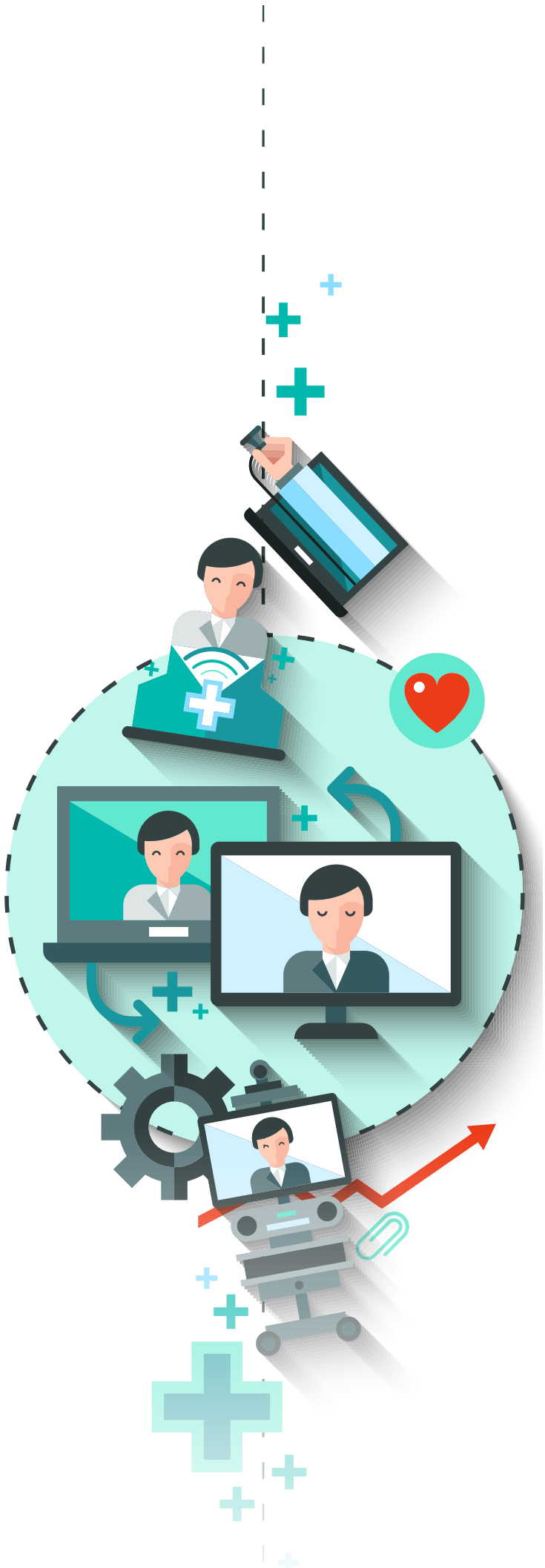
JOHNS HOPKINS MEDICINE

ManagedCarePartners

Winter 2018

A Johns Hopkins Medicine Publication for Managed Care Organizations



Telemedicine Increases Access, Adds Value

The Department of Emergency Medicine at The Johns Hopkins Hospital had a problem: In the early hours of the morning, between midnight and 3 a.m., when fewer triage personnel were available, as many as 25 percent of patients got tired of waiting and left before being seen.

But telemedicine helped provide a solution, says assistant administrator **Gai Cole**.

To save the expense of hiring additional staff, the department invested in telemedicine equipment. Since April, patients with less urgent needs have been taken by a certified nursing assistant to an exam room that has a telemedicine cart. Using a handheld camera, the certified nursing assistant zooms in on wounds and peers into eyes, ears and throats, while a physician, via video conference, interacts with the patient and forms a treatment plan. More than 6,400 patients have been evaluated this way since the program started, says Cole — it's been so successful that within four months of its use, the walk-out rate plummeted to 4.5 percent.

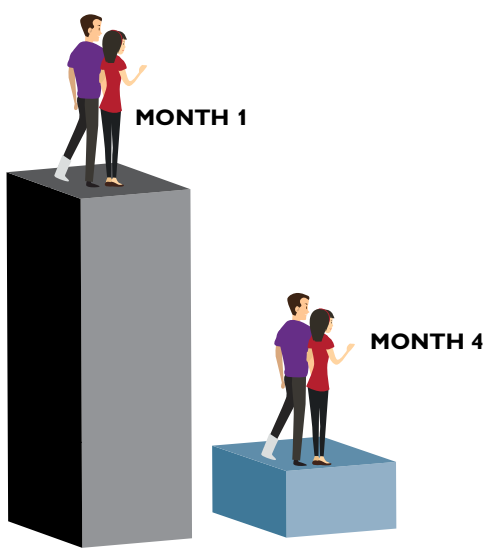
Expansion to Johns Hopkins Bayview Medical Center and Howard County General Hospital is an option.

