A look-back study of Medicare fee-for-service claims affirmed and quantified a long-suspected link between lower rates of coordinated health care services and higher costs of uncoordinated 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 1 percent of Medicare claims using a previously validated set of over 200 procedures and a measure of so-called continuity of care.

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 Snegrove, Howard County General Hospital: One is the global revenue cap in Maryland, which clearly puts us in the population health business overnight. We don’t think about ourselves as just hospital administrators anymore but 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 organizations, such as physicians, skilled nursing facilities, assisted living facilities and home health agencies, to make sure that patients are not just cared for in the hospital but also when they’re discharged so that they don’t have to be rehospitalized.

Gene Green, Suburban Hospital: We are looking at 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 initiatives is to identify ways to align with other care settings and see where there are opportunities to reduce those and have patients seen in the most appropriate care settings.

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

Snegrove: We’re creating a new senior-level position in Population Health and Community Relations. Elizabeth Edilson-Kaminski 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’s funding agency unique to Howard County, our health system’s public school system and other providers.

Green: Let me give you one example here at Suburban. We have a large and thriving oncology service. One of the most significant improvements that has and continues to have is a major positive impact on the patient experience with 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 ambulatory 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 focused on having strategic investments in both 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, is what we do—what is that service that our patients most need to be outside of our hospital.

Davis: 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 healthy people 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 looking for. I’m talking to care centers, to primary care centers and to acute care centers 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?

Davis: 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.

Green: 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 recognition of that and I would say expectancies—expectations from patients and families that their experience needs to be “first-rate.” 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 use where there are opportunities to reduce those and have patients seen in the most appropriate care settings.

Here at Suburban, we’ve introduced a number of more progressive improvement-tools and methods to help us redesign a more efficient and effective care delivery model. My particular interest is in investing in organizational development activities that will educate staff members to help them use tools to help make sure that what we’re doing is having visible success and patient care. We’re developing a culture where we can provide care that is the right care at the right time for the right cost. It’s a very service-oriented attitude.

Snegrove: We’re creating a new senior-level position in Population Health and Community Relations. Elizabeth Edilson-Kaminski 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’s funding agency unique to Howard County, our health system’s public school system and other providers.

Davis: 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.
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 one and a half years ago as director of orthopaedic surgery, patients with musculoskeletal issues might have had to wait weeks to get in to see a specialist. Some patients went to other physicians or wound up in the Emergency Department, he says.

Now things have changed. In addition to offering Ficke had left within the department to open access, the Department of Orthopaedic Surgery is one of the first to have signed on for a new 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.

Department representatives have won a range of conditions. Ficke says, including sports-related leg issues, urgent hand injuries, spine issues and foot and ankle problems. Every physician assistant, nurse practitioner and surgeon on staff now keeps a telephone open during each clinic day. 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% of issues that drive patients to emergency departments are musculoskeletal in nature, Ficke says. “We want to make sure that and be able to see those patients here.”

The divisions of Ophthalmology, and Urology also have been participating in the SUSDR initiative. The divisions of Ophthalmology, and Urology also have been participating in the SUSDR initiative.

The idea, says internist John Flynn, vice president of the Office of Johns Hopkins Physicians and executive director of the Clinical Practice Associates, 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 department is seeing a trend and seeing patients in a timely manner is a result of many clinical leaders like Dr. Ficke bringing about a remarkable change in our culture.”

Shorter Hospital Stays Without Compromising Care

It’s no secret that most inguinal hernia would rather not be at the hospital in the first place—and if they are hospitalized, they hope to leave as soon as possible.

However, the pain in care is often full of unanswerable, unforeseen twists, turns and delays that can extend length of stay.

Though some of these delays are unavoidable, says John Hopkins neurologist H. Arman Tariq, the number of patients waiting or seeing delays has increased. While physicians such as Dr. Ficke have a goal for when such patients will be discharged, the early majority of this discharge often, by a day or more.

Hoping to move these patients through their stay more efficiently without sacrificing the quality of 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 checklist of desirable pieces of care and the process that allowed them to see when they’d be receiving certain types of care and high-lighted which aspects of their care that patients themselves thought to be simple clinical documentation—such as making sure they had transportation back home upon discharge.

At the recent primary care consortium, Vani Bhatt, left, a pediatrician at Johns Hopkins Community Physicians at Odenton, explains her findings on advances coordination and integration of primary care in the medical, public health and nursing disciplines across The Johns Hopkins University. The idea for the new professorship grew out of the first consortium event, established in 2011 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 national 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 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 four-year medical students, and mentorship with local leaders in the primary care field. Current and future residents will be paired with the school of public health.

“The idea behind this initiative is to bring together the expertise of the school of medicine and the school of public health to increase research and teaching activity in primary care,” says McGuire.

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

Reduction in pounds

2011 4,746,807
2012 4,217,781
2013 3,848,175
2014 2,841,937

Trimming the cost

2011 $1,277,631
2012 $984,797
2013 $336,641
2014 $323,311