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STATEMENT BY

KEVIN MOLEY

DEPUTY SECRETARY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

S. 2077 - MEDICAID MANAGED CARE IMPROVEMENT ACT OF 1991

BEFORE THE SENATE COMMITTEE ON FINANCE

SUBCOMMITTEE ON FAMILIES AND THE UNINSURED

APRIL 10, 1992

INTRODUCTION

I am pleased to be here today to voice our strong support for S. 2077, a bill aimed at tearing down the barriers which preclude States from taking full advantage of the benefits coordinated care can bring to the Medicaid program.

Let me take this opportunity to commend Senators Moynihan and Durenberger, the authors of the bill, and to recognize Senators Packwood and Roth, who are also cosponsors. We are grateful for the opportunity to foster our continuing dialogue on this and other key health policy issues.

Coordinated care systems have demonstrated their value to communities all over the country through expanded access for their citizens. To the many who take advantage of their services, they offer continuity of care instead of the hodge-podge of fragmented care. They can also offer improved quality through preventive services, and in particular foster early attention to problems that, if left untreated, could have serious health effects. Coordinated care systems can also offer an extra advantage of less paperwork burden and administrative hassle.

This Administration believes that coordinated care offers a proven, high-value choice for quality health care in the United States. Coordinated care options are an essential building

block in the President's comprehensive plan for health care reform. They are an integral component of a market-based, competitive system and are key to cost control nationwide.

The Administration supports coordinated care as an essential ingredient in any progressive movement toward health care reform in general.

At the outset, let me express the Administration's general support for S. 2077 and underscore our willingness to work with the Committee toward its enactment this year. We have some concerns with the bill as drafted which we are currently working to resolve in staff-level discussions. We are confident that these concerns can and will be resolved to the full satisfaction of both the Department and this Committee, and we will continue to make passage of a Medicaid coordinated care bill a priority.

COMMENTS ON THE BILL

That being said, let me make a few brief remarks on the bill.

- Advantages of Coordinated Care for Medicaid

Coordinated care holds special promise for State Medicaid programs and their recipients. Bluntly stated, fee-for-service medicine is increasingly ~~failing~~ unable to meet the needs of the Medicaid population. Today's Medicaid client faces greater

difficulty accessing care through providers in the fee-for-service system.

Coordinated care systems provide clients with a point of entry into the health care system where their total health care can be managed. Providers in a coordinated care system will know the patient and the patient's medical history. This increases the opportunity for appropriate preventive care to be started before health problems get out of control.

Many Medicaid clients report using the emergency room because they do not have a regular source of care. Having access to a primary care provider through a coordinated care organization is, without a doubt, a much better alternative for a client than waiting in an over-burdened emergency room for care from an unfamiliar provider. [A recent study by the HHS Office of Inspector General indicates over one-half to two-thirds of Medicaid emergency room visits are non-emergency. Moreover, our IG found that treatment in an emergency room increases the cost of the care from 3 to 5 times over the care received in a more appropriate setting for the same condition.]

- State Flexibility and Freedom of Choice Waivers

The Department supports providing States [greater flexibility to manage health care for their Medicaid clients and

to take control of Medicaid costs. On average, States now spend over 20 percent of their budgets on health care. Health care expenditures for Medicaid continue to grow. As States devote more and more of their budgets to health care, they feel the need for greater flexibility in controlling health care costs and an obvious way to do this is to take advantage of high quality, cost-effective coordinated care options.

The bill permits States to offer Medicaid clients a choice among coordinated care options and eliminates Federal approval of the "freedom of choice" waivers. Choices for Medicaid clients would be between, at a minimum, two coordinated care plans, or a coordinated care plan and a primary care case management program. The one exception to this would be in an area where at least two-thirds of Medicaid providers belong to the coordinated care organization. In this case, the client would have a choice among primary care providers participating with that particular coordinated care entity.

Current law requires that, without the "freedom of choice" waiver, Medicaid clients are to be given a choice between managed care and the "unmanaged care" in the fee-for-service system. This, as I already mentioned, often turns into costly trips to the local emergency room for non-emergency care. States, where the "freedom of choice" waiver has been granted, have been able

to increase access to care and many have also been able to reduce inappropriate use of the emergency room.

Waivers to existing law are an appropriate process for the Federal government to provide control and oversight for new concepts where there is some uncertainty about what the economic and behavioral implications might be for the programs and beneficiaries for which we are accountable. Therefore, as HMOs and other forms of coordinated care began to become part of the delivery process for Medicaid clients, it was appropriate that certain conditions be placed regarding the exclusive use of these organizations.

Coordinated care is, however, no longer new. HMOs and other forms of coordinated care have proven themselves on both the quality front and the cost-effectiveness front, both in the private sector and the public sector.

States that have extensively used coordinated care and primary care case management report substantial successes. For example, Kentucky's primary care case management program reduced infant mortality rates and, in the process, saved $25 million. Arizona's exclusive use of coordinated care for Medicaid shaved nearly six percent off of projected fee-for-service costs. HMOs serving the Medicaid population in Wisconsin are able to pay their primary care doctors more than Medicaid fee-for-service

rates due to savings from reductions in unnecessary emergency services and hospitalizations. These HMOs cut expensive emergency room use by a third and inpatient hospital days by more than half.

Despite the promise of coordinated care, 9 of 10 ~~89 percent of~~ Medicaid clients continue to receive care through fee-for-service systems.

- New QA Requirements Replace 75 Public/25 Private Enrollment Rule.

The bill also permits coordinated care entities specified in this bill to serve a total Medicaid client base, eliminating the requirement that 25 percent of the enrollees be private pay. The actual effect of the 75/25 provision, as it is referred to, is that coordinated care plans have significant difficulty in meeting the private pay requirement, largely due to demographic and geographic reasons. The disappointing, end result is that fewer cost-effective, coordinated care options are available for these clients.

The primary purpose for the 75/25 provision has been to assure quality. Quality assurance is an area in health care which evolves regularly with sophisticated advancements toward measuring and improving quality. As this bill recognizes, the

75/25 requirement has not been that effective as a "proxy" for quality. As a replacement for the 75/25 requirement, S. 2077 provides that coordinated care plans establish an extensive quality assurance plan with State oversight responsibility and meet specific standards that measure quality of care. While the Department supports the replacement of the 75/25 requirement with quality assurance standards, we would caution against imposing burdensome standards that create barriers to managed care, or place a managed care institution at a competitive disadvantage to fee-for-service care.

- Case Management

We are concerned with the language of Section 5 which relates to case management. This section does not affect the coordinated care portion of the bill. We are concerned that the provisions of section 5 may be too broadly written and interpreted. We will continue to work with the Committee on drafting language in this and other parts of the bill so that Federal spending would not increase thereby subjecting the bill to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990.

Skipped

CONCLUSION

In closing, let me reiterate our general support for S. 2077 and for your efforts to improve the Medicaid program by fostering greater use of managed care. This legislation both provides

States with the ability to control Medicaid expenditures and offers a quality alternative to the more traditional fee-for-service system that has poorly served Medicaid clients.

Expanded use of coordinated care, as specified in S. 2077, is ~~at the core~~ Consistent w/ direction of the President's Comprehensive Health Care Reform Program. It promises high quality cost-effective care to all Americans. Thank you for the opportunity to comment and I will be glad to answer any questions.

BILL SUMMARY

S. 2077 - MEDICAID MANAGED CARE IMPROVEMENT ACT OF 1991

S. 2077 would change the requirements for States operating Medicaid coordinated care programs and also change some case management requirements. The following description summarizes the general provisions of this bill. In cases where the language is unclear, an intent was assumed.

Coordinated Care:

HMOs, other prepaid health plans, and primary care case management programs are all included in the definition of coordinated care plans. In general, S. 2077 would provide States more flexibility to develop coordinated care programs as an optional Medicaid service. For example, this bill would:

- eliminate the requirement that HMOs contracting with Medicaid have at least 25 percent enrollment from persons not eligible for Medicaid or Medicare.
- expand the scope of the States current option to provide guaranteed Medicaid coverage for individuals enrolled in any coordinated care plans for one to six months, regardless of whether the individual would otherwise become ineligible during the guaranteed period.
- allow States to adopt coordinated care programs as an optional service in Medicaid, without the need to get waivers from HCFA. For example, States would have the option of implementing a mandatory managed care program if recipients have a choice between two coordinated care plans, a plan and a primary care case management program (PCCM), or a choice among physicians if at least two-thirds of the physicians are participating in the plan or PCCM.
- allow the Secretary to continue any successful managed care program operating under a waiver of section 1915 and under section 1115 authority without additional waivers being granted.
- eliminate the prior approval requirement that currently applies to Medicaid coordinated care contracts over $100,000.
- require coordinated care plans to adhere to certain standards for internal quality assurance (QA) programs.

- require States to establish a number of external quality assurance procedures, e.g. setting up toll free numbers for recipients and establishing State-operated grievance procedures.

- add statutory language that offers the possibility of more flexible rate-setting for capitated Medicaid payments.

- require risk-based PCCM programs to meet insolvency and auditing requirements similar to risk-based HMO contracts.

- require the Secretary to convene groups and report on criteria to be used to determine underutilization and the feasibility of using encounter data.

Case Management

S. 2077 also includes some provisions that affect case management programs operated as part of home and community based waiver programs. The first provision that directly affects case management services would add a general provision to section 1902(a) stating that Medicaid is not restricted from paying another provider for services when similar services are provided to a population by the State (or under contract) without charge. While the intent of this provision is unclear, the effect is very broad. Literally, this provision requires Medicaid to pay for any covered services without regard to whether it is provided to all other persons free of charge.

The second provision in this section of S.2077 appears to exempt case management and home and community based care waiver programs from all freedom of choice requirements. The third provision would allow case management agencies to pay case management providers directly for Medicaid services.

THE SECRETARY OF THE TREASURY
WASHINGTON

May 5, 1992

The Honorable Thomas Foley
Speaker
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

On February 6, the Administration published the "President's Comprehensive Health Reform Program." The document provides extensive detail on the President's plan for reforming the health care system, including provisions addressing: market reforms, universal access to affordable health care, cost containment, administrative cost reforms, improved consumer information and containment, and substantial reform of the Medicaid program. Today I am transmitting the "Health Benefits for Self-Employed Individuals Act of 1992," which implements the President's proposal to extend the current twenty five-percent deductibility of health insurance premiums for the self-employed, and to raise the allowable deduction to one hundred percent of the premium costs.

The Department estimates that this legislation will reduce federal revenue by the following amounts:

Fiscal Year
($millions)

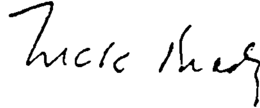
1992	1993	1994	1995	1996	1997	Total 1992-97
-58	-246	-544	-885	-1,292	-2,022	-5,047

These costs must be offset under the Budget Enforcement Act of 1990. The President's Budget includes $5.5 billion in mandatory outlay reduction proposals for fiscal year 1993 and over $68.4 billion in mandatory savings proposals for fiscal years 1992-1997. Any of these mandatory outlay reduction proposals would be acceptable to the Administration as an offset. More specifically, however, the Administration would propose to finance this legislation by adopting reforms to: (a) place the Medicare hospital update on a calendar year basis and (b) reform payment of laboratory services by lowering the cap from 88% to 76% of the median, updated to reflect market factors. The mandatory outlay savings from these two proposals in each of the next five years exceed the costs of our proposal to expand the health insurance deduction for the self-employed. These

proposals were included in the "Medicare Budget Amendment of 1992," transmitted to Congress by Secretary Sullivan on February 21, 1992.

Thank you for your consideration. We look forward to working with the Congress on this legislation.

Sincerely,



Nicholas F. Brady

Enclosure

102D CONGRESS
2D SESSION

To amend the Internal Revenue Code of 1986 to make the deduction for health insurance costs of self-employed individuals permanent, and to provide for a phased-in increase in the deductible amount of health insurance costs from 25 to 100 percent.

IN THE ____________________

May 5, 1992
____________ introduced the following bill; which was referred to the Committee on ____________.

A BILL

To amend the Internal Revenue Code of 1986 to make the deduction for health insurance costs of self-employed individuals permanent, and to provide for a phased-in increase in the deductible amount of health insurance costs from 25 to 100 percent.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SEC. 1. SHORT TITLE.**
4 This Act may be cited as the "Health Benefits for
5 Self-Employed Individuals Act of 1992".

1 **SEC. 2. PERMANENT EXTENSION AND INCREASE**
2 **IN HEALTH INSURANCE DEDUCTION FOR SELF-**
3 **EMPLOYED.**

4 (a) IN GENERAL.--Paragraph (1) of section 162(l) of
5 the Internal Revenue Code of 1986 (relating to special rules
6 for health insurance costs of self-employed individuals) is
7 amended to read as follows:

8 "(1) IN GENERAL.--In the case of an individual
9 who is an employee within the meaning of section
10 401(c)(1), there shall be allowed as a deduction under
11 this section an amount equal to--

12 "(A) 25 percent in the case of taxable
13 years beginning on or before December 31,
14 1993,

15 "(B) 50 percent in the case of taxable
16 years beginning on or after January 1, 1994,
17 and on or before December 31, 1995, and

18 "(C) 100 percent in the case of taxable
19 years beginning on or after January 1, 1996,

20 "of the amount paid during the taxable year for insur-
21 ance which constitutes medical care for the taxpayer,
22 his spouse, and dependents."

23 (b) PERMANENT DEDUCTION.--Section 162(l) of such
24 Code is amended by striking paragraph (6) thereof.

1 (c) EFFECTIVE DATE.--The amendments made by this
2 section shall apply to taxable years beginning after Decem-
3 ber 31, 1991.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

May 8, 1992

The Honorable Dan Quayle
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

On February 6th, the Administration released the "President's Comprehensive Health Reform Program." The document provides extensive detail on the President's plans for reforming the health care system, including the Administration's approach to health insurance market reform, expanded access to affordable health care, cost containment, and substantial reform of the Medicaid program.

Today, I am transmitting the "Health Insurance Market Reform Act of 1992," which implements the President's proposal to reform the health insurance market to make coverage more secure, available, and less costly for millions of Americans. In particular, the bill will expand the availability of more affordable health insurance products to all workers, but particularly to those who are employed by small businesses.

This proposal has four major components:

- All Americans will benefit from the increased availability of health insurance, regardless of health status. Coverage will be renewable and preexisting condition limits will be eliminated for those who maintain coverage. Workers can change jobs without fearing they will be denied insurance coverage based on their health status.

- Coverage for individuals and small businesses, which otherwise would face excessively costly insurance because of their health status, will be more affordable through broad risk pooling. Insurers will participate in broad pooling arrangements to spread health risks evenly across insurers and thereby allow insurers to charge uniform premiums for the sick and the healthy. On an interim basis, pending phased implementation of this new system, insurers will be subject to limits on their ability to vary premiums because of non-demographic characteristics.

- Group purchasing of health insurance by small employers will enable small employers to have the same cost advantage and market power enjoyed by larger employers. They can pool their purchasing power through Health Insurance Networks (HINs).

- Health plans will have increased flexibility to control costs; they will be protected from mandated benefit and anticoordinated care laws that drive up costs and hinder designing cost-effective benefits tailored to individual and family needs.

Section 4 of the "Health Insurance Market Reform Act of 1992" could result in increased receipts to the Federal Government. Therefore, the bill is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. The Office of Management and Budget estimates that the pay-as-you-go effect of this bill would be less than $500,000 annually.

We are advised by the Office of Management and Budget that there is no objection to the submission of the draft bill to Congress, and that its enactment would be in accord with the program of the President.

We urge the prompt enactment of the "Health Insurance Market Reform Act of 1992".

Sincerely,

Louis W. Sullivan, M.D.

Enclosures

LWS to South Carolina Chamber of Commerce

I am delighted to be here today to speak about a topic much in the news recently and one that is vitally important to you as business people -- that is, reforming the American health care system. Specifically, I'd like to talk about the plan that President Bush announced two weeks ago.

Theme

I need not remind you that the issues involved in health care financing and delivery are very complex. Accordingly, the President's plan is comprehensive. It includes 12 different categories of proposals, each of which targets particular problem areas.

But at the same time, these many separate proposals work together in a coordinated way. For while details are complex, the mission is clear: it is to provide affordable health insurance, slow the growth in costs, improve access and continuity of care, and make health insurance more secure.

We want to take what is fundamentally a good system, a system that has set the world standard in health care, and make it better. We want to preserve the benefits that the great majority of Americans enjoy today ... make those benefits more affordable and safe for the future ... and extend them to every citizen of our country.

You have undoubtedly heard other proposals which may appear simpler. But their apparent simplicity is misleading. If we are to be responsible and realistic in confronting the problems of our health care system today, then we must acknowledge at the outset: there is no one simple answer, no panacea, no magic wand, no substitute for sound analysis and hard work.

However, before we can select the particular paths, there is a single, greater decision which must be made. It concerns the fundamental direction we wish to take, and it is a decision which must be made by our citizens as a whole.

The President put this decision succinctly in his recent State of the Union Address. He said:

> Really, there are only two options: We can move toward a nationalized system -- which will restrict patient choice in picking a doctor and force the government to ration services arbitrarily....Or we can reform our own private health care system -- which still gives us, for all its flaws, the best quality health care in the world.

Let's consider each of the alternatives.

The Democratic Alternative

The proposals which have been put forward by Democratic members of Congress -- whether called national health insurance, or expanded Medicare, or Americare, or "Play-or-Pay" -- have this in common: they would all lead us to a government-controlled health care system. Some would do so forthrightly; others attempt to conceal that end. But the truth is that each of these proposals would ultimately put a government bureaucracy in charge of health care financing and health care choices.

In contrast to those proposals, the President would maintain the integrity of the private sector in the health care area. His plan would strengthen the government's role in some important respects:

- it would expand the safety net for the uninsured and those in need;
- it would correct problems in the private insurance market, making insurance more available and secure;
- and it would strongly encourage the use of coordinated care, which provides workable incentives for high quality, <u>with</u> cost control.

The President's Plan

Fundamentally, however, the President's plan differs from the Democratic plans because it would protect consumer choice and private market mechanisms. And it is these private structures, not government promises or wishful thinking, that are truly the best hope for the future of our health care system. If we want to achieve the right balance of cost, quality and access for our citizens, then it makes sense to leave as much choice as possible in our citizens' own hands, to make the decisions that are best for their own circumstances.

Let me briefly re-cap some highlights of the President's plan:

-- I'll start with the most important element for businesses -- particularly small businesses. The President's plan would revolutionize the way health insurance is offered, establishing "risk pools," so that smaller businesses and individuals can enjoy the more favorable health insurance terms that larger businesses enjoy.

We would do this through a mechanism called <u>health insurance networks</u>. And we would eliminate those burdensome state mandates imposed on health insurance policies, which drive up the costs of premiums and restrict competition.

-- <u>Health insurers would be required to provide coverage to all employers requesting it</u>. Coverage would be guaranteed, renewable, and no limits would be allowed on pre-existing medical conditions. Insurance coverage would be secure. And workers would no longer face "job lock" -- the inability to change jobs for fear of losing access to insurance.

-- <u>Insurance affordablity would also be enhanced</u> by limits on premium costs. Altogether, the savings from small market reforms will mean lower premiums for small companies.

-- There would be <u>new health insurance credits and a new tax deduction would benefit more than 90 million Americans.</u> Together, these provisions would make health insurance available to those with low incomes, and make insurance more affordable for those with middle incomes. For example:

If the tax credit were fully in effect today, a family of four, with adjusted gross income up to $14,300, would obtain the maximum credit, enabling them to buy $3,750 of health insurance.

Likewise, a family of four, making $60,000 but without employer-sponsored health insurance, could take the full tax deduction of $3,750, providing about $1,050 that would help with the purchase of insurance.

-- States would be required to develop a basic health insurance package which could be purchased with the tax credit. At the same time, consumers would be free to purchase alternative insurance, if they preferred.

-- Self-employed persons are helped in the President's plan by being able to deduct 100% of the cost of health insurance on their tax returns. Current law allows for only 25%

-- The President's proposal encourages the use of "coordinated" health care. Under this type of arrangement, insured individuals will enroll in a program in which they may choose their own personal doctor, who, in turn, will coordinate the care they may need by other medical specialists, or particular health care facilities.

Not only has this method of service delivery proven more affordable, it also enhances the concept of the "family doctor" in medical practice.

-- The President's plan includes malpractice reform. It also includes initiatives to reduce administrative costs and insurance paperwork, and increase flexibility for state Medicaid programs. In the 1993 budget released two weeks ago, major expansions were also proposed for clinics and providers in underserved areas as well as new resources for disease prevention activities.

-- Finally, we propose to improve consumer information. The President's plan envisions "blue books" of information comparing costs and quality of care provided by physicians, hospitals, clinical laboratories, and other health care providers.

Conclusion

These are the elements of the President's proposal. They include fundamental reform of the insurance market to ensure availability and affordablity. They provide access for all poor families, and support for middle-income families in the purchase of health insurance. And they encourage the growth of coordinated care, with its incentives for quality plus cost control.

Most importantly, they rely on the free market system to continue to provide the finest health care in the world.

In the weeks and months to come, the United States will be answering a fundamental question: Will we turn to government, subjecting our health care sector to the whims and vacillations of budgets and bureaucrats? Or will we maintain our mixed private/public system, drawing on the best strengths of the private market?

Stated another way, the question becomes: How many Americans would turn in the private sector coverage they have today for a government-run system? I believe the answer to that question is self-evident.

And on that note, I would be happy to entertain some questions from you. [Take Q&A -- presubmitted]

# # # # #

HHS ISSUE PROFILE

from the Office of the Assistant Secretary for Legislation
U.S. Department of Health and Human Services

No. 2/September, 1991

COORDINATED CARE

One of the major initiatives of HHS's Health Care Financing Administration (HCFA) has been the development of a continuum of alternatives to its traditional fee-for-service programs. This comes out of a belief that the Medicare and Medicaid programs receive better value for their health care dollar, and that Medicare and Medicaid beneficiaries receive better quality of care, when they enroll in organized health care delivery systems that include networks of hospitals and physicians which can coordinate the delivery of health care services - in short "coordinated care."

Health Maintenance Organizations (HMOs) have been the foundation of HCFA's coordinated care efforts, with over 2 million Medicare beneficiaries and 1.5 million Medicaid recipients now receiving care through these providers. By the end of 1991, close to another 1 million Medicaid recipients will be enrolled in Primary Care Case Management (PCCM) programs that combine coordinated care and fee-for-service features.

These coordinated care programs typically offer more comprehensive services than traditional fee-for-service, greater access to care, better quality care, and more coordination of services. In Medicare, for example, coordinated care generally permits many Medicare risk contractors to provide additional non-Medicare covered benefits (e.g., eyeglasses, hearing aides and prescription drugs) at little or no added cost to beneficiaries. In addition, premiums for risk-based plans are often much less than those for traditional Medigap insurance policies. In the Medicaid program, coordinated care reduces doctor shopping, prescription drug abuse, inappropriate hospitalization and inappropriate or delayed use of emergency room services by Medicaid recipients, while encouraging the use of primary and preventive health services and increasing access to these services. When services are coordinated, in either Medicare or Medicaid, the quality of care is better, dangerous inefficiencies such as adverse drug interactions are reduced, and the wasteful duplication of costly tests and procedures is curtailed.

A recent survey by the Health Insurance Association of America (HIAA) found that HMOs are saving employers money, costing an average of 16.5% less than indemnity plans. Costs are reduced through preventive care, non-duplication of services, and coordination of treatment. Other studies have shown that coordinated care programs are a proven strategy to provide quality health care.

The federal government (through both CHAMPUS and FEHBP), state governments, and numerous corporations have turned to coordinated care techniques to manage care efficiently. The HIAA study and many others have concluded that, through these programs, costs can be lowered while the quality of health care is maintained or improved.

The HMO, which represents the first generation of coordinated care models, has grown and matured while many other alternatives have now been developed. Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs) have evolved from the HMO model to extend coordinated care and its advantages to more people. HCFA is progressing with ways to expand the use of HMOs in Medicare and Medicaid while several new coordinated care initiatives are planned, including FY 1992 legislative proposals.

Recently, OBRA '90 authorized a limited version of the Medicare SELECT option for beneficiaries as an alternative to traditional fee-for-service Medigap plans. Under Medicare SELECT plans, full Medigap benefits generally would be paid only when the service was provided by the plan's coordinated care network. Medicare SELECT policies will be offered by private insurance companies in essentially the same way that traditional Medigap policies are made available. Beneficiaries who buy these policies are expected to be charged a lower premium and have better quality assurance than is available under the traditional Medigap plans.

HCFA has also proposed a "Point of Service" option which will bring coordinated care to all Medicare beneficiaries. It is a coordinated care option that does not require enrollment. Instead, Medicare beneficiaries will make a decision to receive the advantages of coordinated care at the time they actually need care. By allowing a choice within a range of alternative health delivery systems, Medicare beneficiaries are able to choose an option that best suits their health needs and, more specifically, their financial situation.

Coordinated care is beginning to play a major role in reducing costs, increasing quality of care, and providing greater access to care. The Health Care Financing Administration wants it to play an even greater role.

For further information: contact either HCFA's Office of Legislation and Policy at 245-8220 or the HHS Assistant Secretary for Legislation's Office of Health Legislation at 245-7450.

HHS FACT SHEET
from the Office of the Assistant Secretary for Legislation
U.S. Department of Health and Human Services

No.9\May, 1992

MEDICAID AND COORDINATED CARE

BACKGROUND

Medicaid, the Federal-state program which provides medical care to over 30 million low income people annually in the United States, is increasingly turning to **coordinated care** programs as an option to fee-for-service. Effective coordinated care programs improve quality and access, provide continuity of care and help to prevent the delivery of inappropriate services to Medicaid patients. They also help to reduce overutilization of health care services.

Presently, too many Medicaid patients rely on costly emergency rooms and doctors who may not know their medical histories. Coordinated care programs allow Medicaid patients to have their care **"managed" by one doctor.**

Promoting the use of coordinated care programs to serve the Medicaid population is an important initiative on both Federal and State agendas. Faced with growing access problems, limited resources, and the need to make their programs more efficient, an increasing number of States have found coordinated care programs to be a viable alternative to traditional fee-for-service delivery systems. Particular emphasis is being given to enrolling Medicaid-eligible women and children in coordinated care.

Over 10 percent of all Medicaid recipients are already enrolled in some type of coordinated care program including Health Maintenance Organizations (HMOs), other pre-paid health care arrangements, and primary care case management programs (PCCMs).

Coordinated care programs offer these distinct advantages:

- **Access**
  - Capacity for on-call primary care access or referral 24 hours a day, 7 days a week
  - Sufficient number of primary care providers in a geographic area

- **Continuity of Care**
  - A "Medical home" for recipients
  - Appropriate care in appropriate settings
  - Case management and care coordination
  - Reduction in inappropriate episodic care in emergency rooms

- **Quality**
  - Emphasis on preventive care
  - Quality Assurance systems in place

- **Cost Efficiencies**
  - Efficient management of health care resources
  - Reduction in costly inpatient stays
  - Increased ability to project expenditures

Room 416G, 200 Independence Avenue, S.W., Washington, D.C. 20201 • (202) 245-7627

TYPES OF MEDICAID COORDINATED CARE PROGRAMS

Primary Care Case Management (PCCM) - A Medicaid program where States contract with primary care physicians and/or clinics to be responsible for the provision of primary care and to coordinate referrals for specialty care to individual Medicaid recipients. In exchange for case management functions and around-the-clock coverage, States typically pay primary care coordinators a flat monthly fee of $3-$5 per recipient.

Health Maintenance Organization (HMO) - a health care entity that accepts responsibility and financial risk to provide a comprehensive set of health services to a defined group of enrollees during a defined period at a fixed price.

Health Insuring Organization (HIO) - an health care entity that acts as a risk-assuming fiscal intermediary. All HIOs pay for a defined package of services for a certain population in exchange for a fixed or per capita fee from the State. Some HIOs, like HMOs, also arrange for the provision of care to enrollees.

Prepaid Health Plans (PHP) - usually an entity that contracts to provide a subset of services (e.g., acute care services excluding inpatient services) on a prepaid, risk basis. Entities that contract on a non-risk basis for a comprehensive set of services are also included in this category.