It's just one example of active telemedicine projects occurring across Johns Hopkins Medicine, says **Rebecca Canino**, administrative director for the recently created Office of Telemedicine. In other areas, neurologist **Nicholas Maragakis** uses telemedicine to conduct follow-up appointments with his patients who have amyotrophic lateral sclerosis (ALS); Johns Hopkins pediatric cardiologists provide echocardiography consults to patients at Sibley Memorial Hospital in Washington, D.C.; and patients presenting to Howard County General Hospital's emergency department with eye problems are sometimes screened by ophthalmologists at the Wilmer Eye Institute rather than be automatically transferred to The Johns Hopkins Hospital's emergency department.

More than 20 additional telemedicine projects are planned for the next year, Canino says, including a video visit offering that will allow patients to meet with several specialty physicians at the same time, making coordination of treatment possible.

The telemedicine office is also looking to incorporate the registration and copayment process within MyChart so patients can check in from home. Documentation for telemedicine visits, like that for in-person visits, is done through Epic, the electronic medical record.

Telemedicine appointments not only save patients the time and travel costs associated with in-person visits, Canino says, but are also more likely to start and end on time. Overall, patients and physicians like them, adds ophthalmologist **Ingrid Zimmer-Galler**, executive clinical director of the Office of Telemedicine. She says, "We use the internet to order our coffee, say hello to our friends and hold meetings, so why not see your physician online?" ■



BEFORE THE EMERGENCY DEPARTMENT STARTED USING TELEMEDICINE IN TRIAGE, AS IT DOES NOW, AS MANY AS 25 PERCENT OF PATIENTS GOT TIRED OF WAITING AND LEFT BEFORE BEING SEEN. NOW THE WALKOUT RATE HAS PLUMMETED TO 4.5 PERCENT.

From the Office of Managed Care

Patricia Brown
President, Johns Hopkins HealthCare

Big-Picture Innovations Bring Better Care

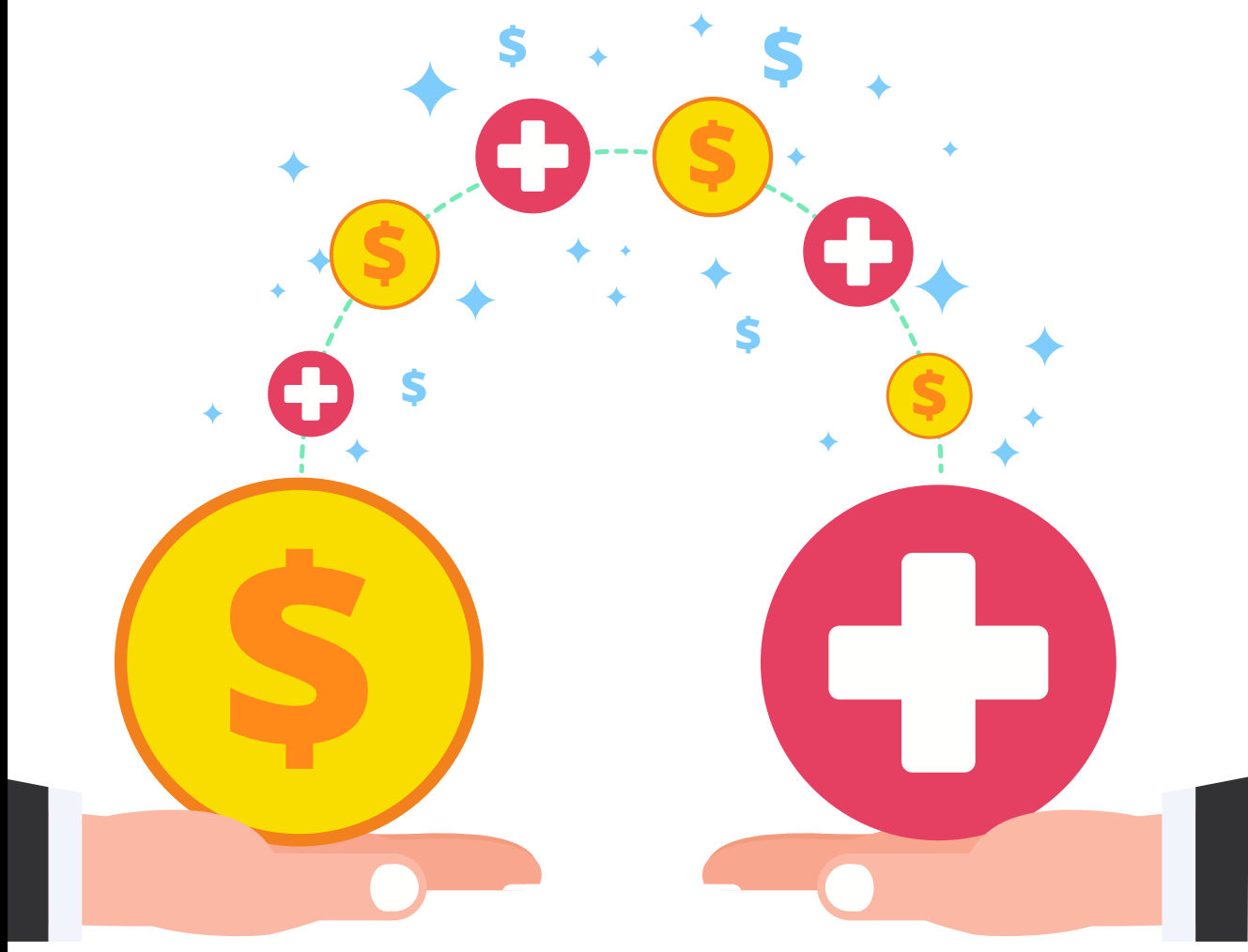
In a traditional fee-for-service model, one wouldn't necessarily expect an academic medical center such as The Johns Hopkins Hospital to closely collaborate on patient care with competitors like Mercy Medical Center or Sinai Hospital. Yet that's exactly what's happening through the Community Health Partnership of Baltimore.

