The Strategic Plan in Motion

Poster Walk Presentations

The Strategic Plan in Motion
**Waiver 101**

J. Colmers/ E. Beranek

Health Care Transformation and Strategic Planning Department, Johns Hopkins Medicine

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**JHHS Maryland Global Revenue Budget**

- Excludes Out of State/International at JHH, JHBMC and Suburban
  - Significant amount – e.g., 25% of JHH revenue
  - 100% variable, lower update
  - Patients still charged HSCRC rates, but excluded from test
- Certain categorical exclusions at JHH and JHBMC
- Transfer in cases from outside JHHS
- Hospital-specific population adjustments
- Population health infrastructure – 0.66%

**Suburban Hospital**

- Assumes out of state revenues of $29M in 2014
  - Excluded from GBR cap
  - Inflated at lower level
  - 100% VCF
- Hospital specific age adjusted population factor 1.06% in FY 2014 and FY 2015
- Population health infrastructure adjustment of 0.66% evenly split between FY 2014 and FY 2015

**Howard County General**

- Assumes out of state revenues of $9.7M in 2014; Included in GBR cap
- Hospital specific age adjusted population factor – 0.7% in FY 2014 and FY 2015
- Population health infrastructure adjustment of 0.66% evenly split between FY 2014 and FY 2015

**JHHS Maryland Global Revenue Budget**

- Reducing cost is good
- Need to maintain volumes at FY 2013 levels by reducing inappropriate volume and increasing appropriate volume
- Need to utilize all of our medical assets
- Out of State/International Volume is good
- There will still be a lot of unknowns

**Concluding Thoughts**

- New waiver is a call to action
- Doing what is best for patients remains paramount
- Value is the new gold standard
  - Quality
  - Appropriate hospital care, appropriate setting
  - Cost efficiency
  - Population health focus
- JHM is well positioned

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**New Waiver Demonstration Agreement**

- 5 year demonstration – 2014-2018
- System continues to be “all-payer”
- Waiver “test” changes
  - From Medicare only, inpatient, per measure compared to US
  - To two new tests:
    - All payer, per capita, Maryland residents hospital in- and outpatient less than 3.58%
    - Aggregate Medicare savings of $330 M over 5 years below national per capita trend
  - Other guardrails – quality, total cost, etc.
- Translates to new payment systems for individual hospitals and system
  - Global Budget Revenue (GBR) Agreements
  - Patients still charged HSCRC unit rates – but now with overall revenue constraint

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**Change is Here, Change is Everywhere**

Historical incentives are changing . . . moving from fee for service model to population health model with a global budget

We have been preparing for these changes . . . we are well positioned

These changes are not unique to Maryland . . . Waiver allows us a “glide path” to change

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**Global Budget Revenue (GBR Agreement)**

- HSCRC has negotiated rate agreements with all hospitals in the state
- GBR agreements cover FY14 & FY15
- Contract between HSCRC and Hospital/Health System
- Establishes fixed revenue structure for each hospital
- Public documents

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**Academic Division**

**The Johns Hopkins Hospital**

- Assumes out of state revenues of $561M in FY 2014 – excluded from GBR cap; Inflated at lower level (1.7%), 100% VCF
- Categorical exclusions – e.g., transplants, high end cancer, etc. 50% VCF above negotiated base. Organ acquisition and oncology drug costs
- Transfer in is “test” – will allow some additional revenue beyond current base. Settled within same fiscal year. Transfer tax to transfer out hospital.
- Age adjusted population factor – 0.4% in FY 2014 and FY 2015 – Inflated at higher rate (2.4%)
- Population health infrastructure adjustment

**Johns Hopkins Bayview Medical Center**

- Assumes out of state revenues of $54M in 2014 – excluded from GBR cap; Inflated at lower level (1.7%), 100% VCF
- Categorical exclusions – burn cases. 50% VCF above negotiated base.
- Age adjusted population factor 0.39% in FY 2014 and FY 2015 - Inflated at higher rate (2.4%)
- Population health infrastructure adjustment
The Johns Hopkins Medicine Strategic Plan comprises six priorities—critical areas of focus for the success and sustainability of the Institution.

**Why Develop a Plan?**

To guide business strategies and decisions for the enterprise in a rapidly changing health care environment. Of prime concern is to respond to health care reform, which encompasses both the direct effects of the Affordable Care Act and broader changes stimulated by federal and state budget constraints, including increased need for accountability, transparency and controlling costs.

**The Launch**

The Strategic Plan was formally launched last July and is making notable impact. During the inaugural year it was quite visible utilizing various channels, including:

- **The JHM Annual Leadership Meeting**—“Delivering on the Promise—The Why, What, and How of the Strategic Plan”
- **Monthly Strategic Plan Executive Council (SPEC) meetings, electronic updates from executive leaders, and rotating Strategic Priority focused leadership luncheons**
- **Dedicated website portal, articles in Dome and Inside Hopkins, electronic displays, print materials, JHM Town Hall meetings, clinical department/division roadshows and awareness surveys**

**Assessing Year 1 Impact**

**FY15 Dashboard**

Dashboards at-a-Glance

<table>
<thead>
<tr>
<th>Strategic Priority</th>
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<th>Yellow</th>
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<td>3</td>
<td>1</td>
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<tr>
<td>Biomedical Discovery</td>
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<td>3</td>
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<td>Performance</td>
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<tr>
<td>Total</td>
<td>68%</td>
<td>19%</td>
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</table>

**FY15 Outcome Measures**

**PEOPLE**—Foster investments in professional development and healthy lifestyles, recruit and engage innovative leaders, and advance an “accountable, collegial, diverse and inclusive” culture, people have from the outset been considered the most important part of the strategic planning process.

**BIOMEDICAL DISCOVERY**—Establish research council to focus on designing programs to improve success with National Institutes of Health grants and identifying strategies to access alternative funding sources, as well as focusing on creating systems to better quantify the impact of research and developing a governance model for the oversight and administration of its funding.

**PATIENT & FAMILY CENTERED CARE**—Phased implementation of a care coordination bundle (risk screening, multidisciplinary care planning, patient and family education, medication management, primary provider handoffs, EM management, and transitions of care) in at least one unit within every JHM hospital.

**EDUCATION**—Actions and investments that will lead to creating new opportunities for collaboration and preparing students to be leaders and innovators who will tackle the realities of health care and medicine.

**INTEGRATION**—Initiating simultaneous and interactive consultative engagements assisting JHM in evaluating its insurance strategy and helping determine the optimal geographic footprint and appropriate size of the clinical delivery network.

**PERFORMANCE**—To maintain fiscal stability—particularly in today’s tough economic climate in health care—the establishment of smart processes, efficient systems and financial controls was deemed critical in executing the tri-partite mission.

**FY15 Refresh**

The FY15 Plan Refresh process was kicked off in January 2014, guided by an iterative road map designed to achieve broad-based input (detailed in the graphic on next page). The goals for the process were to forecast where the SPEC expected to end the year, focus attention on identifying action items for the new fiscal year, and begin a broader discussion on need for greater alignment.

WHEN IS NOW

The year ahead is focused on accelerating a culture of accountability and planning rigor to create impact:

- Create greater focus on those actions that will result in biggest impact
- Streamline implementation planning road to an effort to move more toward outcome measures
- Develop clear alignment between the JHM Strategic Plan, Strategic Objectives, Fiscal 2015 Budget, Enterprise Risk Management and Entity Strategic Planning
- Refine communications plan with the intent to better message actual progress/achievements and empower managers to engage the frontline managers.

**FY15 Outcome Measures**

**PEOPLE**—Improve the Gallup Employee Engagement Grand Mean Score (GMS) by .1

**BIOMEDICAL DISCOVERY**—Increase total research funding / number of federally funded PIs by 2%

**PATIENT & FAMILY CENTERED CARE**—Demonstrate 3 percentage point improvement annually or achieve at least top quartile performance in HCAPS scores by end of FY15 for each member organization

**EDUCATION**—Develop a primary care track for teaching the principles of primary care practice and related topics to Johns Hopkins medical students

**INTEGRATION**—Execute a minimum of 2 growth strategies to increase capacity in clinical delivery network

**PERFORMANCE**—Meet FY15 Performance Improvement ($95 million) and operating plan targets ($182 million operating plan surplus)

*One goal selected per priority, not all inclusive*
Goal

To assist the JHM Radiology department in its efforts to expand stand-alone imaging centers in the region by reviewing the demographic and competitive landscape in the regional market to identify potential locations with the highest likelihood for success.

Methodology

- Analyze the existing imaging centers at Greenspring Station and White Marsh to determine the demographic make-up of its patients, its service area reach, and mix of services.
- Develop a demographic scoring methodology to apply to each census block group in the region to identify geographic clusters of favorable populations.
- Determine locations of existing imaging centers to evaluate competitive factors.
- Identify locations of complementary health care services that could be volume feeders to a new site.
- Select 3-5 general locations that are most favorable to a successful expansion.

Methodology – Items not fully considered

- Geographic preferences of the Dept. of Radiology.
- Real estate / rental costs for office space of selected market.
  - Availability of office space.
  - CON related concerns.
- Detailed analysis of capabilities of imaging center competition in targeted market. Although locations of competing centers were considered.
- JHCP Referral opportunities.

These will be analyzed in the next steps with further detailed analysis.

Analysis Considerations

- Billing data for the imaging center sites at Greenspring Station (GSS) and White Marsh (WM).
- Time period for this billing data was 7/1/2013 – 3/31/2014

Patient Origin

Greenspring Station

White Marsh

Patient Demographics (visits)

At both locations, women make up ¼ of the total visit population. Patients between the ages of 50 and 69 account for just under 50% of the total visits. With the exception of pediatric patients, more female patients are seen in each age group.