MEDICAID COORDINATED CARE ENROLLMENT AS OF JUNE 30, 1991

Type	Number of Plans	Number of Enrollees
Health Maintenance Organization	134	1,283,600
Health Insuring Organization	5	162,000
Prepaid Health Plans	50	419,400
Primary Care Case Management	32	805,200
Total	**221**	**2,670,200**

PROPOSALS FOR LEGISLATIVE CHANGE

Although Medicaid enrollment in coordinated care programs is increasing rapidly, growth in these programs is still constrained by legislative barriers and States' need to obtain Federal program waivers. The President's proposal for Comprehensive Health Care Reform and Senate bill S.2077 [introduced by Senators Patrick Moynihan (D-NY), Dave Durenberger (R-MN), and Bob Packwood (R-OR)] both include measures to eliminate legislative barriers to the use of Medicaid coordinated care programs and to provide States with more flexibility.

***For further information:** contact either HCFA's Office of Legislation and Policy at (202) 245-8820 or the HHS Assistant Secretary for Legislation's Office of Health Legislation at (202) 245-7450.*

(Hinchliffe/Gershowitz)
May 7, 1992 12 p.m.
HMO Draft One

PRESIDENTIAL REMARKS: MANAGED HEALTH CARE EVENT
WEDNESDAY MAY 13, 1992
BALTIMORE, MARYLAND

I'm very glad to be here today -- up at Johns Hopkins, which is not only on a summit in Baltimore, but is at the summit of medical excellence. I've just had the chance to spend some time eight blocks -- and another world -- away from here, in your East Baltimore Medical Center. Before I get onto anything else, I want to say that visiting a place like that, we feel grateful that there are people like you devoting your lives to others.

The center's most impressive -- a terrific example the rest of the country can follow. It's based on a special kind of partnership between this medical institution; a private insurance company; and the government. It's a problem-solving partnership that heralds the future of health care in this country.

Thanks to this partnership, EBMC is the largest and fastest growing Medicaid HMO in Maryland. It's terrific to see the success of this innovative community-based HMO, because it proves what I strongly believe -- that health care and insurance industries **can** meet the challenge of controlling health care costs while providing the finest quality service. I congratulate you for the part you play -- for while this HMO saves members, employers and government money, the health care remains first-rate.

And the key to EBMC's success, especially for Medicaid patients, is that **managed health care makes creative approaches**

possible. It provides coordinated, quality care at a lower cost, while emphasizing prevention and extra benefits, like EBMC's free dental work or Better Beginnings Program.

[ANECDOTE OR STORY]

I was excited to see so many successful pieces of my comprehensive Health Reform Program already at work at EBMC. As you know, I introduced this plan on February 6. In it, I set about to address the twin challenges of **expanding access** and **containing cost** -- while building on the strengths of our present health care system. I was determined to treat the root causes of our problems -- not just the symptoms. As medical professionals, I think you can understand.

I'm appalled to think that in this -- the greatest, most technologically advanced nation on the face of the earth -- one out of every seven Americans has no health insurance. That is a disgrace and we must not tolerate it.

What we must do to remedy this is clear -- and I've put it into a comprehensive 4-part plan. Simply put: **we will guarantee every American universal access to affordable health insurance**.

In this election year, it seems like everybody and his or her brother has their own plan. National Health -- "Play or Pay" -- the options are reproducing like rabbits, and they're just about as deep. Look, it's easy. **People want quality care they can afford and rely on**. We don't need to put government between patients and their doctors. We don't need to shovel Americans into another new level of federal bureaucracy. We need

commonsense, comprehensive health care reform and we need it now.

So I proposed my plan to dramatically reform our market-based system. I was determined that it would put quality care within the reach of every American family -- but be built on choice. I was determined that it would keep costs down, access up. I followed the words of British doctor Sir Frederick Banting, who said: "You must begin with an ideal and end with an ideal."

Part one of my plan says we'll make health care more accessible by making it **more affordable**. We'll give $3750 in health insurance credit for low-income families -- and in tax deductions for middle income families. This alone will bring health insurance to almost 30 million uninsured Americans.

Part two says we'll cut the runaway costs of health care by making the system **more efficient**. We'll call for innovative approaches and provide incentives so that together we'll create workable solutions to our health care challenges.

Part three says we'll **wring out waste and excess** by reforming the system.

And part four says we'll **control federal growth** -- because health care is the fastest growing part of the federal budget.

Our plan states that we can contain costs by encouraging coordinated care programs in both public and private sectors; by offering choice; and by associating state Medicaid programs with coordinated care programs. These are precisely the areas where EBMC excels today. It shows these ideas **do work**.

Well, we unveiled this plan more than three months ago.

During that time, we've moved ahead with our proposals, following through step by step on everything we outlined in that historic plan. Today, for instance, we're releasing regulations that will make it easier for small businesses to join HMOs. [INSERT?]

What's most important is that we've put together a health care legislative package. But, guess what. The ball's in Congress' court. And they're not budging. Now's the time to see if they're really interested in passing useful legislation -- or just in the upcoming election. It's so frustrating, I can tell you. We've got a great plan. It can lift the hearts and ease the pain of literally millions of Americans who today are sick and scared. All of the elements we've introduced can be enacted immediately. Why isn't Congress moving? [INSERT]

Our plan does everything the government can and should do to ensure the quality of life of each citizen of this great land. It doesn't promise the moon -- it does something more important. Its promises the future. We're not building dream castles. We believe in the truth. We'll deliver what we say we can -- and we'll deliver it proudly.

ROBERT C. WINTERS
Chairman and Chief Executive Officer
The Prudential Insurance Company of America

Robert C. Winters became Chairman of the Board and Chief Executive Officer of The Prudential in February 1987.

Before his election to Chairman, Mr. Winters had been Vice Chairman since September 1984. In that capacity, he headed the Company's Central Corporate and Financial Operations.

Mr. Winters joined the Company in 1953 in the Newark headquarters. Subsequently, he held actuarial positions in both group and individual insurance, as well as assignments in the Company's regional home offices in Boston, Chicago and Fort Washington, Pa. In Fort Washington, he was Senior Vice President in charge of The Prudential's Central Atlantic Operations from 1975 to 1978. In 1978, Mr. Winters was promoted to Executive Vice President and became a member of The Prudential's Executive Office.

Mr. Winters graduated from Yale University in 1953, and received his M.B.A. from Boston University in 1963. He became a Fellow of the Society of Actuaries in 1957. He was awarded the Chartered Life Underwriter designation by the American College in 1977 and the Chartered Property and Casualty Underwriter designation by the American Institute for Property and Liability Underwriters, Inc. in 1982. He served in the Army from 1954 to 1956.

Mr. Winters is a past President of the American Academy of Actuaries and a former member of the Board of Governors of the Society of Actuaries. He is a past Director of the Regional Plan Association and a Director of the Life Office Management Association. Mr. Winters served as Chairman of the United Way of Tri-State Campaign for 1989-90, and has served as Chairman of the Board of the Greater Newark Chamber of Commerce.

Mr. Winters is * Chairman of the board of the American Council of Life Insurance and is on the board of the United Way of Tri-State. He is a member of the Business Council, the Business Roundtable and its Policy Committee, its Task Force on International Trade and Chairman of its Health, Welfare and Retirement Income Task Force. Mr. Winters is a member of the Services Policy Advisory Committee to the U.S. Trade Representative's Office, the Committee for Economic Development, the Partnership for New Jersey and the New Jersey State Chamber of Commerce. He is a member of the Education Commission of the States, to which he was appointed by Governor Thomas Kean. Mr. Winters also serves on the Board of Allied-Signal Inc.

Mr. Winters is married to the former Patricia Martini of Minneapolis. They have two daughters and reside in Rumson, New Jersey.

#

2/7/91

* former

Bob Winters Visits with President Bush

Mr. Winters met with the President on Friday December 13, 1991 to discuss managed care as an effective cost containment strategy. Other participants included representatives from Florida Health Access and COSE, two small employer health care purchasing coalitions, and Southwestern Bell.

Mr. Winters also met with the President on March 10, 1992 when he attended the United Negro College Fund reception and dinner at the White House.

Johns Hopkins
Medical Institutions

550 North Broadway/Baltimore, MD 21205
(410) 955-6680 / FAX (410) 955-4452
Office of Public Affairs

TO: Editors, Producers and Reporters

FROM: Marc Kusinitz

DATE: May 5, 1992

SUBJECT: JOHNS HOPKINS BRIEFING ON DEVELOPMENT OF LOW VISION ENHANCEMENT SYSTEM (LVES)

Date: Wednesday, May 13, 1992
Time: 10:30 a.m.
Location: Oncology Center Auditorium (Room 119, Wolfe Street entrance to Hospital)

Researchers at the Lions Vision Center of the Hopkins Wilmer Eye Institute will display and demonstrate the latest prototype headset that compensates for poor vision by displaying in front of the wearer's eyes real-time video images captured by a miniature, built-in camera.

The LVES prototype to be displayed is the first of a line of similar devices that eventually will be able to compensate for vision problems caused by diseases of the eye.

Although designed to compensate for low vision, the system could be used by anyone as a "home entertainment unit," and is expected to be the basis of a virtual reality device in the future.

Hopkins researchers collaborated with the National Aeronautics and Space Administration's John C. Stennis Space Center in Mississippi on the development of the LVES.

EXCELLENT VISUALS AVAILABLE

To attend this briefing, contact Marc Kusinitz or Joann Rodgers at (410) 955-8665.

GETTING HERE IS EASY

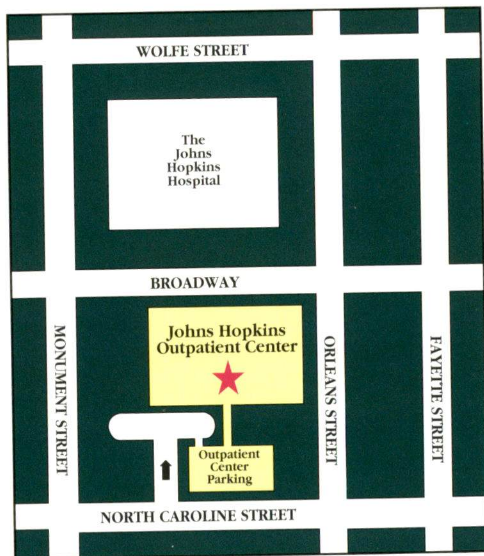
DRIVING FROM THE NORTH

Traveling south on Interstate 83, follow the expressway to its termination at the traffic light at Fayette Street. Turn left on Fayette and continue traveling eastbound to North Caroline Street, then make another left. Cross over Orleans Street and look for directional signs to the Outpatient Center parking garage.

Traveling south on Interstate 95, bear left on I-895, then exit at Moravia Road to Route 40. Follow Route 40, traveling westbound, and bear right onto Orleans Street. Follow Orleans to North Caroline Street, turn right and look for directional signs to the Outpatient Center parking garage.

DRIVING FROM THE SOUTH

Traveling north on Interstate 95, exit at Russell Street. Follow Russell to Pratt Street and turn right. Follow Pratt, traveling eastbound, through downtown Baltimore to North Caroline Street and turn left. After crossing Orleans Street, look for directional signs to the Outpatient Center parking garage.



JOHNS HOPKINS
Outpatient Center
SECOND CENTURY OF JOHNS HOPKINS MEDICINE

601 North Caroline St., Baltimore, MD 21287

For appointment information, call:
Adults: **410-955-5464**
Children: **410-955-2000**

JOHNS HOPKINS
Outpatient Center
SECOND CENTURY OF JOHNS HOPKINS MEDICINE

A PERSONAL APPROACH TO HOPKINS MEDICINE

#

Making Your Visit A Personal Priority

From the time you call to schedule your appointment, through the time of your visit, the entire collective efforts of the Johns Hopkins Outpatient Center staff focus on efficient attention to your medical needs with high regard for your personal time. We're dedicated to delivering a positive patient experience with minimal waiting.

When you visit, you'll find it convenient to park and easy to register and get to your appointments. Medical tests and X-rays will be done quickly and efficiently. Our friendly staff will be there to help and to answer your questions.

Most important of all, this Center offers you quality Hopkins medical care, with state-of-the-art diagnostic facilities, imaging equipment and operating rooms.

We are proud to introduce you to our newest innovation in Hopkins medicine, the Johns Hopkins Outpatient Center–a part of our continuing commitment to be the best in the world.

ADVANCE REGISTRATION

Once you've scheduled an appointment, a patient service coordinator will call you in the evening to collect registration information.

The purpose of advance registration is to collect necessary information while you are in the comfort of your home, so that we can shorten the registration process when you arrive at the Center.

If you prefer, you can call us at 410/955-2453 to complete the registration process. This brief phone call will save you time on the day of your appointment.

Please plan to arrive 10 minutes before your scheduled appointment if you have preregistered and 20 minutes before your appointment if you have not preregistered.

WHAT TO BRING

On the day of your appointment you will need the following:

- your Johns Hopkins Hospital I.D. card, if you have one
- insurance cards and forms
- HMO/PPO referral forms
- medical cards
- Social Security number of the person in whose name the insurance is issued
- name and address of that person's employer

Also, when you make your appointment, you may be asked to bring medical records, X-ray films, or prior test results, if you are being referred to Johns Hopkins by another physician.

EASY ACCESS CONVENIENT PARKING

You'll find directions to the Outpatient Center on the map on the back of this brochure. Once you turn onto North Caroline Street, look for the tall sign that directs patients and visitors to the Center.

If you are driving, follow the directional signs to the Outpatient Center parking garage, located directly opposite the main entrance to the Outpatient Center.

If someone is dropping you off or picking you up, there is a convenient four-lane driveway in front of the building.

CHECK-IN

As soon as you walk up to the main information desk in the first floor lobby, our staff will greet you and direct you to your destination.

Four elevators are reserved for your use. In the elevator lobby on each floor is a directory of clinical departments to assist you in finding the location of your appointment.

AFTER YOUR VISIT

After you have seen your doctor, you will meet with a patient service coordinator to order any lab tests or X-rays you might need, or to schedule return appointments. Please be prepared to pay for your visit at this time. Insurance or referral forms will be collected, and we will send you information that you may require to file an insurance claim.

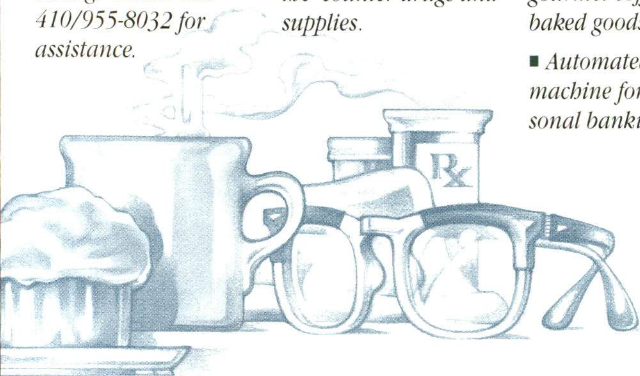
THE ROBERT M. HEYSSEL BUILDING

The Center is located in the Robert M. Heyssel Building. The Trustees of the Hospital and University dedicated and named the building in recognition of Dr. Heyssel's distinguished service as director of The Johns Hopkins Hospital from 1972 to 1983, as its president from 1983 to 1986, and as president of both the Hospital and the Johns Hopkins Health System from 1986 to 1992.

ADDITIONAL PATIENT SERVICES

The Center's lobby offers a number of services for your comfort and convenience.

- *Office of Patient Services - Assists international and other patients with special needs, such as interpreter services, travel, housing, and billing. Please call 410/955-8032 for assistance.*
- *Appointment Referral Office - Assists patients who need an appointment in finding the appropriate physician. Call 410/955-5464.*
- *Freedom Pharmacy - A rapid-fill, complete prescription service, which also stocks over-the-counter drugs and supplies.*
- *Benson Optical Superstore - A one-hour service for eyeglasses (with more than 1,000 frames to choose from) and contact lenses.*
- *Gift and coffee shops - Featuring magazines, cards, and gifts, as well as gourmet coffees and baked goods.*
- *Automated teller machine for your personal banking needs.*



X-RAYS AND LABORATORY TESTING

Blood and urine tests, EKGs, and chest X-rays are all provided in the express testing area of the lobby. All other radiology services, including CT and MRI scans, are also provided in the building.

WE'RE HERE TO HELP YOU

Our employees are knowledgeable about your needs and our services. They are eager to help you if you have questions or need directions. Do not hesitate to ask for assistance at any time.

CLINICAL SERVICES

LOWER LEVEL
- ***Outpatient Surgery***

FIRST FLOOR
- ***Lobby Services***

SECOND FLOOR
- ***Diabetes Center***

THIRD FLOOR
- ***Imaging, including CT, MRI and nuclear medicine scans.***

FOURTH FLOOR
- ***Radiology***
- ***Breast Imaging Center***
- ***Urology***

FIFTH FLOOR
- ***Neurology***
- ***Neurosurgery***
- ***Orthopaedic Surgery***

SIXTH FLOOR
- ***Otolaryngology (Head & Neck Surgery)***
- ***Dermatology***

SEVENTH FLOOR
- ***Adult Medicine and Surgery***
- ***Cardiology and Cardiac Surgery***
- ***Meyerhoff Center (Gastroenterology & General Surgery)***

EIGHTH FLOOR
- ***Pediatrics***
- ***Gynecology & Obstetrics***
- ***Plastic Surgery***

MEMORANDUM

TO: "Interested Parties"

FROM: Elaine Freeman
Joann Rodgers

DATE: May 7, 1992

SUBJECT: Hopkins Background for Bush Visit

Attached is an assortment of materials about the Johns Hopkins Medical Institutions and Johns Hopkins Health System President Robert M. Heyssel, with an emphasis on information relevant to health care reform, cost containment, delivery of services to the urban poor and prevention.

The materials include descriptions of programs, research projects, news releases, speeches, position papers and news articles.

From Hopkins' standpoint, several issues highlighted by the materials stand out:

o The Johns Hopkins Hospital and Health System developed the concept of a Medicaid HMO in Baltimore in 1984 when they took over a small HMO in East Baltimore that went into bankruptcy. The State of Maryland and Hopkins leadership and money "grew up" that HMO, the Johns Hopkins Health Plan, ~~to a 55,000-enrollee success.~~ Prudential acquired the Plan in 1991.

o Keeping health care costs down and the quality up requires appropriate levels of care for each patient and a regulatory system that rewards cost savings. At Hopkins, Dr. Heyssel developed the "vertically integrated" health care system that encompassed neighborhood health centers and the opening this week of the $140 million ~~ambulatory care~~ outpatient center to complement the tertiary care at Hopkins Hospital, called the best in the nation by U.S. News and World Report. In addition, he led the support for Maryland's unique all-payors hospital reimbursement system that helped guarantee fiscal stability and sensible planning of hospital services in the state, while rewarding those institutions that maintained a competitive edge without "dumping" patients.

o When Dr. Heyssel came to Hopkins 20 years ago, he inherited a white enclave in a racially segregated environment. Since then, he has built bridges with the minority community that surrounds Hopkins, culminating with the Hospital-funded Office of Community Health. This office runs health programs and supports minority health career development with agendas set by community leaders, not Hopkins.

o Preventive medicine is a tough sell in an academic medical center where the focus is the advancement of cutting edge knowledge to help the sickest individuals. Yet Hopkins made a substantial commitment to preventive medicine and the cost effectiveness it represents with such model programs as Heart, Body and Soul. HB and S works with dozens of African American clergy to promote health, offer screening programs and reduce death and disability from heart and blood vessel disease. The School of Public Health has numerous programs integrated with medical school and hospital faculty and staff to advance the benefits of preventive medicine.

NEWS RELEASE

Johns Hopkins Medical Institutions

Office of Public Affairs
550 North Broadway / Baltimore, MD 21205 (301) 955-6680 / FAX (301) 955-4452

EMBARGOED UNTIL NOON, E.S.T.

WEDNESDAY, DEC. 11, 1991

HOPKINS TO COMBAT HEALTH PROBLEMS OF EAST BALTIMORE

The Johns Hopkins Hospital is launching a Community Health Initiative for East Baltimore that vastly differs from numerous existing Hospital programs because it asks the community to tell Hopkins what it wants and needs.

Based in a new Office of Community Health (OCH), the initiative has initial funding of $150,000 from The Johns Hopkins Hospital.

"People in our surrounding neighborhood know what their most important health concerns are," says Robert M. Heyssel, M.D., president and chief executive officer of the Johns Hopkins Health System and The Johns Hopkins Hospital. "We need to listen and learn from them where we should concentrate efforts at improving health, and we need to make it easy and convenient for people to get involved and share information.

"Further, we want to demonstrate with the community that measurable changes can be made in community health in a broad population in cost-effective ways, such as education, prevention and early intervention, which are a lot less expensive than treatment later in the course of disease," Heyssel says.

A 12-member Advisory Board is comprised of representatives from East Baltimore community groups, the Mayor's Office, and the Baltimore City Health

(more)

The Johns Hopkins Hospital
School of Medicine
School of Nursing
School of Public Health
Johns Hopkins Health System

Department, as well as from The Johns Hopkins Hospital, School of Medicine and School of Public Health. They will help in determining community health outreach priorities. The OCH then will serve as a clearinghouse for information about all existing health-care programs in East Baltimore, help groups seek financial support for needed projects, and will serve as an information and referral source for groups and individuals.

Existing Hopkins-sponsored community health programs will continue, although they may be expanded or improved based on community input.

The OCH will tackle many of the most difficult health problems the community faces. Based on preliminary Advisory Board discussions, efforts are likely to focus in such areas as: reducing infant mortality, increasing vaccinations, slowing the spread of AIDS, improving primary care, providing low-cost mammography screening, reducing sexually transmitted diseases, promoting healthier lifestyles and influencing many other entrenched problems. The Board will likely select three of these problems for initial concentration.

Terisa James, who established and coordinated the Community Services Program for the Johns Hopkins Oncology Center, has been named OCH'S executive director. Department of Pediatrics and OCH Director Frank A. Oski, M.D., says James was selected because of her established ties and credibility with community leaders and her longstanding commitment to improving the health of people in the surrounding neighborhood.

(more)

"We wanted someone who could relate to the needs of the community and not focus only on what Hopkins perceives are health priorities," Oski says. Julia McMillan, M.D., deputy director of the Department of Pediatrics, is the OCH associate director.

Advisory Board members include:

Pastor Marshall Prentice, president, Clergy United in the Renewal of East Baltimore (C.U.R.E.)

Ralph Moore, director, Project RAISE II

Lucille Gorham, director, Citizens for Fair Housing

Lee Tawney, assistant to the Mayor

Councilman Carl Stokes, 2nd district, Baltimore City, the district surrounding The Johns Hopkins Hospital

Thomas P. Coyle, director, Office of Policy and Program Development, Baltimore City Health Department

Robert M. Heyssel, M.D., president and chief executive officer, Johns Hopkins Health System and The Johns Hopkins Hospital

Catherine DeAngelis, M.D., associate dean for academic affairs, Johns Hopkins School of Medicine

Bernard Guyer, M.D., M.P.H., chairman, Department of Maternal and Child Health, Johns Hopkins School of Public Health

Diane M. Becker, Sc.D., M.P.H., director, Johns Hopkins Center for Health Promotion

Vanessa L. Bradley, residency program coordinator, Department of Pediatrics, Johns Hopkins University School of Medicine

An additional seat for a community representative is still vacant.

The Office of Community Health is located across from Hopkins Hospital at 550 N. Broadway, telephone 410/550-6524.

###

(For press inquiries only, contact Jan Shulman or Joann Rodgers at 410/955-8662.)

SELECTED EXISTING HOPKINS-SPONSORED COMMUNITY HEALTH PROGRAMS

COMMUNITY HEALTH INITIATIVES

- **Clergy United in the Renewal of East Baltimore: Heart, Body and Soul Program**

  (A community/church-based screening and education project that includes screening programs for hypertension, diabetes and cholesterol, as well as a smoking cessation program.)

  The Johns Hopkins University School of Medicine

- **Breast and Cervical Cancer Screening Project**

  The Johns Hopkins Oncology Center, Community Services Program
  (In collaboration with the Heart, Body and Soul Program)

- **Vision Screening Project**

  (Screens for cataracts, glaucoma and other vision problems.)

  Dana Center for Preventive Ophthalmology
  The Johns Hopkins Wilmer Eye Institute
  (In collaboration with the Heart, Body and Soul Program)

- **Dunbar Middle School Clinic Initiative**

  (Assessment, intervention and referral of children -- includes physicals, medical and mental health referrals and health education.)

  The Johns Hopkins Children's Center

- **Hearing Outreach Program for Senior Citizens**

  The Johns Hopkins Center for Hearing and Balance

- o **The ARK Project**

  (Free screening and physical exams for homeless women and children.)

  The Johns Hopkins Children's Center

- o **Pediatric HIV Program**

  (Comprehensive program for high-risk and HIV-infected children)

  Johns Hopkins Children's Center

COMMUNITY EDUCATION AND HEALTH CAREER PROGRAMS

- o **Alternative Careers Program**

  (Introduces high school students to career opportunities in the allied health professions.)

  The Johns Hopkins Hospital, Employment Services

- o **Community Relations and Education Program**

  (Includes a free speakers' bureau and health career day.)

  Johns Hopkins Children's Center, Child Life Program

- o **The Dunbar High School/Hopkins Health Professions Program**

  (Offers assistance to students who select a health-track curriculum and offers paid intern programs.)

  The Johns Hopkins University

- **Professional Readiness Insurance for Minority Excellence (PRIME)**

  (Provides health-care job experience for qualified minority college students with the goal of offering Hopkins employment.)

  The Johns Hopkins Hospital, Employment Services

- **RAISE II**

  (Mentoring program for Dunbar Middle School.)

  The Johns Hopkins Medical Institutions

COMMUNITY VOLUNTEER PROJECTS

- **Community Service Volunteer Work**

  (Students in Community Outreach class at School of Public Health are required to perform two hours of weekly community service.)

  The Johns Hopkins University School of Public Health

- **Community Health Fairs**

  (Offers cancer prevention education.)

  The Johns Hopkins Oncology Center

EAST BALTIMORE GUIDE
DEC. 12, 1991

Hopkins Program Targets Eastside

Johns Hopkins Hospital has begun community health program for East Baltimore based for the most part on input from the community, a rare foundation for hospital programs.

Robert M. Heyssel, M.D., president and CEO of the Johns Hopkins Health System and Hospital, said he hopes the project will emphasize education, prevention, and early intervention, which are cheaper than treating diseases later on. "People know what their most important health concerns are. We need to listen to them, and also make it easy and convenient for people to get involved," Dr. Heyssel said. "We also want to demonstrate that changes can be made in community health in cost-effective ways."

The project was initially funded with $150,000 from Johns Hopkins Hospital, and is based in the Office of Community Health (OCH), 550. N. Broadway, across from the hospital. Terisa James, who coordinated the Community Services Program for the Johns Hopkins Oncology Center, was named OCH's executive director.

A 12-member advisory board, including representatives from area clergy, community leaders, city government, and hospital officials, was formed to help determine the most needed programs.One seat on the board, reserved for a community representative, is vacant.

Health issues most likely to be addressed include reducing infant mortality, increasing vaccinations, slowing the spread of AIDS, improving primary care, providing low-cost mammography screening, reducing sexually transmitted diseases, and promoting healthier lifestyles.

Hopkins-sponsored community health programs already in effect will continue, and may be improved upon depending on community input. They include the Clergy United in the Renewal of East Baltimore (CURE), a community/church-based screening and education project that screens for hypertension, diabetes and cholesterol; the Vision Screening Project; the Dunbar Middle School Clinic Initiative, which includes physicals, medical and mental health referrals, and health education for children; the ARK Project, which provides free screening and physical exms for homeless women and children; aand the Dunbar High School/Hopkins Health Professions Program, which offers assistance to students looking for a career in health care, and offers paid internships.

THE SUN

Still exists under JHMSC / Prudential HealthCare Plan

NOV. 14 1990

HMO's prenatal program pays off

Have checkup, get voucher

By Mary Maushard
Evening Sun Staff

A Baltimore HMO is paying some of its patients to take care of themselves.

As part of a new prenatal health program, the Johns Hopkins Health Plan is giving $10 vouchers to expectant mothers, covered under the state's medical assistance plan, for having regular checkups and attending health-education classes.

The voucher system, which will be extended to pregnant women who also attend smoking cessation or drug-detoxification programs, is the "incentive" part of Better Beginnings, a prenatal health and education program started by the health maintenance organization Nov. 1.

Better Beginnings is open to all HMO members enrolled at the plan's four city offices, but only medical assistance patients are "being offered that incentive to attend their appointments," says Karen Brodsky, program coordinator.

