JOHNS HOPKINS MEDICINE

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Interventions Reduce Unnecessary Readmissions

Intensified patient and caregiver education, timely access to outpatient resources and a focus on high-risk individuals are improving patients' health and experience of care while driving down readmissions and costs.

Helping patients recently discharged from the hospital avoid a health setback requiring readmission is a priority for Johns Hopkins Medicine. Intensified patient and caregiver education, timely access to appropriate outpatient resources and focused follow-up for high-risk patients are some tools deployed to improve the patient's health and experience of care, contain costs and achieve targets for readmission rates set by the Centers for Medicare and Medicaid Services and by Maryland's Health Services Cost Review Commission.

"Patient and family/caregiver education is a critical factor in reducing readmissions," says **Amy Deutschendorf**, vice president of care coordination and clinical resource management for the Johns Hopkins Health System. She cites use of The Johns Hopkins Hospital's Patient Access Line, or PAL, to reinforce key aspects of self-care. Over a three-year study period, patients who did not receive education in self-care via PAL had 45 percent greater odds of readmission compared with patients who did.

Efforts to promote better patient health after discharge helped The Johns Hopkins Hospital achieve a 12.66 percent reduction in readmissions in 2016, the latest year for which full data are available, exceeding its target of a 9.5 percent reduction.

Another success story in reducing readmissions as well as emergency department (ED) visits is the After-Care Clinic, located at the Johns Hopkins Outpatient Center on the East Baltimore campus. Patients identified in the hospital or ED as being at high risk of readmission or ED use are referred to the clinic, which is directed by internist **Rosalyn Stewart** and emergency medicine physician **Arjun Chanmugam**.

Some 60 patients are seen weekly. During a visit, which can last up to 90 minutes, individuals receive instruction in self-care from a nurse and in medication management by a pharmacist. A social worker helps with bus vouchers for those without reliable transportation to appointments. Community health workers act as health coaches. And patients without a designated primary care provider are connected to one for long-term follow-up, says Stewart.

In 2016, the After-Care Clinic saved the health system about $1.4 million in avoided hospitalizations, says Stewart, who adds that data on avoided ED visits is being analyzed now. (Read about another specialty clinic, the Heart Failure Bridge Clinic, in the sidebar.)

Suburban Hospital's Transition Guide Nurses Program also emphasizes patient and family/caregiver education before and after discharge to prevent unnecessary readmissions, says its director, **Margie Hackett**. The program's nurses, six in all, call patients after discharge to reinforce key aspects of self-care taught in the hospital. The conversation typically covers medication schedule, fall prevention and the symptoms that signal a need to contact a physician for guidance. Individuals lacking a primary care provider are connected with one.

Patients who are at elevated risk of being readmitted, such as the very frail, receive home visits. "We work hard to reach the patients who need more, such as help with transportation, personal care, exercise and food, and want to ensure that those who live alone are safe and can manage independently," Hackett says.

Data on patients touched by the program are still being collected and analyzed, but overall the hospital has seen a drop in readmissions, says Hackett.

(To see 30-day Medicare readmissions rates for Johns Hopkins Medicine adult hospitals, visit Hospital Compare: medicare.gov/hospitalcompare.) ■

To reach the After-Care Clinic, please call: **410-955-0545**

Heart Failure Bridge Clinic Helps Patients Stay Out of the Hospital

Heart failure is the single most frequent diagnosis for discharged patients at The Johns Hopkins Hospital. It is also a diagnosis characterized by a high readmission rate.

To address the care needs of patients with heart failure and help them avoid an unnecessary readmission, the Heart Failure Bridge Clinic opened in 2012 at The Johns Hopkins Hospital. The clinic, which handles about 2,500 outpatient visits every year, provides multidisciplinary disease care that includes postdischarge follow-up, intravenous diuretics, laboratory testing, education, pharmacy visits and palliative care. It offers same-day appointments for patients experiencing complications. A heart failure nurse educator visits patients in the hospital to let them know about the clinic and encourage referrals. The goal is to see patients for follow-up within one week of hospital discharge, says clinic director **Nisha Gilotra**.

Nisha Gilotra, director of the Heart Failure Bridge Clinic

The readmission rate for patients seen at the Heart Failure Bridge Clinic is 8.6 percent, says Gilotra, compared with about 25 percent for patients discharged with heart failure nationwide. ■

To reach the Heart Failure Bridge Clinic, please call: **443-997-0270**

From the Office of Managed Care

Patricia Brown
President, Johns Hopkins HealthCare

Helping Patients Avoid Readmission

Hospital readmissions: They're one of the biggest thorns in our sides. They're not good for patients, they tie up our emergency departments and inpatient units and they affect our reimbursement rates and our quality ratings.

