriented attitude.

Gene Green, Suburban Hospital: We hear a lot about health care transformation, but most people don't know exactly what that means. Fee for service is being replaced with value-based payments for safety, quality and the patient experience. Greater efficiencies are required in order to focus on those while decreasing costs. One of the answers is to identify ways to align with other organizations and with physicians, often through an employment model.

What investments are you making, and what strategies are you employing to prepare for the future?

Snelgrove: We've created a new senior-level position in Population Health and Community Relations; Elizabeth Edsall Kromm is helping us establish what population health looks like in Howard County. She's doing so by collaborating with the medical director of the health department, the head of the Horizon Foundation (a funding agency unique to Howard County), the public school system and other providers.

Davis: Let me give you one example here at Sibley. We have a large and thriving oncology service. One of the most significant improvements that has, and continues to have, a major positive impact on the patient experience is the hiring and then assigning of nurse navigators to patients so they'll have a single point of continuity for their care. This navigator makes sure that appointments are followed up, information is provided, questions are answered and so on. We are well-positioned to provide the needed continuity of care for our patients: We have an acute care hospital, we have a rehab hospital, we have an assisted living facility, and we own a home care company. We have robust outpatient activities. We are making strategic investments in more prevention and wellness initiatives. The other area that we're focusing on is creating a more robust ambulatory network. And we're asking questions like, Should be we in pharmacy? Should we be in other locations?

Green: At Suburban, it's our role to be the hub of community wellness. A hospital's main role used to be to take care of you when you were sick. Now our role is expanding to keeping the community healthy. So we are looking for partners, relationships and alignments to keep people healthy throughout all stages of their lives and, when they do become ill, to manage their health throughout the continuum of care—including primary and specialty care, skilled nursing facilities, and even fitness centers. Any relationship that helps build that, we're seeking. I'm even talking to correctional facilities and to area businesses who want to keep their employees well. And we are also looking at ways to bring information technology into this to help us drive change.

What must community hospitals do to reach clinical and financial success?

Snelgrove: We have to embrace the mandate of accountable care and partner with physicians, elected officials and other providers. We need to help citizens understand the value of population health—what it means to the quality of life in our communities—and create a strategy that everyone supports.

Davis: We have to never waver in our focus on quality and safety as the number one priority. And providing excellent service is a strategic priority as well. There's a growing—and I would say appropriate—expectation from patients and families that their experience needs to be "five-star." We are recognizing that care needs to be designed around them, not the provider. For financial success, we have to look at our underlying cost structures and see where there are opportunities to reduce those and have patients seen in the most appropriate care settings.

Here at Sibley, we've introduced a number of more progressive performance-improvement tools for staff to help us redesign a more efficient and effective care delivery model. My particular focus is on investing in organizational development activities that will educate staff members to give them tools to help fingerprint where we're headed. The other initiative we're doing is having physicians visit patients at home after discharge. We believe it's the right thing to do to make sure that patients are doing well and see if they have any questions. It helps reduce readmissions. But it also introduces a cultural dynamic where we can provide care that isn't inside the traditional walls of the hospital.

Green: We must embrace teamwork. That means everybody: physicians, nurses, patients and families. We have a very engaged Patient and Family Advisory Committee that is guiding us toward an enhanced model for patient- and family-centered care. ■

From the Office of Managed Care

Patricia Brown
President, Johns Hopkins HealthCare

Farewell, Heads in Beds

For a century or so, the prevailing business model for most hospitals was to keep the hospital full.

We're now saying goodbye to the "heads in beds" era and permanently transitioning to a new model in which hospitals play a central role in keeping patients out of hospital beds! Of course hospitals always will be responsible for treating sick individuals who need acute inpatient care. But they're now being called upon to do even more, partnering with payors, public health agencies, community advocacy and service groups, and, most importantly, our patients to try to keep people healthy at home, while reserving hospitalizations only for those who cannot get their necessary care in any other setting.

As you'll see in our cover story interview with the presidents of Johns Hopkins Medicine's three community hospitals, there has been a major mindset shift here in Maryland, with its all-payer rate-setting system and now a global budget revenue program that incentivizes hospitals to work in partnership with other providers to prevent unnecessary hospitalizations and readmissions. This will involve creating better discharge processes so patients walk out of the hospital knowing what they need to do, and deliberate efforts to connect those patients to primary care providers if necessary. It also involves collaborating with others that formerly may have been considered our competitors. We call this "coopetition." The exciting result will be a more integrated, seamless care experience for patients and a higher likelihood of maintaining optimal health. We are in the midst of these transitions now and committed to seeing them through.