The four centers serve about 650 pregnant women a year. About half of them are Medical Assistance patients, she says.

And many of these patients are teen-agers, whose age, education, eating habits and home situations put them at risk of having small and premature babies. Better Beginnings is intended to eliminate some of these problems.

Here's how the program works:

When a woman is scheduled for a regular prenatal checkup (once a month through most of the pregnancy but more frequently in the eighth and ninth months), she also will be scheduled to attend a health-education class. If she has the checkup and attends the class, she will get a $10

See VOUCHER, A5, Col. 1

VOUCHER, From A1

voucher that she can cash at the health center. She will get a voucher each time she comes to a checkup and class.

Each patient could have as many as 15 appointments, Brodsky says, although she assumes the average will be closer to 10.

The classes will stress health and nutrition, says Brodsky. As her pregnancy progresses, each woman will visit a pediatrician to learn about child care and be offered childbirth education classes. She also will see a social worker once — more frequently if necessary — during her pregnancy.

In addition to the regular checkups, smokers who are referred to, and attend, smoking-cessation clinics will be given $10 for each class they attend. And women with drug- or alcohol-abuse problems who complete detoxification classes will be given an additional $10 each time their drug screening is "clean," Brodsky says.

Brodsky would not say how much money is budgeted for the incentive program. At an average of $100 per patient ($10 a visit for 10 visits), plus more for smokers and drug and alcohol abusers, the program would cost at least $30,000 to $35,000 annually.

"The cost of the incentive program will be much less than the cost of [caring for] a baby if it were born with serious health problems," Brodsky says. If a woman receives $150 from the incentive program over the course of her pregnancy, "the money will help her and will help her baby."

Caring for an infant with acute health problems can easily cost $50,000, Brodsky says. If predictable problems can be avoided in only one baby, "the whole program will be worth it," she adds.

There will be some savings, too, in normal deliveries, Brodsky says. As part of Better Beginnings, mothers who have uncomplicated, vaginal deliveries and healthy babies will be able to leave the hospital within 24 hours rather than 48 hours, which is now the norm for most mothers.

Some women already leave the hospital in one day, and Better Beginnings is hoping to increase that number by 20 percent.

Through the program, a home health care worker will visit the woman and her baby the day after they return home from the hospital to be sure they are progressing and will make an appointment for the mother's six-week post-partum checkup. "The home-health visit could be repeated, if necessary," Brodsky says.

HMO officials are hopeful that a woman who has had good health care during her pregnancy would be encouraged to continue it for herself and her child.

"We really think it will make a difference," she says.

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Medicine & Health

PERSPECTIVES

August 19, 1991

TWENTY YEARS OF MARYLAND RATE REGULATION

For 20 years Maryland hospitals have operated under a tightly-controlled state-run payment system that sets rates for all payers and all patients. As a result, payments are 8 percent below national average. So why are administrators so happy? And, perhaps more importantly, what can the rest of the nation learn from Maryland?

When Maryland launched its "experiment" with all-payer rate-setting in 1971, hospital costs in the state were among the highest in the nation. Calls were being heard in the state legislature to "sta-tionalize" the industry, turning it into a sort of public utility. Providers naturally balked and the legislation was defeated. But, recalls former Maryland Hospital Assn. President Richard Davidson, the debate set the industry to thinking. After all, state rate setting, if it were done correctly, would have some benefits to hospitals. Facilities would have a steady income flow and would know exactly what they would be paid for each case. And, the system guarantees access to hospital care for every resident, regardless of insurance.

So, rather than waiting for the next legislative battle to begin, Davidson gathered his troops and drafted his own plan. After gaining support from a key legislator and Gov. Marvin Mandel, the proposal was approved, featuring an active role for hospitals in the establishment of the rates and monitoring of implementation.

Operating under a federal Medicare waiver, Maryland's Health Services Cost Review Commission (HSCRC) regulates rates to reflect the cost of operation for the state's 53 hospitals. As a result, Maryland hospitals are the only ones in the nation not being paid under Medicare's DRGs.

IMPRESSIVE RESULTS

The results have been so impressive that state and federal policymakers who are desperately trying to control health care costs are taking a second look at Maryland's system. The National Governors' Assn.'s new health reform proposal, for example, says that states might want to test rate regulation.

But while Maryland hospital administrators say the system works for them, many caution that it might not work in other places. For one thing, Maryland is unique in the degree of cooperation among its hospitals. And even with all of the good news, some serious potential problems — such as continuing cost increases — loom on the horizon.

"The overall merits of the system from a public policy standpoint are very positive," says Jim Xinis, CEO and president of Calvert Memorial Hospital in Prince Frederick County. "But it's not all peaches and cream. The net income over operating expenses that hospitals have obtained has been less than the national average. And the rates [that hospitals are paid] are not going up as fast as the cost of providing services."

John Colmers, executive director of HSCRC, agrees that profit margins are slim, but says the advantages of rate setting far outweigh any drawbacks. "It's more rational, more equitable, and more predictable. And it's saved money — that's the ultimate proof."

F&G Christina Kent, Editor

PERSPECTIVES, August 19, 1991

Some say the debate boils down to a philosophical argument: what is the best way to control costs, the free market or regulation? The only answer that Maryland can give is that, in Maryland — so far — regulation has worked.

Under its system, Maryland sets payment rates for all hospital-based inpatient and outpatient care. First, hospitals inform HSCRC of their estimated costs for medicine, surgery, and other departments. Costs for direct and indirect departmental expenses, uncompensated care, working capital, and buildings and equipment are factored in. Those expenses are compared to the costs of a similar group of hospitals, under the theory that like hospitals should have like costs.

HSCRC decides whether each hospital's estimates are reasonable or unreasonable, allowing hospitals that believe they will have unusually high costs to justify them. If HSCRC believes that the proposed expenditures are overstated, public hearings are held. Hospitals can appeal unfavorable decisions to the Maryland courts. At the end, rates are set for individual departments.

Once a year, the rates are adjusted to take into account the inflation that occurred in salaries, fringe benefits, food, supplies, and other expenses. Hospitals rarely undergo full rate reviews, relying instead on automatic inflation adjustments. Although some hospital administrators criticize the automatic adjustments for not providing enough of a profit "cushion," others say they increase stability throughout the system.

Bad debt and charity expenses are included in the rate base; cross-subsidization among hospital services is prohibited; most nonpatient revenue is used to offset patient care rates; rates include a markup for working capital; and discounts are provided to Medicare and Medicaid, to patients who pay upon discharge, and to third-party payers who, twice a year, accept all applicants.

UNIQUE FACTORS

For those who are looking to Maryland as the panacea for health cost inflation, there are enough similarities to provide encouragement but enough differences to make the going slow. The system was launched in the early 1970s, in the midst of precipitous cost increases and a rise in the number of uninsured. The early going was rocky, as the state sought to drive down costs, says Spencer Foreman, CEO of New York's Montefiore Medical Center and former CEO of Baltimore's Sinai Hospital. "No system that has as its goal the reduction of resources is going to make people happy, and restrictions and cutbacks made relations confrontational and very legalistic."

To aid in its effort, HSCRC interpreted the law's requirement that payments meet the "financial requirements of a hospital" to mean meet the costs of an "efficiently and effectively" run facility. Those were, of course, two very different things. Over the years, hospitals and HSCRC often have debated whether hospitals were or were not efficient, and whether the standards that HSCRC applied were appropriate.

Hospitals have gone to court, arguing that HSCRC must accept a "reasonable" rate structure proposed by hospitals and saying HSCRC does not have the authority to order refunds for rates that are above approved rates. Industry also has challenged the budget review method as arbitrary and capricious, saying the selection of comparison hospitals was subjective. Courts have upheld the principles that HSCRC is solely empowered to determine rate structures and that hospitals may charge only HSCRC-approved rates. Other rulings, however, have said HSCRC's ratings and methods must be supported by "competent, material, and substantial evidence."

Hospital officials say that while they don't always agree with HSCRC, the regulators tend to be responsive to hospitals' concerns. For example, about two and a half years ago, wage and salary increases began to outstrip the inflation adjustments provided by HSCRC. In the first part of 1988, Maryland hospitals' average profit margins dipped to less than one-quarter of the national average. After hearing the case made by hospital administrators, HSCRC agreed to a 1.5 percent across-the-board rate increase, which gave hospitals an additional $45 million. Some say this one-time increase won't stave off future needs, however.

THE RESULTS?

The system has plenty of admirers — and detractors. Robert Heyssel, MD, president of Baltimore's Johns Hopkins Hospital and the Johns Hopkins Health System, says the all-payer method works so well that the federal government should extend it to all hospitals — and physicians.

Rate setting contains costs, Heyssel says. For 15 consecutive years, Maryland hospital admission costs have risen at rates below the national average. In 1990, costs per admission rose 8.7 percent, compared to a national average of 8.96 percent. Rate regulation saved Marylanders $5.3 million in 1990, HSCRC says.

And the system factors "reasonable" levels of bad debt and charity expenses into the rates that hospitals can charge, so those costs are distributed equally among all payers. In Maryland, hospital costs are marked up an average of about 7 percent to cover uncompensated care. In unregulated states, private payers often have their charges marked up by 20-to-30 percent for patients who can't pay. As a result, Maryland has "not had the sort of dumping problems that you have elsewhere," Heyssel says.

The strategy is predictable, he adds. "You can make a good guess in January when you're preparing your budget about what kind of rate change you will get. Who knows what the federal government will do with Medicare from year to year?" And, the system has helped to lock in the status quo. Over the decade of the 1980s, more than 800 hospitals closed throughout the country. In Maryland, the closure total was three.

Those arguments are anathema to those who believe that rate regulation is wrong, both from a practical and a philosophical point of view. "Maryland has been the least oppressive of the rate-setting states [because its rates tend to be higher]," says Michael Bromberg, executive director of the Federation of American Health Systems (FAHS), which represents for-profit hospitals. But even Maryland saves money by squeezing profit margins, which means hospitals have few funds to invest in equipment and buildings, Bromberg says. In 1990, Maryland hospitals had a total profit margin of 1.88 percent, compared to the 4.8 percent margin of hospitals nationwide.

Bromberg adds that rate regulation doesn't really save money. A recent FAHS-sponsored study found that regulated states had higher per capita hospital expenditure increases than states that are competitive (as measured by high concentrations of health maintenance organizations). From 1986 to 1989, per capita expenditures in six regulated states (MD, MA, NJ, WA, CT, NY) increased an average of 9.5 percent — compared to only 7.1 percent in five competitive states (MN, CA, OR, DE, CO). Maryland's per capita expenditures rose 8.2 percent during that period.

Finally, rate regulation inhibits innovation in health care delivery, Bromberg says. "Once you have the same price for everybody, the incentive to experiment, to take risks, evaporates."

HMOs too are not enamored of the all-payer system because it prevents them from negotiating discounts with hospitals. Rate regulation "doesn't preclude our participation, but it doesn't allow us to give as affordable health care as we could under other systems," says Geni Dunnells, executive director of the Maryland Assn. of Health Maintenance Organizations.

CHANGES AROUND THE BEND?

While hospital administrators tend to foresee no major changes in the system in the near future, they are worried about continually rising costs and dropping profits. "The rest of the country can shift costs to private-pay patients," says Xinis. "We can't. It makes things more difficult."

Looming over officials is the potential loss of the Medicare waiver, which would make the all-payer system a thing of the past. If Medicare costs per admission in Maryland at any time creep past the national average, the state will have to design a new payment system and figure out a way to pay for uncompensated care, which last year cost Maryland about $270 million.

It's happened in other states. Only a few years ago, Maryland was one of four states operating all-payer systems under Medicare waivers. But New York, New Jersey, and Massachusetts gradually have dropped from the fold. Only Maryland and a six-hospital system in upstate New York have retained the waivers.

The consequences of losing the waiver can be devastating. New Jersey, for example, is currently paying for uncompensated care by adding a 19.7 percent surcharge to hospital bills, which has sent insurance costs rocketing upward. "Business and industry have notified us of their concern and the governor is trying to get a payroll tax adopted [to take the place of the add-on]," says Pamela Dickson, assistant commissioner for the New Jersey Health Dept.

Maryland officials say that such potential problems make them all the more committed to retaining the all-payer system. "In the long run, I feel quite optimistic about the hospital industry in Maryland," Colmers says. "There remains a very strong commitment among the political leadership and hospitals to keep the system going."

TAKING IT ON THE ROAD

Could portions or all of Maryland's system be transferred to other states or to the nation as a whole? Some say the answer is "no." "I frankly do not think that it would work in larger states or [on a national basis]," says Montefiore's Foreman. "The system requires that the regulators know a good bit about the individual circumstances [of each hospital]. You can't do that when you have to meet national standards."

Nonsense, says Johns Hopkins' Heyssel. If necessary, the U.S. could be broken down into smaller portions for purposes of regulation. In fact, some say that Maryland's system doesn't go far enough. "The Maryland system has stabilized costs, and uncompensated care is covered," says Phyllis Torda, of the consumer advocacy group Families USA. "But it has the obvious weakness of only applying to hospital care — it doesn't guarantee access to physician care." Torda and Heyssel advocate extending rate regulation to physician fees and hospitals around the country.

It may be that certain principles of Maryland's system, such as efficiency, solvency, and paying for uncompensated care, could be incorporated into other systems, says Colmers. "But [the system] is not a panacea for every state. Certain features work quite well in Maryland and would work well in other areas. I'm not a zealot for having it copied, but I am in favor of states being given the flexibility to set up their own systems."

Davidson's recent elevation to the presidency of the American Hospital Assn. has turned a new spotlight on the Maryland system and set some to wondering if the new AHA chief might be interested in exporting the Maryland system to the nation. Definitely not, says Davidson, whose selection was generally greeted with cheers but has some opponents of regulation nervous. Davidson says that Maryland's system works because the law that set it up was written by hospitals and is not punitive. The basic question is not regulation versus competition, Davidson says: "it is defining the appropriate relationship between government and hospitals." In Maryland, that relationship is trust, and that trust would have to be transferred or created, if the "Maryland system" was to work in other places, Davidson adds. "It works in Maryland because the hospitals want it to work — it was their idea."

Still, members of Congress — Democrats in particular — are looking for ways to control costs in order to ease passage of legislation to expand access to care for the uninsured. A proposal (S.1227) by Senate Democratic leaders would establish national expenditure targets for each segment of the health care system and create an independent national board to monitor compliance. While that voluntary system upset some providers, industry is more nervous about a proposal by Sen. Paul Simon (D-IL) to make the controls mandatory. The Simon bill (S.1669) has the backing of organized labor. And a plan (H.R.3205) by House Ways & Means Committee Chairman Dan Rostenkowski (D-IL) includes mandatory spending targets as well. If federal lawmakers can convince providers that they seek a cooperative relationship — a la Maryland — a national rate setting system could be just around the bend.— *CK*

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HEALTHCARE INFORMATION CENTER

DRAFT

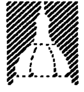
While American congressmen and columnists traipse all over the world in search of a successful health care system, they are ignoring one right under their noses -- in Maryland.

Since 1977 , Maryland has been "excused" from the federal formula for hospital cost containment. For the past 15 years, it has been the only state exempted. Why? Because Maryland had a successful hospital cost containment system in place before the federal government got into the act.

In every state but Maryland, Washington decrees the rates paid to hospitals for treating patients covered by Medicaid and Medicare -- no matter what the actual costs. In all other states, neither the federal government nor non-government insurers, from HMO's to the Blues, are compelled to share in a hospital's cost of providing care to all patients, including the uninsured poor. There is no pressure on the insurers to share in underwriting high cost regional services, such as trauma centers or neonatal intensive care units. They pay only costs related directly to the care of persons covered by their policies.

The consequences are grim -- for the uninsured poor as well as for those who treat them. Urban academic medical centers, the usual and most sophisticated caregivers, are forced to dip into endowment until they, too, are impoverished, unable to develop new programs or properly cover the cost of old ones. Meanwhile, the poor are shunted from hospital to hospital as institutions protect themselves from bad debts by dumping poor patients on the medical centers -- a modern variant of "hot potato."

By contrast, Maryland's unique hospital reimbursement system is the most



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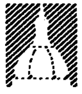
rational and humane in the nation. Ours is the only state with an "all-payor" system. This means that all insurers -- government or commercial -- as well as all who pay their own way, must pay the same rate at a particular hospital. The rate is set not by some distant federal bureaucracy's formula but by a state commission with great flexibility: the Health Services Cost Review Commission.

In a world-class display of common sense, the HSCRC adjusts each hospital's rates to reflect that hospital's reasonable costs of providing services needed by Marylanders. This means that hospitals treating more of the uninsured poor get more leeway in rates than hospitals treating fewer poor. And the rates reflect the true costs of keeping a state-of-the-art emergency room or intensive care unit staffed round the clock, as opposed to costs of a first-aid station.

Through the HSCRC, Maryland's officials acknowledge that it is in the state's best interest to maintain a healthy network of hospitals, including institutions such as Johns Hopkins that offer the most advanced levels of care.

There is, of course, a hitch. To maintain this rational system and protection from the federal formula, the inflation rate in Maryland's hospitals must be less than the national average for hospital inflation. Through constant monitoring, the HSCRC guards this margin of freedom and asks each hospital to make adjustments to keep it.

This year, for instance, our approved rates at Johns Hopkins were 9 percent above the average of the state's hospitals. The Commission agreed these rates were needed to cover the costs of the care we provide. Nonetheless, the HSCRC now has asked us to cut costs 2 percent a year for each of the next two years as our part in lowering the state's overall hospital



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~~inflation rate.~~

Belt-tightening ~~won't be~~ isn't easy, but it is a price we willingly pay to help the State of Maryland retain its unique hospital reimbursement system.

Could other states do what Maryland does? The answer is "yes" if all players, from hospital administrators to government insurers, are willing to put something into the kitty. The gamble seems well worth it to escape the current no-win system that hurts patients and hospitals alike.

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JUN 24 1991

BALTIMORE PROFILE

JOURNAL PHOTO BY TED HOFFMAN

Davidson to guide American Hospital Association into new era.

Health care's voice of reform

By Christopher J. Gearon

Richard J. Davidson, the newly appointed president of the American Hospital Association, has made some folks in the health care industry nervous.

As president of the Maryland Hospital Association for the last 22 years, Davidson helped a hospital system that was one of the costliest in the nation 15 years ago become one of the most efficient today — saving Marylanders more than $1 billion.

And while horror stories abound about hospitals turning away sick people because they lack insurance, that isn't an issue here as Maryland hospitals have agreed to treat patients regardless of their ability to pay.

Even though Maryland saw Homewood Hospital Center close this spring — the first Maryland hospital to close in five years — the state's 52 hospitals overall are stable financially because of a system designed to focus on patient care rather than big profits. Not a lot

Continued on page 33

Nation's hospitals watching as Marylander takes over association

Continued from page 1

of hospital systems can match that.

But while Davidson's appointment in May to the 4,935-member organization reportedly was greeted with enthusiasm, there are some in the industry that feel Davidson will back national rate setting for hospitals.

Davidson, now in the forefront on the debate of American health care reform, said he isn't planning to force Maryland's system on the rest of the country.

"A lot of people say, 'Davidson, can you transport Maryland's system to other states?' and my reaction is "I don't think so,' " the Severna Park resident said.

"What we do here is driven by a set of values," Davidson said of Maryland's hospital system. "We want to ensure care to those who come to our door who don't have the ability to pay. I have an enormous sense of pride to what's happening in Maryland."

On July 15, Davidson will land in the middle of the health care reform debate swirling in Washington as he moves the AHA president's office from the group's Chicago-based headquarters to the nation's capital. While overseeing 850 staffers, the association's highest ranking staff member will be meeting with the nation's leaders advocating ways to make the country's hospital system stronger.

And although hospital leaders around the country are envious of Maryland's system, they are wary of the means by which it's achieved — private sector hospitals working with and depending on the state and federal governments.

Maryland hospitals are heavily regulated by the state, and Davidson is a big reason for that. In the early 1970s, when the cost of admission in a Maryland hospital was quickly outpacing hospitals in other states, lawmakers and hospitals were concerned. Everyone knew something had to be done, and Davidson brought competing hospitals together convincing them that their future was in working with the state.

Through the years, hospitals submitted to regulation so that they could concentrate on their mission of providing care to those who needed it. And by 1975, the federal government and Blue Cross and Blue Shield of Maryland were brought into what has been dubbed as the "all-payor" system. The system subsidizes hospital care for those who can't afford care.

The hitch is that Maryland's hospital costs must stay below national hospital costs or the system unravels. Other hospital systems are petrified of such dependance on the government.

"Most hospital administrators outside of Maryland . . . who don't understand the Maryland system think it's the next step to communism," said Richard M. Sorian, executive director of the Faulkner and Gray Healthcare Information Center in Washington, D.C. "It sounds quite scary (to them)."

"It's a very strong dichotomy," Sorian said, when Maryland hospital administrators praiseing the system to outside administrators, who'd rather distance themselves from increased government ties.

While Maryland's strong hospital-government relationship is in the back of health care executives' minds when Davidson's name is mentioned, Sorian said that industry players are "very receptive to him personally because he's very well respected."

"There's a lot of anticipation about what role I will play in (national health reform) discussion and debate, and it will be as an honest critic of what can and cannot work, and I wouldn't pretend for a minute that what we do here can be replicated in other states," Davidson said.

Davidson believes that the competitive focus of the last decade distracted the nation's hospitals from their mission as care providers. Maryland didn't have that distraction.

"The theme of the 1980s was health care could compete like any other business in selling a commodity. That kind of became the policy or mantra of a lot of people in health care," he said. "Hospitals changed in the '80s, but they got beat up in a lot of places."

Davidson wants to emphasize collaboration, not competition, among the nation's hospitals as the industry's leading spokesman. Collaboration is what takes place in Maryland. That, he said, benefits the patients most.

Hospitals and governments need a better working relationship, too, Davidson said, especially since what both want is so similar. But with the talk of a federal role in health care, hospitals get nervous.

"What you have out there is a terrible distrust of government," Davidson said of the nation's hospitals.

Within the last decade, as the federal government has reimbursed hospitals on a prospective payment system for the caring of Medicare patients, hospitals have been squeezed continually by Washington. The federal government keeps racheting down its payback, making it tougher for hospitals to treat patients effectively and maintain their viability.

Davidson will have his work cut out for him trying to convince all parties that their interests are the same, and an even tougher time trying to convince government and other payors that the long-term financial health of hospitals is not grounded in oppressive cost containment.

But Davidson said he's also concerned about the Maryland hospital system.

"I think hospitals in the state of Maryland will be continuously challenged with holding the payment system together," Davidson said.

As the federal government continues to cut payments to hospitals for providing care to federally subsidized patients, Maryland is not immune from these pressures.

Even with Davidson leaving Maryland's association to lead the national hospital association, Maryland's hospital system, like the rest of the nation's hospitals, will be depending on Davidson's voice during the turbulent debate on health care reform.●

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HOPKINS HEART STUDY RAISES COST VS. CARE DILEMMA

A new Hopkins study of a common diagnostic procedure has put the spotlight on the ethical dilemma of how to provide the highest-quality care while keeping costs under control. In the study, Hopkins researchers compared two types of contrast dye used to diagnose coronary heart disease, and found that the older, cheaper type of dye works as well for most cardiac catheterizations as a widely used new one that costs up to 20 times more. The results of the study are reported in the February 13 issue of the *New England Journal of Medicine.*

"This is a new breed of study that reflects the attention hospitals and physicians are now giving to costs," says Earl P. Steinberg, M.D., M.P.P., principal investigator in the study. "We're entering an era in which expensive innovations will be very critically evaluated before we accept them."

In their study of diagnostic cardiac catheterizations in 500 patients, Steinberg and his team compared reactions to two types of contrast dyes--an older, inexpensive high-osmolality dye and a new, very expensive low-osmolality dye that has been widely adopted by hospitals nationwide since its approval five years ago. The old type costs about $8.00 per injection and the new, about $200.

The study found that patients injected with the old dye experienced slightly more "nuisance symptoms," including nausea, vomiting or hives. They also showed mild changes in heart rate and blood pressure three times as often than those injected with the new one. But because there was little or no difference in the rate

(more)

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of severe reactions, the study concludes that using the new dye only in high-risk patients would be more cost-effective than using it in all patients. "Using the new dye in all patients buys a very small benefit at a very high cost," says Steinberg.

Cardiac catheterization, or angiography, is a routine diagnostic procedure that uses contrast dye to detect blockages in coronary arteries. About 1.2 million are done in the U.S. each year. Similar dye injections are used for the 10-12 million radiographic procedures done in this country annually. According to Steinberg, using the old dye instead of the new for these procedures would save $1 billion a year nationwide. For cardiac catheterizations alone, use of the old dye would save $200 million.

Like Hopkins, many hospitals now employ a team of experts to regularly assess the costs and benefits of adopting very expensive new medical technology. "With elections coming up, everyone is talking about the need for affordable health insurance and cost control," says Steinberg. "But cost control involves trade-offs. Our study is a good example of the cost vs. quality decisions hospitals now have to make."

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(For press inquiries only, call Rachel Wilder or Carol Pearson at (301) 955-6680.) 2/13/92
Note: Our area code is now 410 instead of 301.

THE NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

Arlington, Virginia
~~March 15, 1991~~

Robert M. Heyssel, M.D.

File

Thank you for letting me share my thoughts with you today. What I have to say is a further evolution of ideas presented in a lecture at the IOM last April.

What I said then was that we need what will be perceived by many as radical change if we are to deal with the problems of cost, access and quality in the health care system.

I implied that radical change included not just the delivery system but education of professionals as well, and that radical change will have pain in it for everyone. I will add to that that the pain

will be greater and more expensive if piecemeal changes are pursued.

Change had to have as a goal the betterment of community health broadly bringing providers and the community together in a new partnership to bring about targeted and measurable improvement in the health status of Americans.

I said then that we did not need more money. I will qualify that by saying to obtain the change we need we will have to spend more money up front. We will recover it many times over if we do it right.

And, finally, that organized systems of care -- organized delivery system -- or ODS's in your

new jargon -- is the mechanism through which this can be done.

What I want to do is to get more particular concerning the necessary elements to achieve ordered change toward the objective of community-based delivery systems.

Let me restate my premise, briefly, that addressing equity of access alone (read financing for that) without a clear vision of the shape of the system that will result will frustrate our efforts to control costs, achieve equity and provide quality of care.

Quality of care is individual and measurable, and quality of system services is also measurable in

the community as a whole. Organized Delivery Systems that receive money for a broad array of health services -- population- or enrollment-based -- are necessary to develop the targets and measures of success. The ultimate goal is to allocate resources and hold organizations responsible and accountable for the health of populations within a framework of measurable costs.

The statement made earlier that we do not need more money in the long run is based on the belief that much of the very expensive care we now give is a result of misallocation of resources. We do not have effective community-provider interactions in prevention and treatment. Instead, expensive power

centers of specialty care -- hospital and physician controlled -- characterize the system today.

The base of such a system must be primary care, integrated with a tier of services from home care to specialty care and care of those no longer capable of independent living.

How do we change in practical terms and what are the elements we need to put in place to bring about change most rapidly?

First, we need to put in place through federal government an action plan for universal health insurance coverage. There must be an important role for state, regional and interstate

or intrastate organizations in administration and regulation. The bulk of the funding needed for expansion of coverage to those unable to pay and for subsidies to small businesses unable to pay on behalf of their employees should be federal. We would retain a private-public mix of payment. The German sick funds are probably the closest analogy to a restructured United States system of health insurance rather than the Canadian or United Kingdom system.

A basic set of benefits would be put in place for citizens to include inpatient and outpatient, preventive and catastrophic coverage.

Mechanisms which move away from experience rating for groups to broader community rating of

premium setting must be achieved.

An option for individuals to supplement basic benefits should be offered, but employers or employees would not be able to take advantage of tax deductions for benefits added above the basic package.

There should be co-pays for individuals with a cap on individual expenditures dependent on income.

Second and simultaneously, "all-payor" systems with rate control <u>for hospitals and physicians</u> and other elements of the delivery system should be mandated by the Federal Government as an exchange for federal funding. As indicated earlier, these administrative agencies could be

state-wide, within states by regions or interstate by state agreements, not federally administered. They would not set insurance premiums, rather negotiate rates for payment to providers.

Utilization review and other programs to control rates of use of services would remain, but it is assumed that, over time, quality measures related to outcomes would supplant such measures.

