Integration of Specialty Care into ACOs: Considering JMAP and Beyond

The Seventh National Accountable Care Organization Summit

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Johns Hopkins Medicine Transition to Value

- Johns Hopkins Medicine Alliance for Patients (JMAP)
- Johns Hopkins Community Health Partnership (J-CHiP)
- State of Maryland Waiver/JHHS Care Coordination Initiatives
- Office of Physicians/Armstrong Institute Clinical Communities
- Johns Hopkins HealthCare (Medicare Advantage)
- JHH Cardiology-ED Collaborative
- Others….

JMAP was created to help lead Hopkins' clinical transformation to value-based care

What are Accountable Care Organizations (ACO)?
Organizations, created by the Affordable Care Act, that are accountable for the **quality and cost** of the care they provide.

JMAP Launched in 2014 as a Track 1 Medicare Shared Savings Program ACO and with ~37,000 attributed beneficiaries (~$450M in Part A/B spend).

How is quality assessed?
By metrics designed to show what portion of the population is either getting needed services or achieving specific health outcomes

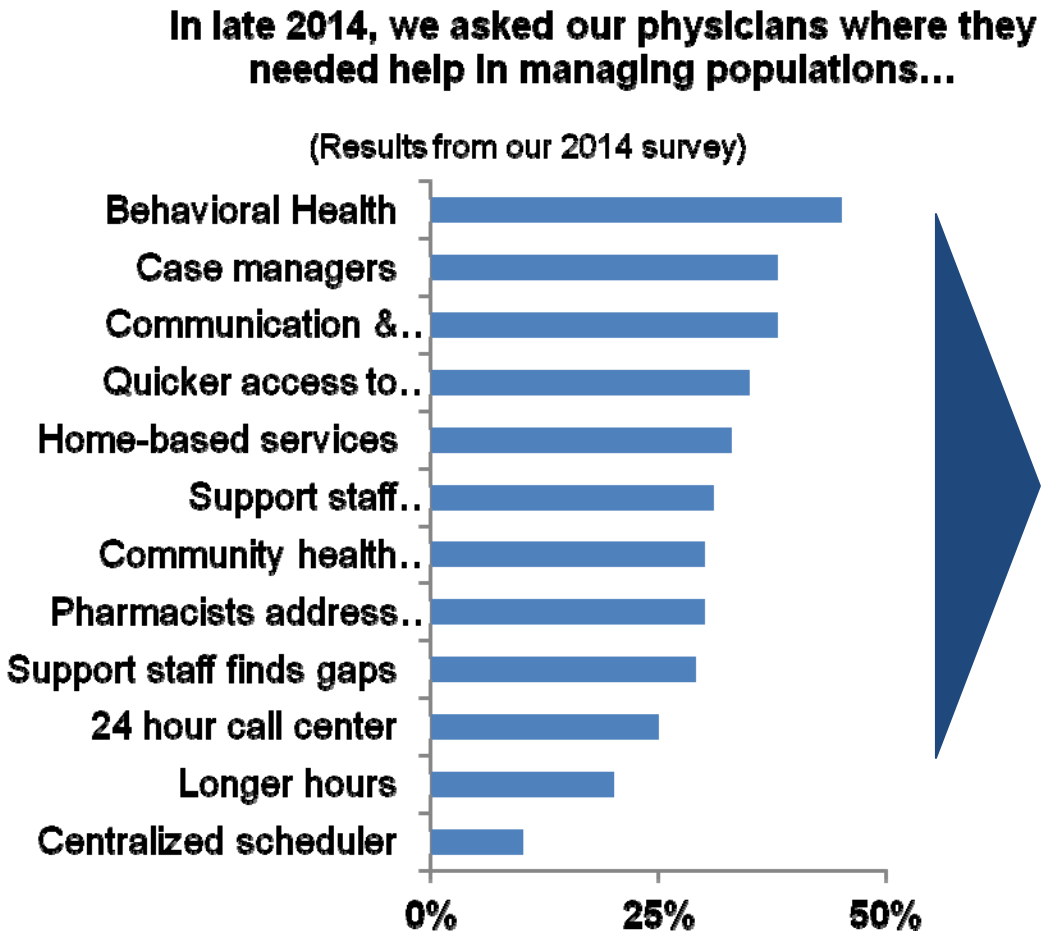
Local and National movement to value

- All Maryland hospital systems have now signed globally capitated budget agreements
- Medicare has committed to 50% in VBP by 2018 and a coalition of private payers has committed to 75% VBP by 2020