Demographic Scoring - Methodology

- Used 2014 population and other demographic estimates from Truven Health Analytics’ Market Expert tool. The source of the Truven data is The Nielsen Company.
- Selected key demographic variables by census block group that would correspond to a favorable population and geography.
  - Favorable, generally means more affluent, likely to be insured, higher population density, higher numbers of employers, and higher concentrations of females in a specific age range.
- The block groups were placed in decile rankings for each variable, with the most favorable indicator for each variable being scored a 10.

Initial Recommendations

- Howard County / Columbia Area
- Montgomery County / Rockville Area
- Montgomery County / Bethesda Area
- Northern Virginia / Falls Church Area
- Washington DC / Near Sibley Memorial Hospital

Next Steps

- Evaluate initial recommendations with the Department of Radiology.
- Select primary preferred site.
- Perform further detailed analysis.
Pyrazinamide in TB Therapy

Pyrazinamide (PZA) is an important first line drug for treating tuberculosis. In combination with rifampicin, isoniazid, and ethambutol, it has remarkable sterilizing activity, and is the keystone drug for short course (6 month) therapy.

Standard therapy (2 months with rifampicin, isoniazid, ethambutol and pyrazinamide, followed by 4 months with rifampicin and isoniazid) has 95% efficacy against drug susceptible TB.

Pyrazinamide is a prodrug which is converted to pyrazinonic acid to kill M. tuberculosis.

Nicotinamide and Nicotinic Acid are Vitamin Precursors of NAD+

- Nicotinic acid (NA) and Nicotinamide (NAM) are Vitamin Precursors of NAD+

Is Pyrazinamide Salvaged?

We propose that pyrazinamide efficacy in vivo and under anaerobic growth is a result of anaerobic induction of the NAD+ salvage pathway. We propose that pyrazinamide is converted via the NAD+ salvage pathway into a pyrazinamide derivative of NAD+, and that this inhibits multiple NAD+ dependent enzymatic reactions.

Analyzing the M. tuberculosis NAD+ Salavage Pathway in Yeast

- NAD+ salvage pathway requires enzymes. Salvage pathway is induced in lung and to anaerobic growth.
- Certain enzymes are expressed constitutively.

Do Enzymes of the Mycobacterial NAD+ Salvage Pathway Act on Pyrazinamide?

1) Can expression of M. tuberculosis enzymes in yeast confer sensitivity to pyrazinamide?

PncB1 and PncB2 do not complement the nptI mutant of C. glabrata, potentially because they function only in the context of the other TB salvage pathway enzymes. We are replacing the entire yeast salvage pathway with the TB equivalents to reconstitute the TB NAD+ salvage pathway in yeast. Growth on NA will indicate a functional reconstituted enzymatic pathway and pyrazinamide sensitivity of the resulting strain can be assessed aerobically and anaerobically.

2) Will PncB1 and PncB2 expressed in E. coli phosphoribosylate nicotinic acid and pyrazinonic acid?

Are pncb1 and pncb2 Mutants of M. tuberculosis Resistant to Pyrazinamide?

M. tuberculosis pncA mutants are resistant to pyrazinamide.

We are constructing double mutants in M. tuberculosis, deleting both pncB1 and pncB2. Our model suggests this should be unable to phosphoribosylate pyrazinonic acid and should be resistant to pyrazinamide.

Conclusions

This project aims to identify the active form of pyrazinamide which will facilitate identification of the therapeutic target of pyrazinamide.

Three approaches are used to determine if pyrazinamide is converted to NAD+ like metabolites by enzymes of the NAD+ salvage pathway and whether those metabolites are the active form of pyrazinamide.

The project success will facilitate design of novel therapeutics for TB, including for drug resistant (pncA) strains of M. tuberculosis.
Addressing Medication Regimen Complexity in Skilled Home Health Care

Cynthia Boyd, MD, MPH; Bruce Leff, MD; Jennifer Wolff, PhD; Kim Carl, RN; Hadi Kharrazi, PhD; Orla Sheehan, MD PhD

Discovery Fund Synergy Award- School of Medicine, Bloomberg School of Public Health, Johns Hopkins Home Care Group

CONCEPTUAL FRAMEWORK

AIM
Improve outcomes of patients receiving Medicare skilled home health services by improving communication around medications and key clinical situations between home health agencies and physicians

OBJECTIVE
Develop (and test) the feasibility of an innovative, largely automated informatics solution (the HOME tool) to efficiently and clearly communicate information about medication regimens and insights gained by the home health nurse in the process of evaluating the patient at home

Who Are We Trying to Help?
- Older adults with multiple chronic conditions (MCCs)
- Homebound
- Multiple medications
- Medicare provides Home Health Care (Nursing, PT, OT) for up to 60 day episodes in their home
- Often recently discharged from hospital or skilled inpatient nursing facilities
- Medications often change during admission
- High risk of adverse drug events and re-hospitalization

What is Wrong with Current Communication?
- When Home Care begins, nurses complete the federally-mandated Outcome and Assessment Information Set (OASIS)
- Physician is sent a plan of care based on OASIS, called “the 485”
- “The 485” must be signed by the physician in order for the home health agency (HHA) to be reimbursed by CMS
- “The 485” is not user-friendly
  - Very small font, bureaucratic language, no logical order to medication lists, no section for the nurse to convey important information relevant to the care of the patient
- “The 485” is viewed as paperwork the physician must sign, often with no or minimal review

Key Innovations
- Improve information flow between older adults with MCCs, their family, home health nurses and physicians
- Translate a complex message into an easily comprehensible format
- Increase efficiency and effectiveness of the nurses and physicians to reduce medication regimen complexity with patients and families

Conceptual Framework

Phase 1: Develop the HOME tool through:
- Human computer interaction design and evaluation principles
- Automated extraction of information from standardized forms (OASIS and “485”)”
- Highlight key insights that have arisen about the medication regimen during the home visit
- Incorporate feedback on content and appearance by in-depth interviews with 10 patients, their families, 4 home health nurses, 1 PT and 5 physicians

Phase 2: Test Feasibility of HOME tool with 20 patients on admission to home care:
- Survey patients, families, nurses, physical therapists and doctors regarding usability and feasibility
- System Usability Scale will address usability factors of affect, control, helpfulness, learnability and efficiency
- Assess workflow integration issues for nurses and physicians
- Results will be used to enhance the graphical user interface and usability of HOME

System Usability Scale will address usability factors of affect, control, helpfulness, learnability and efficiency

IMPLEMENTATION PLAN

PHASE 1: DEVELOP THE HOME TOOL THROUGH:
- Human computer interaction design and evaluation principles
- Automated extraction of information from standardized forms (OASIS and “485”)
- Highlight key insights that have arisen about the medication regimen during the home visit
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PHASE 2: TEST FEASIBILITY OF HOME TOOL WITH 20 PATIENTS ON ADMISSION TO HOME CARE:
- Survey patients, families, nurses, physical therapists and doctors regarding usability and feasibility
- System Usability Scale will address usability factors of affect, control, helpfulness, learnability and efficiency
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Implementation Plan

Preliminary Mock Up of Home Tool

“THE 485” – SAMPLE PAGES (OFTEN 4+ PAGES)
Community Division in the Context of the Integration Strategic Priority

Community Division, Johns Hopkins Medicine

Integration of JHM in the National Capital Region (NCR)

Community Division Components

Health Care & Surgery Centers:
An Important Piece of the Johns Hopkins Medicine Delivery System

Legend:
- Hospitals
- Existing HC&SC
- Potential HC&SC

NCR Priority One - Service Line Strategy and Formation

Community Division Hospitals Footprint and Statistics

Legend:
- Locations

Lean Sigma – Office of Continuous Improvement & Innovation

Howard County General Hospital

Creation of Office at HCGH
- Integrated with Armstrong Institute
- Team of black belts on site
- Drive culture of continuous improvement & innovation

Definitions
- Lean: relentless pursuit of eliminating WASTE (non-value activities) from a process. It is:
  - A methodology
  - A set of tools
  - A way of thinking!
- Six Sigma: Process of analyzing data to identify the root cause of defects

Purpose
- Lean Sigma will enhance efficiency, quality and safety all of which drive the patient experience

Key Results
- Lean Project Overview
  - Surgical Site Infection – Spine
    - Complex issue:
      - Pre-Op and post-op CHG showers
      - Surgical attire
      - Gloves changes and drape standardization
      - Surgical prep consistency
      - Vendor access/behavior
      - Room entry/exit
    - Marked improvement in SSI Rate

Next Project
Focus on pre-operative workflow/handoffs/defects impacting the Patient Experience:
- Surgical posting process
- Case cancellations
- Case delays
- Financial clearance

S T A T I S T I C S

S I T U A T I O N
- S U R G I C A L S I T E I N F E C T I O N
- S I G N I F I C A N T S T R U C T U R A L
- M A N A G E M E N T

B A C K G R O U N D
- D o we currently perform this service or similar at this site?
- Is this a site where the procedure described is performed?
- Is the site where the procedure described is performed of significant structural management?

A S S E S S M E N T
- W h a t i s t h e f a i l u r e r a t e c h a r a c t e r i s t i c ?
- W h a t i s t h e c u r r e n t p r o c e d u r e 

R E C O M M E N D A T I O N
- W h a t a c t i v i t i e s o r s u p p o r t s n e e d t o b e e n g a g e d i n p l a n n i n g / i m p l e m e n t i n g t h e f l o w c h a r t?
Community Division in the Context of the Integration Strategic Priority
Community Division, Johns Hopkins Medicine

GBMC Affiliation - Formalized July, 2007

- **Purpose**
  - To promote accessible affordable patient centered care through the health care facilities and professionals associated with GBMC and Johns Hopkins and to continue to enhance and maintain quality medical care, CME, education and research.
  - To develop and promote strategies to encourage residents of the North Central Maryland Focus Area to use GBMC for services traditionally provided by community hospitals and to use The Johns Hopkins Hospital for tertiary and quaternary care.