Third, and again simultaneously, capital pools by region should be established. These pools would have two purposes, to provide for annual capital replacement, and to retire debt for individual hospitals to make mergers and consolidation of providers more attractive.

Allocation from the capital pools would be through the agencies developed for rate control. Again, capital allocation mechanisms may disappear as competitive systems mature.

Fourth, government activity through the regional all payors system agencies should stimulate system formation by negotiating with existing systems and by calling for the development of new competitive systems. New systems will form in response to opportunities to gain or protect market share. Provider systems would delineate their markets in concert with government insurers and employers.

Federal antitrust laws would require revision. The creation of competitive, public utility-like,

organized systems in health care would lead to market concentration, but market concentration with a purpose.

Incentives for hospitals, physicians, home health agencies, and extended care facilities would include among others:

- Access to capital.
- Incentive payments for the achievement of defined goals.
- Risk sharing with insurers.
- Opportunities to expand their base of patients.

Arguments that the regulatory agencies will be too powerful are countered by two facts. First, they

are no less powerful and much more accountable locally than a federally controlled system. Second, they must be powerful to succeed.

Arguments that systems will not form or are not in sufficient numbers now are arguments against any change at all. In fact, the HMO movement grew by federal stimulus. In fact, incomplete systems, including HMOs, are abundant now.

Arguments that there are too few primary care providers nationally and in many local areas ignore the power of incentives to change many practice patterns of primary care practitioners and specialists alike.

Finally, arguments that it will not work in underserved urban areas or rural areas again ignores the power of incentives for institutional providers and individual practitioners. In fact, the reason for regional and state systems is to allow for local innovation and experimentation.

The argument for such an approach is that it is less draconian and more consistent with American political processes and, therefore, more likely to be acceptable than other suggestions if we are serious about solving the problems of cost, access and quality.

NEWS RELEASE

Johns Hopkins Medical Institutions

Office of Public Affairs
550 North Broadway / Baltimore, MD 21205 (301) 955-6680 / FAX (301) 955-4452

FOR RELEASE ON RECEIPT

OUTPATIENT CARE: A $140 MILLION HOPKINS INVESTMENT

With the opening of a new $140 million Outpatient Center, Johns Hopkins will relocate 10 specialty departments into a single building, providing a convenient, "seamless" medical experience for an estimated 1,200 patients each day.

To identify bottlenecks in patient flow, Hopkins developed a computer model to simulate up to 8,000 patient visits per week. Using this model, they were able to plan the amount of staffing needed to meet their objective -- that patients spend as much or more time with their doctor as on non-clinical activities, such as registration.

"We've tried to keep our patients' concerns first and foremost among all considerations," says Steven H. Lipstein, executive director of the Johns Hopkins Outpatient Center. "We've made it easy to park, we've introduced advance registration to speed up flow on the day of appointment, we've worked hard on layout and directional signage to make it easy to find your way. We've also grouped together diagnostic testing areas so that patients can get through quickly and efficiently."

Some 300 physicians will provide specialty care (not emergency or general medicine) in the new building, in areas such as obstetrics/gynecology, pediatrics, and urology.

Discussions about building such a center at Hopkins began in the mid-1980s, when, nationwide, advances in medical technology, the need to control costs, and changing insurance practices created a shift toward outpatient care. By 1987, detailed planning meetings were under way with physicians, nurses, and administrators.

Today at Hopkins, 55 percent of radiology and 39 percent of surgical procedures are performed on an outpatient basis, and the rates continue to grow each year. Since 1982, in fact, outpatient surgery has increased 30 percent, and last year was a near-record year at Johns Hopkins for total outpatient volume.

"Because many aspects of medical practice are shifting to an outpatient environment, this building is essential to our future," says Lipstein, who has worked on several pivotal projects at Hopkins during his 10-year career there.

(more)

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Room for growth was planned into the building, too. For example, while eight operating rooms have been constructed on the lower level, only six will open at first. Shell space has been constructed for expansion in radiology and for a Pain Treatment Center as well.

Lipstein emphasizes that this project is more than an investment in bricks and mortar. In outpatient services, it also represents an investment in new information systems for patient registration, appointment scheduling, ordering tests, and recording patient charges. Hopkins has mounted a major orientation and training effort for non-medical personnel who provide essential services to outpatients. About a dozen jobs -- registrars, receptionists, clerks, and a host of others -- have been collapsed into a single job title: patient service coordinator, Lipstein says.

"I can't over-emphasize the important role of our patient service coordinators," he says. "They are the first people to greet our patients, they are knowledgeable about patients' needs and our services and can provide needed assistance. As wonderful as the new building is, the building won't make the difference; our people will."

Nearly 800 employees throughout Hopkins have received training on the new computer registration system. In addition, all patient service coordinators will receive training in job skills (including the most up-to-date information on insurance regulations) and customer service skills. "It's been a big success, but also one of our largest challenges," says Bill Kent, director of administrative services for the center.

Patient service coordinators also will look the part in "career apparel" provided by Johns Hopkins. Women will dress in business suits and men in gray or navy blazers.

"The career apparel program is part of our commitment," says Lipstein. "We're doing it so patients recognize our employees -- and because we think it will increase the respect all employees are due."

In a unique ownership arrangement, the Outpatient Center is being financed jointly by The Johns Hopkins Hospital and University, which are two separate corporations. The building is owned as a condominium with three separate units. Areas such as radiology and surgery are owned by the Hospital; faculty offices and research labs by the University, on behalf of the School of Medicine. All other areas, such as exam rooms, are owned jointly.

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(For press inquiries only, call Carol Pearson or Joann Rodgers at (410) 955-5384.) Please note: Our area code is now 410 instead of 301. 4/6/92

NEWS RELEASE

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FOR RELEASE ON RECEIPT

OUTPATIENT CENTER AT JOHNS HOPKINS OPENS FOR BUSINESS MAY 18

A $140 million, eight-story Outpatient Center at Johns Hopkins will be dedicated May 8, and will open for business on May 18. The 450,000-square-foot building is designed to serve 1,200 patients a day, making it the biggest outpatient facility in Baltimore, and one of the largest in the Northeast. More important than the physical facility, however, the new Outpatient Center is expected to change the way Johns Hopkins does business.

With the opening of the center, patients will preregister at home, cutting waiting time on the day of their appointment. Upon arrival, patients will find nearby parking, be greeted by uniformed personnel, and guided by talking elevators. If a blood test or chest X-ray is necessary, it will be done in one convenient location. In addition to the streamlined clinic visit, conveniences such as a pharmacy, optical store, bank machine, and even a gift shop and coffee bar have been added.

It's all part of the "ideal patient experience," an idea culled from the suggestions of patients and staff alike. "As wonderful as the building is, the building won't make the difference, people will," says Steven H. Lipstein, executive director of the Outpatient Center. "We want to give patients personalized attention, to make them feel important and appreciated. They should spend more time receiving medical care than parking, walking, waiting, registering, and looking for the right bank of elevators.

Intensive planning for the facility began in 1987 and has included input from hundreds of people. In addition, Hopkins officials traveled throughout the United States, from Phoenix to New Orleans to Rochester, Minn., gathering ideas from eight centers. They borrowed the idea for advance registration from Duke University, for instance, while "career apparel" originated with the Ochsner Clinic in New Orleans.

"Collaboration between the School of Medicine and the Hospital have sharpened the Outpatient Center's focus on patient care and patient service," says Mark C. Rogers, M.D., associate dean for clinical practice and chairman of the center's management committee. "In developing this center, we have taken input from physicians, nurses,

(more)

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administrators, and the patients themselves. It represents our best thinking in the area of ambulatory care."

To prepare for opening day, employees have been training for the last year. A new computerized registration system called EPIC is now up and running in all of the clinics. A new job title, "patient service coordinator," was created for the team of nonclinical personnel working directly with patients. In addition to computer workshops, trainees will attend sessions to update knowledge of insurance regulations and customer service skills. Refresher courses are mandatory every six months.

In all, 10 specialty clinics--from dermatology to surgery--will move their outpatient practices from various locations inside The Johns Hopkins Hospital's 19 buildings to the new building located across the street, on the west side of Broadway. With the move, some departments will as much as quadruple their present space.

Designed by Payette Associates of Boston and built by George Hyman Construction Co., the building includes 191 exam rooms organized in clusters or "pods." Eight operating rooms are designed using the same pattern. The facility also is equipped with 68 procedure rooms, 28 radiology rooms, and 12 blood-drawing stations. A tunnel will connect the new building to the rest of the Hopkins complex, as well as to the subway station planned for completion in the mid-1990s.

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NEWS RELEASE

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JOHNS HOPKINS OUTPATIENT CENTER: THE ARCHITECTURE

The new 450,000-square-foot outpatient facility at Johns Hopkins, opening for business on May 18, is the largest of its kind in Baltimore, and one of the biggest outpatient facilities in the Northeast. Architects Payette Associates of Boston designed the building to be convenient for patients, energy efficient, and historically relevant to the Hopkins architecture it faces across Broadway.

Ground was broken by the George Hyman Construction Co. in January 1990, and the building opens four months ahead of schedule. During the construction phase, installation of the center's two MRI (magnetic resonance imaging) machines proved particularly challenging. Since the machines were not placed on the ground level, as is usually the case for MRI facilities, the building had to be structurally reinforced to hold the extra weight. Each of the machines' 16.5-ton magnets were lifted by crane through windows on the third floor with about six inches to spare. In addition, copper and steel shields were constructed to provide two-way protection from the powerful magnets--protecting people (and their credit cards and watches), as well as protecting the magnetic images from outside interference.

A tunnel beneath Broadway connects the Outpatient Center to the main Hospital. Last summer, four escalators for the concourse were lifted, swung 200 feet in the air, and then lowered into the tight space between the historic domed Billings Administration Building and the Wilmer Eye Institute on the east side of Broadway. The escalators are encased in a three-story, dome-shaped glass pavilion.

Inside the L-shaped, eight-story center, nearly 200 exam rooms are organized in clusters of four to six rooms, a pattern repeated throughout the building, even in the operating rooms. "We wanted use of the space to be flexible. For example, instead of knocking down walls when someone must move, the 'cluster' concept allows for easy conversion of office space to exam rooms and vice versa," says Anne Colevas, construction manager for the center, whose biggest challenge has been keeping the $140 million project on schedule and under budget.

(more)

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550 North Broadway/Baltimore, MD 21205
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Office of Public Affairs

TO: Writers, editors and producers

FROM: Carol Pearson

DATE: April 29, 1992

SUBJECT: PATIENTS' WISH LIST COMES TRUE AT HOPKINS' $140M OUTPATIENT CENTER

Critics call it the "malling" of American medicine, where health-care facilities become "retailers" and patients "customers"or "clients."

At the new Johns Hopkins Outpatient Center, there's none of the above. Patients are still patients and good medicine is not hustled like new cars. But there IS a new commitment to seeing to it that patients and their families have the easiest time possible when they come to this $140 million center for medical care.

That commitment means they'll find a quick, convenient place to park. They'll be able to register ONCE for everything, get all their tests -- X-rays, blood tests -- in one place. They'll be able to instantly recognize clerical employees by their attire, so they needn't hunt for someone to point them in the right direction or answer a question. And they'll get all the information they need before they even come for the appointment.

"The goal is a positive patient experience," says Steven Lipstein, director of the center. "We know that we can go a long way to reducing the stress, anxiety and frustration that often accompanies a visit for health care."

Lipstein and a team of planners, architects, engineers, health professionals and administrators combed the nation's hospitals and ambulatory care programs for the best ideas and brought them under one roof.

The Johns Hopkins Outpatient Center will be dedicated on May 8, at 2 p.m., and there will be a ribbon-cutting ceremony for the employees of the Hospital and School of Medicine May 11 at 2 p.m. The center will open its doors to the public on May 18. The enclosed materials should provide you background on all aspects of the center. If you are interested in an interview, a tour or other photo opportunities, please call me at (410) 955-5384 or (410) 955-6680.

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Office of Public Affairs

TO: Writers, editors and producers

FROM: Carol Pearson

DATE: April 29, 1992

SUBJECT: PATIENTS' WISH LIST COMES TRUE AT HOPKINS' $140M OUTPATIENT CENTER

The Baltimore Orioles aren't the only venerable Baltimore institution moving to new quarters this spring. One month after the opening of the new baseball stadium, Johns Hopkins physicians and nurses are picking up their stethoscopes and scalpels and moving across the street from The Johns Hopkins Hospital to the new building where they will see 300,000 outpatients a year. While the stadium cost $106 million, the price tag for the Outpatient Center and its high-tech equipment is $140 million.

More important than the facility itself, however, is the philosophy behind the new center. Its planners were committed to seeing that patients and their families have the easiest time possible when they come to the center.

That commitment means they'll find a quick, convenient place to park. They'll be able to register ONCE for everything, get all their tests -- X-rays, blood tests -- in one place. They'll be able to instantly recognize clerical employees by their appearance, so they needn't hunt for someone to point them in the right direction or answer a question. And they'll get all the information they need before they even come for the appointment.

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JOHNS HOPKINS OUTPATIENT CENTER

FACTS AND STATISTICS

- About 67,000 tons of concrete and 540,000 bricks were used to construct the JHOC.
- A piece of the Berlin Wall was mixed into the concrete for the building columns.
- It cost $140 million to build, equip, furnish and finance the center, and connect it to the Hospital with an underground concourse.
- The possible names for the building were reviewed with patients, who preferred the term "outpatient" to "ambulatory care."
- About 1,200 telephones and 300 computer terminals have been installed in the new building.
- The center will house 500 permanent employees, in addition to 300 physicians seeing patients in a typical week.
- Approximately 1,200 patients will be seen there each day, or about 300,000 a year.
- For conservation, the toilets in the center use only 1.6 gallons of water, compared with the usual five.
- At Johns Hopkins, 55 percent of radiology procedures and 39 percent of surgical procedures are performed on an outpatient basis.
- Outpatient surgery at Johns Hopkins has grown from 9 percent of all surgery to 39 percent since 1982.
- The eight-story Outpatient Center is equipped with 191 patient exam rooms, 68 procedure rooms, 28 radiology imaging rooms, 12 blood-drawing stations, and eight operating rooms.
- The center houses two MRI (magnetic resonance imaging) machines, which are unusual in that they were installed on the third floor, instead of at the ground level. The building is structurally reinforced to hold the weight of the machines' 16.5-ton magnets.
- The Outpatient Center building is named for Robert M. Heyssel, M.D., president of The Johns Hopkins Hospital and Health System, who is retiring June 30 after a 20-year career at the Medical Institutions.

American Hospital Association
AHA
Department of Media Relations
840 North Lake Shore Drive
Chicago, Illinois 60611

News Release

FOR IMMEDIATE RELEASE
CONTACT: Donna Gaidamak
312/280-6129

MOST SURGERY NOW OUTPATIENT

CHICAGO (April 21, 1992) — Of the 22 million surgeries performed in U.S. community hospitals in 1990, for the first time more were performed on an outpatient basis, rather than requiring a hospital stay, the American Hospital Association said today.

In 1980, there were 3 million outpatient (same-day) surgeries and nearly 16 million inpatient operations in hospitals. Ten years later, the situation dramatically shifted with the greater portion of surgeries not requiring hospitalization. In 1990, more than 11 million surgeries were outpatient and slightly less were done as inpatient procedures. These are some of the findings in "Ambulatory Care Trendlines: National Trends in Outpatient Surgery," an AHA report released today.

Fueled by technology and changes in reimbursement, outpatient surgery has continued to grow. "The development of increasingly sophisticated technology and the increasing prevalence of managed care are major factors in the shift from inpatient to outpatient surgery," said Irene Fraser, Director of AHA's Division of Ambulatory Care. "Managed care provides incentives to serve patients in an outpatient setting wherever possible."

Another trend cited in the AHA report is the increasing amount of outpatient surgery being performed outside the hospital. Hospitals performed more than 11 million of the 13.3 million outpatient surgical procedures performed in the U.S. in 1990, but their share of the total number of outpatient surgeries is declining.

-more-

In 1985, more than 90 percent of outpatient surgery was performed in hospital facilities, in 1990 it was 83 percent. Nonhospital-owned facilities performed 710,000 outpatient surgeries in 1985, and 2,320,000 in 1990.

Significant growth of all freestanding surgical centers is partially due to the increase of outpatient procedures that the federal government pays for under Medicare. In 1982, there were 450 approved procedures. This year, there are 2,500. Also, in some states, nonhospital-owned facilities are not subject to ~~the same~~ requirements that hospitals face in opening similar facilities.

The AHA, a not-for-profit organization, serves as a national advocate for hospitals and the patients they serve, provides education and information for its members, and informs the public about hospitals and health care issues.

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Editor's note: Copies of the AHA report are available for reporters and editors.

JOHNS HOPKINS OUTPATIENT CENTER

GUIDED TOUR

Lower Level: Outpatient surgery, including eight operating rooms, four preoperative exam rooms, and 12 preoperative holding cubicles.

Concourse Level: Patient services, including Freedom Pharmacy, Benson Optical Superstore, Gift and Coffee Shops, Meditation Room, and Express Testing, including six blood-draw stations, two EKG testing stations, chest X-ray room, and glucose tolerance testing room.

Plaza level: Cafeteria, Diabetes Center.

Third floor: Imaging, including two MRI units, two CT units, and four nuclear medicine scanners.

Fourth floor: Radiology, including special ultrasound and pediatric rooms, fluoroscopy, and general radiography; Breast Imaging Center, including three mammography suites, mammotest room for breast biopsy; Urology, with 11 exam rooms, four cystoscopy procedure rooms and urodynamics lab.

Fifth floor: Neurology/Neurosurgery, with 26 exam rooms, three EEG and four EMG rooms; Orthopedic Surgery, with 16 exam rooms, two radiology procedure rooms, and a cast room.

Sixth floor: Otolaryngology - Head and Neck Surgery, including speech pathology rooms, six audiology booths, two oral surgery exam rooms, and a hearing aid dispensary and repair service; Dermatology, including 16 exam rooms and a phototherapy suite.

Seventh floor: Adult Medicine and Surgery, including the specialties of internal medicine, endocrinology, genetics, nephrology, hematology, and kidney and liver transplants; Meyerhoff Center for gastroenterology and general surgery; Cardiology, including clinics for both adults and children.

Eighth floor: Gynecology and Obstetrics, offering services in general gynecology, obstetrics, gynecologic oncology, reproductive endocrinology, and nurse-midwifery; Pediatrics, offering diagnosis and treatment in 19 subspecialties, from allergy to speech pathology; Plastic surgery, including special expertise in breast reconstruction, cleft lip and hand disorders.

BIOGRAPHICAL SKETCH OF

ROBERT M. HEYSSEL, M.D.

Robert M. Heyssel, M.D. is President and CEO of the Johns Hopkins Health System and The Johns Hopkins Hospital. The Johns Hopkins Health System includes The Johns Hopkins Hospital and Outpatient Center, The Francis Scott Key Medical Center, the Johns Hopkins Geriatrics Center, a physician group practice which staffs some eighteen (18) outpatient centers in the Baltimore region, and Home Health Care programs.

Dr. Heyssel has appointments as Professor of Medicine at The Johns Hopkins University School of Medicine, and Professor of Health Policy and Management at The Johns Hopkins University School of Hygiene and Public Health. He is a Trustee of the Johns Hopkins Health System and The Johns Hopkins University.

Dr. Heyssel came to Hopkins in 1968 as Associate Dean and Director of Outpatient Services. He became Chief Executive Officer of the Hospital in 1972. Prior to that he followed a career in Hematology/Nuclear Medicine, serving for nine years on the faculty of Vanderbilt University where he was a recipient of the U.S. Public Health Service Career Development Award in medical research and Director of Vanderbilt's Radioisotope Center and Division of Nuclear Medicine and Biophysics. He was a senior assistant surgeon with the United States Public Health Service assigned to the Atomic Bomb Casualty Commission in Hiroshima and Nagasaki, Japan, investigating the delayed effects of radiation in humans.

Dr. Heyssel is a Fellow of the American College of Physicians and the International Society of Hematology. He is a member of the Institute of Medicine of the National Academy of Sciences, the Association of American Physicians and the Society of Medical Administrators. He has served on numerous government and foundation sponsored commissions and study groups in Baltimore, the State of Maryland and nationally. He is a member of the Board of Directors of the Signet Bank Corporation and the Monsanto Company.

Dr. Heyssel holds the Distinguished Alumnus Award of the University of Missouri and an honorary degree of doctor of science from St. Louis University. Born in Jamestown, Missouri, Dr. Heyssel received his B.S. degree from the University of Missouri and his M.D. degree from St. Louis University. He took advanced training at St. Louis University, Barnes Hospital, and Washington University School of Medicine in St. Louis. He is married, and he and his wife, Maria, have five children and eight grandchildren.

Robert M. Heyssel, M.D.

Robert M. Heyssel, M.D., is president and CEO of the Johns Hopkins Health System and The Johns Hopkins Hospital. As principal architect of the System, he guided the formation of the vertically integrated health care organization that now comprises the 1100-bed Johns Hopkins Hospital and Outpatient Center, The Francis Scott Key Medical Center, the Johns Hopkins Geriatrics Center, a physician group practice which staffs 18 outpatient centers in the Baltimore region and Home Health Care programs.

An expert in health system governance, Dr. Heyssel has been in the forefront of efforts to reform, reorganize and financially streamline health care. He has chaired the Commonwealth Fund Task Force on Academic Health Centers, the Association of American Medical Colleges and served on numerous national commissions, bringing his expertise to bear on quality assurance, decentralized managment, funding medical care for the poor and elderly, the impact of new payment schemes on hospital management and the interdependence of the teaching, research and patient care missions of academic medical centers.

His cross-disciplinary skills are reflected in his appointments as professor of medicine at The Johns Hopkins University School of Medicine, and of health policy and management at The Johns Hopkins University School of Hygiene and Public Health. He holds membership in the Institute of Medicine, the Association of American Physicians and the Society of Medical Administrators. He is a trustee of the Johns Hopkins Health System and The Johns Hopkins University and a fellow of the American College of Physicians.

Dr. Heyssel has sought and fulfilled broad roles in the Baltimore community in parallel with his efforts as a national leader. When he first came to Hopkins in 1968, the Hospital labored under the growing alienation common at that time to inner city institutions and their neighbors. First as associate dean and director of outpatient services, then as head of the Hospital, he made a commitment to forming long-term partnerships with the East Baltimore Community. He made it forcefully clear that The Johns Hopkins Hospital was a community hospital as well as a national center of excellence. With colleagues, he visited virtually every physician in the community and helped establish the East Baltimore Medical Plan to better meet the health care needs of the area.

An early and strong supporter of black cardiac surgeon Levi Watkins' decade-old annual tribute to Martin Luther King, Jr., he assured the continuation of this program that has brought Bishop Desmond Tutu, Zenani Mandela Dlamini, Coretta Scott King, Rosa Parks and Stevie Wonder to address Hopkins employees.

Dr. Heyssel created the Clarence "Du" Burns Community Service Award honoring Baltimore's first black mayor, who worked with Hopkins as an East Baltimore community advocate and City Councilman. Dr. Heyssel marshalled the Jefferson and McElderry courts Housing Development project to increase affordable housing for Hopkins' neighbors, and committed $150,000 this year to a new Community Health Initiative pledged to take its marching orders from community leaders.

Born in Jamestown, Missouri, Dr. Heyssel received his B.S. degree from the University of Missouri and his M.D. from St. Louis University. His early career in hematology and nuclear medicine earned him a U.S. Public Health Service Career

Development Award in medical research and appointment as director of Vanderbilt University's Radioisotope Center and Division of Nuclear Medicine and Biophysics. He was a senior assistant surgeon with the PHS assigned to the Atomic Bomb Casualty Commission in Hiroshima and Nagasaki, Japan, investigating the delayed effects of radiation in humans.

A member of the Board of Dirctors of the Signet Bank Corporation and the Monsanto Company, he and his wife, Maria, have five children and eight grandchildren.

MICHAEL M.E. JOHNS, MD.
DEAN, THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE

Michael M.E. Johns, M.D., has been Dean of The Johns Hopkins University School of Medicine and Vice-President for Medical Affairs at The Johns Hopkins University since July, 1990.

He came to Johns Hopkins in 1984 from the University of Virginia to be chairman of the Department of Otolaryngology-Head and Neck Surgery. Trained as a head and neck oncologic surgeon, Dr. Johns received joint appointments in the departments of oncology and neurological surgery. In 1986 he also was named Associate Dean for Clinical Practice, with responsibility for managing and coordinating the clinical practice activities of the entire medical faculty as well as the responsibility for planning and developing the new outpatient center.

A specialist in the management of head and neck tumors, Dr. Johns has achieved an international reputation as a cancer surgeon and for his studies of the effects of a variety of treatments, including surgery, radiation therapy and chemotherapy, on improving the survival rates of these patients. He has made major innovative contributions to the field of skull base surgery and has published over 150 papers and chapters in scientific journals and books on a range of issues dealing with the epidemiology, diagnosis, staging, treatment and outcome of head and neck cancer.

His honors include the Young Surgeon Award from the Virginia Chapter of the American College of Surgeons, the Annual Recognition Award from the Speech and Hearing Association of Virginia, the Honor Award from the American Academy of Otolaryngology-Head and Neck Surgery, and the Fowler Award from the American Triological Society.

Dean Johns has served on the editorial boards of several scholarly journals, including the Archives of Otolaryngology and the Journal of the National Cancer Institute, and as a reviewer for the New England Journal of Medicine. He has recently been appointed the Editor of the Archives of Otolaryngology-Head and Neck Surgery. A governor of the American College of Surgeons, he is a member of the Advisory Council for Otolaryngology, President-Elect of the American Society for Head and Neck Surgery, a director of the American Board of Otolaryngology, and the executive secretary of the Triological Society. He has served as president of the Society of University Otolaryngologists and the Maryland Society of Otolaryngology-Head and Neck Surgery. He has served on the steering committee of the Group on Faculty Practice of the AAMC. He currently chairs the AAMC Ad Hoc Committee on Physician Payment Reform. He has participated on numerous national committees.

After completing a Bachelor of Science degree in Biology at Wayne State University in his hometown of Detroit in 1964, Dr. Johns went on to receive his degree

with distinction from the University of Michigan Medical School. Following his internship and residencies in surgery and otolaryngology in Ann Arbor, he joined the Medical Corps of the U.S. Army and served as assistant chief of the Otolaryngology Service at Walter Reed Army Medical Center while on active military duty from 1975 to 1977. From 1977 to 1984, when he moved to Hopkins, he was on the faculty of the University of Virginia Medical Center in Charlottesville.

Mike Johns and his delightful wife Trina have been married for twenty-five years. They have two children: Christina - a ~~first~~ second year student at The Johns Hopkins University School of Medicine, and Michael - currently a pre-medical student at the University of Virginia.

Preventive Medicine Residency Program

STEPHANIE SHIELDHOUSE

Public Health

The Magazine of
The Johns Hopkins
School of Hygiene
and Public Health

Winter 1991

Pat Chaulk, Chief Resident

JEFF BRELAND

Pat Chaulk, chief resident in the Preventive Medicine Residency Program

"DISEASE PREVENTION and health promotion are concepts whose time has come," says Pat Chaulk.

"As we become more concerned about rising health care expenditures, more and more people are looking seriously at ways that prevention strategies can help cut back these rising costs."

Armed with the U.S. Preventive Services Task Force Report, which is the consensus on screening and counseling patients, "We've taken a large step forward. Now the mindset of insurance providers needs to change to make 15 minutes of counseling a patient reimbursable," says Chaulk.

Right out of college, he worked on Capitol Hill with Ralph Nader and spent seven years in a variety of policy-related jobs concentrating on health and the environment. He returned to college, took premed courses and entered medical school. He then completed a pediatric residency at the University of Nebraska Medical Center, where he also received a grant to study child day care issues. Through the grant, he developed health interventions, which he promoted through videos and other teaching aids.

He chose the Hopkins residency program for many reasons but says he was attracted because he knew of Karen Davis, Ph.D., chairman of the Department of Health Policy and Management, and other role models who are involved in policy issues.

After his M.P.H. year, Chaulk spent four months working with the staff of the Governor's Commission on Health Care Policy and Financing, which is examining ways to meet the health care needs of the uninsured. His next rotation was with a Hopkins residency alumnus at a pharmaceutical company in Philadelphia, where he provided clinical care and suggested ways for the company to offer day care services for employees. He also wrote prevention-related stories for in-house publications.