This regional partnership, like similar ones in Howard County and Montgomery County that Johns Hopkins Medicine is participating in, focuses on engaging people at high risk for hospital use, particularly those who are chronically ill and do not have a medical home where they receive high-quality health care. In other words: They are falling through the cracks. What works in Howard County may differ from what works in Baltimore City, but we're learning from each other and bringing our best innovations and practices to the table to help individuals receive coordinated care through health navigators, in-home services and links to community resources.

These partnerships highlight the importance of managing innovation so that it proceeds efficiently. Take our cover story on telemedicine. The technology had been springing up in several areas around Johns Hopkins Medicine on an ad hoc basis, with interested physicians trying to figure it out independently. Now, a newly established Office of Telemedicine helps physicians turn their ideas of how to use telemedicine into reality in an organized fashion: Pilot projects are organized and start small. Once a good model is reached, functionality is built into our electronic medical record system so more health care professionals can participate.

Of course, innovation requires leaders who can see the big picture. For us, that involves serious integration efforts. In "Meet Your Partners," you'll read about Peter Hill, who has taken on the dual role of managing medical affairs for The Johns Hopkins Hospital and for the Johns Hopkins Health System. This means he is not only working in East Baltimore to lead the medical staff and provide direction for patient safety programs and pharmacy services, but he's also working with clinical directors systemwide to improve quality and efficiency. Likewise, Redonda Miller, president of The Johns Hospital, and Rick Bennett, president of Johns Hopkins Bayview Medical Center, are continuing a longstanding tradition of consolidating expertise in specialty areas on one or the other campus to function together as one larger unit.

By keeping open to innovation and working together, we are able to deliver better value to Johns Hopkins patients and payers. ■



Integrating to Create Value

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center are working closer than ever to deliver the high-value care that health system patients deserve.

Lying three miles apart, The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center have long worked together to deliver high-value care. For instance, Johns Hopkins Bayview once hosted the state's only regional burn center. But nearly a decade ago, says the medical center's president, **Richard Bennett**, leaders at Johns Hopkins Medicine realized that children with burns would benefit from the pediatric intensive care unit and surgical expertise found at the Johns Hopkins Children's Center, part of The Johns Hopkins Hospital in East Baltimore. Thus a pediatric burn unit was established there, and Johns Hopkins Bayview focused on adults.

