JOHNS HOPKINS MEDICINE

ManagedCarePartners

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A Total Class Act

A revolutionary way of teaching medicine focuses on the individual patient by pulling together all the variables that influence health.

Vice Dean for Education David Nichols, in the newly opened Anne and Michael Armstrong Medical Education Building. The 100,000-square-foot facility was designed around the new Genes to Society curriculum.

Medical students enrolled at Johns Hopkins this fall are the first to benefit from a new era of medical training. In the most widespread change to the medical school's curriculum in more than two decades, educators have significantly revised their approach to teaching medicine, from one that is disease-based to a holistic practice that factors in patients' unique genetics and environments.

The Genes to Society curriculum, nearly six years in the making, is grounded in the Human Genome Project, which has opened up a much greater appreciation of the enormous variation in the presentation of disease. "We are entering an era where physician educators will no longer be able teach the 'classic' case or discuss the 'average' patient," says David Nichols, vice dean for education. "There will only be individual patients requiring individualized, highly personalized care. The curriculum also recognizes that social and environmental factors contribute to every patient's unique experiences, so it incorporates social and behavioral sciences, as well as public health and policy content, in aiming to improve health outcomes.

"This is a substantial change in our outlook on how to prepare students for the practice of medicine in an era where genomic analysis is possible," Nichols continues. "Genetic medicine is already a reality in the treatment of cancer, and over time, this level of understanding will migrate to every specialty. This is a huge departure from where we are now and a main reason we have to change the way we train people to become doctors."

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Medical education models have typically classified people as either sick or healthy. Physicians now understand, however, that important details such as genotypes and environmental experiences are unique to each individual.

"We're preparing our students to look at a patient's biology down to the genetic level and dovetail that with environmental and societal factors to come up with both an accurate differential diagnosis and effective treatment plan," Nichols says. "This is especially important for patients with chronic illnesses, which now represents the major form of illness in developed countries."

The curriculum's centerpiece is a yearlong Genes to Society course in which first-year students learn major biological aspects of medicine, seeking to understand how internal factors such as genes, cells and organs, and external factors like family, community and environment interact to explain a patient's condition. The program emphasizes communication skills, teamwork in medical problem-solving, and lifelong learning.

Students will spend a year working in one of the Johns Hopkins Community Physicians practices to learn the evolution of chronic illness and the impact of the medical system on their patients. Researchers among the faculty will guide each student in the completion of the scholarly project. The clinical and basic science instruction is completely integrated throughout all four years of medical school. Each student belongs to a college where an adviser teaches the art of physical diagnosis and helps the student decide which specialty to pursue after graduation.

These ambitious revisions started in 2003, beginning with the question, *How will medicine be practiced 10 years from now?* First, the school's leadership formed a strategic planning group comprising basic and clinical scientists, policy makers and former patients who devised a general framework. Then the Dean's Office formed a 30-person Curriculum Reform Committee including faculty, staff and students to put the ideas into a new training module.

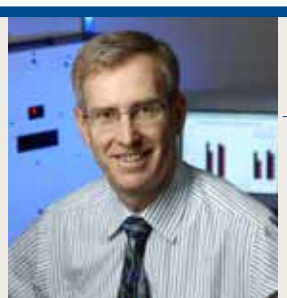
The endeavor was so broad that it evolved over several years of discussion and even altered the campus' physical landscape.

The newly opened Anne and Michael Armstrong Medical Education Building was designed around the new curriculum. The 100,000-square-foot, four-story structure features educational settings ranging from a 70-person learning studio and two large lecture halls to flexible lab space and study areas for smaller groups. The colleges, where students and their advisers form a learning community, occupy the entire second floor.

Also factored into the design were digital technologies, including virtual microscopy tools composed of high-resolution monitors and displays showing multiple images housed on centralized servers. In the anatomy labs, large screens at the end of each dissection table provide students with digital reference tools. The building also is adjacent to the Simulation Center, allowing students to learn and practice clinical procedures on mannequins and robots.

