

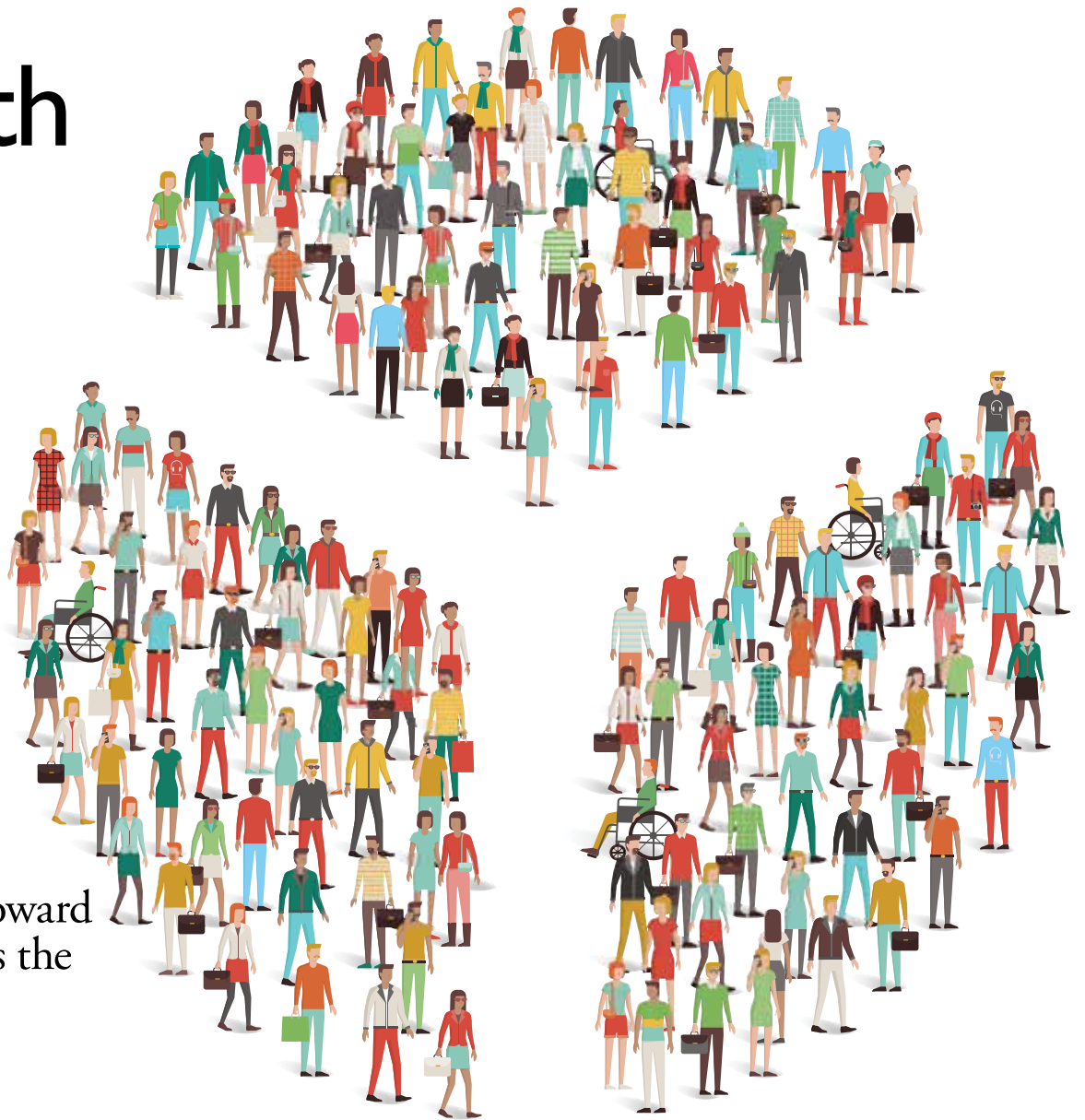
# ManagedCarePartners

Spring 2017

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## Howard Health Partnership's 3-Part Community Approach to Population Health

The partnership, which includes Howard County General Hospital, addresses the needs of high health care utilizers.