"I think the market demand for value is higher than ever," says **Redonda Miller**, president of The Johns Hopkins Hospital. With health care costs at 18 percent of the United States' gross domestic product, she says, "There's simply no more money to infuse into health care. We have to be smarter and use the dollars we do have more wisely."

In many cases, says Miller, it's not in patients' best interest to have two smaller programs on two campuses. "We know from medical literature that the more we specialize and concentrate our services within one team, the more expert the team becomes, which produces better outcomes for patients," says Miller. To that end, all patients receiving solid-organ transplants, eye surgeries or cardiac electrophysiology procedures are now treated at The Johns Hopkins Hospital, while those in need of a sleep disorders specialist, bariatric surgery, total joint replacement, or medical and radiation treatment for new lung cancers are seen at Johns Hopkins Bayview.

In areas where there is a large demand for Johns Hopkins expertise, such as neurosurgery, obstetrics and neonatal intensive care, services are offered at both hospitals but function as one larger unit, adds Bennett.

Integrating pharmacy services across the two hospitals has generated efficiencies and savings. Looking for such opportunities to combine services is a goal of the academic division operating group, which is composed of leaders from both hospitals. Other joint efforts include a value analysis team that standardizes purchases for both hospitals' operating rooms and a high-value care committee working to reduce unnecessary testing and variations in care.

And last year, **Charles Reuland** was named executive vice president and chief operating officer of both hospitals to oversee additional integration efforts. "We approach integration from this perspective: Does it add value? We don't do it just because it's good to say you did it," says Reuland. ■

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—REDONDA MILLER, PRESIDENT, THE JOHNS HOPKINS HOSPITAL

Peter Hill Becomes Senior Vice President of Medical Affairs for Johns Hopkins Health System

Volcanoes were **Peter Hill**'s initial passion, but after meeting and marrying his wife, a hospital administrator, he decided to pursue work that was more connected to others' lives and become a physician. Hill left his volcanology program with a master's degree and attended the University of Maryland School of Medicine. After a residency at Johns Hopkins in emergency medicine, Hill joined the faculty as assistant chief of service.

Today his work considers burning issues of another sort. As senior vice president of medical affairs for the Johns Hopkins Health System and vice president of medical affairs for The Johns Hopkins Hospital, positions he was promoted to in March, Hill is helping the health system address the opioid crisis. To that end, he and colleagues at Johns Hopkins, the University of Maryland and MedStar Health collaborated to make changes to the Maryland Medicaid opioid prescribing initiatives, undertaken July 1. In addition, he has spent time establishing an opioid stewardship clinical community to shape the health system's use of opioids for pain management.

Hill also coordinates weekly calls with other health system leaders to cover system-level issues such as multihospital credentialing for clinicians who work in more than one Johns Hopkins setting, and he works with pharmacy services to identify opportunities to reduce medication costs. He's also part of the Joy of Medicine task force, which is looking for ways to help everyone ease a challenging job.

"What gets me excited is the opportunity to bring people together from diverse backgrounds and disciplines to solve problems," Hill says.

Before taking on his current role, Hill served as vice chair of clinical affairs for the Department of Emergency Medicine. In that position, which he started in 2012, Hill took particular interest in operations, service delivery, risk management and quality improvement. Under his leadership, the department saw increased diagnostic accuracy for patients and reductions in unnecessary hospital admissions. ■

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> —PETER HILL, SENIOR VICE PRESIDENT OF MEDICAL AFFAIRS FOR JOHNS HOPKINS HEALTH SYSTEM

Johns Hopkins Medicine Hospitals Join Regional Partnerships to Improve Population Health

When Maryland's Health Services Cost Review Commission put out a call for regional partnerships to improve population health and decrease hospital readmissions among high-user Medicare recipients, Johns Hopkins Medicine jumped at the opportunity. Now, four of the health system's hospitals are active in three of eight statewide partnerships working to provide better care to these patients. They are the Community Health Partnership in Baltimore, Howard Health Partnership and Nexus Montgomery Regional Partnership.

"What we're finding is these patients are not well-connected to a medical home, so many of them are using the emergency department and the hospital as their primary source of care," says **Linda Dunbar**, vice president of population health for Johns Hopkins HealthCare. So the partnerships aim to connect patients who have three or more hospital admissions to a regular health care provider, work out treatment plans and help with social determinants of health, such as barriers to transportation and healthy food, or finding affordable housing, Dunbar says.

