JOHNS HOPKINS MEDICINE

ManagedCarePartners

Spring 2016

A Johns Hopkins Medicine Publication for Managed Care Organizations

Supply Chain **Set to Save** Up to $100 Million

By streamlining the way goods and services are sourced and delivered, Johns Hopkins medicine saved $20.1 million in the last fiscal year. These savings are ultimately allowing the institution to improve its pursuit of excellence in patient care.

Although the Johns Hopkins Health System is still in the midst of a five-year supply chain transformation for which departments systemwide are carefully scrutinizing their supply ordering and usage, it's already seeing significant financial rewards.

By the end of this fiscal year, the system will see savings of about $50 million, says Ron Werthman, senior vice president and chief financial officer for Johns Hopkins Medicine. "We were targeting anywhere from $80 million to $100 million total, so we're well on our way to achieving the goal."

Werthman credits the success to supply chain's integral relationship with Johns Hopkins' numerous clinical communities—physician-led groups that aim to improve safety and quality in specific therapeutic areas—and the Armstrong Institute for Patient Safety and Quality.

"In supply chain, without the involvement of the clinicians, we can only influence about 20 percent of the cost," he says. "We can deal with price. We can't deal with standardization and utilization — that has to be driven by the physicians. To the extent that the physicians agree to standardize and drive compliance, we can generate substantially greater savings."

There are three key trends expected to impact health care system viability and patient outcomes in the face of rising supply costs this year, Werthman says: increased collaboration between clinicians and supply chain team members, new approaches to counteracting rising drug prices, and advanced inventory management tactics and tools.

The clinical communities have generated noteworthy savings by analyzing and selecting their preferred medical supplies, such as dialysis catheters; spinal, hip and knee implants; and laryngoscope blades, which helps negotiations for better pricing. For example, the Johns Hopkins Spine Clinical Community, made up of spine surgeons from across the health system, helped the supply chain department achieve $3.3 million in annual spinal surgery savings through value analysis of spinal surgery products used at Johns Hopkins hospitals. Their analysis helped the finance department negotiate down the prices for spinal surgery products by demonstrating to vendors their products' value to Johns Hopkins.

To counteract rising drug prices, pharmacists have been establishing protocols to encourage or require the use of therapeutic equivalents to drugs whose prices have skyrocketed in recent years. One for The Johns Hopkins Hospital states that 11 drugs, including intravenous acetaminophen (whose cost rose from $10 a dose to over $40 between 2014 and 2016), should only be administered intravenously when certain conditions are present, such as a patient's inability to swallow. Otherwise, less costly oral-administered medications of equal effectiveness should be used.

There's also a movement to make prescription drug prices more accessible to clinicians so they'll better understand the financial impact of their prescribing. In 2015, prescription drug price information was added to a Johns Hopkins Health System database of referential information about drugs in the formularies of all five Baltimore-area Johns Hopkins hospitals.

In inventory management, the health system is making good use of electronic supply management and ordering software systems. All six Johns Hopkins Health System hospitals conduct inventory management functions through business software. This supports the integration of stockrooms systemwide, making it possible for different departments to share items that otherwise might go to waste. The hospital pharmacies are also joining the trend, tracking supplies used, wasted or about to become obsolete, and adjusting their ordering routines accordingly. And in March, Johns Hopkins All Children's Hospital debuted touch-screen hand-held devices to scan supplies and enter counts in the system via an on-screen keyboard to increase the accuracy of inventory data. ■

Top 6 areas in Which the Johns Hopkins Health System Saved in Fiscal Year 2015

From the Office of Managed Care

Patricia Brown
President, Johns Hopkins HealthCare

Change and Accountability

In the "old days" of health care, supply chain management was largely an operational issue. Today, we're scrutinizing our supply chain—and basically every other aspect of health care—to ensure we're reducing costs to deliver the best possible value and care to our patients.

In 2011, orthopaedic surgeons at Howard County General Hospital felt the medical center was paying more than it should for hip and knee implants. So they performed a systematic team review of the implants, vetting them to verify their quality, determining their value to the hospital and what they felt the hospital should pay for them. Then they told the vendors that the hospital would no longer pay more than a capitated price. The vendors agreed to the price cap.

A couple of years later, the Johns Hopkins Joint Clinical Community, a group made up of orthopaedic surgeons from across the health system, applied the same group evaluation process to total joint implants, resulting in a capitated price program estimated to save the Johns Hopkins Health System $1.5 million a year.