JMAP Participating Provider Organizations

1. Johns Hopkins Community Physicians
2. JHU School of Medicine Faculty
3. Columbia Medical Practice
4. Potomac Physician Associates
5. Cardiovascular Specialists of Central Maryland
6. All 5 JHM Hospitals in Maryland/DC:
   - Johns Hopkins Hospital
   - JH Bayview Medical Center
   - JH Howard County General
   - JH Sibley Memorial
   - JH Suburban Hospital

JMAP's 2015 M&Q strategy began by asking our physicians what they needed most



JMAP 2015 Quality Strategy

- Care Coordination
- Population Health Pharmacists
- Urgent specialist access hotline
- Behavioral Health Specialists
- Community Health Workers
- Outreach to close care gaps

JMAP employs a variety of methods to deploy interventions regionally

	1 Embedded services w/ regional coverage	2 Central resources deployed on a population basis	3 Local development, supported by central framework
Deployed	• Care coordination, CHWs • Pharmacist consult service	• Urgent specialist access • Pharmacist-driven quality improvement	• Reporting measures, quality improvement teams
Planned	• Health Behavioral Specialists • Psychiatry	• Pharmacist-driven poly-pharmacy review • Remote patient monitoring	• Level of Care Guidelines • COPD pathway • Primary Care Access
In development			• SNF/Post-acute synergies strategy • Advanced directive pathway/Palliative Care • Patient-centered medical neighborhood

SUSDR (Urgent Access to Specialists)

Patient has urgent problem

Sees or calls PCP who validates and refers to hotline

Practice calls hotline for RN triage of case

Specialty department schedules appt. within 48 hours

Specialist visit

Signed note in chart within 1 week

Specialties currently offered

Orthopedics	Cardiology	Neurology
Ophthalmology	Gastroenterology	ENT
Urology	Plastic Surgery	Pulmonary
Endocrinology	General Surgery	Hematology
Nephrology	Dermatology	Rheumatology
Asthma and Allergy	GYN	ID