"We believe the new curriculum will create physicians best prepared to meet the challenges of 21st century medicine," Nichols says. ■

Inside MCP



From the Office of Managed Care

Patricia Brown
President, Johns Hopkins HealthCare

Competing in Competitive Times

With our nation battling a recession, I feel especially fortunate these days to work in a relatively recession-proof industry. But I also recognize that even though most people need health services, they don't have to spend their time or health care dollars at our hospitals and clinics. Despite Johns Hopkins' rich history and excellent reputation, it's even more imperative now that we, like other businesses, stay at the forefront of our field to maintain our competitive edge.

I'll give you an example. For the past several years, David Nichols, Pat Thomas and many others in the School of Medicine have put in countless hours devising a new curriculum that launched this fall. By highlighting all factors that affect a patient's health—from genetics to lifestyles—it's designed to ensure our graduates' success in a rapidly changing medical arena. And, these concepts are being delivered in a state-of-the-art facility incorporating the newest technologies. The concepts and skills our doctors of tomorrow are learning here will not only continue to produce national physician leaders, but will uphold the school as an educational model.

Over at The Johns Hopkins Hospital, administrators and care providers are working to implement a patient-family centered care model that has been gaining momentum across the country. Clinicians on two units now include patients and their families in decisions about each patient's care and offer special services like extended visiting hours for family members. The pilot has been so well received that it will be incorporated in our clinical buildings now under construction. In fact, on one cancer wing, patients ask to return to that unit during subsequent hospitalizations because of its excellent customer service—a true testament to a job well done.

Sometimes business opportunities come to us, like when Bethesda's well-regarded Suburban Hospital approached the Johns Hopkins Health System last year about a formal affiliation. Hopkins executives were thrilled by the opportunity and worked quickly to officially bring the medical center into the Johns Hopkins Medicine family. Suburban will help us expand our outreach to patients in the Washington, D.C., area and enlarge opportunities for clinical research and teaching for community physicians.

As we ride out these troubled times, diversification and good value will continue to be the cornerstones of our portfolio. ■

MANAGED CARE NEWS

When Surveyors Come Calling

Helping Home Health Services achieve the remarkable are (front, from left) Suzanne Havrilla, Kim Carl, Kathleen Mayfield, (back, from left) June Biggerman and Sheri Huppenthal.

Not that there isn't plenty to crow about at Johns Hopkins Home Care Group. But for the second time in a row, the organization's Home Health Services (HHS) division has received a deficiency-free survey by the Maryland Department of Health and Mental Hygiene.

Making the almost unheard-of feat even more impressive, says Kim Carl, Home Health Services director, is that this review for Medicare certification is much tougher than that of other states.

Mary Myers, HHS administrator and vice president and chief operating officer for the Home Care Group, attributes the accomplishment to giving top care every day, a management team that provides smart, planned growth, and hiring the best staff.

"We're not trying to just fill positions," says Myers, whose home-health division provides diabetes management, cardiac care, rehabilitation and more for homebound patients. "We aim to hire people who are really engaged and consider it an honor to work here."

Home Health Services first passed the three-year survey with flying colors in 2006. When it repeated the distinction this year, a state surveyor told Myers that in 25 years of work she had never seen two back-to-back deficiency-free reviews, and that she'd "even seen progress from last time."

During the weeklong, unannounced review, surveyors scrutinize every facet of the organization's operations. Medicare patients must be considered homebound to receive services, for example, and their home care must be medically necessary and provided on an intermittent basis by skilled professionals. Reviewers also go along on home visits, review patient charts, human resources records and board meeting minutes, and interview staff and management teams at will.

> "We aim to hire people who are really engaged and consider it an honor to work here."

"There are a lot of places where you could fall short," Carl says. On average, the staff of 80 handles 300 patient admissions and 3,500 home visits each month. But knowing that a complaint could spark a review at any time, there's a no-tolerance policy for providing poor care, not following up, or not completing required documentation. "We're survey-ready every day," says Carl.