Community Health Partnership is coordinated by Johns Hopkins HealthCare and comprises The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, as well as Sinai Hospital, Mercy Medical Center and two MedStar hospitals. Working with community health partners, Community Health Partnership serves residents in 19 ZIP codes surrounding East Baltimore, with about 200 of a planned 1,300 patients enrolled. Its network of community care teams and workers reaches out to patients for initial health assessments and creates care plans. Additional efforts are medical visits for homebound seniors, transitional housing for the homeless and a bridge to community-based mental health services.

Linda Dunbar, vice president of population health for Johns Hopkins HealthCare.

"Some of the individuals we contact have as many as six or seven chronic comorbid conditions, mental health diagnoses and substance use diagnoses, so it's a very complex picture that we're seeing," says Dunbar.

Leaders at Howard County General Hospital study their inpatient list every morning, looking for eligible adults for the Howard Health Partnership, says **Elizabeth Edsall Kromm**, vice president of population health and advancement. They want to make patients feel like they're active participants in their health care, says Edsall Kromm.

A multidisciplinary community care team provides one to three months of help offering home care visits, accompanying patients to primary or specialty care appointments, and connecting patients to resources for any socioeconomic needs. Other initiatives smooth transitions to home or a postacute care unit, offer disease management classes and caregiver help, and supply rapid access to behavioral health care. More than 500 people have been touched by this partnership since it started in July 2016.

A third partnership, based in Montgomery County, includes Suburban Hospital, along with five non-Johns Hopkins Medicine medical centers. The Nexus Montgomery Regional Partnership's programs include WISH (Wellness and Independence for Seniors at Home), which provides case management to some 7,000 seniors in 42 independent-living facilities found to have high hospital use. Other efforts furnish funds for a crisis house for patients with severe mental illness and help get uninsured patients access to specialty care.

The best part, says **Margie Hackett**, a transition guide nurse manager at Suburban, is how the partnership allows better care coordination for patients who might be seen at multiple facilities: "This collaboration between facilities is like none other." ■

BITS, BYTES & BRIEFS

Unneeded Medical Care Is Common

A national survey of more than 2,000 physicians finds that they believe overtreatment is common, mostly perpetuated by fear of malpractice, though patient demand and profit motive are factors, too. A report on the findings was published Sept. 6 in *PLOS ONE*. "Unnecessary medical care is a leading driver of the higher health insurance premiums, affecting every American," says **Martin Makary**, professor of surgery at the Johns Hopkins University School of Medicine and the paper's senior author. Unwarranted medical services represent the majority of wasted health care resources in the U.S., accounting for about $210 billion in excess spending a year, according to the National Academy of Medicine. Studies show that overtreatment is directly associated with preventable patient harm. On a national scale, the issue represents a significant opportunity to improve patient safety and lower health care costs, says Makary.

Eliminating a Widely Used—and Unnecessary—Blood Test

Based on five peer-reviewed studies, researchers at the Johns Hopkins University School of Medicine and the Mayo Clinic have created guidelines to help physicians and medical centers stop the use of a widely ordered blood test, creatine kinase-myocardial band (CK-MB) testing, because it adds no value in evaluating patients with suspected heart attack. The report, published Aug. 14 in *JAMA Internal Medicine*, is the first in a series of peer-reviewed implementation guides coauthored by faculty members from the High Value Practice Academic Alliance (HVPAA), a national coalition created by the Johns Hopkins University School of Medicine. Faculty members from more than 80 academic institutions have joined HVPAA to advance value in medicine.

HOPKINS IN THE NEWS

Johns Hopkins Health System Reduces Unnecessary Transfusions

A blood management program launched five years ago has reduced unnecessary and potentially dangerous transfusions in the Johns Hopkins Health System, leading to improved care and annual cost savings of more than $2 million, according to a study published Sept. 7 in the Online First edition of Anesthesiology, a peer-reviewed journal. The program's educational outreach consisted of live, in-person Grand Rounds presentations to clinical departments to inform physicians, nurses and others about transfusion policy guidelines and the results of eight landmark studies that support reduced use of transfusions.

"Doctors don't want to be told how to practice medicine by computer pop-up alerts—they would rather hear about the studies supporting the guidelines," says Steve Frank, professor of anesthesiology and critical care medicine at the Johns Hopkins University School of Medicine and the paper's first author. Frank is now working with NYU Langone Health and the Cleveland Clinic on a publication to educate other health systems about transfusion use.

ManagedCarePartners

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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, at the above address.

Produced by Johns Hopkins Medicine
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Baltimore, MD 21231

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