- **Collaborative Activities Underway**
  - Cardiology
  - Pediatric Surgery
  - Otolaryngology, Head and Neck Surgery (OHNS)
  - Gynecology/OB

Anne Arundel Health System Affiliation – Formalized 2007

Future JHM Footprint
Planning Beyond Inpatient Services

Future Growth Delivery in the Community Division Delivery Network

Highmark Health Relationship – Formalized July, 2014

JHM and Highmark Collaboration (to Date):
- Program Collaboration Agreement between Allegheny Health Network and Sidney Kimmel Comprehensive Cancer Center (SKCCC) – July, 2014
- Other joint provider collaborations under development include:
  - Durable medical equipment/ home care/ sleep services/ infusion services
  - Supply chain management, strategic sourcing, supply logistics
  - Population health management
  - Quality/Safety
  - EPIC implementation

Kaiser Relationship – Formalized March, 2014

Initial Focus of Agreement
- Sharing best practices; leveraging delivery networks and common EPIC platform
- Strengthening Suburban Hospital relationship to create an advanced model of care
- Increasing tertiary/quaternary services at JHM Academic Hospitals
- Bringing care into the home by exploring and leveraging technology to deliver personalized medicine
- Advancing the patient experience and improve treatment outcomes while reducing costs
- Pursuing opportunities to develop educational programs and research-based best practices
Trinidad and Tobago Health Sciences Initiative

Johns Hopkins Medicine International (JHI)

Language Access Services

JHI helps meet the needs of domestic patients with interpretation needs—either limited English proficiency, deaf or hard of hearing. We also provide accurate medical translations in many languages for discharge instructions and patient education materials.

In FY13, these qualified interpreters and translators fielded:
- 56,534 interpretation requests
- 632 translation requests
- 1,323 American Sign Language (ASL) requests (since assuming responsibility for these services on Mar 1)
- Requests in 85 languages

International Patient Services

- Our multidisciplinary division supports international patients before, during and after their medical visits to Johns Hopkins Medicine with a comprehensive menu of services. We are dedicated to easing the experience of those who travel here for care.
- To meet the needs of international patients with embassy-sponsored medical care, we forge close working relationships with the medical attachés at embassies.
- The goal of our work with affiliates is to improve and increase local options for care. For complex cases, JHI provides continuity of care between our affiliated hospitals and Johns Hopkins Medicine to make sure that each patient has the best possible outcome.

Trinidad and Tobago Health Sciences Initiative

In November 2011, San Fernando General Hospital opened Trinidad and Tobago’s first dedicated cardiac ward at a public hospital.

This was made possible by Johns Hopkins Medicine’s efforts to train the necessary medical personnel.

Transformation of a Health Care System

Our first-of-its-kind health care joint venture is expected to set clinical standards, serve as a model for the provision of health care and contribute to the development of the health care sector in the region. With Saudi Aramco’s support, the physicians and staff will be able to focus on delivering the highest quality care.

What have we achieved?
- Quality plan and key performance indicators
- Clinical induction program
- Facility design
- Electronic medical record

What is next?
- Patient Centered Medical Homes
- Specialty practice development
- Clinical training curriculum and learning management system

What’s next for Johns Hopkins Medicine International?

- Johns Hopkins Medicine experts will consult in more than a dozen areas, including managed care and occupational health and wellness. We will work with our local counterparts to advance and apply strategies for population health management in a way that’s tailored to local needs.
- We will take an interdisciplinary approach when necessary for example, in addressing diabetes in a nation with a nearly 24 percent prevalence.
- These efforts can improve Saudi Aramco employees’ health and improve their productivity.

Through our two major service lines, Johns Hopkins Medicine International transforms the lives of patients in nearly every country across the globe. Global Services

Project teams work hand in hand with leading health providers, governments and educational institutions around the world to raise the standard of health care. We leverage Johns Hopkins’ extensive knowledge base to provide customized, sustainable solutions to health care’s biggest challenges.

Patient Services

JHI supports the institution’s strategies to attract non-Maryland patients by providing education about Johns Hopkins Medicine’s world-class medical care and then facilitating patients’ access to care.

We strive to make patients and families comfortable and stress-free so they can focus on better health.
Mission
To provide leadership in child health through treatment, education, advocacy and research.

Values
Honesty and Integrity; Inspiration and Hope; Collaboration and Teamwork; Inquiry and Innovation; Compassion and Respect; Responsibility and Safety

Strategic Plan Goals
• Commitment to Quality & Patient Safety as a core foundational element in All We Do
• Creating an Academic Culture and Institutional Capability
• Positioning ACH as the Recognized Leader Providing Pediatric Specialty Care in Our Region and Beyond
• Managing the Health of Populations: Clinically Integrated Network, Care Management and Transformation
• Financial Sustainability

Strategic Plan “Themes”
- 9 Goals
- 48 Strategies
- 228 Tactics/Process Milestones
- 168 Metrics/Process Measures
- 76% Process, 24% Outcome

Culture Statement
Our Past and Our Future
Founded in 1926 by compassionate community volunteers helping children in need, over time All Children's Hospital has evolved into an essential statewide provider and referral center committed to advancing child health through treatment, education, advocacy and research. All Children's latest transformation of partnering with Johns Hopkins to become a national academic institution reflects our ongoing dedication to being top leaders in pediatric health. In so doing, we value and embrace change in healthcare to deliver the most advanced care, while never losing sight of our goals to foster inspiration and hope among children and families. We drive change by seeking opportunities for improvement, identifying new needs and exploring new solutions.

Our Commitment to Excellence & Respect
Quality and safety are our highest priorities – our patients deserve no less. We demonstrate excellent service to patients, families and to each other. A long tradition of putting patients first, respecting each other and striving to improve further is inherent to both All Children’s and Johns Hopkins.

We approach our work with a positive attitude and professional manner. Taking responsibility to get the job done and holding ourselves—and each other—accountable is a vital part of “who we are.” We respond promptly to situations with honesty and integrity. We not only follow best practices and standards of care, we redefine them by looking for ways to increase efficiency and innovation while always keeping patient safety first.

Our work is too important to be slowed down by gossip, negativity, bullying or avoiding responsibility. These types of behaviors have no place in our organization. We respect and celebrate different perspectives, lifestyles, cultures, ethnicities and religions of our colleagues, patients and families. We treat others as we hope to be treated ourselves.

We are here to touch lives, save lives and create healthy futures. Whether we deliver frontline clinical care or maintain behind-the-scenes operations, we each play an important role in children’s health. When we have questions, we inquire and seek clarity. We admire our colleagues who face challenges with confidence, and learn positive lessons from setbacks. We strive to be the best.

Our Drive to Collaborate
Collaboration and teamwork are critical to our success. We, the All Children’s family, work together to support our organization’s strategic direction, to solve problems, to accomplish tasks and to sustain ourselves financially. We consider patients and families valued partners in the diagnosis, treatment and care of ill children, the creation of new knowledge, and training of future leaders in healthcare.

Partnering with community leaders, academic institutions and other healthcare providers shapes our identity and creates channels for growth. We have a duty to engage with our communities to help ensure local, regional, national and global access to our quality care and to create healthier and safer neighborhoods for children and their families.
TAP Mission

TAP was implemented in May 2009 to improve access to effective, compassionate, evidence-based health care for uninsured and underinsured patients in our community with demonstrated financial need.

Primary Care Locations

Johns Hopkins Clinics
- JHCP East Baltimore Medical Center
- JHH Adult Medicine Clinic
- JHBMC General Internal Medicine Clinic
- JHBMC Children’s Medical Practice

Community-based Clinics
- Health Care for the Homeless
- Chase Brexton Health Services
- Esperanza Center
- Baltimore Medical Systems

Eligibility Requirements

- Primary care at a participating TAP primary care location
- Insurance Eligibility
  - Uninsured
- Geographic Eligibility
  - 21202, 21205, 21213, 21219, 21222, 21224, 21231
- Financial Eligibility
  - Income levels at or below 200% of poverty guidelines

Improving Access to Care

- Total Referrals (9,124)
  - Approved Referrals (8,155) 89.4%
  - Referrals Closed for Clinical Reason (965) 10.6%

Clinician and Patient Satisfaction

- 82% of clinicians strongly agree or agree that TAP has helped them to be more thoughtful about appropriateness of referrals to specialists.
- All clinicians strongly agree or agree that TAP has improved their ability to serve uninsured/underinsured patients.
- 88% of patients reported that they were able to obtain needed health care after TAP versus 33% before TAP.
- 92% of patients were satisfied with health care received after TAP versus 25% before TAP.

“The people here at EBMC are like angels to me. The program has been a blessing.”
- Nellie Bell
Future Organizational Success Requires a New Strategy

The Affordable Care Act and the Maryland Waiver are changing the hospitals’ business model. To survive these changes and truly thrive, we must rethink how we approach Community Benefit programs, focusing on our mission and population health initiatives. We must engage in multisectoral partnerships with primary care clinics, community and social services, health departments and other organizations in the community.

What are Community Benefits?

Tax-exempt hospitals are required to conduct activities that are intended to address community needs through disease prevention, care coordination, and improvement of health and well-being.

Embedding Community Benefits in the Organizational DNA

- **Education**
  - Investing in our future health care professionals. Training programs for physicians, nurses and residents, medical students, nurses and nursing students, pastoral care trainees and other health professionals is community benefit.

- **Research**
  - Advancing our understanding of the communities we serve. Clinical and community health research, as well as studies on health care delivery that are generalizable, shared with the public and funded by the government or the hospital is community benefit.

- **Clinical Care**
  - Providing free care for patients with demonstrated financial need. Charity Care for health services provided to persons who cannot afford to pay and who meet the eligibility criteria of the hospital’s financial assistance policy is community benefit.