Myers admits the jobs can be difficult, with long hours and traveling to different neighborhoods, so all new hires get a realistic preview to make sure they know what they're signing on for. New employees spend a day shadowing current workers, and during an intense clinical orientation, new staff work half-time for about three months while learning the ropes. "It takes a good year to be performing up to par," Carl says.

Myers says their experienced health care providers "constantly have the desire to excel." Some staff who had left the company for other jobs have even come back, she adds, saying they respect Hopkins' commitment to patient safety and quality.

"They really care about their patients," she says. "They want to live up to being the best of the best." ■

PATIENT SATISFACTION

Being in the Middle Can Be a Very Good Thing

Aiming to make the care that will be delivered in Johns Hopkins' new clinical towers on the East Baltimore campus every bit as advanced as the structures themselves, administrators and clinicians are embracing what's called patient-family centered care. The philosophy is simple: Care revolves around the preferences and needs of each patient, families are viewed as a patient's source of strength, and patients and families are included in treatment discussions.

"We need to not just talk at patients," says Elizabeth Flury, senior director of clinical integration and transformation support for the Johns Hopkins Health System. "We need to listen to them, educate them, and allow them to have a voice in their own care."

In developing care models for the different patient units, Flury and colleagues interviewed some 1,800 staff, patients and family members.

A pilot started last fall in a Weinberg Building unit serving pancreatic cancer patients. Nurses, physicians, patients and families participate in "huddle rounds" at the bedside, where daily goals are written on a white board in patients' rooms. The unit offers extended visiting hours for family and a visitor lounge with coffee and Internet access.

This concept was first introduced several years ago in the Nelson Building's cardiac surgery unit. Nurse practitioners and physician assistants remain on the unit and are available to answer patient questions any time. There's also a social worker assigned to the unit, and physical and occupational therapist come to patients' rooms.

Including patients and families in all communications "sounds simple, but it's a very difficult thing to do," says Deborah Baker, director of nursing for the Department of Surgery, noting that through typical chains of command, a resident passes information to the attending physician without necessarily including others.

"We need to not just talk at patients," says Elizabeth Flury. "We need to listen to them, educate them, and allow them to have a voice in their own care."

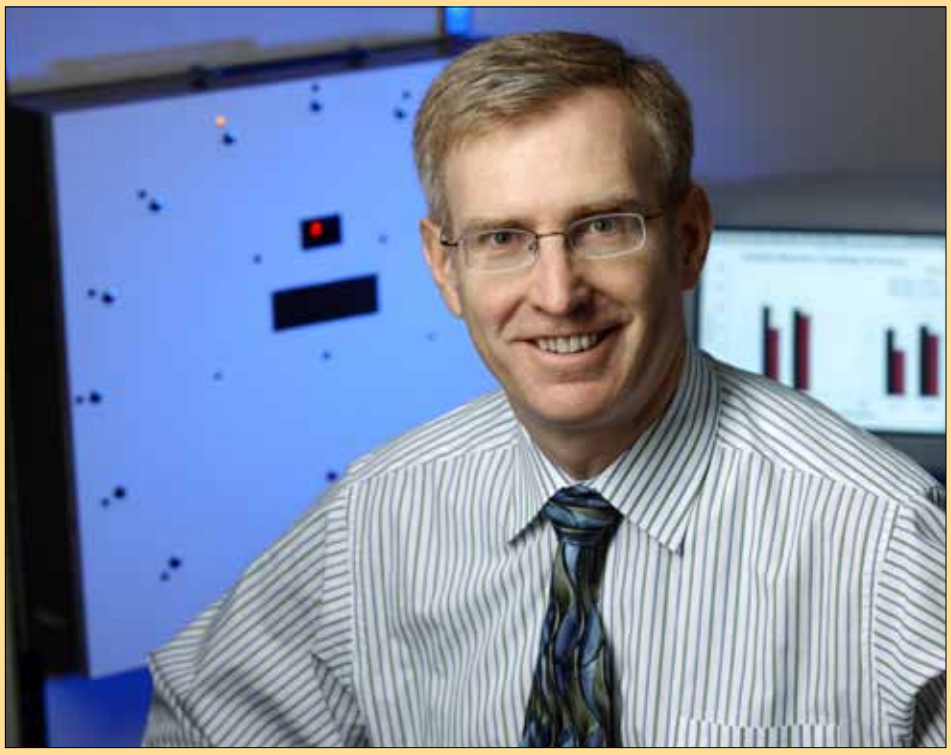
Yet when patients and families are included, the results speak for themselves. Baker says patients who have stayed on the Weinberg unit ask to return there because of the customer service. Hospital lengths of stay are down, and there's little turnover among the staff. Nelson 6 has the highest patient-satisfaction score in the hospital and the lowest perioperative mortality rates. ■