Through efforts like these systemwide, supply chain already has saved about $50 million of a targeted $80 million to $100 million. Ron Werthman and his team have taken the normal business process of buying supplies and converted it into a very powerful, impactful strategic tool.

Our self-scrutiny is playing out in other ways too. In the "old days," Kim Sherbrooke, the new chief operating officer of the Office of Johns Hopkins Physicians, would have been hired to manage the necessary operations of the practice. Now, we look to our chief operating officers not only as excellent managers of our work processes and systems, but as our strategic partners in building new capabilities to manage unprecedented change in virtually all that we do. And so, yes, excelling in change management will be the key to our success as we all maneuver through this time of reform and transformation. Johns Hopkins has maintained an excellent reputation for well over a century. But health care demands that we continually redefine ourselves to be more valuable. I look forward to sharing new highlights with you in the next issues. ■

Pharmacies Combine Forces for **Efficiency and Savings**

What started as a simple request for help from Johns Hopkins Bayview Medical Center's pharmacy division to The Johns Hopkins Hospital has resulted in integrated pharmacy services between the two medical centers and significant shared savings.

In 2013, when Johns Hopkins Bayview's pharmacy was in search of a new director and in need of interim leadership, Daniel Ashby, chief pharmacy officer for the Johns Hopkins Health System, and his colleagues saw an opportunity to do more than offer a temporary helmsperson. They began exploring strategies for how to share activities across the two hospitals, and that fall, a systemwide planning retreat gathered representatives from the pharmacies and administration from five Johns Hopkins Health System hospitals. The consortium looked at successful integration models from areas such as facilities and pathology.

A memorandum of understanding between The Johns Hopkins Hospital and Johns Hopkins Bayview, finalized in April 2014, identified 11 areas in which pharmacy could share services across its academic division, including strategic planning, compliance with regulatory affairs, fiscal management, and the scope and quality of services supporting safe medication use.

"We wanted to optimize our available resources," Ashby explains. "We wanted to make sure that people within the system who had similar responsibilities were connected, we wanted to identify best practices within each hospital and share them, and we wanted to see what could be done to bring savings through performance improvement initiatives."

The pharmacy at The Johns Hopkins Hospital, for example, set a performance improvement target of $3.1 million this fiscal year. Six months in, the division was projected to achieve at least $4.2 million in savings, Ashby says.

The direct cost savings reflect not only improved formulary management but also savings resulting from sharing services across campuses. For example, Sheila Lind, a senior financial analyst for the pharmacy, used to prepare a monthly analysis of drug spending and budget performance for The Johns Hopkins Hospital; she now does so for both hospitals. Bob Feroli, medication safety officer for The Johns Hopkins Hospital, travels to Johns Hopkins Bayview and the community hospitals to help them prepare for any upcoming Joint Commission accreditation surveys.

$4,200,000
PROJECTED SAVINGS FOR CURRENT FISCAL YEAR

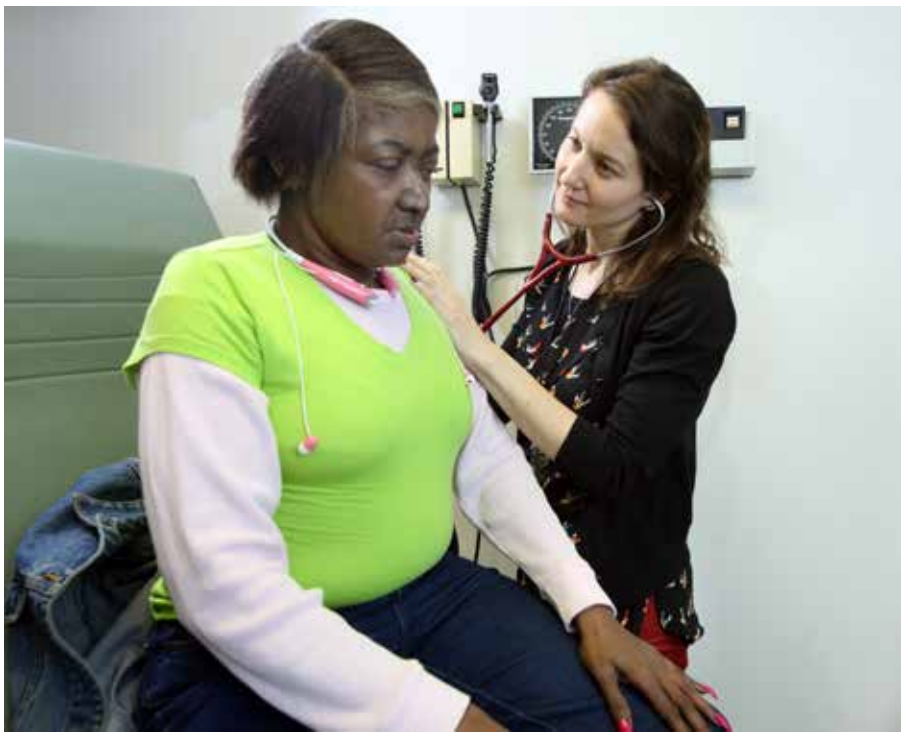
"We wanted to make sure that people within the system who had similar responsibilities were connected, and we wanted to see what could be done to bring savings through performance improvement initiatives."