**W**ITH NEARLY \$1.5 MILLION in grant funding from the Maryland Health Services Cost Review Commission, Howard County General Hospital is well on its way to establishing a community population health model to reduce health care costs and improve outcomes.

The program, called the Howard Health Partnership, targets Howard County adults who have Medicare, are eligible for both Medicare and Medicaid, or have had at least two encounters with the hospital in the past year, including inpatient stays and Emergency Department visits. Some 80 percent of the targeted population is 65 or older, and 66 percent have multiple chronic conditions. The partnership, which started last fall, comprises Howard County General Hospital and other community groups, and has the support and participation of organizations including the local health department, Horizon Foundation and members of the local health improvement coalition.

“Through a collaborative community process, we put together an intervention framework that helps address the needs of high health care utilizers,” says Elizabeth Edsall Kromm, the hospital’s vice president of population health and advancement. “We focus on the social determinants of health in addition to making sure we offer the right clinical care. Our Community Care Team of community health nurses, licensed clinical social workers and other community health workers not only addresses patients’ clinical needs, but also conducts home visits to try to address any social needs, whether it’s food

insecurity, transportation or physical issues requiring modifications to patients’ homes so they can remain in place longer and live independently.”

The partnership’s numerous interventions fall in three categories: complex care management, care transitions and self-management supports. As part of complex care management, the hospital established its Community Care Team for primary care coordination and is working with Johns Hopkins Home Care Group on remote patient monitoring. This home-based program for patients with heart failure, diabetes or chronic obstructive pulmonary disease provides daily monitoring by a nurse case

manager as well as disease education. Through Gilchrist Services’ Support Our Elders Program, nurse practitioners and case managers provide in-

home medical care for homebound, frail elderly with chronic conditions. To deliver seamless care transitions, the hospital has partnered with Way Station Inc., a subsidiary of Sheppard Pratt Health System operating an outpatient mental health clinic in Columbia, to offer rapid access for urgent behavioral health needs. Patients presenting to the hospital’s Emergency Department with such needs are connected to Way Station within two business days and are provided initially with up to six counseling visits and two prescriber visits. The hospital also is part of a skilled nursing facility collaborative that provides standard care pathways for conditions like heart failure and sepsis, and can refer patients to the Community Care Team after discharge.

Additionally, the Howard Health Partnership offers self-management supports, such as classes from the Office on Aging on how caregivers can care for themselves and their loved ones and navigate the health system. Journey to Better Health is a faith-based program offering screening, classes and social support for those with conditions like hypertension and diabetes. Many of the partnership programs are free or subsidized for eligible participants.

“The whole point is to identify the risk factors of patients in the community and keep them healthy and out of the acute care setting,” says Steven Snelgrove, Howard County General Hospital president. “We’re very pleased by how things are going.” ■

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—STEVEN SNELGROVE, HOWARD COUNTY GENERAL HOSPITAL PRESIDENT

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## From the Office of Managed Care



Patricia Brown  
President, Johns Hopkins HealthCare

## Will Our Health Care Priorities Change?

For several years, we at Johns Hopkins and other health care institutions across the country have focused on achieving the so-called Triple Aim—better care, better outcomes and reduced health care spending—a framework established in 2007 by the Institute for Healthcare Improvement. At a recent meeting, one of my colleagues cautioned against using that term to describe our work, as it may be wrapped up in the political turmoil we all expect to see in health care in the near future. Since the election, health care leaders are anticipating change in the national policy landscape.

That change is afoot has caused some of us to question if we are going to alter directions regarding our health care priorities. I think the answer should be, and will be, no. If we still focus on the core tenets of the Triple Aim, even if that term goes away, we can achieve the goals that all policymakers want: reduced health care costs and improved quality of care.

In early December, the Association of American Medical Colleges sent a letter to leaders of the U.S. Senate and House of Representatives urging them, as they consider changes to the Patient Protection and Affordable Care Act and any future reform, to uphold a number of key principles, such as making high-quality, affordable health insurance available to all; relying on the expertise of health care stakeholders in developing any new plans; and ensuring that payments to physicians and hospitals be at sufficient levels to ensure that access to care is not compromised. Whether or not the act is repealed or revamped, I think politicians will reinstate the programs that are working. Meanwhile, we can continue to frame our work into any new structure.