He finished the practicum year through a rotation with the Department of Epidemiology helping to put together an HIV-AIDS Surveillance Manual for mid-level field workers in Africa and developing nations. Funded by the World Health Organization, the manual is to be tested in Rwanda, Kenya and Malawi.

In June, he received the Burroughs-Wellcome A.M.A. Resident Leadership Award at the American Medical Association meeting for his volunteer work in day care-related issues and with the Maryland Committee for Children. His project included an assessment of the day care needs of the Baltimore community.

HMO PRACTICE

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Johns Hopkins Ambulatory Care Groups

A Case-Mix System for UR, QA and Capitation Adjustment

WEINER— A new ambulatory case-mix system developed by researchers at Johns Hopkins University has potential for use in HMOs. In addition to assisting with the analysis, financing and management of care, ACGs can also be used in clinical areas such as utilization and quality management. **PAGE 13**

SECTION EDITOR
Edward H. Wagner, MD, MPH

Johns Hopkins Ambulatory Care Groups (ACGs)

A Case-Mix System for UR, QA and Capitation Adjustment

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This paper describes a new ambulatory case-mix system developed at The Johns Hopkins University and known as Ambulatory Care Groups (ACGs). ACGs categorize a person into one of 51 categories based on the diseases and conditions for which they received treatment over a period of time, such as a year. ACGs can be used to describe the "illness-burden" of a population and are up to ten times more predictive of ambulatory care resource use than age and sex alone. ACGs can be determined using a computerized "grouper" software package based on ICD-9-CM diagnosis codes and demographic information presently found in virtually all claims or encounter data systems. They were developed and tested at four HMOs and a state's Medicaid program. This paper discusses the potential application of ACGs to analysis, financing, and management of ambulatory care, specifically as it relates to utilization review (UR), quality assurance (QA) and the adjustment of capitation payment within managed care settings. (Key words: Ambulatory care, Case-mix, Capitation, Utilization review, Quality assurance)

The structure of the American health care system has created strong incentives for providers to develop and utilize advanced medical procedures and services. The positive impact of this is undisputed. However, these advances have not occurred without undesired consequences, the most significant of which are financial; costs have been spiraling out of control for the past decade.

Efforts to contain the rise in health care expenditures and to achieve efficiency have taken many forms, including altering the unit of payment, development of utilization controls, and restructuring the organizational framework within which health care is provided. More specifically, payment increasingly is pre-paid or pre-determined; HMOs, preferred provider organizations (PPOs), and private and public insurers are "managing" the provision of medical care, largely by profiling and monitoring physicians' practices. The locus of care has switched away from the hospital and has moved towards ambulatory care.

ILLUSTRATION: ROBERT BYERS

These trends have led to an increase in the importance of population-oriented perspectives, particularly as they relate to ambulatory care. In turn, this has led to a demand for relevant case-mix measures that can assist in comparing groups of patients in terms of their utilization experience, morbidity, or health care expenditures. While approaches have been applied to

adjust for case-mix differences in the provision of hospital care (e.g., DRGs), similar approaches have been not been applied on a wide scale in the ambulatory care environment.[1,2]

An effective ambulatory care case-mix approach can be expected to have many applications for payment, utilization review (UR), quality assurance (QA), and management. Moreover, many analysts believe that without such methods of case-mix adjustment, the growth of prepaid and managed health care approaches will be stymied by allegations of inequities due to "biased" selection; that is, where it is perceived that the patients served by managed care plans are "healthier" than those receiving care elsewhere.

SECTION EDITOR'S COMMENTS

Clinical/Outcomes Research

Edward H. Wagner, MD, MPH
SECTION EDITOR

This section has the audacious goal of trying to change the way care is provided by the nation's leading HMOs, since these are increasingly being viewed as national models for innovation in health care delivery. We hope to change care by presenting empiric evidence that supports changes in care delivery. Such data will pertain to both problems with current delivery approaches and system successes (innovations). Successes include systematic clinical approaches to providing care for specific health problems, new ways of generating and using information to manage care, or changes in practice organization that contribute to improved outcomes. Key outcomes include (in descending priority) patient health and function, patient satisfaction, provider satisfaction, and cost.

The "Clinical/Outcomes Research" section will give emphasis to papers that present fresh data and use sound research designs and methods to generate that data.

On first glance, it may seen odd to inaugurate a section devoted to clinical research and changing care with two papers that will strike many clinicians as dealing more with health economics than clinical care. Further reading will reveal that these papers describe efforts to make sense out of the chaos of ambulatory care by defining subsets of patients sharing common clinical problems and care requirements. They also recognize groups of patients who are costly in terms of dollars and provider time where one might direct early practice improvement efforts.

Many clinicians and clinical trainees are finding ambulatory care to be more and more stressful, and less and less satisfying. Ambulatory care, especially primary care, tends to be reactive and unplanned, the day defined by who happens to be sitting in the waiting room. Stressed providers are feeling the need to gain better control of care and provider satisfaction, especially in "managed care organizations,"would be to manage care—i.e., plan and organize practice resources to better meet the needs of important patient groups. Although the objectives and methods of the papers in this section are quite different, the logic is similar. Enrollee populations are clinically diverse, but clinical problems and geographic characteristics define groups requiring very different intensities of care. The papers show how these groupings might be used to help manage resources. They just might help manage patients as well.

Submissions should be sent to the Editor, HMO PRACTICE, *Health Care Plan, 900 Guaranty Building, Buffalo, NY 14202.*

Dr. Wagner is the Director of the Center for Health Studies at Group Health Cooperative of Puget Sound and Professor of Health Services with the University of Washington School of Public Health and Community Medicine.

OVERVIEW OF THE AMBULATORY CARE GROUP SYSTEM

This article, targeted at clinicians and managers, describes a new ambulatory case-mix measure and some of its potential applications for health care financing, UR, and QA. The Johns Hopkins Ambulatory Care Group (ACG) system, provides a conceptually simple, statistically valid, and clinically relevant measure useful in predicting the need for ambulatory health care services. ACGs are based on the premise that a measure of a population's "illness burden" can help explain variation in health care resource consumption. ACGs represent a simple method for categorizing persons based on their age, sex, and ICD-9-CM diagnoses assigned during their contacts with the delivery system.

The development and validation of the ACGs relied on the analysis of computerized encounter/claims data obtained from five separate large "enrolled" population groups (total sample size 150,000).* Four of the populations came from HMOs; the fifth from the Medicaid program of the State of Maryland. The test organizations included the:

- Columbia Medical Plan (Maryland)
- Harvard Community Health Plan (Boston)
- Med-Centers Health Plan (Minneapolis)
- Maxicare (Los Angeles)
- Maryland Medicaid

ACGs represent a methodology for clustering ambulatory ICD-9-CM diagnostic codes. The overall theoretical goal of ACG assignment is to cluster similar conditions based on their expected impact on health care services resource consumption. The first step in the grouping process is the assignment of over 6,000 ICD-9-CM diagnostic codes to one of 34 clusters. These clusters are termed Ambulatory Diagnostic Groups, or ADGs. Table 1 displays examples of some of the ADGs and some diagnoses commonly

* *Note: Other organizations have successfully applied ACGs since the development phase.*

assigned to them. The process was guided by clinical judgment and statistical analysis to cluster different conditions into a single ADG. In relative order of importance, the clinical criteria for assigning conditions were as follows:

- The expected persistence/recurrence of a condition over time;
- The likelihood that the patient would make a return visit to continue treatment for a condition;
- The likelihood that a specialty referral would be required;
- The expected need and cost of diagnostic and therapeutic procedures associated with a condition;
- The likelihood that the patient would require hospitalization for a condition during the near term;
- The likelihood that a condition would result in either short-term or long-term disability; and
- The likelihood that a condition would lead to decreased life-expectancy, either over the short or long term.

During a single year, a patients' diagnoses may place them into anywhere from 1 to 34 distinct ADGs. That is, ADGs are not mutually exclusive and there are potentially as many different unique ADG combinations as there are combinations of the 34 categories (i.e., over a million). In order to develop a system for practical use, it is necessary to collapse this huge number of possibilities into a manageable number.

The DRG development process served as a general model for the reduction of the data into ACGs. The 34 ADG categories were collapsed into twelve "Collapsed ADGs", or CADGs. Each CADG is a group of ADGs that is similar with regard to the likelihood of persistence or reoccurrence of the diagnoses within them. Based on the combination of CADGs, patients are then assigned to a clinically logical, mutually-exclusive grouping that we termed Major Ambulatory Categories or MACs. These categories are roughly analogous to the Major Diagnostic Categories (MDCs) used in the DRG system.

After each patient was assigned to a single MAC, the use of statistical variance reduction techniques resulted in the further splitting of some of the MACs into one of 51 mutually-exclusive ACGs based on their age, sex, and combination of ADGs. Table 2 displays several examples of ACGs. Interested readers are referred to two more detailed descriptions of the ACGs and their development.[3,4]

To summarize, the ACG "grouping" process involved four stages of categorization:

1. ICD-9-CM-CM codes are assigned into one of 34 Ambulatory Diagnostic Groups (ADGs);
2. Similar ADGs were "collapsed" into twelve Collapsed ADGs (CADGs);
3. Based on the combination of CADGs, the patient is placed into one of 25 mutually exclusive Major Ambulatory Categories (MACs); and
4. Based on age, sex, presence or absence of certain individual ADGs, and number of individual ADGs, persons within some MACs were further partitioned.

Ultimately, each person was categorized into one of 51 mutually exclusive ACGs. (All of this is handled automatically by a "grouper" software program that runs either on a PC or mainframe).[5]

At the five test sites multiple regression techniques were used to explore the explanatory/predictive power of the ACG casemix system. The results of these analyses allowed us to document the degree to which the ACGs (and their components) can be used to explain the variation in ambulatory care resource consumption.

The summary of key multivariate regres-

TABLE 1

Examples of the 34 Ambulatory Diagnostic Groups (ADGs)

AMBULATORY DIAGNOSTIC GROUP	COMMON DIAGNOSIS
▶Time Limited: Minor	▶Dermatitis
▶Time Limited: Major	▶Synovitis
▶Likely to Recur: Progressive	▶Diabetic Ketoacidosis
▶Chronic Medical: Stable	▶Hypertension
▶Chronic Medical: Unstable	▶Coronary Atherosclerosis
▶Psychosocial: Chronic	▶Depression
▶Signs/Symptoms: Minor	▶Headache
▶Malignancy	▶Malignant Skin Neoplasm

TABLE 2

Examples of some Ambulatory Care Groups (ACGs)

▶ACG 1	Acute minor condition(s) only, age less than two
▶ACG 6	Likely to recur condition(s) and allergies
▶ACG 13	Psychosocial condition(s) only, but no major psychiatric diagnosis
▶ACG 17	Acute minor condition(s) and chronic medical-stable condition(s)
▶ACG 43	Four or five different ADGs, age 17-44

TABLE 3

Summary of Explanatory Power of ACGs and its Components by Type of Regression Model, Site, Dependent Measures, and Year

	DEPENDENT MEASURES				
	Ambulatory Visits		Ambulatory Charges		Total Charges
	Year 1	Year 2	Year 1	Year 2	Year 1
▶*Model A: Age-group, sex*					
Columbia Medical Plan	.05	.05	.03	.03	
MedCenters Health Plan					.04
Maxicare	.06		.06		
Harvard Community Health Plan	.03				
▶*Model B: Age-group, sex, ADGs*					
Columbia Medical Plan	.59	.23	.46	.21	
MedCenters Health Plan	.52		.47		.19
Maxicare	.57		.49		
Harvard Community Health Plan	.40				
Medicaid	.48		.42		
▶*Model C: 51 ACGs*					
Columbia Medical Plan	.50	.20	.38	.18	
MedCenters Health Plan	.44		.38		.15
Maxicare	.45		.39		
Harvard Community Health Plan	.32				
Medicaid	.42		.34		

(All figures represent adjusted R-square of linear regression equations.)
Note: R-squares are roughly equivalent to percent of variance explained by each model.

sion analyses exploring the explanatory/predictive power of ACGs and their components is presented in Table 3. This table summarizes the results of the statistical model that attempts to explain variation in annual ambulatory visit rates and charges at the five research sites. The dependent (outcome) measures included:

- ▶ annual face-to-face ambulatory visits;
- ▶ annual ambulatory charges—which included all professional fees and ancillary costs; and,
- ▶ ambulatory charges as well as all charges associated with inpatient care.

At each site we attempted to explain these three resource measures during the same year (year 1) for which we determined the independent (explanatory) variables. At one site (CMP) we were also able to use the year-1 independent variable to predict the second year's (year 2) resource use. Based on three models, Table 3 presents the R-squared statistic for each of the resource variables indicated. The R-squared can be considered roughly equivalent to the percentage of the variation in the dependent measure explained by the independent variables included in each model.

The first model (model A) included only age and sex of the enrollee as explanatory (independent) variables. This model suggests that for the three dependent measures, the variation explained by these commonly applied demographic variables is limited to about 5%.

The second model (model B) incorporated each of the 34 individual ADGs, age, and sex. The results across the two years suggest that ADGs explain more variance in utilization for the year in which they were assigned (i.e., up to 59%) than for utilization in the subsequent year (i.e., up to 23%). The results also suggest that ADGs have a somewhat greater predictive ability for visits than they do for ambulatory charges. The explanatory power for total charges is significantly lower (19%) but still almost five times that of age and sex alone.

The final model (model C) shows the degree to which the mutually exclusive ACGs explain variance. This suggests that ACGs can explain up to 50% of certain resource use measures, or ten times the explanatory power of age and sex alone.

The explanatory power of ACGs (model C) is somewhat lower than the model (model B) using ADGs combined with age and sex. This suggests that in developing the mutually-exclusive fixed ACG categories from the non-mutually exclusive ADG clusters, a proportion of explanatory power was lost. This is to be expected given that the number of ACGs (51) is significantly smaller than the millions of potential ADG, age, sex combinations. Given that most non-research applications of case-mix require a fixed number of categories (rather than multivariate statistical technique) this modest loss in predictive ability should be considered a reasonable trade-off. (It is suggested, however, that applications relying on multivariate analyses (e.g. regression) should use ADGs, age and sex, rather than ACGs.)

POTENTIAL APPLICATIONS OF ACGS

Throughout the last decade, a great deal of emphasis has been placed on analyzing the utilization and cost of inpatient care. For example, most methods used to assess illness severity or predict resource consumption have focused on hospital-based services. Hospital stays are much easier to categorize: the episodes of care have discrete starting and ending points; the cost per episode is relatively high; and inpatient databases are relatively well developed.

In contrast, the evaluation of ambulatory care poses numerous difficulties: there are many more settings with many more providers; the endpoint is ill-defined; there are a large number of units of services with relatively small costs per unit of service; and defining an ambulatory episode of care, particularly when patients have multiple conditions, is problematic.[1,6] For these reasons, focusing an analysis only on the patient visit usually will not yield meaningful results. ACGs are designed to overcome many of the limitations inherent in a visit-oriented assessment of ambulatory care by taking into account the complete illness profile of a patient across a period of time (e.g., one year).

Because they focus on persons and populations (or beneficiaries), it is likely that HMOs, PPOs, and other public and private health insurance plans will have the greatest use for the ACG system. ACGs are particularly well-suited to plans employing managed care methods or capitation payment. For example, health plans, or physician groups participating in them, can use ACGs to evaluate care provided to the beneficiaries/patients they serve or tailor capitation or premium rates. ACGs will probably not be useful for payment or analysis at the level of the individual patient encounter or service. Visit-based ambulatory case-mix and severity systems such as Ambulatory Patient Groups (APGs),[7] Products of Ambulatory Care (PACs),[8] and the Ambulatory Severity Index (ASI),[9] should be more applicable to this purpose. The next sub-sections describe several potential applications of The Johns Hopkins Ambulatory Care Groups.

Setting Capitation or Premium Rates. In the past, HMOs relied mainly on community rating to prospectively determine premiums for member groups. In response to pressure from employers and others, many HMOs are increasingly applying alternative rating mechanisms, such as community rating by class (CRC) or adjusted community rating (ACR). Both CRC and ACR rating attempt to prospectively adjust the community rate by incorporating selected characteristics of the group (such as age and sex) to be covered. The ACG system could be used as a basis of these and similar rating techniques to adjust capitation or premium rates for the predicted morbidity of a population of enrollees selecting a particular health benefit plan or delivery site within a plan.

Tables 4 and 5 display a comparison of ACG-derived capitation rates to two other approaches. Table 4 presents the actual year-1 and year-2 ambulatory care charges and alternative capitation rates for five enrollee sub-groups selected at one HMO. These groups were selected on the basis of their resource consumption during year-one, where group "A" used the least services and group "E" the most. The three alternative year-2 capitation rates for each sub-group were calculated by using:

- a "community rate," where the amount paid per-capita is equal across sub-groups and is based on the previous year's HMO-wide average ambulatory charge (plus an inflation adjuster);
- an age-sex adjusted rate, where the sub-group's rate is based on the previous year's use within age/sex "class" (plus inflation); and
- an ACG adjusted rate, where rates are calculated on the basis of the previous year's use within ACG "class" (plus inflation).

Table 5 assesses how well each alternative capitation rate (based on year-1 characteristics) predicted the actual year-2 charges. A percentage of "100%" indicates that the

TABLE 4

A Comparison of Actual Ambulatory Charges With Capitation Rates Calculated by Three Approaches

HMO ENROLLEE GROUP	ACTUAL CHARGES		ALTERNATIVE CAPITATION RATES FOR YEAR 2		
	Year 1	Year 2	Community	Age-Sex	ACG
A	$ 25	$ 221	$ 452	$ 417	$ 130
B	133	291	452	433	310
C	150	363	452	442	441
D	420	480	452	495	547
E	1055	860	452	487	818
Plan-Wide Avg.	389	452	452	452	452

TABLE 5

The Three Alternative Capitation Rates as a Proportion of the Actual Average Year-2 Ambulatory Charges

HMO Enrollee Group	ALTERNATIVE CAPITATION APPROACH Community	Age/Sex	ACG
A	205%	189%	59%
B	155	149	107
C	125	122	113
D	94	103	114
E	53	57	95

(Figures Represent Capitation Rate Divided by Actual Year-2 Charges x 100)

capitation rate was equivalent to the actual charge. Table 5 shows that ACG adjusted capitation rates, in general, are significantly closer to the actual year-2 charges than either the community rate or age/sex CRC approach. Both community and age/sex-adjusted CRC ratings result in capitation rates that are highly skewed with respect to many enrollee groups. It should be noted, however, that the ACG method is skewed for the "A" enrollee group; based on their year-1 experience, this group of very low utilizers were not, on average, categorized into many "serious" ACGs. This regression to the mean is expected, since all members of a "very healthy" group are unlikely to remain "very healthy" from year to year. It appears that capitation rates for people in very low ACGs would have to be adjusted upward to compensate for this.

TABLE 6

An Application of ACGs as a Mechanism for Adjusting Utilization Review Measures at an HMO

	(1) Avg. Amb. Charges for Sub-Group	(2) Sub-Group Avg. ÷ Actual HMO Avg.	(3) Sub-Group Avg. ÷ Age-Sex. Adj. Expected Avg.	(4) Sub-Group Avg. ÷ ACG Adj. Expected Avg.
▶Enrollee Sub-Group A	$ 133	.34	.36	.50
▶Enrollee Sub-Group B	420	1.08	1.06	.89
▶Enrollee SubGroup C	1055	2.71	2.49	1.49
▶Overall HMO Average	389			

Utilization Review (UR)

ACGs can be used as a method for adjusting utilization review measures across providers or organizations when there is question about one cohort of patients being sicker than another. For example, when profiling providers' patterns of practice (e.g., based on claims data), ACGs might be applied to adjust for differences associated with varying morbidity levels across physicians' caseloads.

Table 6 displays such an application of ACGs. It compares unadjusted and adjusted UR screening ratios derived from practice profiles. These "screens" are based on the average (per person) annual ambulatory charges (including both professional fees and ancillary services) within three enrollee sub-groups at one HMO. Each of the three populations have different use patterns—low, medium, or high—when compared to the overall plan average.

For total ambulatory charges, the four columns of Table 6 represent:

1. the average annual per person charge for each enrollee sub-group;
2. the ratio of this sub-group's average to the unadjusted mean for all HMO enrollees (which include enrollees outside these three sub-groups);
3. the ratio of actual charges to the expected* age/sex adjusted average of each sub-group; and
4. the ratio of the actual charges to the expected* ACG adjusted average of the persons in the sub-group.

Note that ACG-adjustment (column 4) tends to bring the UR screening ratios closest to 1.00 (i.e., where the sub-group's use is the same as the HMO-wide average). Without any adjustment (column 1), the patients in sub-group "C" appear to be receiving 2.71 times the average resources. After charges have been adjusted using age and sex, the ratio indicates that these patients are receiving 2.49 times the expected average. After ACG adjustment, the ratio suggests that the patients are receiving only 1.49 times the expected. These types of analyses could readily be performed for populations cared for by a single physician, a panel of physicians, or those practicing within a particular geographic location.

Quality Assurance (QA)

Many quality assurance activities revolve around the development of profiles of patterns of practice (i.e., process of care) or patient outcomes associated with one or more disease entities. One stumbling-block associated with this approach is the inability to adjust for severity of illness across different groups of patients. ACGs could be used to control, at least to some degree, for case-mix differences across groups of patients, particularly as they relate to varying disease burdens or co-morbidities. For example, when monitoring specific outcomes of care for diabetics across individual providers or groups within an insurance plan, ACG adjustment could assist in controlling for co-morbidities across the different patient cohorts. Furthermore, as is sometimes done with inpatient severity measures, ACGs might also be compared across two points in time as a prognostic indicator of change within a population's morbidity status.

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* *The expected rates were determined by multiplying the number of persons in each age/sex or ACG "cell" by the average plan-wide charge for all persons with the same characteristics as persons in that cell.*

Another potential—though untested—application of ACGs relevant to quality might be as a prospective tool to identify patients with special needs. Individual primary care practitioners or medical directors could use the system to identify patients who are likely to require more attention (and resources) than others because of their high morbidity-burden. Based on this selection approach, it might be possible to better match patients to clinicians or to offer special case management. For example, primary care physicians specializing in patients with multiple or unstable morbidities would not be expected to care for as many patients as physicians without a preponderance of patients in such "sicker" ACG categories.

THE FUTURE OF ACGS

The Johns Hopkins Ambulatory Care Group methodology reported here represents the culmination of years of research, development and testing and involves input from many clinicians and researchers. Nonetheless, assessing this measure's full potential awaits continued application and testing in a wide range of health care settings. The ACG system, which can be calculated on the basis of existing computerized claims data, will facilitate the application of case-mix adjustment to ambulatory care. We believe that this new technology will allow providers and insurers to manage health care resources more effectively and equitably than ever before.

REFERENCES

1. Gold M. Common sense on extending the DRG concept to pay for ambulatory care. *Inquiry* 1988;25:281-289.
2. Smithline N and D. Arbitman (eds.). Ambulatory case mix classification systems. *J Ambulatory Care Management* 11 (Summer 1988).
3. Weiner J, Starfield B, Steinwachs D. Development and application of a population oriented measure of ambulatory care case-mix. *Medical Care.* 1991;29:452-472.
4. Starfield B, Weiner J, Mumford L, Steinwachs D. Ambulatory care groups: a categorization of diagnoses for research and management. *Health Services Research* 1991;(26):54-74.
5. Johns Hopkins Health Services Research and Development Center. ACG "Grouper" Software, Baltimore, Md. 1991.
6. Weiner J. Ambulatory case-mix methodologies: application to primary care research. In Grady, M. (edt.) Primary care research: theory & methods USDHHS, U.S. Agency for Health Care Policy and Research, AHCPR Publ #91-0011, Rockville, MD, 1991.
7. Averill R, Goldfield N, McGuire T, et. al. Design and evaluation of a prospective payment system for ambulatory care. (Wallingford, Connecticut: 3M-Healthcare Information Systems, Inc.), HCFA Contract 17-C-99369/1-02.
8. Tenan P, et al. PACs: classifying ambulatory care patients and services for clinical and financial management. *J Ambulatory Care Management* 1988;(11):36-53.
9. Horn S, Buckle J, and Carver C. Ambulatory severity index: development of an ambulatory case-mix system. *J Ambulatory Care Management* 1988;(11):53-62.

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A PUBLICATION OF THE JOHNS HOPKINS MEDICAL INSTITUTIONS VOLUME 40 NUMBER 4 SUMMER 1990

INSIDE

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Special tribute:
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Star-studded "Dick Tracy" premiere benefits Hopkins, p. 8

◀ Hopkins celebrates top honors earned in three national surveys published recently in Business Week and U.S. News & World Report.

The Housekeeping Department uses more than 6,000 gallons of wax each year to polish the Hospital's floors. (See the department's new director, p. 4.)

Tons of Broadway dirt, excavated for the Metro by the MTA, will be used in construction of the new stadium grounds at Camden Yards (see Update, p. 2).

A HOPKINS FIRST

Thirty years ago, DOME reported closed cardiac chest massage (now known as CPR) was developed by Hopkins physicians William Kouwenhoven, James Jude, and Guy Knickerbocker. According to the Journal of the American Medical Association, the manuscript Kouwenhoven and his colleagues published describing their new technique "may have resulted in saving more lives than any other medical manuscript during the past century."

HOPKINS TOPS POLLS

We came out on top in survey after survey ranking the nation's hospitals and medical schools for everything from academics to quality of nursing.

High marks come from such nationally prominent sources as *U.S. News & World Report* and *Business Week*, as well as government agencies. For example, *Business Week* recently singled out Robert M. Heyssel, president of the Hospital and Health System, as one of the nation's five best managers in the health service field. The article, "Profiting from the Non-Profits," cited the lessons company managers can learn from well-run institutions like Hopkins.

One characteristic of a good manager, says *Business Week*, is the ability to articulate clearly the organization's overall mission — a task that Heyssel puts high on his agenda. "I'm happy to be included on the list," he says, "but it's important for employees at every level to get the credit for making Hopkins a place that knows where it's going and why — to provide the best patient care of any hospital here or abroad."

According to *U.S. News & World Report*, we're close to achieving that goal. The magazine recently sang our praises in two different surveys — one ranking the nation's hospitals and one comparing medical schools. In these surveys, both Hospital and Medical School received some of the highest ratings of any medical institution in the country.

To rank the nation's hospitals, *U.S. News* asked 400 doctors coast to coast to name the 10 leading hospitals in their specialties. Fifty-seven hospitals (out of 6,500) were mentioned often enough to make the final list of "the best of the best." Hopkins was number two.

In addition, 10 of 12 clinical areas were considered top notch by the specialists in the survey — a very close second to Minnesota's Mayo Clinic, which had 11 clinical specialties recognized as outstanding by the doctors surveyed.

The Hopkins departments of ophthalmology and urology received the highest praise. They were number one on their respective lists, which means the doctors surveyed cited Hopkins more often than any other hospital for excellence in those areas. In fact, 92 percent of them listed the Hopkins ophthalmology department as among the best — by far the highest score given to any department at any hospital in the country.

Hopkins ranked among the top two institutions in the U.S. for treatment of AIDS and cancer. Other areas at Hopkins that won special commendation from doctors surveyed were cardiology, gastroenterology, neurology, otolaryngology, pediatrics, and rheumatology.

Hopkins was high on a list of bests in another *U.S. News* survey, this one rating the country's graduate schools. Out of America's 124 medical schools, Hopkins ranked second in academic reputation for producing outstanding students. Harvard topped that list, and Duke came in third. "I think the survey was wrong about us," says Richard S. Ross, M.D., dean emeritus of the School of Medicine. "We're number one in terms of having the best balance between research, education, and good patient care."

The same graduate program survey rated our Biomedical Engineering Department as the country's very best. It was number one on a list of five winning departments in that field, followed by Duke and MIT.

The experts who review U.S. government grant proposals obviously are impressed with Hopkins, too. Our School of Medicine received more money for research, training, and fellowships from the Alcohol, Drug Abuse and Mental Health Administration in 1989 than any other institution. The Medical School received the second-highest number of National Institutes of Health grants in 1989 — more than Stanford, Yale, or Duke, but behind UCSF.

Does this mean it's time to get smug? Not yet, if ever, administrators agree. "We've got to keep up the good work and look for ways to do even better," says Heyssel. Incoming Medical School Dean Michael E. Johns adds, "If our goal is to be better than the best, we've got to top ourselves."