Community Health Improvement

- Improving the health and well-being of the communities we serve. Programs designed to improve population health and extend beyond patient care activities is community benefit.

The Sweet Spot

Our hospitals are now being held accountable for the health of our patient populations and we are responsible for implementing health improvement strategies to address community health needs. Finding that sweet spot and adopting a population-based approach to care that includes a broad spectrum of determinants of health is essential for us to thrive in the new era of health care.

Community Benefits at Johns Hopkins is a system collaboration where all six JHHS hospitals work together and learn from each other.
Introduction

Blood transfusion is the most common procedure performed in US hospitals. In 2012, the Joint Commission held an “Overuse Summit” and determined that blood transfusion was one of the top five most overused procedures, when considering recently released evidence-based transfusion guidelines. Given the cost, risk and potential adverse outcomes associated with transfusion, we decided to expand our relatively new Johns Hopkins Hospital blood management program to the entire Johns Hopkins Health System (JHHS), with the aim of reducing unnecessary transfusions.

Objectives

To gather experts in transfusion medicine and blood management from all five Johns Hopkins affiliated hospitals, in order to share best practices and reduce transfusion overuse and overall cost.

Materials and Methods

A comprehensive multidisciplinary team of clinicians and administrative staff from the departments of Pathology, Anesthesiology/Critical Care Medicine, Hematology, Medicine, Surgery, Finance, Quality and Clinical Analytics, as well as Supply Chain and Value Analytics was chosen to lead the effort, which was supported by the health system leadership and the Armstrong Institute for Patient Safety and Quality. Blood management began at the main campus (JHH) in January, 2012. Expansion to the whole health system began with a planning phase (January – June, 2014), and then implementation in July, 2014.

• Setting our strategic course –
  1. Sharing best practices from each of the JHHS affiliates, including agreement upon common transfusion guidelines across the JHHS for all four blood components (RBCs, FFP, PLTS, and CRYO).
  2. Education on evidence-based lab values as transfusion triggers as well as the added risks and costs of unnecessary transfusions.
  3. Harmonization of transfusion computer provider order entry (CPOE) ordersets with clinician decision support (CDS) and best practice alerts (BPA).
  4. Design and implement standardized data reports.
• Lessons learned –
  1. Transfusion guidelines were either inconsistent or unclear.
  2. Harmonization resulted in uniform evidence-based guidelines.
  3. A combination of education and CPOE best practice alerts, which started at the main campus (JHH) in April, 2013, was effective, and resulted in a 14.3% decrease in RBC transfusion for all surgical patients.
  4. Education is of primary importance and CPOE helps maintain best practice.

Blood transfusion guidelines were either inconsistent or unclear.

A combination of education and CPOE best practice alerts, which started at the main campus (JHH) in April, 2013, was effective, and resulted in a 14.3% decrease in RBC transfusion for all surgical patients.

• Strategic plan and budget alignment –
  Reports will include clinical outcomes and cost, which will show the value of a successful blood management program.

• JHM strategic objectives –
  Blood management aligns with JHM objectives by reducing risks and costs.

Results

The combination of education and CPOE best practice alerts, which started at the main campus (JHH) in April, 2013, was effective, and resulted in a 14.3% decrease in RBC transfusion for all surgical patients.

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Conclusion

Implementing a health system-wide blood management program has enabled us to share best practices, standardize transfusion guidelines, and utilize CPOE ordersets with best practice alerts to reduce unnecessary transfusions. Successful blood management will reduce transfusion-related risks as well as cost for the health system.
EQUIP: A System-Wide Hospitalist Approach to Improving Quality and Value


Introduction

Nationally, Hospitalists (40,000 per AHA) work in virtually every hospital (93% of institutions with >200 beds). Hospitalist processes similar to healthcare in general exhibit wide variations in both quality and cost. Therefore, momentum is building to reduce variation in clinical and operational processes. Specifically within Johns Hopkins Medicine, there are >100 doctors, 21,000 discharges in FY13 and accounted for ~$92M in hospital charges. Due to the ever-increasing pressures on improving quality in tandem with reducing cost – the “Value” equation for the served patient population. It is difficult for individuals or units to improve performance without a more efficient system and infra-structure. The Johns Hopkins Health System (JHHS) hospitalist clinical community recognized the need for new approaches to improving quality and cost within processes over which they have significant control and decided to pilot a more appropriate model.

Objectives

The goal was to create new processes and infra-structure within the JHHS hospitalist community to identify and address opportunities for quality and cost to improve value to their patients.

Materials and Methods

The EQUIP (Excellence in Quality, Utilization, Integration and Patient-Centered Care) program was initially created and funded by a partnership of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, Suburban Hospital, and the Armstrong Institute for Quality Patient Safety and Quality (AI). Collectively, the group formed the EQUIP Oversight Council and piloted the following methodology across JHHS:

- Modelled on the National Leader Strategy already in use by AI in conjunction with Core Measures Work Groups and CUSP teams.
- Identified metrics and annual goals for each of the EQUIP teams.
- Formed each entity-based team with clinical, technical, Lean Sigma, IT, financial and administrative members.
- Established a structure of A3 problem solving, weekly team meetings, weekly program-wide calls, a dashboard report system, and quarterly reports to the Oversight Council. All designed to drive a rhythm of discovery, tests of concept, cross-communication of learning, best practice sharing, and results.

Results

The EQUIP (Excellence in Quality, Utilization, Integration and Patient-Centered Care) program was initially created and funded by a partnership of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, Suburban Hospital, and the Armstrong Institute for Quality Patient Safety and Quality (AI). Collectively, the group formed the EQUIP Oversight Council and piloted the following methodology across JHHS:

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Conclusion

Multi-disciplinary, empowered groups of frontline hospitalist providers can significantly improve both the quality and value of care delivered. Keys to success in this effort included leadership support and collaborative, cross-functional support teams.

The structure and methodology of the EQUIP Program within the Johns Hopkins Health System can be adapted and extended to other clinical communities.
Enhanced Recovery After Colorectal Surgery


1 Departments of Surgery and 2Anesthesia, Johns Hopkins University School of Medicine and Johns Hopkins Hospital, Baltimore, MD, USA and 3Department of Surgery, Sibley Memorial Hospital, Washington, D.C.

Introduction

Colorectal surgery procedures are common and have high morbidity. There is opportunity to decrease morbidity (infectious complications) and increase value (length of stay). Presently, there is high variability in the perioperative management of colorectal surgery patients amongst hospitals across the country, including within the Johns Hopkins Health System as well as between providers within a hospital. Evidence supports best practices for the following domains but frequently this is not translated into practice: pre-operative education, anesthetic plan, pain management, fluid resuscitation, resumption of oral intake, mobility protocol.

Most surgical teams lack a system for critical review of performance and continuous process improvement.

Objectives

The goal was to improve the quality and value of care delivered to colorectal surgery patients at Johns Hopkins Hospital.

Materials and Methods

Expanding on the colorectal surgery perioperative comprehensive unit based safety program (CUSP), a multidisciplinary team including surgeons, anesthesiologists and anesthesia providers, nurses, advanced practice providers, office coordinators, with the support of hospital leadership developed (July 2013 - January 2014) and implemented (February 2014) an enhanced recovery protocol at Johns Hopkins Hospital for colorectal surgery.

This initiative was supported by the surgery and anesthesia leadership structure (department directors, administrators and nursing leadership) as well as Mr. Ron Werthman, Dr. Peter Pronovost and Ms. Renee Demski.

Concurrently, the surgical clinical community discussed best practices in JHHS for colorectal surgery (best practices from each Hospital highlighted).

Results

Engaged groups of frontline providers supported by leadership can significantly improve both the quality and value of care delivered.

The elements of the colorectal surgery enhanced recovery program at Johns Hopkins Hospital can be adapted and spread to other service lines and practice environments.

Conclusion

The goal was to improve the quality and value of care delivered to colorectal surgery patients at Johns Hopkins Hospital.

Engaged groups of frontline providers supported by leadership can significantly improve both the quality and value of care delivered.

The elements of the colorectal surgery enhanced recovery program at Johns Hopkins Hospital can be adapted and spread to other service lines and practice environments.
Introduction

Spine surgery within the Johns Hopkins Health System (JHHS) is performed by both orthopedic and neurosurgeons. After identifying process and outcome variations, these surgeons across JHHS decided to work together to achieve three overarching goals:

1. Provide the highest quality of care for patients
2. Care for patients in an evidence-based, best practice manner
3. Minimize unintentional variation

Standardization is critical in a clinically integrated system. As providers are increasingly held accountable for managing populations of patients, best practices will be a key method of providing efficient, patient-centered care.

Objectives

The group focused on Anterior Cervical Discectomy and Fusion (ACDF) procedures for their first best practice pathway in order to increase quality of care, decrease length of stay, increase patient satisfaction, increase staff and provider satisfaction, increase quality of care, decrease length of stay, increase patient satisfaction, and decrease cost per case.

Materials and Methods

The team created a best practice pathway for ACDF procedures performed on up to three levels for degenerative disease. These criteria make the pathway applicable to the entire health system, though the pilot focused on the Johns Hopkins Hospital. With the participation of a wide group of stakeholders, including physicians (ortho and neurosurgeons, PM&R), physician’s assistants, nurse managers and informaticists, and administrators, the team took a step by step look at the inpatient ACDF procedure to identify opportunities for harmonization and/or standardization. Multiple sites of variability were identified, which the team used to create a multi-step pathway outlining key activities during the pre-operative, intra-operative, and post-operative phases that would minimize variation and improve patient care. The pathway is divided further into specific time frames for each activity, with an ultimate goal of one day length of stay.