This newsletter once again highlights programs in which innovative thinking is leading to improved care. In Columbia, Howard County General Hospital is co-leading a community health partnership to help high users of hospital care take charge of their health needs and stay well at home. The Johns Hopkins After-Care Clinic, which offers primary care follow-up services to patients discharged from The Johns Hopkins Hospital and its Emergency Department, is demonstrating big savings by intervening before repeat ED visits or hospital readmissions occur. A novel program at Johns Hopkins All Children's Hospital in Florida is decreasing lengths of stay and time to hospital discharge. Efforts like these all are geared toward achieving the Triple Aim. Let's do all that we can to put the patient first, while we continue to leverage all incentives to drive improved health care, improved outcomes and better costs. ■

## IDEAS AT WORK



Standing, left to right: Kimberly Williams, financial counselor; Jennifer Rice-Assenza, social worker; Fernando Mena-Carrasco, nurse; Caitlin Dowd-Green, pharmacist; Altheria Burton, patient service coordinator. Sitting and kneeling, left to right: Melissa Richardson, care coordination director; Sophia Pemberton, nurse practitioner; Rosalyn Stewart, director; Heather Dilworth, medical assistant.

# After-Care Clinic Reduces Utilization, Saving \$1 Million a Year

Over a 13-month period, the clinic helped prevent 296 Emergency Department visits and 61 admissions.

**W**HATEVER HAPPENS TO the Patient Protection and Affordable Care Act, the intractable issues it addresses are not going away: fragmented care, health disparities and soaring costs. Improving all three at once is a bold goal, but it is one that The Johns Hopkins Hospital's After-Care Clinic has tackled, with impressive results.

Directed by internist Rosalyn Stewart and emergency medicine physician Arjun Chanmugam, the clinic has improved the odds that patients who struggle to manage their health will avoid Emergency Department visits or readmission. And in so doing, they have saved the health system more than \$1 million while providing a highly vulnerable population with much-needed transitional care.

The concept is straightforward: After treatment in the Emergency Department or after discharge, connect patients with primary care and help them manage their health. But delivering on that mission is a complex task, requiring a multidisciplinary team of primary care providers, nurses, pharmacists and social workers.

The After-Care Clinic is not an urgent care center, nor is it a primary care office, explains Stewart. Rather, it provides a setting where patients can be assessed, treated and transitioned to a community provider.

Patients at high risk of readmission or Emergency Department use are referred to the clinic, located in the Johns Hopkins Outpatient Center, for an appointment within a week. A typical visit lasts 90 minutes, during which time the patient might see a provider for care, a pharmacist for medication review, a nurse for disease education and a social worker for connections to community resources.

"Many of our patients face significant barriers to care. They may have poor health literacy. They

may lack secure housing or reliable transportation. Our team helps patients get appropriate follow-up care, and that includes educating them about their condition and addressing their social barriers," says Stewart, who was recently recognized with a 2016 Johns Hopkins Medicine Clinical Award for Clinicians and Care Teams for Innovations in Care.

Since opening in March 2015, the clinic has seen about 3,000 patients and sharply reduced admissions and Emergency Department visits. Stewart and Chanmugam performed a pre- and post-analysis. The readmission rate for clinic patients before they visited the clinic was 3.7 percent. After, it dropped to 1.1 percent. Over a 13-month period, Stewart says, the clinic avoided some 296 Emergency Department visits and 61 admissions. In all, the clinic saved the health system \$1,361,288 in medical costs during that time span.