— *Rachel Wilder*

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News

THE CHILDREN'S CENTER LOVES COSBY
Cosby — not the famous comedian, but a Holland Lop bunny — is the new star of the CMSC 9 playroom. Donated by local veterinarian Mary Lee Lynch, Cosby was introduced on CCTV's Bunny Show at Easter. Now patients like Tara Heuman (pictured) can play with Cosby any time the playroom is open and, on special occasions, Child Life staff bring him in for bedside visits.

A NEW GENERATION JOINS THE HOPKINS FAMILY

Hopkins has been a household word since Amy Margolis and Carol Coffey Burns were born. A fourth-year student at the School of Nursing, Amy is the daughter of Simeon Margolis, M.D., Ph.D., associate dean of the School of Medicine, and Mary Alice Margolis, who has worked in adminstration for the Department of Medicine for more than three decades. The daughter of Donald S. Coffey, Ph.D., professor of urology, oncology, and pharmacology and molecular science, Carol is an '89 SON graduate.

Amy and Carol first met as undergraduates at Susquehanna College in Pennsylvania. Hopkins was the only nursing school either of them considered. "I had heard my father talk about Hopkins all my life. It was the only school I wanted to go to," says Carol.

Drs. Margolis and Coffey are also enthusiastic about their daughters' decision to follow them into health careers at Hopkins. Says Margolis, "Becoming a nurse is the fulfillment of an ambition Amy's had for a long time, and the School is just the kind we need more of."

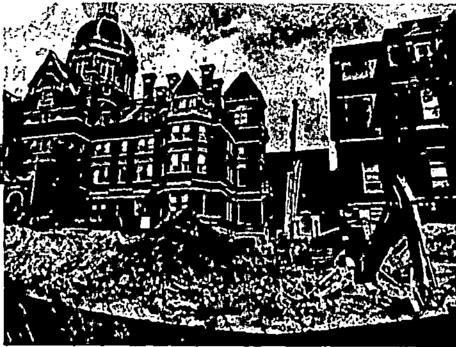
Carol and Amy both plan to stay at Hopkins: Carol has been working in adult medicine since graduation, and Amy will begin work in psychiatric nursing after her graduation in May.

Dick Holden

School of Nursing student Amy Margolis walks through Hopkins corridors with her father, Dr. Simeon Margolis.

HOPKINS-DUNBAR PROGRAM CELEBRATES FIRST GRADS

Thirty-seven Dunbar High School students were recently honored as the first graduates of the Hopkins-Dunbar Program, a cooperative effort to prepare minority students for college and for careers in medicine, nursing, and related professions. Eighty percent of the graduates are college-bound, including Tanya Jeffries and Jonathan Johns, who will attend Hopkins this fall. Jeffries and Johns, along with classmates Marlo Price and Sadiq Russell, are each recipients of a $1,000 Hopkins Centennial Scholarship — a gift from Hopkins employees. Hopkins Medical Staff recently voted to continue to give a $1,000 scholarship to a Dunbar student each year.



CONSTRUCTION UPDATE: MORE MUCK TO COME

Men and machines are burrowing under Broadway to build the east/west concourse (above) connecting the Hospital complex with the Outpatient Center and other buildings west of Broadway. Meanwhile, construction of the 876-foot Metro station — the longest in the system — is beginning on Broadway between McElderry and Madison streets, and a 22-foot machine from Wisconsin has begun north-south tunneling for the Hopkins leg of the Metro. A compressor plant between Jefferson and Orleans operates 24 hours a day producing compressed air to stabilize the dirt around the tunnel and prevent water from leaking into it. Workers go through a decompression chamber when they enter and leave the tunnel. For your information, the dirt — called muck — which is excavated is transported by muck trains to a muck pit and stored in a muck bin. Trucks cart the muck away to the construction site of the stadium at Camden Yards.

EVERY EMPLOYEE COUNTS IN THE 'HOPKINS CENSUS'

Watch your mailboxes in late July for the "Hopkins census," a skills survey to be distributed to all employees by the Hospital's Human Resources Planning and Staffing Department. The survey will ask employees about their education and skills, and data collected will be used to create a skills inventory data base, which will assess future training needs. The survey is strictly confidential, and individual data will not be made available. For details, call Sam Haggar, ☎ 5-1518.

$1 Million Park Dedicated at Bayview: *You'll find a pond, fountain, walking paths and benches in the new $1 million community park recently dedicated at the Bayview Research Campus. The 6.4-acre park, which borders Eastern Avenue, was developed by Baltimore City and the Dome Corp. "It is a fine example of cooperation between the city, the neighborhood, and private enterprise," says James D.M. McComas, president and CEO of the Dome Corp., which had promised the park to Bayview's neighbors.*

SUPER SECRETARIES
Nine secretaries and administrative assistants were tops in typing and spelling contests held at a School of Medicine fair following National Secretaries Week. Winners were Sunny Robinson, Lisa Stronsky, Starleen Murray, Gary Lloyd, Brenda McKay, Barbara Izzo, Nola Miller, Gail Schneider, and Lona Bannasch. Each had a pick of prizes, including luggage and a popcorn machine. All participants enjoyed food, music, and workshops.

TWO FOR ONE SALE
Over the past year, one of every four to five couples in the in vitro fertilization program has gone home with at least one baby. Claire Stackhouse and Jim Banks went home with two. Stackhouse, a nurse in GYN/OB, and Banks, a Hopkins pediatrician, are parents of Alex and Maggie (pictured), now 6 months old. Twins account for 20 percent of the program's births, but a record has just been set: the program's first triplets.

HOSPITAL HOSTS HIGH SCHOOL STUDENTS
Thirty high school students will volunteer time and talent to the Hospital for eight weeks this summer. "They'll see state-of-the-art equipment, help care for patients, and learn in an environment which may lead them to choose health care as a career," says Debbie Bangledorf, acting Volunteer Services supervisor. Students will work two to four days a week in nursing units and laboratories, and will attend tours and lectures on AIDS, drug and alcohol abuse, and teen pregnancy.

GOING FOR THE GOLD
Janet Worthington (pictured), editor of Hopkins Medical News, was all smiles when the magazine won a gold medal in the college magazines category of the annual Council for the Advancement and Support of Education Recognition Program. Hopkins public affairs came out on top in other categories, receiving a gold medal for the Centennial registration package, and bronze medals for the publications program, "Pride! Pick It Up! campaign, and Centennial media campaign.

GOT A BEEF ABOUT SECURITY OR TRANSPORTATION?
Among your options is writing a letter to the new Security and Transportation Committee created to serve as a connecting link between Hospital and University administrators and students, employees, and patients, according to Antoinette F. Hood, M.D., committee chair. Send letters to Hood at 913-D Blalock or to any of the other committee members: John Bartgis, David A. Blake, Ph.D., Dorothy A. Brillantes, Mary Bruno, Patricia Charache, M.D., Sydney O. Gottlieb, M.D., Richard Grossi, and Mumtaz B.B. Kammerer. You can also address questions or concerns to the security office (Tower, Room 109) and parking office (550 Bldg., Room 104).

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Extra

HOMING IN ON HEALTH CARE
This Dome supplement will introduce you to some of the patients, the employees, and the services involved when the Hospital extends Hopkins health care into people's homes.

HOPKINS MAKES HOUSE CALLS

Hopkins care doesn't stop when patients leave the Hospital. That's where Social Work, Home Care and Med-Care come in. They work together to provide the seamless sequence of quality care that begins when a patient enters the Hospital.

It was a day worth celebrating: Home Care primary nurse Kim Schonfeld congratulates cancer patient Becky Bailey on her last visit for treatment at the Hospital.

OVERCOMING POST-OP PROBLEMS

Sally Voreacos noticed George Chin was feeling depressed and she wasn't surprised. As senior clinical social worker in otolaryngology - head and neck surgery on Meyer 9, Voreacos understood and expected such a mood.

Because he had cancer of the larynx, the 62-year-old retired chef had undergone radical neck surgery, including a laryngectomy and a tracheotomy. His vocal chords were removed so normal speech was impossible, and he had a tracheotomy tube coming out of an opening in his throat.

Senior clinical social worker Sally Voreacos provides moral support for George Chin, a patient in otolaryngology - head and neck surgery.

To help Chin change his outlook, Voreacos invited him to a support group for people with head and neck cancer. On a piece of paper he wrote that he would come, but only "to sit in."

"He enjoyed the meeting very much," she remembers. "We talked about how people felt depressed in the beginning, but how they could learn to talk." Soon Chin was writing questions that Voreacos read aloud to the group. "Just talking about his problems buoyed him up."

Before Chin was discharged from the Hospital, a plan was made to take care of him at home with the help of three departments whose job is continuity of Hospital care: Social Work, Home Care, and Med-Care, a subsidiary of Hopkins' Dome Corp. Voreacos, his social worker, met with the in-hospital coordinator for Home Care and Med-Care and — along with Chin's physician — decided how the services of each of these departments could be brought into play.

Teaching Chin to take care of himself was a priority. His trach tube must be suctioned and cared for daily, and he needs enteral feeding, since it's hard for him to chew and swallow.

His primary Home Care nurse, Alice Gelcich, came to his home three time a week, monitoring his progress and continuing the teaching that was started at the Hospital. Now Chin cares for his own trach, with the help of equipment supplied by Med-Care.

If Chin needs help between visits, Home Care is ready. "Everyone here knows that if we get a call and all we hear is tapping, it's Mr. Chin. Two taps for yes, one for no," says Carol Sylvester, Home Care's nursing director. But not for long. "Mr. Chin is learning to use an electrolarynx, so I'm expecting him to say a few words the next time I see him," Voreacos says with a smile.

FIGHTING CANCER DOWN ON THE FARM

"She has no hair and weighs about 24 pounds, but she's doing well," says Home Care primary nurse Kim Schonfeld about one of her favorite patients, 3-year-old Rebecca "Becky" Bailey.

The regular routine of Becky's life, indeed the lives of everyone close to her, was interrupted when she was still a baby. She was less than a year old when a rare tumor was found lodged in her abdomen against her spine.

At the time, a course of radiation was begun to shrink the cancerous growth. Later, after surgery at Hopkins to remove the tumor, chemotherapy began.

It was difficult for Becky and her mother, who had other children at home, to travel from their farm in Thurmont, some 72 miles west of Baltimore, to Hopkins for the treatments. The solution to their dilemma — the Baileys call it "a godsend" — was a combination of Home Care services and Med-Care resources, which allowed Becky to be treated at home.

"Suzanne Vazzano and I have been taking turns going up to Thurmont four days in a row once a month," says Schonfeld. "I sit and play with Becky a while. Then I prepare her medication, and hook up the IV line to the catheter."

Vazzano and Schonfeld have taught Becky's mother to administer IV drugs to Becky, such as the sodium phosphate she needs to supplement her diet. Med-Care provides the intravenous medicine, as well as dressings, syringes, and other supplies needed for Becky's daily care.

Even when Becky's course of chemotherapy ends, she will continue to be seen by Home Care nurses and utilize Med-Care resources. "We'll continue to see her for blood work and follow-up, and she will have to continue the sodium phosphate intravenously," Schonfeld says. "And of course we'll be at the party the Baileys are having to mark the end of her chemotherapy."

— *Sharon Bondroff*

Extra

HEALTH CARE TO GO

Social workers, Home Care nurses, pharmacists: they're on the team that can deliver Hopkins health care right to our patients' doorsteps after they leave the Hospital.

CARRIE VICK, SOCIAL WORKER

It happens all the time. "A girl comes in, says there's no milk, or she has no place to go, or she's had a fight with her mom," says Carrie Vick, senior clinical social worker, who works with teen-age mothers at Hopkins.

Many adolescent mothers who deliver a baby at the Hospital are referred to TAC, the teen-age clinic. "We see them when the baby is about 2 weeks old," says Vick, who is the social worker in what's known formally as the Hospital's Adolescent Parenting Program. Its mission — and hers — is to provide comprehensive health care and social services for between 900 and 1,000 teen-age mothers and their babies.

Her door is always open. Vick interviews about four new mothers a week to find out what they and their babies need, then follows mothers and babies for four years. "We're there to support the whole family, to refer them to the right services," says Vick, a 15-year Hopkins veteran. "We work with dads at times, too. We can refer them for job placement."

Vick's main focus is counseling girls about their relationships to parents or boyfriends and helping them with parenting, while giving them emotional support. After four years, when mother and child graduate from the clinic, Vick makes sure they have a place to go for health care.

Seventeen-year-old Laquitta Butler knows about the program firsthand. "I was a mother at 13. The program lent me a helping hand. It has people who care about people. It taught me to become a better parent and how to better myself," Butler says.

"Most people see teen-agers as parents who don't make it. There are many who do," says Vick. Butler and her now 4-year-old son Darren are about to graduate from the TAC clinic. Butler also graduated from Dunbar High School this June with honors, and plans to attend college in the fall and learn to be an emergency medical technician.

Vick's clients at the clinic are not ill. Often, however, it is a social worker's task to deal with very sick individuals and their families, doing everything from coordinating home care to helping them find the best possible resources to assist recovery.

That task becomes more challenging with today's emphasis on shorter hospital stays, says department director Jerry Reardon. An estimated 15 percent of patients discharged from the Hospital need follow-up care at home — and the help of social workers like Carrie Vick.

Teen-age mothers can turn to senior clinical social worker Carrie Vick (right) for counseling on health care, parenting, and relationships.

Duty calls Home Care nurse Karen Pechulis, who heads out on o

KAREN PECHULIS, HOME CARE NURSE

Most days Karen Pechulis starts out early, around 7 a.m., hoping to be back in the office by noon or 1 o'clock. That's when she and her Home Care nurse colleagues do the paperwork and make calls to doctors, social workers, and referral agencies. "But things never go as planned. You may get a call from a patient and have to go out at 4 p.m. You learn to roll with it," Pechulis says.

"I love home care nursing because I spend all my time with patients, not answering an intercom. That means I can teach patients — our priority — without interruption. We teach them to change their own dressings, to eat properly, to look out for certain symptoms, to know when to call the doctor.

"I sometimes call in a nutritionist to help a diabetic with a diet or a social worker to counsel a dying patient's family," says Pechulis, who sees from five to seven patients a day. "Recently I helped a patient, an alcoholic, get admitted to a rehab program. You can't change everything in a person's life but, if we make one little dent, we feel great."

In addition to working with Home Care, Pechulis works part-time on Nelson 8. In fact, she says, "I've had patients in the Hospital that I later took care of through Home Care. This takes primary care nursing as far as it can go."

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IT HAPPENS ALL THE TIME.
"A GIRL COMES IN, SAYS THERE'S NO MILK, OR SHE HAS NO PLACE TO GO, OR SHE'S HAD A FIGHT WITH HER MOM," SAYS CARRIE VICK, SENIOR CLINICAL SOCIAL WORKER, WHO WORKS WITH TEEN-AGE MOTHERS AT HOPKINS.

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"BECAUSE OF THE NEW TECHNOLOGY, WE CAN NOW CARE FOR SOME PATIENTS AT HOME AS WELL AS WE COULD IN THE HOSPITAL, AND THEY THRIVE. THAT'S THE SATISFACTION IN MY JOB," SAYS REID ZIMMER, MED-CARE PHARMACY DIRECTOR.

...e of her many patient visits.

REID ZIMMER, MED-CARE PHARMACY DIRECTOR

Reid Zimmer is smiling. "It was like inheriting a million dollars," he says, describing his feeling upon hearing that a little girl with an immune deficiency had been successfully treated at home using medicines and equipment provided by Med-Care.

Patient contact is a bonus for Zimmer, Med-Care's director of pharmacy. His job is to make sure that patients receive the best medication as well as the most comfortable and efficient means of taking it.

Typically a clinical pharmacist on Zimmer's staff visits a new patient at home to "see the atmosphere. Is there refrigeration? Do they know how to take the medicine properly? You have to treat each patient as an individual."

Pharmacy makes up intravenous medications, chemotherapy, and nutrition for home use. Through a glass wall in his office, Zimmer has a clear view of the aseptic clean room where his staff prepares the prescriptions. Before entering, everyone must scrub and wear a cap, gown, and gloves.

Every morning Zimmer meets with other Med-Care staff members to discuss the patients they're going to have for the day. The delivery person finds out what needs to be sent and when. The client service person calls patients to make sure they have what they need.

In addition to IV therapies, Med-Care provides respiratory and medical equipment such as wheelchairs, apnea monitors, ventilators, and hospital beds. Med-Care also keeps other smaller items on hand, including oxygen, tubing, and dressing supplies.

Also on their shelves are IV pumps small enough to hang from a belt, allowing patients to move around freely. Zimmer remembers one patient who took his IV pump on a European vacation. "Because of the new technology, we can now care for some patients at home as well as we could in the hospital, and they thrive. That's the satisfaction in my job," Zimmer says.

— *Sharon Bondroff*

Currently, Home Care makes 3,500 visits a month — a figure that's expected to double in one year. There are 30 nurses on staff, plus speech, physical, and occupational therapists, a nutritionist, home health aides, and clinical social workers. Some nurses specialize in IV therapy and work out of the Med-Care office, where IV prescriptions are formulated and the delivery of equipment and supplies are coordinated.

Med-Care pharmacy director Reid Zimmer's job is to make sure Med-Care's patients receive the best medication and most comfortable and efficient means of taking it.

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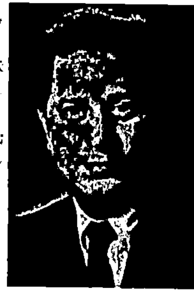

HOME CARE: NOW IT'S SYSTEMWIDE

As president and CEO of Dome Management Services, an important part of Irwin Bloom's job is to coordinate Med-Care and two Health System home health agencies, Hopkins Home Care and Hopkins Home Care Alternatives, a new service which is a "major effort to provide a network of home care services to our patients," Bloom says. "These programs will be Hopkins quality with direction from Hopkins health professionals."

HOME HEALTH CARE:

WHAT WE DO AND HOW WE DO IT

"WE HELP PATIENTS AND FAMILIES COPE WITH ILLNESS AND PLAN FOR THE FUTURE ONCE THE PATIENT LEAVES THE HOSPITAL."

JERRY REARDON, PH.D., DIRECTOR, SOCIAL WORK

"THE POINT OF HOME CARE IS TO PROMOTE CONTINUITY OF CARE, HELP PATIENTS ADAPT AND REMAIN INDEPENDENT."

SHARON BROWN, R.N., M.S., PRESIDENT, HOPKINS HOME CARE

"WE PROVIDE HIGH-TECH PRODUCTS AND SERVICES FOR HOME CARE, BUT OUR FOCUS IS ALWAYS ON THE PATIENT."

DEBBIE ZIENTS, M.B.A., PRESIDENT, MED-CARE

☐ DEPARTMENT OF SOCIAL WORK

The Department of Social Work was established at the Hospital in 1907 by a group of volunteers concerned with home hygiene, nutrition, and other problems that would affect the patient's condition after hospital treatment. Today, the department has 57 social workers on staff, continuing the tradition of helping patients and families make successful transitions from hospital to home, as well as helping them cope with the impact of illness and hospitalization. ☎ 5-5885

SERVICES OFFERED BY THE DEPARTMENT

- Help with admission and discharge for patient and family
- Evaluation of patients with psychological and social problems, working with Hospital staff to lessen the effects of those problems on the patient's health
- Patient counseling
- Help for patients in obtaining Hospital and community services
- Health education for patient and family
- Community program development

☐ HOME CARE

Johns Hopkins Home Care has been part of the Hospital since 1984 and is one of the fastest growing segments of Hopkins health care. In July, when it becomes a Health System-wide service, Home Care will expand to offer private duty nursing and homemaker services, and will be available to all Hopkins affiliates. ☎ 5-6788

SERVICES OFFERED BY HOME CARE

- Home care planning before a patient leaves the hospital
- Home visits by nurses, therapists, social workers, home health aides, nutritionists
- Health education for patient and family
- Intravenous therapy
- Hospice services
- Referrals to other community services
- 24-hour on-call and visits
- Delivery of supplies to the home
- Private duty nursing (begins soon)
- Homemaker services (begins soon)

☐ MED-CARE

Med-Care, a subsidiary of the Dome Corp., provides IV pharmaceuticals, respiratory therapy, and high-tech medical equipment to patients receiving home care. Twenty-seven full-time employees include client service representatives, respiratory therapists, pharmacists, and drivers, as well as administrative personnel. ☎ 385-4100

SERVICES OFFERED BY MED-CARE

- Intravenous nutrition, chemotherapy and antibiotic drug therapy
- Pharmacy services, including pain management, hydration therapy, and other IV therapies
- Transfusions of platelets or red blood cells
- Central venous catheter care
- Care for the terminally ill
- Enteral nutrition therapy for patients who cannot swallow (provided directly to the stomach through a catheter)
- Respiratory therapy to help patients breathe, using oxygen, ventilators, nebulizers, and apnea monitoring
- Medical equipment, such as wheelchairs, hospital beds and walking aids
- Home visits by pharmacists
- Nursing through Johns Hopkins Home Care
- Training for patient and family in proper use of equipment
- Delivery of supplies to the home

— Sharon Bondroff

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Then | Now

SHE OUGHT TO KNOW
"He's a perfectionist," says Lyn Dwelley, Ross's secretary for 15 years, "and I admire him. He's precise, and his memory is unbelievable. It's difficult for people to realize how busy the dean's job is — people in and out every half hour, so many things to do, and crises in between. I think his life will calm down considerably, but I think he'll always be busy because he enjoys it."

A DEAN FOR 15 SEASONS

Richard Starr Ross has left the Dean's Office, but he — and his namesakes — will still be part of the Medical Institutions

Leonard Graff

Dean emeritus Richard S. Ross

The first dean of the School of Medicine, William Henry Welch, posted this notice announcing office hours: "The dean will be in from 3 to 4 Tuesday afternoons."

"That was all it took," says Richard S. Ross, M.D., a bit wistfully. "But it's pretty clear now it's not only a full-time job but, in addition to one person's activity, it takes a tremendous staff, and support from a great number of people."

Many of those people — and many of the people Ross has supported during his 15-year tenure as dean — got together to recognize him at a banquet on June 22 to mark the occasion of his retirement from the position.

It was scarcely a farewell, though. Dean Ross's name will be a permanent and prominent part of Hopkins. The new medical research building on Rutland Avenue will be named after him (an honor voted by the Board of Trustees), and so will the Richard Starr Ross Fund for the Physician Scientist (his own favorite project, which offers internal grants to young researchers). And Ross will maintain an office at the School to make himself available as needed to his successor, Michael E. Johns, M.D.

Instead of a farewell, the banquet was a celebration of 43 years spent in the service of Hopkins. Ross came to the School of Medicine in 1947, intending to complete a one-year internship and return to Harvard, where he took his undergraduate and medical degrees. But the blue baby operation developed by Drs. Blalock and Taussig at Hopkins had just opened wide the field of research and treatment for previously incurable heart ailments. This was an exciting time at Hopkins, with a new Department of Medicine chairman, A. McGehee Harvey, M.D.

"It was the beginning of my love affair with clinical medicine," Ross says. "Those were wonderful days, and priceless emotions. Patients came from all over the world with tremendous diagnostic problems that nobody really knew much about. And Helen Taussig was putting it all together."

Still, Ross calls the 1960s and early 1970s "the most exciting period of my life at Hopkins." He was director of the Wellcome Research Laboratory and director of cardiology, and he and radiology chief Russell Morgan introduced cineangiography to the Hospital and Medical School. "We were taking the first motion pictures of the heart at Hopkins," Ross says.

"I THINK THE MOST FUN HAS BEEN IN GETTING TO KNOW A LOT OF BRIGHT YOUNG PEOPLE WHO COME THROUGH THIS OFFICE AND ARE WILLING TO TEACH ME SOMETHING."

In those years, too, came recognition of many kinds: a request from Judge John J. Sirica for Ross to examine ex-President Nixon to determine whether he really was too sick to testify in the Watergate trials (a job Ross accepted); as well as an offer of the directorship of the National Heart, Lung, and Blood Institute (a job he declined). He has been president of the American Heart Association and an editor of the classic Hopkins textbook, *The Principles and Practice of Medicine.* He is also a member of the National Academy of Sciences' Institute of Medicine.

In 1975 he became dean, a position he has filled longer than all but one of his predecessors. His list of accomplishments is long, but his favorite moments have involved honors to other people: watching Drs. Hamilton Smith and Daniel Nathans receive the 1978 Nobel Prize in Medicine for their discovery of how to slice genes, and presenting President George Bush with an honorary degree as part of the Hopkins Centennial celebration. "I think the most fun has been in getting to know a lot of bright young people who come through this office and are willing to teach me something," Ross says.

Ross credits his wife, Elizabeth "Boo" Ross (whom he met at Hopkins), for her support over the last 40 years, and for doing "far more in raising our three fine children than I did." He looks forward to spending more time with his four grandchildren, playing golf, taking long walks, and fishing, after July 1.

How would he like people to remember his deanship? "As an exciting, pleasant, stimulating time to be part of The Johns Hopkins Medical Institutions," he answers. "I've tried to make it that way for people."

As for his strategy for achieving excellence in medical education, Ross believes in selecting "the best possible students — bright, well-rounded, motivated, imaginative people. Put them together with good faculty who enjoy teaching, and provide good facilities. Then leave it alone. Just let the process work. That's worked for 100 years."

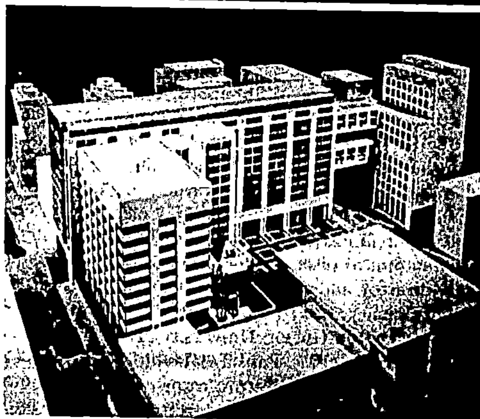
— *Anne Childress*

Material for this story came from interviews with Ross by Janet F. Worthington and by Richard Johns, M.D.

ROSS: 'ALL THAT YOU HAVE HELPED TO ACCOMPLISH'

In a recent letter to his colleagues in the School of Medicine, Dean Richard S. Ross listed "all that you have helped to accomplish" during his tenure as dean. The list includes:

- Defending the right of private medical schools to select their own students. In 1977, the federal government tried unsuccessfully to force U.S. medical schools to admit foreign-trained, underqualified American students.
- Rebuilding the physical plant for patients, students, and scientists. Major construction projects include the Preclinical Teaching Building, the Denton A. Cooley Recreation Center, the A. McGehee Harvey Building, the Hunterian Building, the Richard Starr Ross Medical Research Building on Rutland Avenue, and the Asthma and Allergy Center. The Hospital has replaced every bed.



Richard Starr Ross Medical Research Building

- Encouraging more broadly educated young people to enter medicine. The medical school dropped the MCAT requirement for admission, approved a Flex-Med program with greater options, and expanded the enrollment of minority students.
- Developing the $5 million Fund for the Physician Scientist to support the budding research careers of young physicians. By December, 71 young faculty had received grants, and all who received two years of funding went on to win government or foundation support.
- Established 29 new endowed professorships to support senior faculty.
- Increased Hopkins' share of federal biomedical research funding. Since 1975, Hopkins has moved from seventh to second place in NIH awards to medical schools.
- Celebrated the Centennial of Johns Hopkins Medicine in style.

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Who/What

BEA GADDY HONORED The second annual Clarence "Du" Burns Award for Community Service was recently awarded to Bea Gaddy for her commitment to helping Baltimore's homeless. The award and its $1,000 prize, created by the Health System last year, is awarded to the individual who has contributed most to the quality of life in East Baltimore during the preceding year.

Warren Beatty and Madonna were on hand to greet Hopkins employees and others attending the benefit premiere of "Dick Tracy."

'DICK TRACY' PREMIERE BENEFITS HEMATOLOGY

Dozens of Hopkins doctors and staff members attended the star-studded premiere of the summer's much talked about movie, "Dick Tracy," — an event that raised more than $120,000 for Hopkins' hematology research program. "Dick Tracy" stars Warren Beatty (whose family has had a long association with Hopkins) and Madonna, who also attended, as did newscaster Ted Koppel, actress Linda Carter, and White House Chief of Staff John Sununu. Underwritten by the Walt Disney Co., the event was held at D.C.'s Uptown Theatre and was followed by a party at the National Building Museum. Moviegoers also enjoyed a pre-screening cocktail party with Beatty, underwritten by Xerox Co.