DANIEL ASHBY

"I think the real key to success has been the engagement of leadership across all pharmacy departments," Ashby says. "Our colleagues at Johns Hopkins Bayview, Sibley Memorial Hospital, Suburban Hospital and Howard County General Hospital all have recognized the value in working together." ■

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center identified 11 areas in which their pharmacies could share services, including strategic planning, compliance, fiscal management and medication safety initiatives.

High-Intensity Primary Care Delivers a 2-to-1 Return on Investment



Since the PAPC pilot began a year and a half ago, ED visits among its patients have dropped 30 percent and admissions 41 percent, and it has shown a 2-to-1 return on investment. It is set to run through 2016.

One Wednesday morning as she walked through the door of East Baltimore Medical Center, internist Laura Sander got a call: A patient with uncontrolled diabetes had been admitted to another health system's emergency department (ED). Within a half-hour, Sander was on the way. That week, the woman would receive a home visit and then, the following week, she would come into the office for an extended appointment. Between visits, someone from Sander's team called the patient to check on her.

The young woman is one of 70 enrolled in the Priority Access Primary Care (PAPC) pilot, which Sander directs from East Baltimore Medical Center. The pilot is a collaborative effort between Johns Hopkins Community Physicians and the Priority Partners Managed Care Organization, which is jointly owned by Johns Hopkins HealthCare and the Maryland Community Health System.

The program aims to keep Medicaid patients out of the ED and the hospital by providing very intensive primary care services that are integrated with behavioral health care and social services. A highly successful strategy to decrease unnecessary ED visits has been direct access to providers: Patients call, text or video chat with PAPC providers 24/7 for acute needs. Also, PAPC gets a notice within 15 minutes when one of the patients is admitted to a hospital or ED in the state, not just within the Johns Hopkins system, thanks to CRISP, Maryland's health information exchange.

The pilot's inspiration is the Hot Spotters program that physician Jeffrey Brenner launched in Camden, New Jersey; Atul Gawande wrote about it in *The New Yorker*. The program's patients are the costliest among Priority Partners' population, with "incredibly complex medical and psychosocial needs," says Sander, and a history of ED and hospital admissions. Priority Partners looks at its claims data to identify candidates for the program, although Sander encourages Johns Hopkins providers to make referrals too. Sander makes the final determination of eligibility.

Working side by side with Sander is a multidisciplinary team composed of nurse practitioner Kate Shockley; certified medical assistant Sherrell Byrd-Arthur, who serves as a "health navigator" to help patients negotiate the health system; licensed clinical professional counselor Laura Fukushima; and community health worker Brian Adams, who connects patients to community resources and coaches them in disease self-management.

Since the PAPC pilot began a year and a half ago, ED visits among its patients have dropped 30 percent and admissions 41 percent, and it has shown a 2-to-1 return on investment. It is set to run through 2016. ■

MEET YOUR PARTNERS

Kimberlee Sherbrooke, COO of the Office of Johns Hopkins Physicians

"What the marketplace is telling us is physicians are looking for tighter alignments and want options for what that looks like."

Kimberlee Sherbrooke was perfectly happy working as chief operating officer for Indiana University Health Physicians, a large multispecialty group practice in Indianapolis, when she heard from Johns Hopkins. An Indiana native, Sherbrooke already had spent 20 years with the university in various health administration jobs and had been ignoring every other call from a headhunter.