**"MANY OF OUR PATIENTS FACE SIGNIFICANT BARRIERS TO CARE. THEY MAY HAVE POOR HEALTH LITERACY. THEY MAY LACK SECURE HOUSING OR RELIABLE TRANSPORTATION. OUR TEAM HELPS PATIENTS GET APPROPRIATE FOLLOW-UP CARE, AND THAT INCLUDES EDUCATING THEM ABOUT THEIR CONDITION AND ADDRESSING THEIR SOCIAL BARRIERS."**

—ROSALYN STEWART

Over time, adds Stewart, "We want to make the After-Care Clinic an entry point for patients into a medical home that connects them with Johns Hopkins primary care—the place where they can receive comprehensive services and patient education under one roof." ■

## Charles Reuland: Integrating Excellence

The executive vice president and chief operating officer of both The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center does integrative work across the two campuses to maximize efficiency.

**I**T ISN'T EASY to take established academic medical centers like The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center and get them to function as one hospital with two campuses. But if anyone is up to the task, it's Charles Reuland.

Reuland, who in October was named executive vice president and chief operating officer of both hospitals, has spent 26 years with Johns Hopkins Medicine in a range of administrative positions on both campuses. He arrived in the summer of 1989 as a master's degree student in health policy and management at what is now the Johns Hopkins Bloomberg School of Public Health. After considering medical school, Reuland realized that his talents would be put to better use reorganizing systems to allow health professionals to be successful.

Now, he's spending time doing integrative work across the two campuses while also handling issues local to each medical center. At The Johns Hopkins Hospital, he is setting benchmarks, doing cost analyses, establishing productivity metrics for managing labor, working on capacity and throughput, reviewing business plans for new programs, and recruiting leadership for such areas as perioperative services. At Johns Hopkins Bayview, you'll find him planning and reorganizing clinical programs and departments.

"I think it's going very well, in the sense that there are even more opportunities than we thought to act creatively across the campuses," Reuland says. Ensuring that both campuses are purchasing similar or compatible equipment is one example. Rather than purchasing endoscopy equipment for each campus separately, Reuland assured that the two teams worked together to share the existing equipment and then purchase only what was needed jointly.

"We want to position the academic division to continue to survive and thrive in an environment that's uncertain," he says, noting that the evolving Maryland hospital reimbursement system presents opportunity as well as challenge. Part of the work comes down to which programs are best suited to each campus. "A lot of what we do is community medicine for the people who live around these hospitals. We have to do that well and competitively,



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—CHARLES REULAND, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER OF BOTH THE JOHNS HOPKINS HOSPITAL AND JOHNS HOPKINS BAYVIEW MEDICAL CENTER

with great outcomes and low costs. At the same time, we have to establish magnet programs that will attract patients from afar—this is what differentiates Johns Hopkins. We want to be the No. 1 academic delivery system in all of those ways."

Prior to assuming his current role, Reuland had been executive vice president and chief operating officer for Johns Hopkins Bayview since 2009. Before that, he was chief administrative officer for the Department of Medicine at the Johns Hopkins University School of Medicine and The Johns Hopkins Hospital. Additionally, he held positions in managed care contracting, social work and patient relations.

Reuland has served as a consultant to other academic medical centers, has been an author and reviewer for the *Journal of General Internal Medicine*, and continues to serve in various state committees for the Maryland Hospital Association and the Health Services Cost Review Commission. ■

### IDEAS AT WORK

## Decreasing Length of Stay at Johns Hopkins All Children's Hospital

The 24-Hour Care Progression Team's intensive quality improvement resulted in nearly a 30 percent reduction in length of stay, increasing patient satisfaction, opening up access and saving costs.

**W**E HAVE A 24-HOUR hospital. What could we do to improve our 24-hour service to patients and families without using additional resources?"

This was the broad question that pediatrician Akshata Hopkins and the rest of the 24-Hour Care Progression Team at Johns Hopkins All Children's Hospital considered. Composed of nurses, case managers and social workers, as well as physicians and residents, the team wanted to expand rounding and discharge hours to better serve working families. It also wanted to reduce the time between discharge order entry and actual discharge.

The team's combined efforts led to a 30 percent reduction in that metric and nearly a 30 percent drop in length of stay.

"We will discharge a child at 1 a.m. if that child is ready to go home, and this can make a real difference in terms of cost and convenience for families—it may mean one fewer day of work missed for a parent," says Hopkins.



Discharge planning is now an active part of daily care, she says. Residents round in the evenings at bedside so that working parents are involved in care.