A Treatment Sum That's Greater Than Its Parts

When administrators with the Cornerstone Clinic, a drug and alcohol treatment center at Johns Hopkins Bayview Medical Center, were seeking participants for a grant-funded study, they turned to a relatively new resource: the Johns Hopkins Center for Substance Abuse Treatment and Research.

Rita Cardim, the center's assistant administrator, put them in touch with leaders at other Hopkins substance abuse programs, such as the rapid detox unit at The Johns Hopkins Hospital and Hopkins-run outpatient programs located at 911 N. Broadway.

As recently as two years ago, however, it would have been much tougher to make those connections because, even though there are 16 formal substance abuse programs on Hopkins' East Baltimore and Bayview campuses, each got started independently.



Psychiatrist Eric Strain is director of the Johns Hopkins Center for Substance Abuse Treatment and Research.

"Johns Hopkins has a long history of very strong clinical research programs related to addiction," explains psychiatrist Eric Strain, director of the new center. (In its outpatient programs alone, Hopkins treats more than 1,000 patients a day.) "But the programs tended to intersect primarily related to research and not in a formal, regular way."

Hopkins leaders, he says, didn't have a clear sense of how much care was being provided to which patients, how much care was uncompensated, or how many patients had particular disorders such as opioid addictions. They also wanted to know whether any care was being duplicated or if there were any unmet needs.

The idea for a center arose two years ago, when a Hopkins Hospital committee chaired by Executive Vice President and COO Judy Reitz was investigating challenges in discharge planning. One group of inpatients they identified were those with substance abuse problems being treated at the myriad programs run by either the Department of Medicine or the Department of Psychiatry

As a result, says Anita Langford, vice president of Care Management Services at Bayview, "everyone began to see opportunities to link both campuses and departments." Langford, because of her psychiatric nursing background and contacts, was tapped by Reitz to facilitate early discussions that led to the center's creation.

Now an umbrella for overseeing all Hopkins' substance abuse efforts, the center has been working on numerous fronts. Cardim had found, for example, that most individual program managers admitted not knowing enough about what the other programs do. So she's compiled a referral tool detailing each program and plans to add information from additional programs that provide substance abuse care as part of other clinical offerings. And she and Strain are developing a Web site with links to the various programs and information for patients, referring physicians and family members.

Strain says he also hopes to interest young investigators in substance abuse research, take on more of a government advocacy role, hold continuing medical education courses and work with providers in the community.

To that end, the center has been actively involved with Baltimore Substance Abuse Systems, a city agency that administers grants. In addition, Strain and representatives from Priority Partners, Hopkins' Medicaid managed care organization, spoke out during the last Maryland legislative session against a proposal to take money out of MCOs to hire an administrative service organization to provide substance abuse services for Medicaid patients. The center has also organized a CME course on the use of buprenorphine to treat opioid dependency.

Overall, Strain says, he hopes the center will become a valued resource: "We don't want to lose the entrepreneurial spirit of the distinct programs. It's as if we have these individual jewels, and we want to create a bracelet." ■

Bits, Bytes & Briefs

Cost-Cutting Conundrums

The latest biannual report to Congress by the Medicare Payment Advisory Commission (MedPAC) cites many reasons for the program's soaring costs but offers few surefire methods for cutting them.