New Initiatives

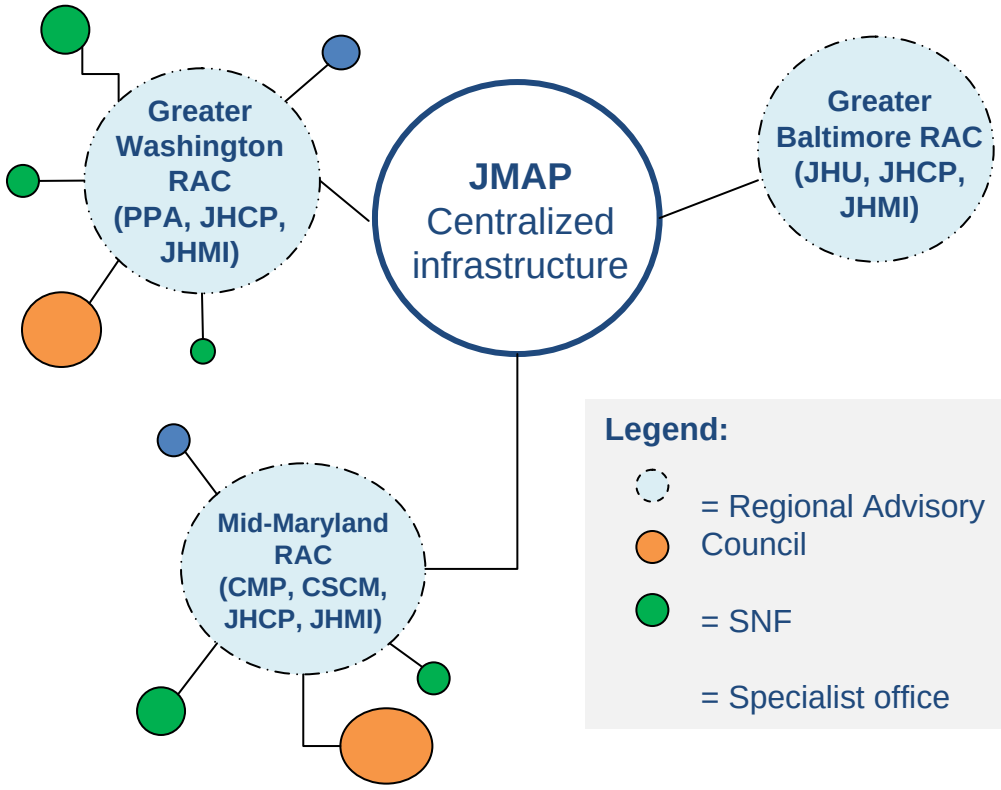
Heart Failure Bridge Clinics

JHH Emergency Department

More to come…

To be most effective, ACO interventions should be well integrated with regional delivery system transformation

JMAP's regional structure presents opportunities for a deeper level of integration and collaboration with neighboring practices functioning as regional networks.



JMAP activity within each region

Regional Advisory Councils (RACs) bring together relevant practices and facilities within JMAP to focus on key areas of population health strategy

JMAP Regional Medical Directors (RMD) work with JHCP regional leadership to tailor approach to geography and keep JMAP locally informed

RMDs participate in **collaborative efforts with regional provider organizations** (e.g. PCP-specialist integration)

Participant abbreviations:

PPA: Potomac Physician Associates CMP: Columbia Medical Practice JHCP: Johns Hopkins Community Physicians
JHU: Johns Hopkins University School of Medicine JHMI: Johns Hopkins Medical Institutions (i.e. JHM hospitals)

Possible PCP-Specialist Compact

Focus Area	*Goals*	*Stakeholders*
Access & Administrative Arrangements	Establish and maintain appropriate access to care for emergencies, same day visits, phone consults, etc.	PCPs, urgent care, practice administrators, specialists
Clinical Roles	Establish referral guidelines for pre-consultation exchange, formal consultation, secondary referrals and when appropriate co-management of patients.	PCPs, specialists
Communication /EHR	Maintain accurate and up-to-date clinical records including the timely sign-off and transmission of the consultation notes within 7 days.	PCPs, specialists
Patient referral guidelines	Follow mutually agreed upon patient care pathway protocols to promote clinical integration, coordination and continuity of care consistent with medical necessity, payer policies and patient choice.	PCPs, specialists, access
Patient & Family Engagement	Embrace the philosophy of patient centered care philosophy of collaborative decision-making including assessing patient/family/caregiver knowledge and preferences, and ensuring complete explanation of reasons for recommended diagnostic or treatment plans along with the responsibilities of each party.	PCPs, specialists, practice administrators

To be impactful, JMAP Communication efforts have focused on engagement and meeting people where they are

- Bimonthly Newsletter
- RAC meetings
- Site One Pagers of Staff
- Dashboards
- “Road Show” Visits
- Updated Website
- Email – JMAP@jhmi.edu
- Program synopsis/FAQ

JMAP Value Rounds

Johns Hopkins Medicine Alliance for Patients, LLC (JMAP) is an accountable care organization (ACO) participating in the Medicare Shared Savings Program (MSSP). JMAP includes around 38,000 Medicare beneficiaries and nearly 3,000 providers, including all Johns Hopkins University faculty, Johns Hopkins Community Physicians, Columbia Medical Practice, Potomac Physician Associates, Cardiovascular Specialists of Central Maryland, and all of the JHM hospitals in Maryland and Washington, DC. Through collaboration, JMAP is committed to improving the quality, experience, and value of healthcare services provided to our patients.