Along this same theme, this issue also highlights an effort by Johns Hopkins neurologists to reduce hospitalizations for patients with multiple sclerosis. By developing checklists of treatment steps and patient responsibilities, they tripled the number of patients receiving early discharge.

I'm also pleased to report that many of Johns Hopkins' specialty departments are now opening clinic spots to accept more patients for urgent visits within a day or two of a physician referral, saving patients weeks of waiting to see a specialist and potentially reducing the number of emergency department visits.

Efforts like these are new ground for Johns Hopkins but core to our mission. By keeping the patient at the forefront of our efforts, the work will fall into place. ■

MANAGED CARE NEWS

New Initiative Opens Access

SUSDR, or Specialty Urgent Same-Day Response, aims to get patients in to see a specialist before their conditions escalate.

When James Ficke joined Johns Hopkins a year and a half ago as director of orthopaedic surgery, patients with orthopaedic issues might have had to wait weeks to get in to see a specialist. Some likely went to other physicians or wound up in the Emergency Department, he says.

Now things have changed. In addition to efforts Ficke has led within the department to open access, the Department of Orthopaedic Surgery is one of the first to have signed on for a new Johns Hopkins program called Specialty Urgent Same-Day Response, or SUSDR. Through this initiative, patients with urgent orthopaedic issues who are enrolled in the Johns Hopkins Medicine Alliance for Patients (JMAP), a Medicare accountable care organization, can be referred to Johns Hopkins orthopaedic surgeons through a dedicated telephone line. Typically, they are then seen within a couple of days, with an appointment in one day as the goal.

James Ficke

Department representatives have seen a range of conditions, Ficke says, including sports-related knee injuries, urgent hand injuries, spine issues, and foot and ankle problems. Every physician assistant, nurse practitioner and surgeon on staff now keeps a timeslot open during each clinic for SUSDR referrals at all Johns Hopkins locations.

"We have definitely opened space to be able to see these patients," he says. "It's uniformly been positive." Some 70 percent of issues that drive patients to emergency departments are musculoskeletal in nature, Ficke says. "We want to capture that and be able to support our patients here."

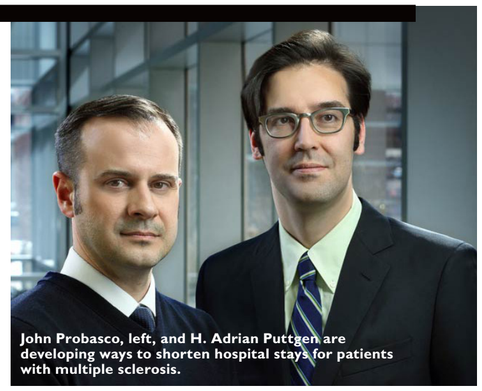
The departments of Ophthalmology and Urology also have been participating in the SUSDR initiative. The divisions of Gastroenterology and Hepatology, and the departments of Surgery, Dermatology, and Otolaryngology–Head and Neck Surgery go live July 1.

Phone calls are triaged by a registered nurse, who confirms the urgent nature of the patient complaint and notifies the specialty department, which then contacts the patient to schedule an appointment. The SUSDR line then follows up with referring physicians to confirm that an urgent appointment has been scheduled, and specialists complete clinical documentation within seven days. For now, the service is primarily for JMAP patients, with some departments accepting additional patients.

The idea, says internist John Flynn, vice president of the Office of Johns Hopkins Physicians and executive director of the Clinical Practice Association, is to refer patients to SUSDR rather than wait until the patient has an emergency that requires an ED visit, driving up medical costs. "We're working as a health system to provide the right care at the right time and prevent unnecessary escalation." The fact that the departments are listening and signing on, he says, "is a result of many clinical leaders like Dr. Ficke bringing about a remarkable change in our culture." ■

MANAGED CARE NEWS

Shorter Hospital Stays Without Compromising Care



John Probasco, left, and H. Adrian Puttgen are developing ways to shorten hospital stays for patients with multiple sclerosis.

It's no secret that most inpatients would rather not be at the hospital in the first place—and if they must be hospitalized, they hope to leave as soon as possible. However, the path to care is often full of countless twists, turns and delays that can extend length of stay.

Though some of these delays are unavoidable, say Johns Hopkins neurologists H. Adrian Puttgen and John Probasco, many of them could be prevented, allowing for in-hospital treatment in a more efficient manner without compromising care quality. That's why they and their colleagues in the Department of Neurology recently embarked upon a study that has the potential to streamline care and shorten lengths of stay for patients hospitalwide by eliminating unnecessary barriers and interruptions to care.