But intrigued by Johns Hopkins' reputation and environment, Sherbrooke says, "it became clear that it would be a great fit for the next phase of my career." Last July, she became chief operating officer of the Office of Johns Hopkins Physicians and vice president of Johns Hopkins Medicine.

In her previous post, Sherbrooke brought together about 60 private groups and academic departments, and oversaw practice operations in some 150 locations and physician services in 11 hospitals. She also helped develop a centralized call center focused on singlecall resolution.

She admits her niche is helping to create effective and efficient operations for the delivery of patient care: "I really enjoy working with physicians. They're brilliant individuals. They have a tough job. I connect well to them, and I want to come alongside of them and really help their practice."

At Johns Hopkins, Sherbrooke manages many core functions, including the revenue cycle, practice management, physician training, Access Services and telemedicine. She has been working to develop alternative affiliation models with referring and community physicians for the benefit of patients.

"What the marketplace is telling us is physicians are looking for tighter alignments and want options for what that looks like," she says. "Our work with community physicians must align with our tripartite mission around teaching, patient care, and research, and also support their need for autonomy and control over their own destiny in times of significant change."

She's also been studying ambulatory operations at Johns Hopkins and doing some targeted planning for areas where physician services should grow. "I'm loving it," Sherbrooke says. "Hopkins is everything that I hoped and expected it to be—a fantastic culture, one that is always striving to be the best in the right ways. The focus on quality and safety here is second to none."

Sherbrooke earned her undergraduate degree in psychology from Purdue University and a master's degree in health administration from Indiana University. She is a fellow of the American College of Medical Practice Executives and the chair of the American Medical Group Association's Chief Operating Officer Leadership Council. ■

BITS, BYTES & BRIEFS

High-Quality Care Model for Outpatient Facilities

When implementing a unified, whole care delivery system, a strong organizational framework that includes the participation of all staff members—from the board room to the community practice—is critical, Johns Hopkins researchers report.

An article, published online ahead of print in *Academic Medicine* describes the model used by Johns Hopkins Medicine to coordinate high-quality care across the institution's two hospital outpatient centers and more than 39 primary and specialty care outpatient sites. The effort mapped improvement initiatives to a dozen government-required performance metrics, such as breast cancer screenings, childhood immunizations, diabetes management and prenatal care. One year after the plan's implementation, participating ambulatory care centers improved in all measures.

Johns Hopkins and MedImmune Announce Joint Program to Train Ph.D. Students for Careers in Biopharma

The Johns Hopkins University and MedImmune, the global biologics research and development arm of AstraZeneca, announced a first-of-its-kind Ph.D. training program between a major university and a biopharmaceutical company in the United States. Known as the Johns Hopkins-MedImmune Scholars Program, this new initiative will build on an ongoing collaboration between MedImmune and Johns Hopkins, and reinforces both partners' commitment to grow the Maryland biotech region.

HOPKINS IN THE NEWS

First and Only Center in the United States Approved for HIV-Positive to HIV-Positive Organ Transplants

Johns Hopkins recently received approval from the United Network for Organ Sharing to be the first hospital in the U.S. to perform HIV-positive to HIV-positive organ transplants. The institution was the first in the nation to do an HIV-positive to HIV-positive kidney transplant and the first in the world to execute an HIV-positive to HIV-positive liver transplant.

The procedure took place in March of this year.

Johns Hopkins Medicine's 6 Member Hospitals Named Leaders in LGBT Healthcare Equality by Human Rights Campaign Foundation

All six Johns Hopkins Medicine member hospitals have been designated as Leaders in LGBT Healthcare Equality by the foundation of the Human Rights Campaign (HRC), the largest LGBT civil rights organization in the United States. The recently released designations are part of the latest edition of the HRC Foundation's Healthcare Equality Index, a national survey conducted annually that promotes equitable and inclusive care for lesbian, gay, bisexual and transgender (LGBT) patients and families.

ManagedCarePartners

The Johns Hopkins University and
The Johns Hopkins Health System Corporation.

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6704 Curtis Court
Glen Burnie, MD 21060

Managed Care Partners is published three times a year by Johns Hopkins HealthCare LLC. For more information, call 410-614-3227, or write to Patricia Brown, president of JHHC, at the above address.

Produced by Johns Hopkins Medicine
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