If you have any questions about JMAP, send an email to JMAP@jhmi.edu or visit our updated website.

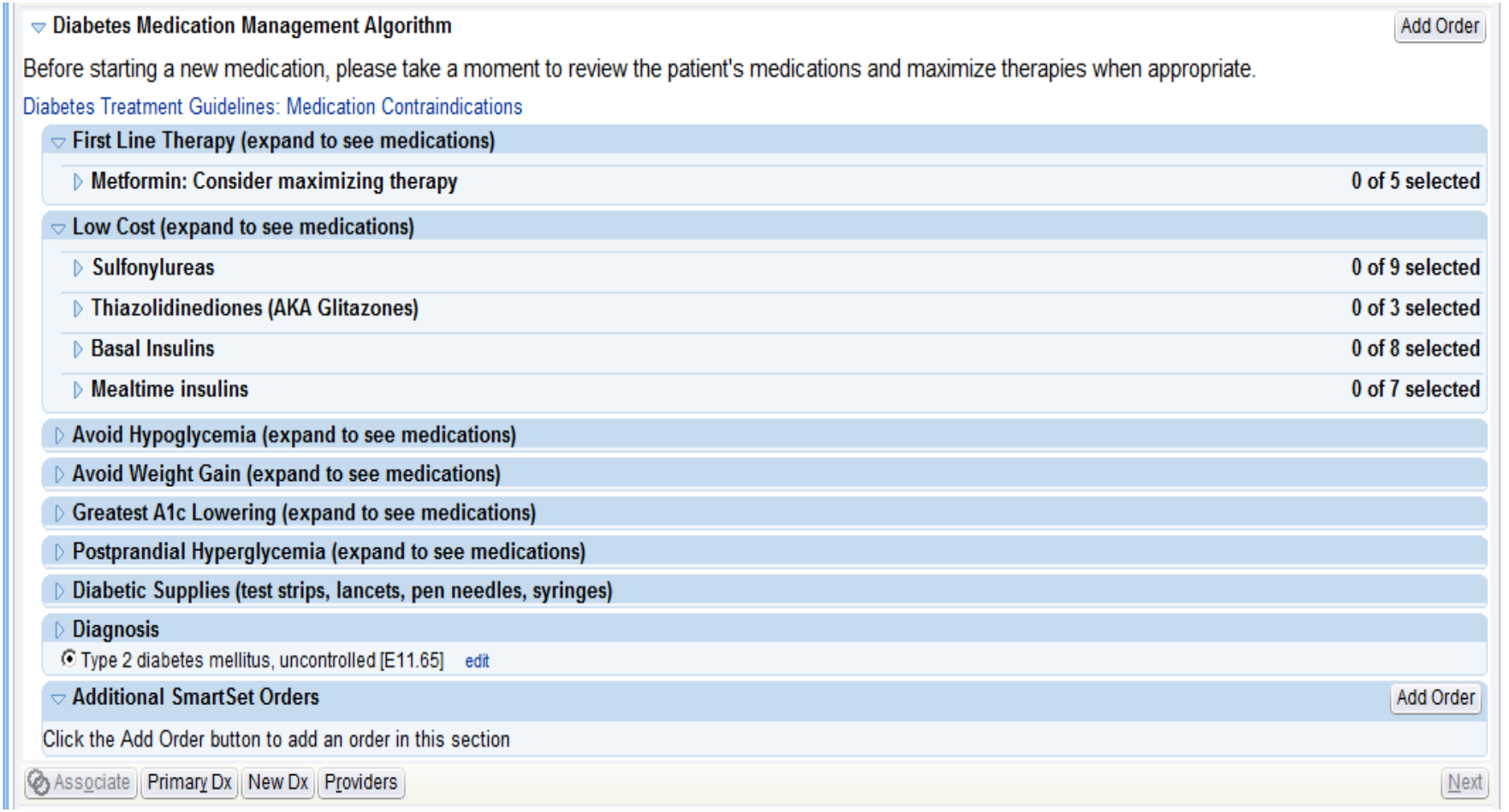
New 2016 Strategies

Medication Management

Patient Engagement Training (PET)