Results

The pathway and corresponding order set have gone into effect at Johns Hopkins Hospital. The team still has some work to achieve the length of stay goal at JHH, but has seen progression towards it. Monitoring pathway utilization and compliance with feedback to clinical team will be key in this process. Pathway work is across JHHS. The pathway will be programmed in Meditech. In addition, there will be a review of existing order sets in EPIC. The team has begun to focus on a pathway for Lumbar Fusions across JHHS.
Excess of Operating Revenue over Expenses (Excesses over Revenue) Actual vs. Budget for the Year Ended June 30, 2014

As Johns Hopkins Medicine plans for fiscal year 2015, healthcare reform continues to unfold. The conversion to population health and the new state waiver brings considerable uncertainty, including on new capital spending. These uncertainties have resulted in an extended capital due diligence process and, at times, hesitation to invest in capital opportunities. Moving forward, it will be increasingly important to drive prudent investment in projects that meaningfully reduce operating costs.

The fiscal year 2015 Johns Hopkins Medicine Capital Budget includes an overall capital investment decrease of $50.4 million (or 7%), in comparison to budgeted fiscal year 2014 capital spending.

The most notable increase in capital spending for fiscal year 2015 is the addition of EPIC Phase II-B. Other key capital items during fiscal year 2015 are as follows:

- The Johns Hopkins Hospital will complete a 136 private inpatient bed renovation of Nelson Harvey in October 2014. Other JHH reinvestment efforts in fiscal year 2015 will focus on the renovation of the Meyer Building and extensive work in the Park Building to house various departments of medicine clinics and multi-disciplinary services. Planning and design of the Viragh Building, which will house Oncology multi-disciplinary clinics and all solid tumor infusions, will continue.
- Johns Hopkins Bayview Medical Center will continue construction on a new oncology center, focusing on lung cancer, and expansion of the emergency department, with both projects scheduled to open during the last quarter of fiscal year 2015.
- All Children’s Hospital will embark on planning for a new Research & Education Building.
- Johns Hopkins Medicine will begin development for the planned expansion for Pavilion 3 at Green Spring Station, including land acquisition.
- Sibley will continue with two major initiatives, a modern bed tower and a proton therapy facility.
- Suburban will continue with their Campus Enhancement project, which will result in a replacement hospital facility in approximately five years.

As outlined, the proposed fiscal year 2015 spending demonstrates JHM’s commitment to grow in key markets while also reducing capital consumption to best address impending healthcare reform.

FY2015 Budget - Introduction

The fiscal year 2015 Plan is meaningful in many ways as it will undoubtedly be a year of significant challenges for both operations and finances. Management believes that JHM is extremely well positioned for the future despite significant revenue, volume, and expense challenges already in play. This sense of relative comfort can be attributed to an unwavering commitment to mission and values, a portfolio of high-quality and diverse operating entities, a strong system of organizational governance and management and a disciplined approach to setting and meeting targets for both the short and long term.

Fiscal year 2015 will be the second year operating under the priorities established in the JHM Strategic Plan as we continue to address organizational realignment and consolidation, and pursue operational efficiencies.

Once again, the scope and variety of initiatives that will be undertaken by Johns Hopkins Medicine are numerous, however, the following outcomes those that represent significant new commitments of human resources and financial investment:

- Investments in the people of JHM, as identified in the Strategic Plan, including expansion of healthy workforce initiatives.
- Growth of academic programs and services including the research and educational programs at All Children’s Hospital.
- Continued investment in the development of a comprehensive provider network.
- Improvement in the structure and capabilities of services relating to access for patients and referring physicians.
- Continued development of an integrated delivery system infrastructure including implementation and financing of Epic.
- Continued development of our managed care capabilities in order to respond to future demands in the health care environment.
- Continued efforts to capitalize on the intellectual assets resident within Johns Hopkins Medicine through initiatives such as Johns Hopkins Medicine International, Technology Transfer, and HealthCare Solutions.

FY2015 Capital Budget

Across Johns Hopkins Medicine, approximately $95 million of performance improvements are assumed in the fiscal year 2015 budget (equivalent to 1.4% of consolidated JHM expenses). Of this total, $40.2 million of improvements are assumed in the Academic Division (The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center) equivalent to 1.6% of expenses.

Performance improvements are primarily focused on cost reduction and process improvement. Efforts are a combination of entity-specific actions and JHM-wide strategies/tactics that are part of “the Initiative.” Management is actively developing an enterprise-wide procurement / supply chain function, and has also engaged external consultants to help identify additional cost structure opportunities.

Income from Operations (in millions) Operating Margin Percentage

FY2015 Performance Improvement Plan

The new era of health care
Supply Chain Strategic Initiative – Driving Performance
Department of Finance, Supply Chain and Armstrong Institute

Linkage to the Strategic Plan

The “Supply Chain Integration Five-Year Strategic Plan” is a significant effort to identify and act on opportunities to reduce and control expenses relating to the purchase of supplies and purchased services. Its scope includes all of JHM including Affiliates and International operations.

Strategic Plan Goals

- Supply chain management can contribute $80-100 million in cost reductions over the next four years towards the achievement of the Initiative’s goals.
- Significantly increased strategic value will be created through the adoption of an enterprise wide GPO augmentation strategy.
- Execution and deployment of a Strategic Sourcing strategy to complement the GPO augmentation strategy will be vital to accelerate the rate of performance improvement and cost reduction.
- Supply chain management can be a tool to initiate and secure market alliance opportunities, forge new affiliation relationships, and utilize supply chain strategies as one of the foundations for future expansion and growth of the organization.
- A market leadership position in supply chain management will also create the potential for JHHS to commercialize supply chain services, generating new net operating revenues for the enterprise.
- Regional Cooperatives with other provider organizations will add value in the future, after JHHS has achieved internal goals for supply chain excellence. Improvements and scale achieved within the JHHS Supply Chain organization and operation will also be leveraged for the mutual benefit and inclusion of Johns Hopkins International organizations and affiliations.

Overview of the “Now, Next, Later” 5-Year Supply Chain Strategy

- Accelerating Regional Co-Op from Year 3 to Year 1
- Proactive engagement from potential provider partners
- Balancing act to align Premier GPO augmentation strategy, Savings Initiatives, and Regional Co-Op Buildout
- Required accelerated build out of organizational and operational enablers

Have you heard?

- The “Supply Chain Integration Five-Year Strategic Plan” is a significant effort to identify and act on opportunities to reduce and control expenses relating to the purchase of supplies and purchased services. Its scope includes all of JHM including Affiliates and International operations.

Value Equation and The Optimal Model

Value = Quality / Cost

Transformational readiness criteria:

- Governance
- Focus on Total Non-labor Spend
- Strategic Sourcing vs. Self Contracting
- Supporting Systems
- Deep Category Knowledge
- Policies & Procedures

Commercial Services

Opportunities

- Fiscal 2014
  - $13M JHHS Net Impact
  - $15.6M Savings
  - $11.6M Premier IPC Cash Proceeds and Sharebacks
  - $46M in Price Reductions

- Fiscal 2015
  - $20M JHHS Net Impact Budget
  - $24.7M in Savings – Price Reductions
  - $25.8 in Premier Equity

The Armstrong Institute serves as the convener among Supply Chain, Finance, and the Clinicians.

TO THE NEW ERA OF HEALTH CARE
**Lean Project EBMC PEDS & MED-PEDS - Decrease Patient Wait Time**

Stephanie Lee, Benzette Alexander-Fields, Denisse Mueller, M.D.

Ambulatory Management Program, East Baltimore Medical Center, Pediatrics and Med-Peds

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**Introduction**

**Problem Statement:**
Patient wait times exceed JHCP standards of 15 minutes from registration to the provider evaluation, leading to decreased patient, provider & staff satisfaction scores resulting in patients leaving before seen by provider & decreased encounters.

**Objectives**

- **Goal:** to decrease wait times from baseline by 20% on average per provider in sample.
- **Scope:** All Well Child & Acute visits during normal day and late day schedules including walk-in visits.
- **Benefits:** Increased pt, provider and staff satisfaction. Increased encounter capacity. Improved work flow throughout practice.

**Materials and Methods**

- **Measure:** Baseline Process:
  - Value Stream Map for patient flow
  - Staff Utilization Analysis
  - Spaghetti Diagrams for CMA workflow
  - Schedule Utilization Reports
  - Templates Analysis
  - Established baseline wait times for two providers in sample
  - Collected data from all Well Child & Acute visits during normal day and late day schedules for provider 1 and provider 2 for 7-9 sessions

- **Key Metric(s):** time from sign-in to discharge from exam room

**Conclusion**

- **Interventions/Next Steps**
  - Piloted “Open Schedule” with undesignated appointment types and without visit limits - OMD
  - Recruitment of two additional providers to implement - PA
  - Adjustments in current templates to create an even distribution of visit types throughout daily schedules – Admin Mgr

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  - Recruitment of two additional providers to implement - PA
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Problem Statement
Patient time in clinic from registration to discharge is too lengthy resulting in patient, provider and staff dissatisfaction.

Goal:
Reduce lead time 25% from patient arrival to discharge, by May 23, 2014

Scope:
Patients scheduled at Johns Hopkins Bayview Musculoskeletal Center with Dr. Hasenboehler.

Benefits:
- Improve patient, provider and staff satisfaction
- Decrease overtime for staff
- Increase visit volume
- Improve utilization of limited clinic space

Key Metric:
Lead time

Interventions/Next Steps
- Study patient flow of all services
  Shiflett/Kries 7/1/14
- Implement communication board for all pods and services
  Hasenboehler/Shiflett/Kries 8/1/14
- Complete exam room vital taking process
  Shiflett/Kries 7/1/14
- Map registration value stream
  Shiflett/Kries 8/1/14

Post Project Results/Actions
- Team pods created
  - Improved communication between staff and providers
- Cast room utilization workflow implemented
  - Decreased movement of patients
- Communication board utilized
  - Improved communication between staff, x-ray technician, resident/mid level and provider
- Examination room supplies standardized and labeled
  - Decreased delays due to lack of supplies readily available in room
- Return visit appointment length decreased from 20 minutes to 15 minutes

Control
- Lead time data analyzed at 6 month intervals
- Performance improvement plan implemented based on analysis
Finding a Better Way- Pediatric Specialty Clinic
Nancy Cournoyer, Meghan D’Angelo, Peter Mogayzel, Barry Solomon, Cindy Thompson
Department of Pediatrics, Johns Hopkins Children’s Center

PROBLEM STATEMENT
Patient wait time from arrival in the Pediatric Specialty Clinic until being seen by the provider is excessively long. Inefficiencies and delays result in poor room utilization, staff and provider frustration, low patient satisfaction, and patients leaving without being seen.