DON'T MISS...

The NEH Summer Film Series, "Soul Doctors: The Psychopathology of Everyday Life," running Wednesdays through Aug. 8, 7:30 p.m., Preclinical Teaching Building, main floor auditorium. ☎ 5-3363 for details.

NEWSMAKERS

John Bacon has been named the Hospital's EEO/AA Officer . . . **Joseph T. Coyle**, M.D., director and distinguished service professor of child psychiatry, and professor of neuroscience, of pharmacology and molecular science, and of pediatrics, and **Murray B. Sachs**, Ph.D., professor of biomedical engineering, of neuroscience, and of otolaryngology, have been elected to the Institute of Medicine . . . **Catherine DeAngelis**, M.D., deputy director of the Children's Center, received the Ambulatory Pediatric Association's research award for her contributions to pediatric knowledge . . . **Morton Goldberg**, M.D., F.A.C.S., chairman and professor of ophthalmology, has been elected president of the Association of University Professors of Ophthalmology . . . **Sidney O. Gottlieb**, M.D., assistant professor of medicine and director of the cardiac catheterization laboratory at FSKMC, has been elected chairman of the Medical School Council. **Julia Haller**, M.D., assistant professor of ophthalmology, has been elected vice chairman of the council . . . **Steve Hegedeos**, M.S.Ed., has been appointed administrator of rehabilitation medicine . . . **Bruno Lima**, M.D., associate professor of psychiatry and mental hygiene, is the recipient of the 1989 Award of the Brazilian Psychiatric Association . . . **Carolyn Machamer**, Ph.D., assistant professor of cell biology and anatomy, has been selected for a 1990 Pew Scholars award . . . **Deborah McGuire**, R.N., Ph.D., assistant professor of nursing, was reappointed for a second term as the American Cancer Society, Maryland Division, Mary Edna Busch professor of nursing in oncology . . . **Vernon B. Mountcastle**, M.D., University professor of neuroscience, presented the John P. McGovern Award Lecture in the Behavioral Sciences at the 156th annual AAAS National Meeting . . . **Stanley E. Order**, M.D., professor of oncology and director of the radiation oncology division of the Oncology Center, was named chairman of the board of directors of the American Society for Therapeutic Radiology and Oncology. Order also recently completed *Radiation Therapy of Benign Diseases* . . . **Frank A. Oski**, M.D., director of the Children's Center, received the 1990 Joseph St. Geme Award, the only such award presented by the nation's major pediatric organizations, for outstanding leadership in pediatrics . . . **Albert H. Owens Jr.**, M.D., director of the Oncology Center, was named vice president and president-elect of the Association of American Cancer Institutes and chairman of the National Coalition for Cancer Research . . . **Thomas D. Pollard**, M.D., director and Bayard Halstead professor of cell biology and anatomy, was elected to membership in the American Academy of Arts and Sciences . . . **Joan Richtsmeier**, Ph.D., assistant professor of cell biology and anatomy, has won the 1990 Maryland's Outstanding Young Scientist Award . . . **John Rock**, M.D., director of the division of reproductive endocrinology and professor of gynecology and obstetrics, has been appointed to the board of directors of the American Fertility Society . . . **Curtis L. Ruegg**, a graduate student in the Department of Pharmacology and Molecular Sciences, received the 1990 Sandoz Award presented by Sandoz Pharmaceuticals in recognition of superior academic achievement and contribution to health care . . . **Norman Sheppard**, Ph.D., assistant professor of biomedical engineering, was awarded a Presidential Young Investigator Award from the National Science Foundation . . . Medical student **John Sinard** was awarded the 1989-90 Straus Award honoring the Hopkins medical student who demonstrates the greatest fascination with anatomical research . . . **Solomon H. Snyder**, M.D., director and distinguished service professor of neuroscience, received an honorary doctorate of science at Ben-Gurion University of Negev, Beer-Sheva, Israel . . . **Paul Talalay**, M.D., J. J. Abel distinguished service professor of pharmacology and molecular science, has been elected a member of the American Philosophical Society, the nation's oldest learned society . . . **Henry N. Wagner Jr.**, director and professor of nuclear medicine, was awarded an honorary degree from the Free University of Brussels.

Leonard Graf

Alfred Sommer, M.D., M.H.S., professor of ophthalmology with joint appointments in epidemiology and international health, and director of the Dana Center for Preventive Ophthalmology, has been appointed dean of the School of Public Health, effective Sept. 1.

Mary Jo Wagandt was elected president of the Hospital's Women's Board at the organization's annual meeting last May. In the upcoming year, the Women's Board will contribute more than $400,000 to Hospital projects.

Edward A. Hallo has been appointed senior vice president for administration of the Hospital and Health System. Since 1984, Hallo had been vice president for administration. He's been with Hopkins since 1970.

Jane E. Stanek has been named director of governmental relations for the Hospital and Health System. For the last three years, she served as deputy to Robert R. Neall, who has resigned to run for public office.

Mike Plank is the Hospital's new director of housekeeping. Formerly an area manager for Broadway Services Inc., with clients including FSKMC, Plank helped start the company's housekeeping division at Hopkins.

John E. Hoopes, M.D., who directed expansion of the division of plastic surgery over the last 20 years, retired June 30. Hoopes has published 160 scientific papers, more than 50 book chapters, and has been co-editor of three books.

DOME

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A JOINT PROGRAM OF THE CITY OF BALTIMORE, THE BALTIMORE CITY PUBLIC SCHOOLS, AND THE PREVENTION CENTER OF THE DEPARTMENT OF MENTAL HYGIENE, JOHNS HOPKINS UNIVERSITY, SCHOOL OF HYGIENE AND PUBLIC HEALTH.

PROMOTING SELF-ESTEEM, HIGH ACHIEVEMENT, AND FULL POTENTIAL. PREVENTING DROP OUT, MENTAL DISORDERS, DRUG ABUSE AND VIOLENCE.

THE PREVENTION PROGRAM

ince 1984, the Baltimore City Public Schools and the Prevention Research Center of the Johns Hopkins School of Hygiene and Public Health have been working together on a program to improve learning and behavior for 2400 school children. The goal of this Prevention Program is for all children to reach their full potential and to feel good about themselves.

The Prevention Program was based on studies of children's experience in first grade. These studies show that how children behave, how they feel about themselves, and how they learn are good indicators of whether they will have problems when they are teenagers.

For instance, learning difficulties as early as first grade are related to depression in adolescence. Some ways of behaving in first and second grade, such as not obeying rules, staying away from school or habitually fighting with classmates, predict later problems with alcohol and drug use, dropping out of school and delinquency.

Children who are very shy, such as those who sit alone most of the time, have no friends and do not participate in class, may have anxiety problems as teenagers. Based on these studies, the researchers in the Prevention Center have developed programs to change or improve behaviors and skills at an early stage, and thus affect the way these children will act when they are teenagers.

As a first step in their Prevention Program, the Baltimore City Public Schools and the Prevention Center worked with school teachers and principals and with parents to obtain information about each child. Parents were requested to give consent for the participation of their children in 19 elementary schools.

In confidential interviews, classroom teachers were asked about each child's progress in learning and behavior in class twice each year. School records were examined for test scores, classroom grades, attendance, and similar information related to learning and behavior. The children themselves were asked how they felt about themselves. They were asked how they thought their classmates were doing in school, who made friends easily, and who stayed away from others. Of course, all this information was obtained on a confidential basis, in accordance with School District and Medical Institution regulations.

After first learning about the children and their classrooms, the Prevention Program carried out two separate interventions, one directed at improving learning and the other at improving shy and aggressive behavior.

The first intervention, Enhanced Mastery Learning, works to increase learning for all the children in the class. Each child is given enough time to learn, helped with difficulties, and regularly checked to see how much has been learned. Children do not go on to the next learning task until most of them have achieved mastery of the previous task.

THE PREVENTION PROGRAM WAS BASED ON STUDIES OF CHILDREN IN FIRST GRADE. THESE STUDIES SHOW THAT HOW CHILDREN BEHAVE, LEARN, AND FEEL ABOUT THEMSELVES IN FIRST GRADE ARE GOOD INDICATORS OF WHETHER THEY WILL HAVE PROBLEMS WHEN THEY ARE TEENAGERS.

RESULTS FROM THE FIRST YEARS OF THE PREVENTION PROGRAM SHOW THAT THE INTERVENTIONS WERE SUCCESSFUL. FIRST GRADERS IN THE ENHANCED MASTERY LEARNING CLASSROOMS HAD GREATER SUCCESS IN LEARNING TO READ THAN THEIR PEERS. WHERE THE GOOD BEHAVIOR GAME WAS PLAYED, CHILDREN BEHAVED LESS AGGRESSIVELY AND LESS SHYLY AFTER A YEAR AND TEACHERS WERE ABLE TO TEACH MORE EFFECTIVELY.

The second intervention, called the Good Behavior Game, works to reduce aggressive and shy behavior in the classroom. Children form teams and rewards are given the team when members behave appropriately in class by sitting quietly and participating in classroom activities rather than breaking rules and fighting. All teams can win.

Results from the first years of the Prevention Program show that these interventions had, at least, short term benefits on achievement and behavior. First graders in the Enhanced Mastery Learning classrooms had greater success in learning to read according to national test scores than their peers who were tested in our standard setting classrooms. In first grade classrooms where the Good Behavior Game was played, children behaved less aggressively and less shyly after a year and teachers were able to teach more effectively in a more cooperative environment.

The Prevention Program can help us understand when children start thinking about and using drugs and weapons during their later years, whether the two early interventions help, and what else is needed. The Baltimore What's Happening (BWH) project asks children what they know about tobacco, alcohol, and other drugs and whether they use them. The interviewers also ask each child privately and confidentially whether they get into fights or carry weapons.

One of the most common and important problems a child may have in school is impaired attention. The Attention Project has been developing new methods of evaluating and helping with these problems by studying how children perform on computer, card sorting and memory tasks that measure different aspects of attention.

These and similar assessments conducted every year allow us to identify children who may have problems and to develop ways to help them before these problems occur or at least before they reach the crisis stage. Professionals in the schools and in the Prevention Center work with teachers, parents and the child in finding new ways for prevention.

Weekly Reader Children's Book Club

Several strategies are planned next to ensure that parents are heavily involved and have ample opportunity to participate in the Prevention Program during its next stages. The rights of the children must be protected including confidentiality and strong respect for the parents' role in the formal consent in each child's participation. Several strategies are planned to provide these opportunities:

1) The formation of a Community Advisory Board which will include parents, community leaders, and legislators. 2) The formation of a Parent Council which will work closely with the Prevention Center so that the parents can inform the Prevention Program staff about their views, and work with staff to develop acceptable programs and measures. 3) Creation of a quarterly newsletter.

In working with large numbers of young children through the Prevention Program, some children come to our attention who are in urgent need of help. Emotional, behavioral, and home problems all have been brought to our attention. The Prevention Program is not empowered to provide direct services, but the staff is obliged to help children receive services, if possible, through the proper designated officials in the schools or in other agencies within the city. Efforts will be made by special prevention staff to assess a child's needs and the staff will require the support and consent of parents in doing so.

It is important that we continue following the progress of the children who have participated in the Prevention Program well into teenage years. We plan to continually evaluate who benefits, who does not, whether the benefits from these programs continue into their later years, and what else is needed. At each stage, the Prevention Center actively plans to include parents in assessing how their children are doing. Interviewers will ask what concerns parents have about their children, what difficulties families and children face, and what problems they think the Prevention Program should address in the future. Meetings with groups of parents are planned, and special workshops and seminars will be available.

AT EACH STAGE, THE PREVENTION PROGRAM PLANS TO INCLUDE PARENTS IN ASSESSING HOW THEIR CHILDREN ARE DOING. INTERVIEWERS WILL ASK WHAT CONCERNS PARENTS HAVE ABOUT THEIR CHILDREN, WHAT DIFFICULTIES FAMILIES AND CHILDREN FACE, AND WHAT PROBLEMS THEY THINK THE PREVENTION PROGRAM SHOULD ADDRESS IN THE FUTURE.

The Prevention Research Center has recently been funded for the next five years to develop four new interventions for children and families in the areas of behavior, achievement, and attention.

We plan to combine the Mastery Learning and the Good Behavior Game and to evaluate whether this strengthens the impact of each on school achievement and on aggressive and shy behaviors. We will also develop and offer families of entering first graders an opportunity to participate in a family learning environment program to promote each child's learning in school and we will evaluate its effectiveness. A program in behavior management will be developed to help families promote good behavior in their children and to evaluate its effectiveness. Children who show early signs of attention problems will be offered new programs that we are preparing to improve this vital part of the child's classroom behavior. They also will need careful evaluations and development.

To achieve these goals we will be collaborating with legislators, school leaders, community organizations, individuals and parents.

THE PREVENTION PROGRAM PARTNERSHIP

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Charlene Cooper-Boston, Ph.D., Assistant Superintendent, Special Projects/Director of Central District
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Charles Burke, Director III, Elementary Schools
Matthew Riley, Director III, Elementary Schools
Nancy Gimbel, Director, Elementary Curriculum Development
Carla Ford, Curriculum Specialist, Early Childhood Education

Prevention Research Center, Department of Mental Hygiene, The Johns Hopkins University
Sheppard G. Kellam, M.D., Center Director
James Anthony, Ph.D., Substance Abuse
Bruno Anthony, Ph.D., Attention Problems
Lawrence Dolan, Ph.D., School Achievement and Mental Health
Lisa Werthamer-Larsson, Sc.D., Child Services
Nicholas Ialongo, Ph.D., Family and Child Mental Health
George Rebok, Ph.D., Health and Development
Penelope Keyl, Ph.D., Child Injury Prevention
Mary Bruce Webb, M.A., M.S., Chief of Operations
Elva J. Edwards, M.S.W., L.C.S.W., Director, Community Relations
Amir Saharkhiz, M.S., M.B.A., Data Manager

The Prevention Program is funded by grants and contracts from the National Institute of Mental Health and the National Institute on Drug Abuse.

For more information on the Prevention Program, call Mrs. Elva J. Edwards - 301-955-3945
or write to:
The Prevention Research Center
Department of Mental Hygiene
School of Hygiene and Public Health
624 North Broadway
Baltimore, Maryland 21205

DOING WHAT

WE DO BEST...

EVEN BETTER

Quality Management at Work

JOHNS HOPKINS HEALTH SYSTEM

1991 ANNUAL REPORT

THE YEAR IN REVIEW

Superb medicine has been the basis of Hopkins' reputation for 100 years. Today, however, superb medicine is not enough. Quality in medicine must be backed by a system that adds efficiency and reduces cost at every turn. In the 1990s, health care providers will live or die by how they manage investments in technology and facilities, how they are perceived in terms of quality in medicine and services, and whether they can deliver quality at an affordable price. Consequently, over the past three years, we have focused an intense effort on improving the services we provide patients.

As a large health care system with an academic medical center at its core, Hopkins has a responsibility to lead the search for new and better ways to deliver superb medicine and related services. With an ultimate goal of centering operations around the imperatives of patient care, this search is taking place in every area of our organization, from tracking the flow of people and paper among departments to exploring optimal configurations for the System itself.

While we were focused on long-term quality improvements, the year that closed June 30, 1991 was one of challenges in other areas as well. Financial performance in the hospitals of the System was less than budgeted, a combination of soaring expenses—primarily in the supply area—and State of Maryland Medicaid cutbacks which reduced revenues.

Nevertheless, gains were made in general operations, volume remained strong at The Johns Hopkins Hospital and The Francis Scott Key Medical Center (FSKMC), and length of stay declined further. Hopkins Hospital reached national averages for Medicare length of stay in one year rather than two, as planned. The latter accomplishment is very important for preservation of the State Medicare waiver. The efforts of the medical staff made that possible.

At the same time, it became apparent that one of the acute inpatient units in the System—Homewood Hospital—required a complete change of direction if it were to serve the purposes of the public and the Johns Hopkins Health System. In 1991, we concluded that the contribution of Homewood Hospital to the System and the community simply did not warrant its continued operation as an acute hospital. We were supported in the decision to close it by the Health Resources Planning Commission and the Health Services Cost Review Commission of the State of Maryland, and the political structure of the City and State. Every effort was made to ease the painful transition to other employment for Homewood Hospital employees. We are grateful to them for their competence and help in a diffi-

H. Furlong Baldwin (left) and Robert M. Heyssel, M.D.

cult time. Many now are employed at other Johns Hopkins Health System sites. We currently are negotiating the sale of Homewood Hospital's assets on North Charles Street, and hope to return the facilities to productive efforts in health care.

This year we also announced the sale of The Johns Hopkins Health Plan to the Prudential Insurance Company. That decision had been under exploration for nine months, during which time we held conversations with several potential buyers. We based our action on what we believed to be changes in the health insurance market. Large employers—the clients an HMO must attract to be profitable—are looking for single insurers who offer a spectrum of services from traditional indemnity insurance through managed care. We decided to focus on what we do best—provide health care—rather than remain in the insurance business.

In that vein, the agreement with Prudential resulted in our retaining physician groups and 18 sites of care in the Baltimore region. The sale of the insurance, marketing and membership services and claims processing to Prudential included an agreement for Johns Hopkins to continue providing services to Prudential members. Importantly, as part of the agreement, we will continue to enroll Medicaid recipients as before in the only HMO in the Baltimore region to mix public and private members.

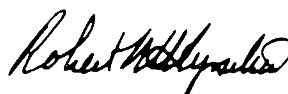
This strategic divestiture allows us to concentrate on building outpatient services at Homewood North and the sites formerly owned by the Hopkins Health Plan. Dr. Richard Tompkins joined us in March to lead a combined physicians' group composed of former Hopkins Health Plan physicians and those of the Wyman Park Medical Associates. In the coming year, the combined group will have revenues of $100,000,000 from contracts with the Department of Defense and Prudential and fee-for-service income.

During all of these changes, the legal, financial, human resources and general management staff of the Johns Hopkins Health System performed superbly.

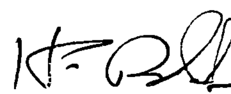
Three new facilities represent the thrust of our plans for the future. A state-of-the-art Outpatient Center will open in May at The Johns Hopkins Hospital. At FSKMC, The Johns Hopkins Geriatrics Center opened in the spring, and a new 190-bed acute care patient tower will begin construction this fall.

Of course, cutting costs, increasing efficiency and focusing more closely on the needs of patients is not just a matter of facilities design. These concepts must be made tangible in daily operations and in the worklife of everyone associated with Hopkins.

Toward that end, our Quality Management initiative, begun three years ago with the help of a generous grant from the Baxter Foundation, is taking hold. More people become involved every day. And even more are feeling the positive results of change. Managing for quality is an ongoing force that will enable Hopkins people to put their good ideas to work, matching our reputation for superb medicine with one for superb service to our patients.



Robert M. Heyssel, M.D.
President and
Chief Executive Officer



H. Furlong Baldwin
Chairman
Board of Trustees

DOING WHAT WE DO BEST... EVEN BETTER

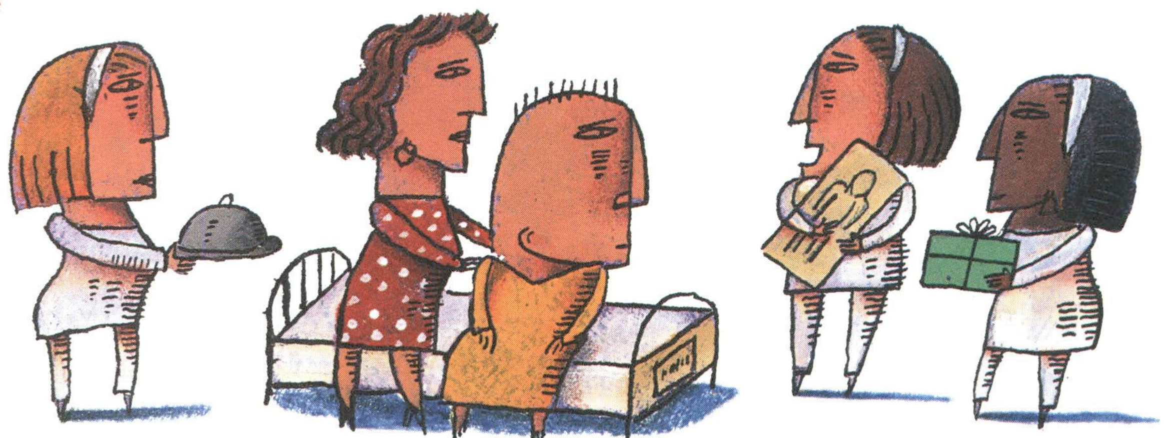
Have you ever spent three hours waiting for a 10-minute lab test? Or been dazzled by an array of indecipherable bills after a hospital stay? Do you ever find senseless hospital routines bogging you down? Or that the simplest procedure triggers an avalanche of forms? Don't you think it's time we did something about it? We are. Read on............

This year, The Johns Hopkins Hospital was recognized as "The Best of the Best" by *U.S. News & World Report*. According to the magazine's survey of physicians nationwide, Hopkins is at or near the top in 13 of the 15 specialties reviewed. This recognition of the high calibre of medicine practiced here is a tribute to everyone who works at Hopkins. For more than 100 years, offering patients the highest standards of quality in medicine has been our mission. But there is another side to the quality story that is proving equally crucial, if a bit less acclaimed, in this age of cost

WHAT IF EVERYONE DID THIS?

"First we defined our 'customers': the families of our patients. Then we looked for the coffee stains, anything that would upset or aggravate them," says Ski Lower, nurse manager of the Neuro-Critical Care Unit. "The goal was to find ways to do 99 things just 1 percent better. This approach to QM has tapped into the creativity of our nurses, and the ideas are great.

"We looked for things that would cause stress to families," she continues. "Like the phone ringing 12 times before it's answered. Or meeting us and seeing the unit for the first time on admitting day, when their anxiety is highest. Now the phone is answered in three rings, and patients come for tours well before surgery. None of these ideas is earth-shattering, but together they make a tremendous difference in the comfort level of our patients and their families.



"Each year, we're going to pick a different 'customer' and look for new '1 percenters.' The 'customer' might be pharmacy, another nursing unit, even ourselves, any relationship that could benefit from fresh ideas and better teamwork. This is really the root of QM. Can you imagine how it would be if everyone did this? Quality management would be part of everyday life. We constantly would be making the system better for ourselves and for our patients."

concerns and shrinking labor pools. For the past three years, we have been taking a hard look at the non-clinical aspects of health care delivery within the Johns Hopkins Health System. We haven't always liked what we've discovered. Surveys of our patients, physicians, nurses and employees have revealed a litany of frustrations that often cloud the ideal of giving and receiving excellent care.

To focus on these issues, we launched a Systemwide Quality Management (QM) process in 1989. With the wave of total participation now swelling, we know one thing for certain: We have what it takes to be "The Best of the Best" in service as well as in medicine. Slowly but surely, we are bringing that knowledge to life throughout our organization.

THE TAIL WAGGING THE DOG

"We discovered that new nurses were often upset by the time they began orientation," says Linda Arenth, vice president for nursing and patient services at Hopkins Hospital. Arenth is also chairman of the hospital's QM Steering Committee. "Who could blame them. As it turns out, we had a potentially frustrating employment process."

A 16-person, multidisciplinary QM team called the Employment Task Force set to work, with the idea that taking care of the caregivers supports a more caring environment for patients.

Composed of people from human resources and nursing, the team took the entire employment process apart, piece by piece, using a flow chart to map the path of paper and people that new nurses travel before starting work. With all possible frustration-causers now gathered together on a single diagram, a few likely culprits began to emerge.

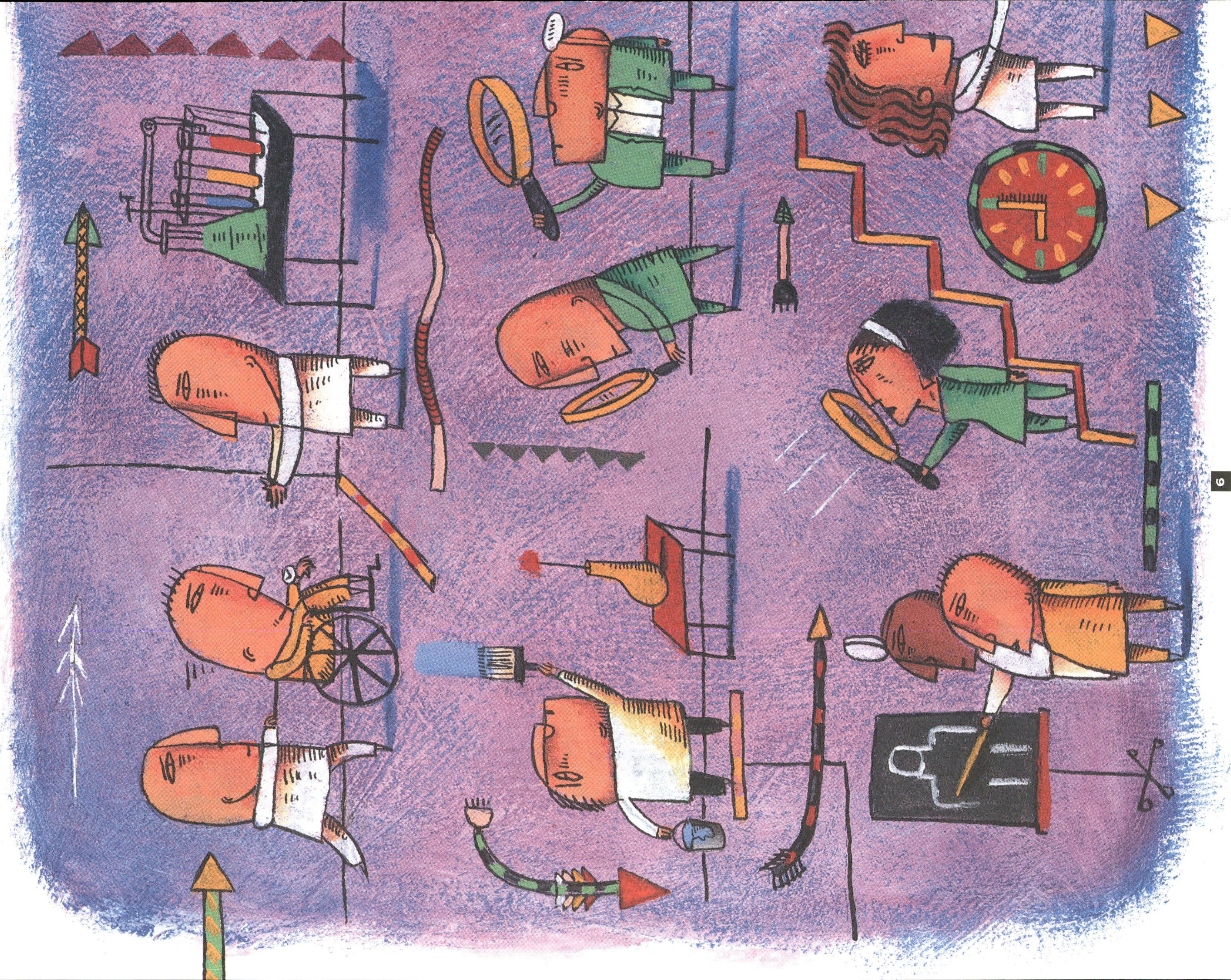
"For one thing, the flow of paperwork couldn't keep up with the flow of people," says Peter McGinn, Ph.D., vice president for human resources. "New nurses had too many places to go and things to do just to sign on." Other villains? Fingers pointed to the lack of tracking mechanisms for paperwork and well-defined pre-employment procedures for staff and recruits.

The QM team's recommendations—including redesign of the work flow, clearer linkage between departments, and a new employee information packet and map—are already easing the transition for new employees. Creative solutions are turning a once difficult initiation into a warm welcome to Hopkins.

THROUGH THE LOOKING GLASS

Of course, arriving at solutions that seem self-evident after the fact is not always easy. As any scientist will acknowledge, moments of insight usually are powered by long hours of scrutiny rather than flashes of serendipity. The path to new and better ways of doing things is lined with

QM IS LIKE UNRAVELING A MYSTERY. IT FORCES YOU TO UNTANGLE THE PIECES OF AN ACTIVITY, THEN SEE HOW YOU CAN BEST PUT THEM BACK TOGETHER.



BILL
YANG

days spent collecting data, analyzing systems, testing hypotheses and measuring results. It is this step-by-step approach that eventually peels away layers of complexity to reveal the essence from which new answers come.