For example, MedPAC suggests that hospitals, specialists and primary care physicians might be encouraged to join "accountable care organizations" that would pay bonuses if the group meets quality and cost-trimming targets but penalize members if it doesn't. Such a plan's potential savings, however, are unsure and could be slim to none, the report says.

Similarly, pilot programs that Medicare initiated to cut costs by linking insurance companies and other private groups in coordinating care for patients with chronic diseases have improved care quality—but they cost Medicare more than it spent on such cases before.

The only certainty seems to be that Medicare cannot survive under present spending and utilization trends. "Part of the problem is that Medicare's fee-for-service payment systems reward more care—and more complex care—without regard to the quality or value of that care," MedPAC says.

Reporting HAIs to Save Money—and Lives

Health-care-associated infections (HAIs) cost the nation more than $20 billion a year in extra medical expenditures—and claim 99,000 lives annually.

Five professional organizations representing experts in infectious disease, health care infection prevention, disease prevention and public health are backing a proposal that would require hospitals and ambulatory surgical centers to report HAI data to the Centers for Disease Control and Prevention or lose the right to participate in Medicare and Medicaid.

If enacted, the bill would establish a single national standard for HAI reporting, guaranteeing that public health scientists at the CDC's National Healthcare Safety Network will know which infections are reported and how. The goal would be to significantly enhance the study, monitoring and prevention of HAI.

Patient, Treat Thyself

With the U.S. population aging and more people developing chronic conditions, efforts to curb the accompanying increase in treatment costs and burgeoning demand on medical facilities is prompting drug companies to develop more consumer-friendly methods of self-medication, according to the medical marketing consulting firm Greystone Associates. Among the products are prefilled plastic syringes and cartridge-replaceable pen injectors for patients requiring insulin and other injected drugs.

The demographics-propelled increase of home health care and the high cost per dose of such medications make prefilled injection technologies economically appealing to drugmakers. Exact dosage administration also is improved by the use of the new devices, the report notes.

Unintended Consequence

The ancient Chinese philosopher had it right: People pray for a long life but fear old age.

Modern medicine's ability to lengthen our lives has produced potentially devastating financial consequences—mammoth increases in the number of patients requiring long-term treatment for Alzheimer's disease and age-related osteoporosis.

According to the Alzheimer's Association, the Medicare cost of treating Alzheimer patients will soar from the $62 billion that was spent in 2000 to $189 billion by 2015. The 2050 Medicare bill for Alzheimer's-related costs will be $1 trillion, according to a report in Managed Healthcare Executive.

The Alzheimer's Association notes that costs of treating patients who have Alzheimer's and comorbid medical conditions also jumps significantly. For example, the Medicare bill is $12,979 for an average diabetes patient but $20,655 if the patient also has Alzheimer's.

Similarly on the rise are fractures or dislocations likely related to osteoporosis, according to the Agency for Healthcare Research and Quality. Since 1995, the annual hospitalization rate for such cases has gone up 55 percent to more than 254,000, at a cost of $2.4 billion in 2006. Ninety percent of those hospitalizations were for patients 65 or older; 37 percent were for patients 85 or older. ■

Expanding to Improve Patient Care

Johns Hopkins Medicine welcomes one more hospital into the fold.

When Suburban Hospital CEO Brian Gragnolati was looking for a partner to help his organization transform the delivery of clinical care in the Washington, D.C., metro area, he immediately thought of Johns Hopkins.

"When you look at consumer research reports about who provides the best health care in the capital region, number one is Johns Hopkins and Suburban is number two," says Gragnolati, who directs the 238-bed Bethesda, Md., community hospital.

The two hospitals already had a history of working together for several programs, including a cardiac care center at Suburban. And he was impressed to see Johns Hopkins HealthCare executing comprehensive, effective managed care programs for clients such as the U.S. Family Health Plan and Priority Partners: "That was really an 'aha' moment for me," Gragnolati says.