GOAL
Reduce time from arrival in clinic to being seen by a provider by 30%.

SCOPE
Patient arrival time in the Pediatric Specialty Clinic to the time that triage is completed.

BENEFITS
Increase efficiency and patient satisfaction through streamlining patient arrival process and enhancing patient- and family-centered care.

KEY METRICS
• Time from patient’s arrival to registration.
• Time from registration to completion of triage process.
• Patient/Family satisfaction

PROBLEM
Patient wait time from arrival in the Pediatric Specialty Clinic until being seen by the provider is excessively long. Inefficiencies and delays result in poor room utilization, staff and provider frustration, low patient satisfaction, and patients leaving without being seen.

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SCOPE
Patient arrival time in the Pediatric Specialty Clinic to the time that triage is completed.

BENEFITS
Increase efficiency and patient satisfaction through streamlining patient arrival process and enhancing patient- and family-centered care.

KEY METRICS
• Time from patient’s arrival to registration.
• Time from registration to completion of triage process.
• Patient/Family satisfaction

Steps in the Registration Process
1. Enter the clinic via Orleans St. Garage or Wolfe Street
2. Obtain wristband from Security
3. Take ticket from NEMO
4. Enter information into Welcome Kiosk
5. Wait for number to be called to come to Registration
6. Complete registration process with PSC
7. Wait for name to be called for Triage
8. Triage obtains vitals, pain score, pharmacy preference
9. Patient is placed in exam room or return to waiting room if exam room is unavailable

Conclusions/Lessons Learned
• The registration & triage processes runs more efficiently than expected
• Overall time for registration & triage is 11-14 min
• Eliminating certain steps in the registration process made little difference in front line times but did improve satisfaction with the registration process. We tested the following:
  ‒ Using & Not using NEMO for tickets
  ‒ Using & Not using Welcome Kiosks
  ‒ Placing a staff member in waiting room to assist patients with the Welcome Kiosk
  ‒ Changing layout of waiting room furniture
• Families are less satisfied with the check out process than previously known.
• A staff member in the waiting room aiding families with registration process was very well received

Future Directions
• Analyze check out process to improve efficiency and family satisfaction
• Develop concierge services in the waiting room to enhance patient- & family-centered care
• Expand project to Harriett Lane Primary Care Clinic
**Patient Access Line (PAL)**

Susan Brittain, RN, BSN; Shelia Dennis, RN, MSN, APMH-BC; Allison Gill, MS, BSN, CNRN; Susan Glinsmann, RN, MBA, NE-BC; Melissa McAdam-Cox, RN, BSN; Sharon Schromsky, RN, BSN; Franz Vergara, MSN, RN, ONC

**The Need**

- Patients are most vulnerable immediately following discharge
- Care instructions and medication schedules are often complicated and unclear
- Patients may be hesitant to contact physicians or have trouble reaching them for concerns

**The Drivers**

- Penalties for potentially preventable readmissions
- Required reductions in utilization and cost associated with revised Maryland waiver
- Preparation for ACO
- Desire to provide patient and family-centered care (“like it was your loved one”)

**The Start-Up**

- Using funds from Johns Hopkins Community Partnership (JCHP) grant, we developed the PAL service to reach out to patients in this critical time period
- Began soft roll-out to adult units at JHH and JHBMIC in July 2013
- Currently supporting 14 units with goal of blanketing both campuses and serving as model for JHM enterprise

**Who We Are**

- A team of dedicated nurse case managers focused upon helping patients manage their transition from hospital to home
- Diverse, seasoned group with experience working in ED, ICUs, PACU, specialty floors, behavioral health, and regular medical/surgical areas

**What We Do**

- Contact patients within 24-48 hours after discharge to home
- Following scripted survey tool and using Discharge Worksheet as a guideline; review:
  - How patient is doing (better, same, worse)
  - Medication regimen
  - Instructions for self-care management (do's & don'ts)
  - Red flags, “signs & symptoms,” and who to call
  - Appointments (and plans/ability to keep them)
- Identify any “stop the call” acute needs and make immediate referrals (e.g. 911, ED, inpatient clinical team) as appropriate
- Provide education using Teachback technique to reinforce instructions and highlight important aspects of self-care management
- Assess patient’s ability to manage and, where appropriate, identify/recommend resources to provide additional support
- Document results in PAL database and Epic

**Possible Follow-Up Interventions**

- Email to clinical team (author of d/c instructions, attending MD, and any others pre-designated by service) informing them of question or concern and requesting receipt confirmation
- Referral to unit Case Manager or Social Worker for follow-up on arrangements started in-house or needs identified during call (e.g. vouchers, appts.)
- Referral to Transition Guide to provide in-home and/or telephonic follow-up by RN for up to 30 days post-discharge
- Referral to Home Care Coordinator for arrangement (with provider) of skilled services where potentially appropriate
- Referral to Transitional Pharmacist for phone call(s) to provide additional teaching on high risk and/or new medications
- Referral to Service Excellence (via electronic Guest Relations reporting system) for recording, acknowledgement, and follow-up (where desired) on compliments or constructive comments
- Referral to PAL Medical Director or Physician Advisory Board where there are recurring issues that require review

**Outcomes**

**Majority of Calls Receive at Least 1 Intervention**

13% Relative Decrease in Readmissions in Patients Eligible for & Receiving Calls

**Stories from the Field**

While most patients are doing well, PAL nurses have identified many issues – from minor misunderstandings to serious medical conditions. Examples of “saves” include:
- Patients in clinical decline (e.g. neurologic event, non-stop bleeding, uncontrolled severe pain, etc.)
- Patients with low health literacy or functional illiteracy (e.g. double dosing from confusion between brand name and generic meds, inability to read d/c instructions, etc.)
- Patients with medication issues (missing, incorrect, can’t afford) that could cause serious problems

**Next Steps**

- Complete installation and implementation of RelayCare call management software
- Expand to remaining adult non-ICU units at JHH and to one remaining unit (Surgery) at JHBMIC
- Produce reports with new software to identify trends and areas for improvement on service-specific basis
- Begin planning for expansion to inbound call center and 24/7 service

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Improving Patient Outcomes by Activity and Mobility Promotion in Hospitalized Patients.

Erik Hoyer, MD; Michael Friedman, PT, MBA

Why is promoting activity and mobility in the hospital important?
Most hospitalized patients currently spend most of their time in bed.

Lower levels of physical fitness are directly associated with all-cause mortality and increased complications.

Patient centered: Affects patient’s ability to perform activities of daily living and basic needs, which can affect a patient’s dignity.

Our current health-care environment is emphasizing patient centered outcomes (i.e., Hospital Readmissions).

Activity and Mobility Promotion Initiative (AMP)

Mobility is part of many hospital initiatives inclusive of readmissions, hospital acquired complications, and meaningful use. We believe targeted mobility interventions can create broad system impact.

Create metric to document mobility

Highest Level of Mobility (HLM) – progression of observable mobility milestones captured in the EMR

Outcomes of the Medicine Pilot

In multi-variable regression analysis, patients with a 1 point increase in HLM had:

- Shorter LOS by 0.4 (95% CI 0.2-0.6, p<0.001) days
- Increased odds of discharge to home, OR 1.6, (95% CI 1.3-1.9, p<0.001)
- Fewer hospital costs by $800 (95% CI 200-1400, p=0.01)

Strategies to Improve the patient HLM Trajectory

- Formalize and integrate the common “Interdisciplinary Functional Assessment” as part of care coordination
- Physician engagement of patient/family in mobility
- Patient specific daily mobility goals
- Target Therapy resources (i.e. Choosing Wisely)
- Evaluate nursing workflows and resources to promote mobility

Choosing Wisely: Who is the “right” provider to mobilize patients?

To best use our resources we must target right provider, right patient, right time

Outcomes of the Medicine Pilot

How do we reconcile function? AM-PAC Inpatient Scale

The simple assessment can score functional impairment both within a setting and across the continuum

Resource Utilization: Physical Therapy Evaluations

Many independent patients who require no services upon discharge receive a PT consult. This may be an opportunity to use other resources and target PT to more impaired individuals

Smart Orders to Target Resources

- A recommendation will be made based on your selections
- PT and/or OT consults will be automatically ordered if recommended
- You may override recommendations if warranted

Next Steps for AMP

- Integrate AMP within Enhanced Recovery After Surgery (ERAS)
- “Choosing Therapy Wisely” QI with Neuroscience, Medicine, and Surgery
- Assess and reconcile mobility in the primary care, ambulatory and home care settings
- Establish AMP Workflows within the EPIC harmonization process
Johns Hopkins Community Health Partnership (JCHiP)
The JCHiP Team

Community Intervention

- Sisters Together & Reaching, Inc. (STAR) Community Health Workers (CHWs)
  - Trained 5 CHWs to deliver intensive, longitudinal community-based case management to high-risk patients residing in 3 target zip codes (21202, 21205, 21213)
  - Are employed and overseen by STAR
- Men and Families Center (M&FC) Neighborhood Navigators (NNS)
  - Provide 30 NNs to conduct outreach, resource connection, and social support to neighbors who live on and around their blocks in one neighborhood within the target zip codes
  - Receive stipends and support from M&FC

Hospital / Transitions / ED Component

- Readmission and transition efforts began through JHHS Readmissions Task Force efforts in 2009.
- HSCRC ARR program ➔ New Waiver
- “All Payer:"

Skilled Nursing Facilities (SNF) Component

Who Does J-Chip “Touch”?