According to the Agency for Healthcare Research and Quality (AHRQ), addressing three key areas prior to discharge helps prevent adverse events: medication reconciliation/review, patient education and structured discharge communication that covers medication schedules, pending tests and studies, and follow-up needs.

But even with safeguards in place, we all know what can happen. Patients arrive home and get confused about which medication to take when. Maybe they experience another health symptom, but they don't want to call their doctor or they hope it resolves on its own. Unfortunately, notes AHRQ, there's no consensus on how to ensure patient safety after hospital discharge, but as you'll see in our cover story, Johns Hopkins Medicine is focusing on empowering patients to practice active self-care, connecting them to appropriate outpatient resources and providing higher-level assistance, including home visits, to patients at higher risk of readmission. The goal is to prevent problems from happening or resolve them before they necessitate hospital-level care.

This focus has made an impact on our bottom line. In 2016, for instance, The Johns Hopkins Hospital reduced its readmission rate by 12.66 percent, and a catch-all after-care clinic at the Johns Hopkins Outpatient Center saved an estimated $1.4 million in avoided hospitalizations.

This issue of *Managed Care Partners* also provides an update on our Johns Hopkins Medicine Alliance for Patients (JMAP) accountable care organization, a partnership between our Office of Physicians and Office of Population Health. Scott Berkowitz and his talented team are continually expanding the services offered to JMAP's 39,000 beneficiaries, from a care management plan for high-risk members to helping older adults with physical disabilities age in place.

In addition, we highlight Johns Hopkins' efforts in precision medicine. With centers for prostate cancer and multiple sclerosis already in place and several more in the works, Johns Hopkins physicians are harnessing the power of big data to help pinpoint the treatment—or watchful waiting protocol—that is most likely to be beneficial for each individual.

We welcome surgeon Jonathan Efron to his new role as senior vice president for the Office of Johns Hopkins Physicians, overseeing the activities of all physicians within our system.

Until next time, have a great summer! ■

IDEAS AT WORK

Precision Prostate Care Is High-Value Care

For years, men coming to Johns Hopkins for treatment of prostate cancer relied upon the experience and intuition of their providers to help them navigate the best options. But with a new partnership between the Johns Hopkins Individualized Health Initiative (inHealth), a personalized medicine program, and the Johns Hopkins University's Applied Physics Laboratory, clinicians can add sophisticated computations of similar patients' histories into their decision-making through the Precision Medicine Center of Excellence for Prostate Cancer.

Since January 2017, nurse navigators with the center have fielded more than 500 phone calls, says **Kenneth Pienta**, center co-director. About 30 percent of callers have been referred directly to providers at Johns Hopkins, and 50 percent of those have been seen in the precision medicine center.

There, clinicians assess each patient's cancer grade using lab tests, biopsies and imaging results, then combine those measurements with family histories and symptoms to determine the right level of treatment. For some patients with low-grade cancers, this might mean active surveillance requiring careful follow-up but no current treatment. On the other end of the spectrum, a clinical trial of a potentially curative treatment for men with metastatic disease has enrolled over 40 participants.

"We develop a partnership with patients to provide them longitudinal care," Pienta says. Patient satisfaction is "extremely high," he says. "We have a high participation rate in clinical trials, and over 90 percent of participants give us permission to collect data and biospecimens. It's a win for everybody."

Clinicians traditionally use their expertise to place patients within subgroups they think will best be managed by one treatment or another, says **Antony Rosen**, vice dean of research for Johns Hopkins Medicine and co-director of Johns Hopkins inHealth. "In some cases, you get it right; in other cases, you don't get it right immediately, so there's this trial-and-error element." Humans have only a limited capacity to factor in clinical information and patient histories. "Even though we can be highly intuitive and wise, we are challenged by processing all this data," he says. Computer analysis tools can crunch all the data efficiently, helping providers determine which subgroups their patients belong to, and thus what treatment is needed.

Although the focus here is individualized health, computational tools help place patients into more homogeneous subgroups who behave and look alike, putting forth patterns that help define treatments for these patients as part of a learning health system, says **Mary Cooke**, co-director of Johns Hopkins inHealth and vice president of the Johns Hopkins US Family Health Plan: "It really does help to identify the most appropriate therapy more quickly and eliminate unnecessary costs."

A second precision medicine center of excellence, for multiple sclerosis, opened in April 2017. Six more centers—in scleroderma, arrhythmia, myositis, neurofibromatosis, pancreatic cancer and bladder cancer—will launch soon, Rosen says.