JMAP Begins Development of New 2016 Strategies

Best Practice Pathways:
Diabetes Medication Management Algorithm



- Guidance on ordering medications based on goals & priorities for treatment.
- Considers currently prescribed mediations to remove options that are not relevant

Best Practice Pathways: Outpatient COPD Management

JOHNS HOPKINS MEDICINE

Full Order Set

JHM Outpatient COPD Management

- Pulmonary Rehabilitation (always consider)
- Pulmonary Function Tests
- Routine COPD treatment
- Management of COPD exacerbation
- Specialist Referral
- Smoking Cessation
- Vaccinations
- Osteoporosis Prophylaxis and Therapy for Patients on Glucocorticoids
- Educational Patient Handouts
- Additional SmartSet Orders

Click the Add Order button to add an order in this section

Ex) Breakout of PFT and Routine COPD Treatment

JHM Outpatient COPD Management

- Pulmonary Rehabilitation (always consider)
- Pulmonary Function Tests
  - Pulmonary Function Tests
    - ☐ Spirometry without bronchodilator in clinic
    - ☐ Spirometry with and without bronchodilator in clinic
    - ☐ Bayview Pulmonary Function Tests
      Procedure Master: PFT10010
    - ☐ JHOC Pulmonary Function Test
- Routine COPD treatment

General treatment guidelines: progress down the list as patient gets more severe

  - Short-acting rescue inhaler as needed
    - ☐ albuterol (PROVENTIL HFA) 90 mcg/actuation inhaler
      Normal
  - Long-acting Anticholinergics
  - Long-acting Beta Agonist
    - ☐ salmeterol (SEREVENT DISKUS) 50 mcg/dose diskus inhaler
    - ☐ formoterol (FORADIL) 12 mcg capsule for inhaler
    - ☐ olodaterol 2.5 mcg/actuation Mist
    - ☐ indacaterol 75 mcg CpDv
  - Long-acting Beta Agonist plus Inhaled Corticosteroid
  - Long acting beta agonist/muscarinergic combination (LAMA/LABA)
  - Phosphodiesterase 4 inhibitors
- Management of COPD exacerbation
- Specialist Referral
- Smoking Cessation

Armstrong Institute Clinical Communities

- Blood Management
- Cardiac Surgery
- Congestive Heart Failure
- Diabetes
- ICU (Adult)
- Joint Replacement Surgery
- Palliative Care
- Spine Surgery
- Surgery
- Brain Tumor
- Cleaning, Disinfecting and Sterilization
- Hospitalists (EQUIP)
- Medication Safety
- Patient Centered Care-Maternity
- Patient and Family Advisory Councils
- Psychiatry

Cardiovascular Perspective

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Cardiology and Accountable Care

Oluseyi Ojeifo, MD, MPH; Scott A. Berkowitz, MD, MBA

- *Pre-consultation*
  - e Referral @ UCSF (70% improvement in care, 90% easier referral tracking
- *Consultation*
  - Tele-health @ UPMC (fewer admissions, better provider efficiency)
  - e Consult @ MGH (high provider satisfaction)
  - Specialty Observation Units (Syncope at Mayo; diagnosis made in 67% v. 10% in usual care; 43% admitted v. 98% usual care)
  - Outpatient Infusion Centers (JHM)
- *Co-Management*
  - Skilled nursing facilities

Accountable Care Organizations

Ensuring Focus on Cardiovascular Health

Kavita K. Patel, MD, MSHS; Joaquin E. Cigarroa, MD; Jeffrey Nadel, BA;

Table 1. 2015 Medicare Accountable Care Organization Quality Measures Most Relevant to Cardiovascular Specialists