Up to 40,000 adult annual discharges from JHH/JHBM by year 3. Thousands of ED visits.

About 7,000 adult Medicaid and 10-14,000 Medicare patients receiving local community care will be monitored and 3,000 targeted.

-JMental illness, substance abuse and chronic illness.

J-Chip Vital Statistics (as of Q8 Report 7/30/14)

- Quarter 8 Milestones: 17/4 (other w/ mitigation strategy)
- Total Program Participants: 52,108
- Total Staff Trained/Hours: 1,572 staff /10,741 hours (not unique)
- Total New Workers Hired and Trained: 77
- Presentations: 199
- Program Participants from 7- zip code area: 18,074 (35%)
- Number/Percent of Medicare: 14,678 (28%)
- Number/Percent Eligible: 3,663 (7%)
- Number/Percent Medicaid: 11,155 (21%)
- Inpatient Units: 34 (14 JHBM; 20 JHH)
- Ambulatory Clinics: 8
- SNF Sites: 5

Community Health Partnership

- Built on existing programs
- Over 200 people involved
- Transforms patient care across continuum: clinics, SNFs, hospitals, home, and EDs
- Catalyzed by a three-year, $19.9M CMS grant
- East Baltimore Community – 7 zip codes

East Baltimore Community

- 20 year difference in life expectancy
- Major portion of mortality difference due to treatable conditions
- Readmission and transition efforts began through JHHS
- 20 year difference in life expectancy
- Total Program Participants:
- By year
- Presentations
- SNF Sites:
- 1. Member identified to be in high risk of inpatient admission

Driver Diagram

The project described was supported by Grant Number 1C1CMS331053 from the Department of Health and Human Services, Centers for Medicare and Medicaid Services. The contents of this presentation are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The research presented here was conducted by the awardee. These findings may or may not be consistent with or confirmed by the independent evaluation contractor.
The Affordable Care Act (ACA) created the Medicare Shared Savings Program (MSSP) or Medicare ACO. Accountable for the quality, cost and overall care of a set of patients. Voluntary program. “Fee-for-Service” beneficiaries ONLY. See Any Physician. No “Lock in”. Maintains Governing Board. 3 Year Agreement Period.

JMAP Participants
- Johns Hopkins Community Physicians
- Johns Hopkins School of Medicine – Clinical Practice Association
- Columbia Medical Practice
- Potomac Physician Associates
- Cardiovascular Specialists of Central Maryland
- 5 JHM Hospitals in Maryland/DC

JMAP Beneficiaries
- PATIENTS
  - Patients-focused care
  - Standardized care
  - Care coordination
  - Use data, assess outcomes
  - Patient representatives in ACO governance (JMAP 1-800 number (1-855-390-5803))
  - Receive announcement letter and opportunity to decline to share health information

All JMAP Beneficiaries

Governance and Management

How will providers and patients be impacted?
- PROVIDERS/PRACTICES
  - All physicians included
  - No change in management
  - Fee for Service
  - Data reports
  - ACO-related activities compliance with policies & procedures, such as:
    - Beneficiary communication
    - Reporting quality metrics
  - Potential for shared savings

Data and Analytics

Launch/ Regulatory Requirements
Approved to start January 1 as Medicare ACO.
Launch “Regulatory” Requirements:
- Beneficiary Notification and Decline to Share Process
- Practice Signage, Office, and Training Materials
- CMS Claims Data Request

Physician/Practice Communication Strategy
- CPA/JHCP “Blitz” Emails
- Overview Webinars for Physicians/Practices: January/February
- Frontline Staff Webinars/Training: March
- >50 “Road Show” Presentations for Departments/Divisions, Practices, etc
- Regional Advisory Councils: Representative from Each Practice

More to come...

Medical and Quality Strategy

Medical and Quality Strategy, Continued

MSSP-Required Quality Metrics = 33 Measures
Goal: CMS regulatory requirement – 33 measures in 4 domains (like PQRS)
Status/Next Steps: Regulatory work with CAHPS Survey/GPRO (Group Practice Reporting Option) for JMAP to begin in late 2014. Currently determining internal monitoring measures/metrics for development of provider, practice site, and ACO level dashboards

Next Steps
- Data/IT/EMR
  - Development/Validation of Predictive Model
  - Epic Healthy Planet Initiative (JHM Only; Harmonize for Other EMRs)
- Quality Measure Reporting for 2014
  - Development of EMR Quality/Internal Monitoring Reports in Epic and non-JHM EMRs
- Care Coordination Enrollment
  - EMR Referrals into Care Management via Epic
  - Care Management Brochures/Provider Referral Tip Sheet
  - Beneficiary Letters
- Physician/Practice Communication Strategy
  - JMAP Site Survey – Analysis/Dissemination of Results
  - Continued “Road Show” Presentations

For Additional Information - Medicare
For general questions or additional information about Accountable Care Organizations, please visit www.medicare.gov/acos.html or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-1048.
**People**

- 250+ specialty pharmacy staff for adults and pediatrics
- Employee Engagement action plan initiatives
- Continued to exceed JHM Diversity goals
- National Home Infusion Association Certification
- Board Certification in Ambulatory Care
- Continuing Education for Pharmacists and Technicians
- Developed clinical ladders for technicians
- Infusion Nursing Society Certified nursing
- Chemotherapy administration certification by JHU SON

**Biomedical Discovery**

- Expanded participation in research and grants through collaborations with:
  - Johns Hopkins Oncology
  - UMMS Greenbaum Cancer Center
  - Oncology and investigational treatments at home
  - Trabectedin, Onconova-J I 118, 5-AZA
  - Fisher Center Grant-Catheters in the Community; Study of Midline and Outcomes (PI: Dr. Pearl)

*SPECIALTY PHARMACISTS, INFUSION NURSING & EQUIPMENT ARE AVAILABLE FOR NUMEROUS RESEARCH OPPORTUNITIES WITH LARGE HOME BASED PATIENT POPULATIONS*

**Patient and Family Centered Care**

- Created a Patient and Family Advisory Committee
- Deliver care to home, workplace, hotel, international
- Employee discounts and pharmacy assistance programs
- Disease State Management

**Medication Therapy Management (MTM) Services provided by JH Specialty Pharmacies**

- Comprehensive medication review
- Personal Medication List
- Medication Action Plan
- Referral/Intervention
- Documentation/follow up

**Performance**

- Improved patient outcomes on complex medication regimens
- Continued patient engagement throughout home therapy
- Patient Experience: Convenient access to drug, Complete, integrated patient care that promotes effective communication
- Pharmacist Case management with complete EHR access minimizes preventable readmissions and ED visits
- Appropriate medication spend through rigorous review
- Reduce Costs

**Achieving the Triple Aim: The Role of Specialty Pharmacy**

**Differentiating Specialty and Community Pharmacy**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Specialty Pharmacy</th>
<th>Community Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Volumes</td>
<td>Specialty pharmacy accounted for less than 1% of all prescriptions dispensed according to the 2014 Express Scripts drug trend report</td>
<td>NASCDs reports that chain drug stores dispensed more than 72% of the almost four billion total prescriptions received by patients</td>
</tr>
<tr>
<td>Financial Navigation</td>
<td>Prior authorizations frequent, and require pharmacy assistance to communicate clinical information between payers and providers that can only be found in the electronic health record</td>
<td>Prior authorizations less frequent</td>
</tr>
<tr>
<td>Distribution</td>
<td>Frequently special requirements exist from entities such as FDA and manufacturers to procure and distribute drug</td>
<td>Drug purchased from distributor through normal practices</td>
</tr>
<tr>
<td>Patient Management</td>
<td>Higher touch, and more frequent, patient management includes twenty-four hour services and intensive pharmacist-patient interaction to ensure medication adherence and promote positive outcomes (e.g., monitor for adverse drug reactions)</td>
<td>Less intensive patient management</td>
</tr>
</tbody>
</table>

**Education**

- American Society of Health-System Pharmacists (ASHP) accredited PGY1 Community Pharmacy Residency Program
- Mentored:
  - Pharmacy students from area schools of pharmacy
  - Nursing students from area schools of nursing
  - Fuld Scholars

**Integration**

- Sterile compounding for Wilmer
- Obtained Wholesale distributor license to provide medication to JHM providers for domestic and international use
- Providing specialty medications for JHHC
- Transitions services for health system hospitals
- Expanded support of JHI
- Support All Children’s Hospital Outpatient pharmacy system
- EPIC access to EMR for clinical pharmacy integration across the continuum

**Transformation**

**Johns Hopkins Home and Community Based Specialty Pharmacy Integration**

Johns Hopkins Home Infusion Services and Johns Hopkins Outpatient Pharmacy

- 2014 Express Scripts drug trend report
- 72% of prescriptions received by patients
- 4 billion total prescriptions
- Domestic and international use
- Domestic and international use
- American Society of Health-System Pharmacists (ASHP) accredited PGY1 Community Pharmacy Residency Program
- Mentored:
  - Pharmacy students from area schools of pharmacy
  - Nursing students from area schools of nursing
  - Fuld Scholars
- Sterile compounding for Wilmer
- Obtained Wholesale distributor license to provide medication to JHM providers for domestic and international use
- Providing specialty medications for JHHC
- Transitions services for health system hospitals
- Expanded support of JHI
- Support All Children’s Hospital Outpatient pharmacy system
- EPIC access to EMR for clinical pharmacy integration across the continuum

**Performance**

- Implemented scalable systems to support continued expansion of specialty pharmacy services throughout JHM
- Preparing for Specialty Pharmacy accreditation through URAC to capture payor contracts and additional specialty medications in JHM
- Center for Pharmacy Practice Accreditation
- Selected as the preferred provider at Children’s National Health Services
- IV, Outpatient and 340B Pharmacies Contributions after HOA $23.7m
A Roadmap to Achieving a Patient Centered Medical Home Domestically and Globally

Steven Kravet, MD, MBA; Jennifer Bailey, RN, MS
Johns Hopkins Community Physicians

Abstract

Where or not you aspire toward Patient entered Medical Home (PCMH) accreditation, practice redesign adhering to domains of PCMH is of value. Using a well-tested, multi-faceted assessment process applicable to practice anywhere along the pathway toward PCMH has been beneficial in transformation redesign. Our goals are to (1) describe the principles and domains of the Patient Centered Medical Home model, (2) demonstrate how to prepare for and conduct a PCMH readiness assessment using a structured gap analysis tool, (3) describe how the process to transform using a phased-in implementation plan, and (4) describe the challenges and successes of developing a PCMH model in a culturally challenged environment.