"Expanding discharge hours and other initiatives have increased access and throughput, and I'm looking now at the impact on the bottom line," says Hopkins. "But the real value is how much our patients and families appreciate getting home as early as they safely can. It's just the right thing for the patient."

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—AKSHATA HOPKINS

The team's work was recognized with a 2016 Johns Hopkins Medicine Clinical Award for Clinicians and Care Teams in Innovations in Clinical Care. Of the award, Hopkins says: "It is a big honor for the group, and it really was a group effort: Nursing, social work and residents took ownership of the changes we needed to make. We were all passionate, we were all determined and we all wanted to be leaders of change." ■

**J-CHiP Case Study in Healthcare**

Johns Hopkins cardiologist and Senior Director for Accountable Care Scott Berkowitz and colleagues have published an extensive report of a four-year, \$19 million Centers for Medicare and Medicaid Services grant in the December 2016 issue of the journal *Healthcare*. The Johns Hopkins Community Health Partnership (J-CHiP) aimed to provide more efficient, less expensive care for people living with multiple chronic conditions in the neighborhoods closest to The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. J-CHiP's acute care-based program targeted the 40,000 adult patients admitted annually to those medical centers, who were screened for risks of readmission. The case study presents lessons learned regarding getting patients and providers to engage in the care model.

**Johns Hopkins to Host High-Value Health Care Symposium in October**

Reducing the costs of health care and optimizing patient outcomes and experience by eliminating unnecessary tests, treatments and procedures are the goals of high-value care. At Johns Hopkins, such care includes evidence-based criteria for blood transfusions that saved the health system \$2.8 million annually. To learn from other academic medical centers' experience with high-value initiatives, the Johns Hopkins University School of Medicine is hosting the first High Value Practice Academic Alliance national symposium. All academic medical centers are invited to participate. It will be held Oct. 9, 2017, in Baltimore. For more on the symposium, visit [hypaa.com/symposium/](http://hypaa.com/symposium/).

**Center to Reduce Diagnostic Errors Opens**

Diagnostic errors affect one in 20 adults in the U.S. per year, with as many as one-third of these errors resulting in serious permanent injuries, including disability or death. In response, Johns Hopkins Medicine opened the Armstrong Institute Center for Diagnostic Excellence, led by neurologist David Newman-Toker. The center's aim is to enhance diagnostic accuracy, reduce unnecessary diagnostic testing and move the needle on eliminating preventable harm from diagnostic errors worldwide. Made possible by a \$5 million gift from C. Michael Armstrong, the center will include a team of physicians, nurses, allied health professionals, scientists and other staff members from The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. The center's first initiative will be to prevent stroke misdiagnosis in five adult emergency departments across the Johns Hopkins Health System, with the goal of reducing harms from missed stroke by 50 percent in five years.

**Johns Hopkins, Under Armour Collaborate**

Johns Hopkins Medicine and Under Armour are collaborating to introduce evidence-based science along with expert insights to the Under Armour Connected Fitness platform. The goal is to help more than 190 million users maintain and improve their health and wellness by tapping into the expertise of specialists in sleep, fitness, activity and nutrition. The collaboration builds upon the 2014 commitment between Johns Hopkins Medicine and Under Armour to develop programs on breast cancer treatment. The two Baltimore institutions are also working together to share health and wellness insights with Under Armour's digital communities through the brand's Connected Fitness blog network.

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Marketing and Communications:  
901 S. Bond St., Suite 550  
Baltimore, MD 21231

Dalal Haldeman, Ph.D., M.B.A., *senior vice president*  
Christina DuVernay, *managing editor*  
Karen Blum, Christina DuVernay, *writers*  
Lori Kirkpatrick, *designer*  
Keith Weller, *photographer*

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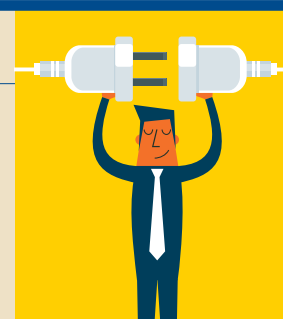
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