As proof of principle, the duo studied patients with multiple sclerosis (MS) with exacerbations that required treatment with intravenous steroids, the standard of care for MS flare-ups. Such patients typically require care that involves a range of members across the department's team: neurologists, nurses, physical therapists, occupational therapists, speech therapists and pharmacists, among others. While physicians usually have a goal for when such patients will be discharged, the vast majority missed this deadline, often by a day or more.

Hoping to move these patients through their stays more efficiently without sacrificing the quality of their care, Puttgen, Probasco and their colleagues developed a checklist of essential pieces of necessary care in the order that patients needed to receive them. They also developed a second checklist for patients and their families that allowed them to see when they'd be receiving certain types of care and highlighted which aspects of their care that patients themselves would be responsible for—such as making sure they had transportation back home upon discharge.

(continued on page 4)

MANAGED CARE NEWS

At the recent primary care consortium, Vani Bhatt, left, a pediatrician at Johns Hopkins Community Physicians at Odenton, explains her findings on integrating medical records to Maura McGuire, JHCP director of education.

A Focus on Primary Care at Johns Hopkins

When Americans talk about physicians, many speak enthusiastically about their family doctors, pediatricians or general internists. Among medical students, however, a primary care career remains less favored than other specialties: Lower pay, longer hours, low Medicare reimbursements and more elderly, complex patients contribute to its unpopularity across the nation. By 2025, experts predict a potential shortfall of up to 31,100 primary care physicians.

Now, with the creation of a Bloomberg Distinguished Professorship devoted to primary care—a position that includes teaching nursing and public health students—Johns Hopkins Medicine hopes to invigorate and advance the field, says Maura McGuire, assistant dean for part-time faculty. This year, the school of medicine will also launch a primary care track for medical students, with a focus on chronic disease treatment, research and health care delivery.

The professorship was announced at the recent Johns Hopkins Primary Care Consortium, a biennial event intended to "share the energy around creating a collaborative, multidisciplinary academic home for primary care at Hopkins," says McGuire, who also serves as Johns Hopkins Community Physicians' director of education.

Held in February, the daylong conference drew more than 200 health care professionals, Johns Hopkins leaders and trainees from across the institution. Speakers addressed evidence-based clinical processes, leadership, education and public policy development on primary care.

The idea for the new professorship grew out of the first consortium event, established in 2013 by a core group of seven colleagues from the schools of nursing, medicine and public health who felt the need to be more aggressive in advancing primary care. Leading the nationwide search are John Flynn, vice president of the Office of Johns Hopkins Physicians, and David Chin, distinguished scholar at the school of public health.

"People around Johns Hopkins are becoming more attuned to the importance of primary care," says McGuire. "They're realizing that primary care is part of the solution to improving quality, outcomes and cost."

When it debuts this summer, the school of medicine's primary care track will include a three-year clinical experience in innovative practices, research projects, a clinical rotation for fourth-year medical students, and mentorship and interaction with local leaders in the primary care field. Colleen Christmas, Johns Hopkins Bayview Medical Center's internal medicine residency director, will oversee the new track and hopes that the students who complete it will enter primary care-oriented residencies.

The new Bloomberg Distinguished Professor will guide these and other efforts, notes McGuire, "and become an accelerator to connect with others doing primary care research." That person will also boost philanthropy and advance coordination and integration of primary care in the medical, public health and nursing disciplines across The Johns Hopkins University. ■

MANAGED CARE NEWS

Winning the Race Against Waste

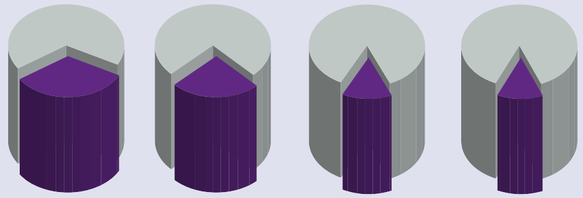
The Johns Hopkins Hospital has reduced regulated medical waste by more than half in four years.

The state of Maryland requires hospitals to handle and dispose of items contaminated with potentially infectious materials differently from everyday garbage. The disposal process is costly and can pollute the environment.

Since 2011, The Johns Hopkins Hospital has reduced its annual production of regulated medical waste by 57 percent. Kristian Henderson-Hayes, former assistant director of general services, attributes the reduction to a hospitalwide awareness campaign aimed at educating staff on the difference between regulated medical waste and plain trash, and on how to properly dispose of it.

The initiative has cut disposal costs by 77 percent per year. The reduction also earned a 2014 award for environmental excellence from Practice Greenhealth, a nonprofit organization dedicated to sustainable health care. ■

The Johns Hopkins Hospital's regulated medical waste is shrinking.



Reduction in pounds

Trimming the cost