"I believe the ability to effectively manage care is a critical element for organizations to remain relevant in the future. Regardless of what you believe will happen in health reform, the reality is that we are seeing payment reform occur. This requires that providers have a number of competencies: They must be able to integrate care, they need to manage risk and they need to understand pricing."

So Gragnolati approached Johns Hopkins last fall, and in a record nine months, officials from both organizations completed and signed documents on June 30 converting the medical center into a wholly owned subsidiary of the Johns Hopkins Health System. Under terms of the transaction, which does not involve any financial exchange, Suburban will retain its voluntary medical staff and will operate under the same governance structure as Hopkins' three other hospitals. Hopkins also will work with Suburban to gain approval for a multimillion-dollar proposal to expand the Bethesda campus.

Brian Gragnolati, CEO of already-strong Suburban Hospital, initiated a momentous change.

From Hopkins' perspective, partnering with Suburban was a strategically driven decision, explains Johns Hopkins Hospital and Health System President Ronald R. Peterson. The total revenue of Suburban and its joint ventures is approximately $400 million.

"Suburban is strong financially, very highly regarded in its community and located virtually on the doorstep of the nation's capital," he says. "Having it as part of the Hopkins family provides us the critical mass to better position ourselves to provide an integrated, regional approach to care that we anticipate the future will demand."

The acquisition "allows us to have a much broader network of physicians and services in the national capital area," says Steven Thompson, senior vice president of Johns Hopkins Medicine, who helped negotiate the arrangement. "It creates options and opportunities for patients who previously had gone into the District for care.

"The new era in health care delivery today demands more rational, efficient models. Proposed reform measures argue for regional, integrated health care systems that unite community hospitals and the most advanced medical centers into systems that ensure both high quality and continuity of care for patients. This expanded network of medical services really allows patients from the Montgomery County area to be treated in the most appropriate setting, on an outpatient basis in their community."

Johns Hopkins Medicine and Suburban Hospital have enjoyed an alliance dating back to 1996. In 2006, the two institutions and the National Institutes of Health collaborated to develop the NIH Heart Center at Suburban Hospital, offering advanced cardiovascular specialty care, including cardiac surgery.

The hospitals now plan to expand the cardiovascular program and develop joint programs in oncology, and neurology/neurosurgery, including areas such as stroke and movement disorders. They're also working to bring together the institutions' two physician groups.

So far, Gragnolati says, "I've been thrilled by the tone of the conversations. It's been very collaborative, working shoulder to shoulder." ■

Hopkins in the News

A Nobel Outcome

Carol Greider, a pioneering researcher on the structure of chromosome ends known as telomeres, has been awarded the 2009 Nobel Prize in Physiology or Medicine by the Royal Swedish Academy of Sciences. The director of molecular biology and genetics in Johns Hopkins' Institute for Basic Biomedical Sciences, Greider was recognized for her discovery of telomerase, an enzyme that is critical for the health and survival of all living cells and organisms.

She shares the Nobel with Elizabeth Blackburn, a professor at the University of California, San Francisco, and Jack Szostak of Harvard Medical School. The trio also shared the 2006 Albert Lasker Award for Basic Medical Research for this work.

The Streak Rolls On

For the 19th consecutive year, The Johns Hopkins Hospital has earned the top spot in *U.S. News & World Report*'s annual ranking of American hospitals, accumulating 30 points in 15 of 16 specialties.

The hospital ranked first in Ear, Nose and Throat, Rheumatology and Urology; No. 2 in Geriatric Care, Gynecology, Neurology and Neurosurgery, Ophthalmology and Psychiatry; No. 3 in Cancer, Diabetes and Endocrine Disorders, Digestive Disorders, Heart and Heart Surgery, and Respiratory Disorders; No. 5 in Orthopedics; No. 6 in Kidney Disease; and No. 16 in Rehabilitation.

***U.S. News* analyzed data on more than 4,861 medical centers to produce this year's rankings. Details: usnews.com/besthospitals**

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