CMS Quality Measure	Description	Applicable Patients*
ACO #2	Patient survey of provider communication	Age≥18 y
ACO #3	Patient survey of rating of providers	Age≥18 y
ACO #4	Patient survey of access to specialists	Age≥18 y
ACO #5	Patient survey: health promotion and education	Age≥18 y
ACO #6	Patient survey of shared decision making	Age≥18 y
ACO #7	Patient survey of health status/functional status	Age≥18 y
ACO #8	Risk standardized all-cause readmissions	Patients≥65 y discharged from hospital†
ACO #10	Risk standardized heart failure hospitalization rate (observed/expected)	Patients ≥ 18 y; expected discharges from hospital with heart failure primary diagnosis
ACO #16	Adult weight screening and follow-up	Age≥18 y
ACO#17	Tobacco use assessment and cessation intervention	Age≥18 y
ACO # 21	Percentage of adults who had blood pressure screened in past 2 y	Age≥18 y
ACO #28	Percentage of beneficiaries with hypertension whose blood pressure <140/90 mm Hg	Age 18–85 y with diagnosis of hypertension
ACO #30	Percentage of beneficiaries with ischemic vascular disease who use aspirin or other antithrombotic	Age≥18 y with diagnosis of ischemic vascular disease or discharged alive after acute MI, PCI, or CABG
ACO #31	β-Blocker therapy for LV systolic dysfunction	Age≥18 y with a heart failure diagnosis and current or prior LV ejection fraction <40%
ACO #33	ACE inhibitor or angiotensin receptor blocker for patients with CAD and diabetes mellitus and LV systolic dysfunction	Age≥18 y with a CAD diagnosis and LV ejection fraction <40%, seen within 12 mo

ACE indicates angiotensin-converting enzyme; ACO, accountable care organization; ASC, ambulatory sensitive conditions; CABG, coronary artery bypass grafting; CAD, coronary artery disease; CMS, Centers for Medicare & Medicaid Services; LV, left ventricular; MI, myocardial infarction; and PCI, percutaneous coronary intervention.

*From beneficiaries assigned to or aligned with the ACO. Note, beneficiaries can opt out of claims reporting to the ACO and may continue to seek care under fee-for-service arrangements outside the ACO.

†Excluded hospitalizations include those primarily for cancer treatment, psychiatric disease, rehabilitation care, and others. Additional denominator qualifications and description of performance measures are available from CMS.[42]

Source: Patel et al. Circulation. 2015.

Medical-Imaging Stewardship in the Accountable Care Era

Daniel J. Durand, M.D., Jonathan S. Lewin, M.D., and Scott A. Berkowitz, M.D., M.B.A.

Imaging Stewardship Analogue	Implementation Steps
Making necessary investments and committing publicly to a cultural shift toward appropriateness and away from easy access to imaging	Endorse Choosing Wisely list items related to imaging; allocate budget for investments in information technology and nonclinical time
Appointing a single leader within each imaging specialty; establishing joint accountability among the multiple relevant specialties	Shift compensation away from volume-based metrics to include measures of imaging appropriateness
Making imaging specialists responsible for executing appropriateness interventions	Designate stewardship champions (with formal roles and partial salary support) within each imaging department
Implementing interventions to ensure systematic evaluation of appropriateness at the time of ordering and encouraging dialogue between referring physicians and imaging experts	Change the imaging-order workflow, through CDS, consultation with imaging specialists, or both
Monitoring imaging utilization and appropriateness scores for providers and tracking per-capita costs and radiation doses	Gather, and share with providers, data on ordering appropriateness for commonly overused exams
Informing referring physicians about their imaging utilization rates and the best available measures of imaging appropriateness	Generate quarterly reports for physicians showing their ordering performance relative to that of their peers
Identifying key knowledge gaps on imaging appropriateness and educating referring physicians on relevant evidence-based guidelines	Request or require that ordering physicians review consensus guidelines on imaging relevant to their practice

The Future