Methods and Materials

A phased-in road map was developed to implement the PCMH transformation process. See Table 1 below (implementation plan). The phased-in approach starts with a readiness assessment. See Table 2. The readiness assessment is preformed as an interview with the site administrative and clinical leadership and via direct observation in the clinic. The observation determines adherence to expected processes. Documents are gathered as part of the assessment to demonstrate structure and outcomes. Examples of these documents include policies and reports.

Introduction

Patient Center Medical Homes conceptualize a primary care delivery framework that emphasizes open access, the use of data and technology for population management, adding additional support to high risk patients through care management, enabling patients to help care for themselves, coordinating care with other care providers, and implementing continuous quality improvement. In Maryland JHCP is a leader in the implementation and NCQA recognition of PCMHs. JHCP partially attributes these successes to the use of a structured phased in process for transformation.

Results

Use of this phased-in implementation plan and readiness assessment has resulted in the highest levels of NCQA recognition for PCMH. All 11 JHCP sites have achieved level 3 recognition, the highest level, with scores all above 95 of 100.

Discussion

In the early stages, this process has allowed for PCMH transformation across rural, urban and suburban settings. Through PDSA-type learning we refined the transformation process. Early adopters were leveraged to advise and mentor colleagues. This process has been adapted to apply to international population and practices and has resulted in concrete action plans toward PCMH.

Challenges domestically included increased busyness expressed from front line staff and providers as we become more proactive managing between visits. One challenge internationally is engagement of patients and population not familiar with a primary care / preventive oriented care. Another has been the reality that training of healthcare providers (doctors, nurses, and medical assistants) varies significantly and almost universally does not include robust ambulatory care and workflows.

Conclusions

• The 3 phased PCMH implementation allows for growth and adaptation, and can succeed in a variety of settings
• Assessment using a structured tool that combines pre-work, interviews, and direct observation captures key data points for a gap analysis
• Challenges in PCMH transformation include shifts in workloads from clinicians to support staff that impact overall busyness.
• The culture of a community must be fully embracing of primary care to success in PCMH, and it not then building a culture becomes the first step
• Differences in training between US and international clinical teams is an important potential barrier in PCMH development
Education Strategic Priority

Goal 1

Build an effective culture for learning and education across all JHM member organizations, leverage the University’s infrastructure, and facilitate interprofessional educational programs

Ensure that the core competencies for interprofessional collaborative practice are disseminated to every medical student, resident and clinical fellow at Johns Hopkins, and show that the majority of surveyed learners are familiar with these competencies.

- Core competencies distributed to 100% of target groups
- Directors for interprofessional education named for SOM (Laura Hanyok, MD) and SON (Elizabeth “Ibby” Tanner, PhD, RN)
- Dr. Hanyok named one of six Macy Foundation Scholars in the U.S.

Interprofessional Education & Practice

Ten Tips to Foster Interprofessional Collaboration

1. Always introduce yourself to your interprofessional colleagues.
2. Get to know your colleagues: Who are they? What is their educational background? How do they contribute to the healthcare team? Make sure they get to know you.
3. Value and respect the unique contributions of each profession.
4. Seek input from all clinical caring for the patient. You may be surprised what they know!
5. Listen respectfully.
6. Actively participate in team meetings.
7. When communicating with others on the team, minimize the jargon of our own profession. Use language which all members of the team will understand.
8. When on rounds, consider who else should be present. Think: Am I rounding in my own professional ‘silo?’ Who else can contribute to this patient’s care?
9. Support each other. Mutual support is the essence of teamwork.
10. When speaking with patients and families, show respect to all health care workers by acknowledging their contributions and avoiding negative comments.

Goal 2

Ensure that medical and biomedical education at Johns Hopkins is transformative as reflected by curricula that emphasize cutting-edge science, novel treatments, wise use of technology, and avoidance of unnecessary medical tests and procedures.

Require each residency program to implement an intervention to reduce or eliminate 1 unnecessary or wasteful test or procedure.

- About one-third of the 90 residency and fellowship programs developed an intervention to reduce/eliminate an unnecessary/wasteful test or procedure
- Johns Hopkins Bayview eliminates more than $1M of unnecessary cardiac enzyme testing
- National attention from ABIM Foundation
- Publication in JAMA Internal Medicine
- Cost conscious care curriculum implemented for medical students

Supporting Literature

Berkheimer Faculty Education Scholar Grant Winners

Project Title: Improving Medical Students’ Practice of High Value Care
Healthy Beverage Initiative

Favorable pricing for healthy beverages
- Fruit drinks, soda, sports drinks, coffee
- Beverages with more than 100 calories per 12-serving

Serving only healthy beverages at company
- Beverages with 26 to 100 calories per 12-serving

FJ, Thompson JW and Ludwig DS: The public health and economic benefits of taxing

Examples:
- Point of purchase education
- Dashboard

Examples:
- Red beverage availability: ≤20% of total offerings
- September 2014

Healthy beverages at eye level

Low

Increasing availability of healthy beverages
- Red beverage availability: ≤20% of total offerings
- September 2014

Implementing a Culture of Health

Sugar Sweetened Beverage Trends

Mean Intake of Added Sugars & Percentage Contribution of Various Foods Among US Population, by Age

Statements Supporting Reduction of Sugar-Sweetened Beverages

Mean Weight According to Trends in Sugar-Sweetened Soft Drink Consumption by Women

Relationships Between Changes in Beverage Consumption and Weight Changes Every 4 Years

Healthy Beverage Initiative

Rethink Your Drink

Green: Healthier choices
- Beverages with 0 to 25 calories per 12-ounce serving; skim and 1 percent milk
- Examples: water, unsweetened tea/coffee; diet beverages with artificial sweeteners

Yellow: Better choices, but don’t overdo it
- Beverages with 26 to 100 calories per 12-ounce serving; 100% fruit/vegetable juice and 2 percent milk
- Examples: Low-calorie fruit or sports drinks, 100% fruit/vegetable juice and 2 percent milk

Red: Drink sparingly, if at all
- Beverages with more than 100 calories per 12-ounce serving that are high in sugar, calories, sodium and/or fat
- Examples: fruit drinks, soda, sports drinks, coffee drinks, whole milk

Implementation Plan

Dashboard

Healthy Beverage Initiative Subject Matter Experts

Lawrence Appel, MD, MPH, Professor of Medicine, Epidemiology and International Health (Human Nutrition); Director, Welch Center for Prevention, Epidemiology and Clinical Research, School of Medicine

Sara Bleich, PhD, Associate Professor, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health

Roger Blumenthal, MD, Professor, Department of Medicine / Cardiology, Director of the Ciccarone Preventive Cardiology Center, School of Medicine

Benjamin Caballero, M.D., M.Sc., Ph.D., Professor of International Health, School of Medicine

Thomas Donner, MD, Associate Professor Medicine / Endocrinology; Director, Johns Hopkins Diabetes Center, School of Medicine

Creating a Culture of Health

Changing the Context

Strategies for Promoting Healthy Beverages

- Increasing availability of healthy beverages
- Favorable pricing for healthy beverages
- Healthy beverages at eye level
- Point of purchase education
- Reduce serving size of sugar-sweetened beverages
- Serving only healthy beverages at company meetings and events
Part – The Role by Leaders

- Champion the concept and purpose of leadership competencies at JHU / JHM
- Model the leadership competencies
- Utilize competencies in decisions involving compensation, searches, promotions, development, and internal/external selections
- Use the established HR tools and resources to support the process
- Hold self and others accountable

JHU / JHM Leadership Model

- JHU / JHM Leadership Competency Model
  - To provide a detailed description of leadership to aid in the development of leaders.
  - Help leaders develop their skills, knowledge, and abilities in order to successfully perform in current and future leadership roles.
  - Does not replace being technically competent

Plan – How the Leadership Competencies were Developed

- Interviewed and surveyed a total of 71 JHU and JHM Officers
- Established Leadership Competency Advisory Committee – 24 JHU and JHM leaders
- Finalized leadership competencies for the Johns Hopkins Enterprise
- Established four levels of leadership within the competency model
- Developed interview questions, learning activities, e-learning, instructor-led courses, books
- Determined points of integration of the finalized leadership competency model into leadership processes

Human Resources

Leadership Competencies for Johns Hopkins Leaders

- Need to create and sustain a Leadership Talent Pipeline for JHM
- Drive by current and future JHM Strategic Priorities
- Demographics

- Achievable: the outcomes of leadership in future success
- Relevant: the strategy
- Measurable: the strategy
- Different: the strategy
- Aspirational: the strategy

- In the role of a leader, you must be able to:
  - Articulate a vision
  - Describe a time when you helped members of your work unit reach a goal. What did you do? What were the results?
  - Prioritize and manage multiple responsibilities at the same time.
  - Interview and survey a total of 71 JHU and JHM Officers
  - Describe how you go about
  - Can fund the vision.

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