It's feasible that, eventually, every patient encounter could occur in the context of a precision medicine center, Rosen says: "The use of measurement and the sophisticated analysis of data is going to change the face of medicine as we know it, across the entire continuum of health." ■

To make an appointment, call: **410-955-6100 (in Maryland) or 855-695-4872 (out-of-state)**

MEET YOUR PARTNERS

Jonathan Efron: Creating New Care Models

The new senior vice president of the Office of Johns Hopkins Physicians envisions creating value through a more integrated delivery network and greater collaboration with patients.

One thing **Jonathan Efron** says he has enjoyed about holding leadership positions within Johns Hopkins has been the ability to craft collaborative care models across Johns Hopkins Medicine (JHM). Now he continues that work, in the new role of senior vice president of the Office of Johns Hopkins Physicians (OJHP). The office coordinates the activities of all JHM physicians systemwide.

"I work with a great group of colleagues," Efron says. "The OJHP brings people together from disparate parts of the organization to see how we can better facilitate patient care and improve clinical outcomes."

A highly regarded colorectal surgeon with a clinical focus in colon and rectal cancer and inflammatory bowel disease, Efron joined the Johns Hopkins faculty 10 years ago. He also serves as chief of surgery for Johns Hopkins Community Physicians (JHCP); executive vice director for the Department of Surgery; and the Mark M. Ravitch, M.D., Endowed Professor in Gastrointestinal Surgery. At OJHP, he succeeds William Baumgartner, who has retired from the OJHP role but remains vice dean of clinical

Innovating and Integrating for Higher-Value Care:
An Update on the Johns Hopkins Medicine Alliance for Patients

Back in 2014, Johns Hopkins Medicine created the Johns Hopkins Medicine Alliance for Patients (JMAP), a Medicare Shared Savings Program Accountable Care Organization (ACO), with the aim of increasing value and access for patients across Maryland.

The model intrigued DeWayne Oberlander, CEO of Columbia Medical Practice, whose 25 providers focus on primary care.

"We saw joining JMAP as a way of developing more robust clinical integration of care for our patients," says Oberlander. "While the primary care physician plays a key role, we needed closer working relationships for access to specialty care, and for complex patients, access to Johns Hopkins and tertiary care."

JMAP has delivered everything Oberlander hoped for, and more. Through its SUSDR program—SUSDR stands for specialty urgent same-day response—JMAP offers rapid access for enrollees to Johns Hopkins physicians in 24 specialties. Being part of the ACO also helped the practice get resources for Medicare patients such as health behavior specialists—social workers who support patients' mental and behavioral health needs—and pharmacists to review patients' medications and help find affordable options.

"What the ACO brought us is a structure within which we could review, develop and implement strategies to improve the quality of care for our patients," Oberlander says, as well as resources to address larger population health challenges at the disease management level.

These highlight just a few of JMAP's efforts to lead high-value care for its 39,000 beneficiaries. At the core is creating a medical "neighborhood" for its enrollees, with a primary care medical home as well as a broader network of participating specialists, hospitals and skilled nursing facilities.

The work has not gone unrecognized. JMAP received a quality score of 92.42 percent from the Centers for Medicare and Medicaid Services for 2016. Compared with the previous year, the ACO increased its primary care services by 4.5 percent, decreased hospital readmissions by 5 percent, decreased emergency department visits by 1.5 percent and decreased emergency department visits leading to hospitalization by 2 percent. They also came in a half-million dollars under their benchmark spend.

JMAP leaders strive to continually improve the program through annual strategic reviews and planning, says Executive Director **Scott Berkowitz**. Other high-value areas of focus include appropriateness for magnetic resonance and computed tomography imaging, in collaboration with the Johns Hopkins Health System's high-value care efforts, and employing pharmacists to help identify potential areas of cost savings for injectable drugs for Medicare Part B recipients. Over 2,000 individuals have been enrolled in a care coordination program where nurse case managers help coordinate care for at-risk patients.

JMAP partnered with the Community Aging in Place, Advancing Better Living for Elders (CAPABLE) program, developed by Sarah Szanton from the Johns Hopkins University School of Nursing, to address the needs of older adults with physical disabilities. The ACO also is looking into further support for home-based primary care needs for older adults who are chronically ill, frail or cognitively disabled.

In all efforts, JMAP pulls together expertise from Johns Hopkins HealthCare, the Armstrong Institute for Patient Safety and Quality, the Office of Johns Hopkins Physicians and other organizations within JHM, in support of high-quality care for patients.

"JMAP has been successful in bringing together talented team members from across Johns Hopkins Medicine—along with our primary care partners from Columbia Medical Practice and Potomac Physician Associates—in support of improved care for our patients," says Berkowitz. "Although there is important work still to be done, JMAP has provided a key foundation from which we can continue to optimize patient-centered care." ■

For more information: **1-855-390-5803 or hopkinsmedicine.org/alliance_patients**

affairs for the Johns Hopkins University School of Medicine.

Among the tasks Efron has jumped into is looking at whether JHM should partner with federally qualified health centers and investigating whether the establishment of a JHM clinically integrated network would be of benefit to patients and physicians. In addition, he says, "we are constantly working toward better improving the flow of patients and clinical resources among all of the JHM entities. We are examining new methods of providing primary care and population management, and we are helping align physician strategies with the hospitals and care management organizations within JHM."

Borrowing an analogy from Landon King, executive vice president of the school of medicine, Efron says he views the OJHP as the connective tissue between the medical school, individual physician groups, ambulatory sites, the hospitals and Johns Hopkins HealthCare. "The OJHP is also the enzymatic catalyst for change."

Efron's experience developing innovative care delivery strategies and commitment to engaging patients will be invaluable assets in furthering the OJHP's mission, says Dean/CEO Paul Rothman, "to advance new, innovative care models and coordinate the clinical activities of faculty, JHCP, and community and aligned physicians across Johns Hopkins Medicine."

A Baltimore native, Efron earned his medical degree from the University of Maryland School of Medicine. He completed a residency in general surgery at North Shore University Hospital and a fellowship in colorectal surgery at the Cleveland Clinic Florida, where he then joined the faculty. From there, Efron became an associate professor of surgery at the Mayo Clinic College of Medicine in Arizona before coming to Johns Hopkins. ■

For more information, visit: **hopkinsmedicine.org/office-of-johns-hopkins-physicians**

Surgeon Jonathan Efron is the new senior vice president of the Office of Johns Hopkins Physicians.

BITS, BYTES & BRIEFS

App for Tuberculosis Management Replaces In-Home Visits

Tuberculosis requires a rigorous months-long treatment regimen that can be challenging for some patients. Directly observed therapy, or DOT, is sometimes used to ensure compliance. But daily visits by a health care worker are expensive and, to some patients, intrusive. Now a smartphone app developed at Johns Hopkins providing connection via video to a health care worker offers a high-value alternative. A study of 28 adult patients found that treatment compliance was slightly higher with the use of the app compared with DOT, and patients greatly preferred it. Video DOT via the app cost an average of $674 per patient over a six-month treatment period, compared with $2,065 for in-person DOT.

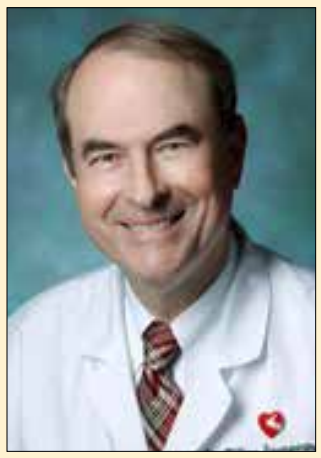
To learn more, visit: **bit.ly/2GNNBsz**

Minimally Invasive Surgery Underused in Older Patients

A study of 200,000-plus Medicare patients found that less invasive procedures, which are associated with fewer complications, shorter lengths of stay and lower readmission rates compared with standard surgeries, are underused in older patients. The study's lead author, Johns Hopkins surgeon **Martin Makary**, says preventing complications is especially crucial for older, frailer patients, as a single complication can lead to a cascade of harmful and costly events. "This study shows there is an opportunity for Medicare and other payers to spend health care dollars more wisely so that they reward high-value care over low-value care," says Makary, who, in addition to being a surgeon, is also a widely published expert on health care disparities.

For more information, visit:
bit.ly/2IKGsuJ

HOPKINS IN THE NEWS



Managed Care Partners wishes to honor **William Baumgartner**, who recently retired as senior vice president of the Office of Johns Hopkins Physicians (OJHP), for his extraordinary leadership in improving care quality and value. His work leading the OJHP and his vision for high-value health care that is responsive to the individual patient inspire all who continually seek new ways to increase safety, quality and value in health care delivery, and we thank him for his service. Baumgartner, the Vincent L. Gott Professor of Cardiac Surgery, remains vice dean of clinical affairs for the Johns Hopkins University School of Medicine even as he steps down from his OJHP leadership role.

For more information, visit:
bit.ly/2s9JeT2

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