"QM is like unraveling a mystery," says Judy Reitz, Sc.D., vice president for patient care and medical support services at The Francis Scott Key Medical Center (FSKMC). "That's what's so exciting. The process forces you to untangle all the pieces—to find out how something actually works—then see how you can best put it back together again."

QM teams throughout the Health System now are prying into the secrets of interdepartmental, intradepartmental and Systemwide functions. The projects cover the gamut—admissions, discharge, patient transport, medical records, to name a few—and are proving to be as complex as they are fundamental to the smooth functioning of every department.

PUTTING THE HORSE BEFORE THE CART

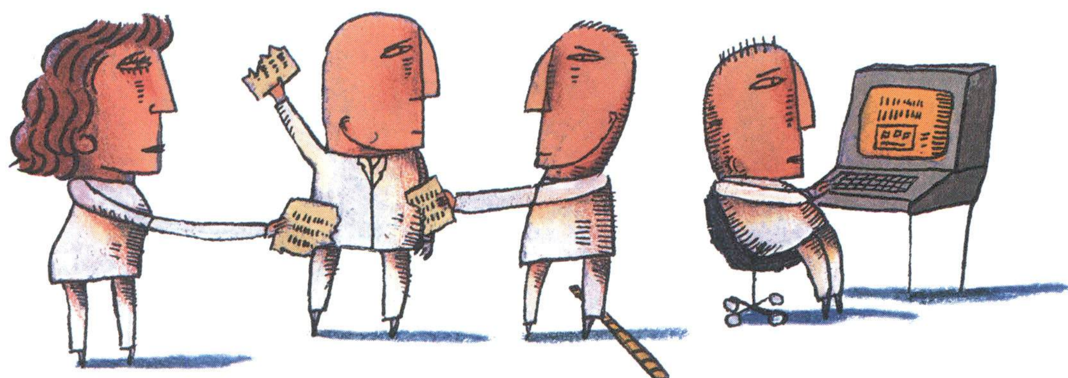
The QM-powered hunt for functional glitches has revealed some elemental truths. For one, rarely is the solution a matter of simply working harder. Clearly, Hopkins people already apply large doses of industry and elbow grease to their jobs. And as Ronald Peterson, president of FSKMC, points out, "QM doesn't mean throwing money at a problem. It's a common misconception that high quality and low cost are incompatible. Clarifying procedures and resolving issues between people and departments will result in quality improvements."

Quality issues in hospital management often are a case of having put the cart before the horse, of having operations—rather than the needs of patients—dictate procedures. As Reitz points out, trouble spots also arise from outmoded routines. "We're finding that many of the procedures we use no longer make sense," she says. "As an organization grows and changes, inefficiencies get embedded. We need to look at all areas—medical records, visitor control, admissions—to see if they are serving us and our patients well today."

IN SEARCH OF THE MISSING LINKS

Unlocking the mysteries of cash balances and bill collection rates ordinarily would be relegated to the number crunchers in the accounting department. But, thanks to QM, a team at FSKMC representing every major area of the hospital, from nursing and medical staff services to risk management, computer operations and admitting, is on the case. Its mission? To make billing more accurate. Getting it right the first time will mean fewer hassles for patients, third-party payers and the hospital.

As Ken Grabill puts it, "Timely, accurate billing is tied to the entire process of information capture from admission on." Grabill is vice president of finance at FSKMC. "The way diagnoses are filed, the way procedures are reported, the speed with which medical documents are passed along all affect billing." Interdepartmental cooperation will be the key to cutting through hang-ups and delays.



The early phases of information collection have given way to a timetable for accomplishing 65 specific action plans. As part of those plans, the team is creating unified policies, procedures and performance measurements for every step of the billing process throughout the patient flow. Coupled with the QM effort, a powerful new computer system will correlate data across hospital functions.

The catalyst for improving non-clinical aspects of health care came three years ago in the form of a $1 million grant from the Baxter Foundation. The idea was to look at management processes with an eye toward creating a national model for improving the service side of health care. The grant heralded what has become a rallying cry in the industry. Where accrediting organizations such as JCAHO once looked only at medically oriented quality assurance programs as indicators of excellence, they now are moving toward mandating quality management programs that handle issues of patient satisfaction as well.

Robert M. Heyssel, M.D., president of the Hopkins Health System and Hospital, believes QM to be an essential force for the future. "We're asking people to think differently about how they do things," he observes. "This is a process for the long-haul, not just a quick fix. Once QM takes hold, it will represent a change in the culture of our institution. The process empowers people to do their best work, and will ultimately ensure even better, more efficient care for our patients."

MORE THAN A MOUTHFUL OF JARGON

Of course, to be anything more than the slogan of the month, QM must become a deeply ingrained mind-set that emphasizes practical solutions to everyday problems. Training and the inspiration of other companies' experiences are helping jump-start creative attitudes toward worklife at every level.

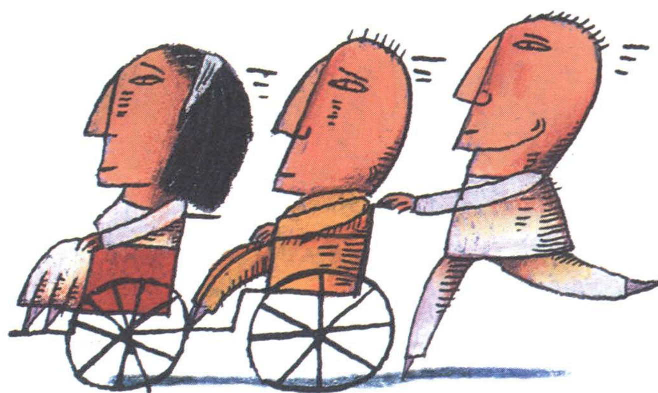
Understanding how to set up and work on a QM team is not an innate talent. Successful QM depends on knowledge of problem-solving, the use of statistical tools and the dynamics of teamwork. Intensive training, which every Health System employee eventually will undertake, is the critical first step. Teams train together to build esprit de corps. More than 500 people have received training so far. An additional 900 people at Hopkins Hospital alone will attend the 16-hour program in the coming year.

"It was fascinating," says Steven Lipstein of the training sessions developed by Dome Learning Systems Inc., a Hopkins subsidiary. Lipstein is executive director of the new

IF AT FIRST YOU DON'T SUCCEED

It's a tale replete with mistaken identities and circuitous twists and turns. The plot: "What's the matter with patient transport?," says Gerard Reardon, director of social work and co-chair of the X-ray transport QM team at Hopkins Hospital. "There was a legendary story of a patient leaving at 8 a.m. for a routine chest X-ray and not returning until after lunch."

Fingers pointed to the escort messenger service, the people responsible for transporting patients in wheelchairs or on gurneys to and from the units. But, as the team found out, the first suspect isn't always the culprit. "Over the past year, we've discovered how complex something as simple as moving a patient to radiology really is," says Reardon. "We asked our own experts—X-ray technicians, escorts, nurses, clerical staff—how things actually worked in their departments, and found a lack of coordination at key interchanges."



The first solution? Block times when nursing units could send patients to radiology, coupled with a goal of returning patients to the unit within one hour. "After we put the plan in effect, we started meeting the time goal," Reardon explains. "But strangely enough, when we evaluated further, we found that most patients were not going down during the block times. It was very perplexing.

"I think what actually happened was a subtle shift in awareness. Radiology scheduling had been organized around outpatient needs," he continues. "Now they schedule around inpatient needs, as well." The team's most recent survey of key players reveals better communication and, in typical QM fashion, new areas for improvement.

Outpatient Center. "In one of the exercises, each team member got a series of cards with facts relative to the care of a lawn. We had to figure out why the lawn wasn't growing. Based on their own cards, everyone believed that he knew what the problem was. When we started putting all the cards together, a whole different picture took shape. It became clear that pooling information and building consensus must happen before you can work on solutions."

Colene Daniel-Forde, vice president for corporate services, finds the experience of other businesses equally enlightening. "We invite corporations here on a monthly basis to find out how they have implemented the QM process," she says. "Managers and supervisors from organizations like Healthcare Forum, 3M, Abbott Laboratories and Federal Express bring us concrete examples of how QM can work in different environments. This is having a profound effect on my managers."

LEARNING TO HEAR, NOT JUST LISTEN

As the process gathers momentum through increasing staff participation, important lessons are emerging. One of the most significant has to do with listening to our customers, discovering what they actually mean by a criticism or compliment.

Says Barbara Reick, director of Quality Management at Hopkins Hospital, "In our initial surveys to identify areas that needed work, patients said that our facilities were not as clean as they could be. But when we started talking with people and looking at the problem from the patients' point of view, we realized that cleanliness wasn't the issue. The rooms were immaculate. The real problem was that some of the rooms needed a fresh coat of paint, new curtains or perhaps a brighter lightbulb."

The QM team working on this project decided to talk to some of our own experts manning the front-lines in facilities and housekeeping, as well as experts in hotel management at Marriott Corporation. The team's recommendations, now being tested in a pilot program at the Hopkins Children's Center, include a room refurbishment plan modeled after Marriott's.

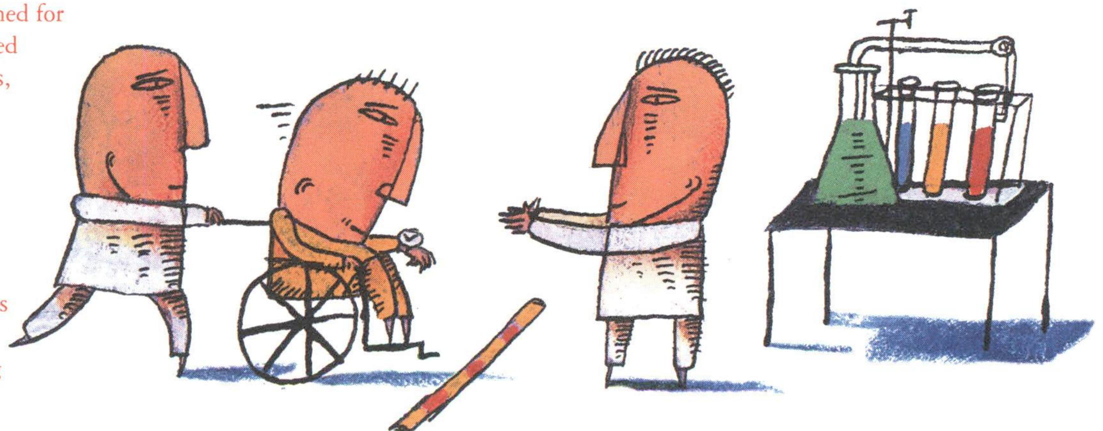
HOMING IN ON PATIENT SATISFACTION

Imagine a hospital experience in which every aspect of care moves like clockwork. For an outpatient that would mean scheduling all appointments with one phone call, moving swiftly through reception to the physician's office, having every step along the path clearly defined. Or for an inpatient, always receiving care by familiar faces, having services like X-ray and physical therapy right on the unit, receiving a single invoice for all aspects of care.

We call it the *ideal patient encounter*, a concept which has guided the planning of two new facilities, the Outpatient Center, scheduled to open at Hopkins Hospital this spring, and a new patient tower at FSKMC slated to begin construction this fall.

Says Steven Lipstein, executive director of the Outpatient Center, "The ideal patient encounter has three components: first, we'll deliver expert medical care; second, we'll treat patients with kindness, attentiveness and caring. Importantly, our third goal is to have patients spend more time seeing the clinician than they do registering, waiting for appointments or walking between offices. To achieve this, we've used computer modeling to determine the best organization of services for 8,000 outpatients per week."

The result is a facility designed for smooth patient flow. Automated systems and defined procedures, like advance registration, will help avoid bottlenecks. Diagnostic services, like radiology and blood testing, will be grouped together for convenience. Patient service coordinators will guide patients through the process. And systems for continually measuring our performance will be in place before our first patient walks through the door.



LOOKING TO OURSELVES FOR ANSWERS

Gathering an arsenal of QM tricks from other industries can be misleading, however. The case for change must be built on facts and goals that reflect the multiple missions of our own institution. According to Peterson, Hopkins' tri-fold mission of patient care, medical education and research complicates matters. "This is not like for-profit businesses where the mission is clearly organized around the bottom line," he says. "We have to address business imperatives in the light of our social and educational missions."

As McGinn puts it, "The challenge in health care is to identify the right things to measure and to gather that data in a way that is non-intrusive. We don't want to build a new bureaucracy. This has to be a built-in process, carried out by the people involved in patient care."

Industrial quality-management techniques designed to root out inefficiencies and streamline procedures are most applicable to functions involving information trails, accuracy and timeliness. "It's interesting to note that the statistical tools we're using to gather and analyze data on non-clinical functions are not easily applied to issues of medical efficacy," observes Lipstein. "Quality management serves a different purpose from traditional quality assurance."

Hot on the heels of QM fact-finding and analysis comes a step-by-step outline and timetable for implementing changes, and a strategy for measuring results. Consistent monitoring of progress and periodic reassessment of goals will plant the seeds for continual improvement in all things related to patient comfort and satisfaction.

BACK TO BASICS

Perhaps the most basic lesson learned so far is that there is no substitute for good communication. "Consistently we find that people don't understand how their job affects someone else's," observes Arenth. "The QM team working on the admissions process is tracing every step from the physician's initial referral to the moment the patient enters the room. We find that simple things, like a physician's secretary holding paperwork to send in batches, can slow everything down all along the line. Now that we know how all the pieces link together, we can determine how each connection is best achieved."

"As QM progresses, we're finding that more people look to their peers and co-workers to solve problems or increase efficiency," adds Daniel-Forde. "Quality teams define their own projects and design new systems themselves. They begin to understand the importance of their jobs and the value placed on their ideas. Clearly this makes the Health System run better and improves the patient care environment."

And that's the whole point. With the QM process helping us bring more mysteries of managing the Health System to light, everyone at Hopkins will have more opportunities to do what we do best even better.

QM DOESN'T MEAN THROWING MONEY AT A PROBLEM. IT'S A COMMON MISCONCEPTION THAT HIGH QUALITY AND LOW COST ARE INCOMPATIBLE.

FACTS AND FIGURES

Hospital Operating Statistics

Fiscal Year 1991	JHH	FSK[1]	JHMSC[3]	Total
Discharges	37,263	13,234	5,279	55,776
Deliveries	3,734	1,136	0	4,870
Patient Days	292,856	87,799	38,550	419,205
Average Length of Stay (Days)	7.9	6.7	7.3	7.5
Average Daily Census	802	241	106	1,149
Outpatient Visits/Encounters[2]	397,135	180,327	394,820	972,282
Emergency Visits	83,887	36,972	8,279	129,138
Operating Room Procedures				
– Inpatient	14,362	2,990	1,221	18,573
– Outpatient	9,553	2,051	2,407	14,011

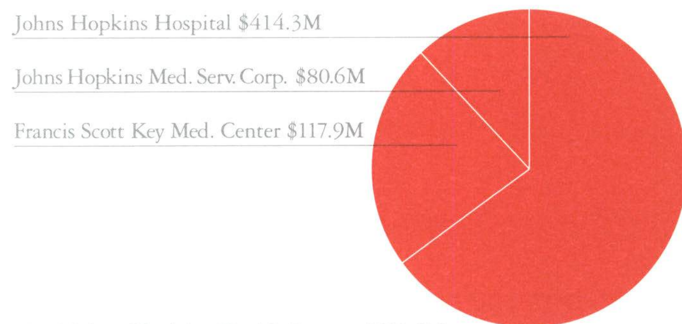
[1]*Acute Care Hospital - excludes Mason F. Lord*
[2]*JHH includes Hospital and University Clinics*
[3]*JHMSC includes The Johns Hopkins Health Plan and The Homewood Hospital Center Inc.*

Financial Statistics

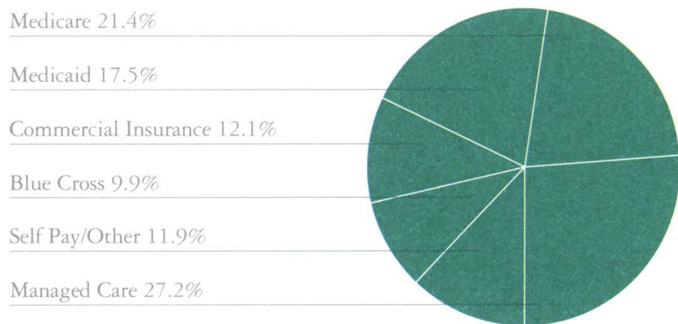
Fiscal Year 1991	JHH	FSK[1]	JHMSC[2]	Total
Gross Revenue	$ 414.3	$ 117.9	$ 80.6	$ 612.8
Net Revenue	367.8	120.1	85.8	573.7
Total Expenses	365.3	118.6	87.6	571.5
Margin Before Debt	2.5	1.5	–1.8	2.2
Margin After Debt	0.0	1.5	–3.9	–2.4
Uncompensated Patient Care	37.0	11.9	6.7	55.6

[1]*Includes Mason F. Lord and Grant Programs*
[2]*Includes Net Operating Revenue, Other Revenue and Net Financial Results of Discontinued Operations for The Johns Hopkins Health Plan and The Homewood Hospital Center Inc.*

Gross Revenues
Fiscal Year 1991



Revenue Payer Mix
Fiscal Year 1991



Hospital Patient Origin

Calendar Year 1990

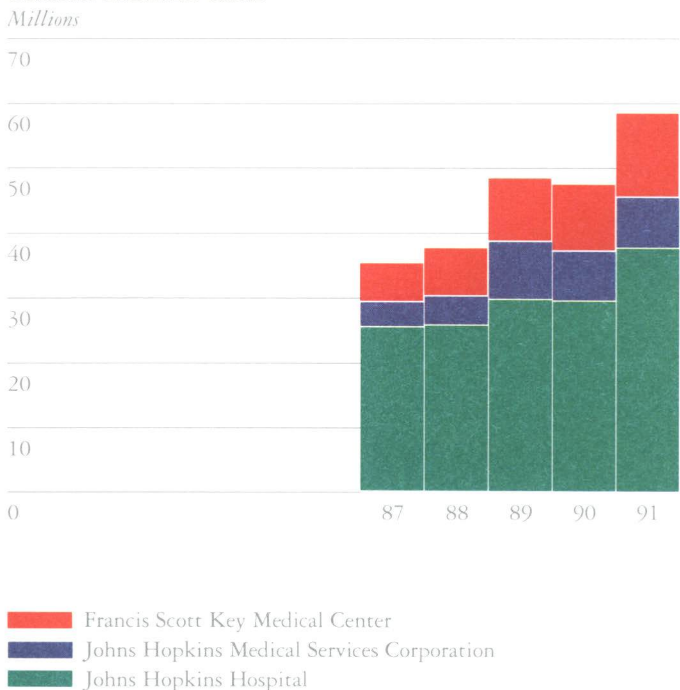
	Baltimore City and Adjacent Communities	Baltimore Metropolitan Area	Remainder of Maryland	Other USA & International
Johns Hopkins Hospital	57%	15%	13%	15%
Francis Scott Key Medical Center	90%	5%	3%	2%
Johns Hopkins Medical Services Corporation	86%	11%	2%	1%
Johns Hopkins Health System	68%	13%	9%	10%

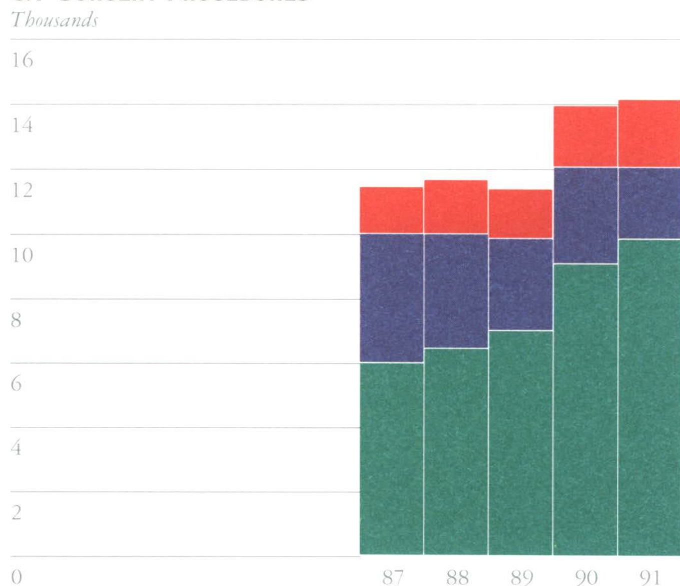
Medical Staff and Personnel

Fiscal Year 1991

	JHH	FSK[1]	JHMSC	Total
Total Employees (FTEs)[2]	5,617	1,579	1,590	8,786
Medical Staff[3]	1,527	471	457	2,455
Registered Nurses (FTEs)	1,522	359	190	2,071
House Staff[4]	597	107	0	704

[1] *Acute Care Hospital - excludes Mason F. Lord and Grant Programs*
[2] *Excludes Hospital Medical Staff*
[3] *Active, Courtesy, and Associate Staff*
[4] *Interns and Residents - includes some shared appointments*





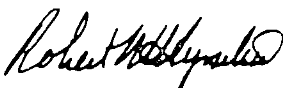
Francis Scott Key Medical Center
Johns Hopkins Medical Services Corporation
Johns Hopkins Hospital

We were pleased this year to be recognized once again by *U.S. News & World Report,* this time as "The Best of the Best." In a national survey of physicians, we ranked at or near the top in 13 of the 15 specialties reviewed.

This has been a most significant year for the discovery of new knowledge that will benefit patients. Two findings in particular—the gene whose altered forms cause two inherited types of colon cancer and a gene responsible for Marfan syndrome —should lead to the rapid development of screening tests and earlier treatment for high-risk individuals. The opening of the Richard Starr Ross Research Building in June increased School of Medicine research space by more than one third, and will support the continued flow of such advances from laboratory to bedside.

Hopkins physician scientists also are looking at the impact of various technologies and procedures on patient recovery. This research, together with ongoing quality assurance and quality management programs, will support our efforts to maintain quality while controlling the cost of health care.

Finally, work on the new Outpatient Center is proceeding smoothly. We expect to open our doors for business in May 1992.



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BALANCE SHEETS* *(in thousands)*	*June 30, 1991*	*June 30, 1990*
Assets		
Current Assets		
Cash and temporary investments	$ 24,936	$ 27,163
Accounts receivable, net	94,783	83,664
Other current assets	4,649	5,031
Total current assets	124,368	115,858
Investments at cost, which approximates market	9,367	8,971
Property, Plant and Equipment, net of depreciation	236,662	210,051
Capital Improvement Funds	4,701	3,764
Assets Whose Use Is Limited	46,243	65,100
Other Assets	9,567	8,895
Total Assets	$ 430,908	$ 412,639
Liabilities and Capital		
Current Liabilities	$ 81,517	$ 67,760
Long-Term Debt	181,752	182,172
Unexpended Restricted Gifts and Grants	9,226	8,760
Other Liabilities	884	884
Fund Balance	157,529	153,063
Total Liabilities and Fund Balance	$ 430,908	$ 412,639

STATEMENTS OF REVENUE AND EXPENSE *(in thousands)*	*June 30, 1991*	*June 30, 1990*
Gross revenue from services to patients:		
Inpatient	$ 333,842	$ 307,566
Outpatient	80,422	74,271
	414,264	381,837
Allowances	54,237	45,490
Net revenue from services to patients	360,027	336,347
Other operating revenue	6,219	6,149
Total operating revenue	366,246	342,496
Operating expenses	365,278	337,883
Excess (deficiency) of operating revenue over operating expenses	968	4,613
Non-operating revenue	1,542	1,884
Excess (deficiency) of revenue over expenses	$ 2,510	$ 6,497

**For full financial statements, write:*
Senior Vice President for Finance, the Johns Hopkins Health System,
600 North Wolfe Street, Baltimore, Maryland 21205.

Last year's successful $99 million bond issue enabled us to move briskly ahead with our redevelopment plan for The Francis Scott Key Medical Center. We celebrated the opening of the new Geriatrics Center in June. Phase I, which included the center and a new central utilities plant, is officially complete.

We now are beginning redevelopment Phase II. Plans for the new acute patient tower are nearing completion, and construction is slated to start this fall. We expect the new facility to open late in 1993, with 190 replacement beds and new ancillary and support services. The design process has been most exciting. Because we are building from the ground up, the tower will embody the most progressive ideas for delivering efficient, patient-focused medical care and services.

Ronald R. Peterson
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BALANCE SHEETS*

(in thousands)

	June 30, 1991	*June 30, 1990*
Assets		
Current Assets		
Cash and temporary investments	$ 18,122	$ 14,226
Accounts receivable, net	34,761	29,688
Other current assets	1,446	1,473
Total current assets	54,329	45,387
Property, Plant and Equipment, net of depreciation	64,054	45,052
Assets Whose Use Is Limited	57,202	0
Other Assets	3,859	268
Total Assets	$ 179,444	$ 90,707
Liabilities and Capital		
Current Liabilities	$ 29,486	$ 20,585
Long-Term Debt	97,204	19,067
Unexpended Restricted Gifts and Grants	781	593
Other Liabilities	184	184
Fund Balance	51,789	50,278
Total Liabilities and Fund Balance	$ 179,444	$ 90,707

STATEMENTS OF REVENUE AND EXPENSE

(in thousands)

	June 30, 1991	*June 30, 1990*
Gross revenue from services to patients:		
Inpatient	$ 92,955	$ 90,334
Outpatient	24,943	21,340
	117,898	111,674
Allowances	18,221	16,280
Net revenue from services to patients	99,677	95,394
Other operating revenue	19,419	17,482
Total operating revenue	119,096	112,876
Operating expenses	118,684	110,794
Excess (deficiency) of operating revenue over operating expenses	412	2,082
Non-operating revenue	1,043	1,179
Excess (deficiency) of revenue over expenses	$ 1,455	$ 3,261

**For full financial statements, write:*
Senior Vice President for Finance, the Johns Hopkins Health System,
600 North Wolfe Street, Baltimore, Maryland 21205.

We are in the process of pulling together two physician groups—the Hopkins Health Plan Associates and the Wyman Park Medical Associates—into a single organization. At the same time, we are reorganizing the management of 18 clinical sites under the umbrella of the Medical Services Corporation.

These two entities share a series of common goals: to offer Hopkins-quality managed and fee-for-service care in the community, to be a referral source for Health System hospitals, and to participate in the broader mission of medical education by providing on-site clinical experience for students. Through these physician groups, we also will fulfill our commitment to care for Prudential Health Plan members and Uniformed Services dependents and retirees.

We look forward to strengthening the Hopkins presence in an expanding area of medical services.

Richard K. Tompkins, M.D.
President and Chief Executive Officer

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BALANCE SHEETS*
(in thousands)

	June 30, 1991	*June 30, 1990*
Assets		
Current Assets		
Cash and temporary investments	$ 5,599	$ 22,956
Accounts receivable, net	10,642	22,524
Current assets of discontinued operations	33,347	0
Other current assets	193	983
Total current assets	49,781	46,463
Investments at cost, which approximates market	0	142
Property, Plant and Equipment, net of depreciation	40,271	60,321
Assets Whose Use Is Limited	73	1,161
Other Assets	3,488	1,791
Total Assets	$ 93,613	$ 109,878
Liabilities and Capital		
Current Liabilities	$ 7,279	$ 38,848
Liabilities related to discontinued operations	39,990	0
Long-Term Debt	11,035	21,495
Unexpended Restricted Gifts and Grants	66	21
Other Liabilities	921	1,427
Fund Balance	34,322	48,087
Total Liabilities and Fund Balance	$ 93,613	$ 109,878

STATEMENTS OF REVENUE AND EXPENSE
(in thousands)

	June 30, 1991	*June 30, 1990*
Gross revenue from services to patients:		
Inpatient	$ 204	$ 379
Outpatient	2,078	3,965
Capitation	78,366	60,627
	80,648	64,971
Allowances	2,866	2,191
Net revenue from services to patients	77,782	62,780
**Other revenue	7,973	5,936
Total revenue	85,755	68,716
Operating expenses	87,520	69,897
Deficiency of revenue over expenses	($ 1,765)	($ 1,181)

***Includes Net Gain from Sale of The Johns Hopkins Health Plan Commercial Insurance Line of Business and Closure of The Homewood Hospital Center Inc.*

**For full financial statements, write:*
Senior Vice President for Finance, the Johns Hopkins Health System,
600 North Wolfe Street, Baltimore, Maryland 21205.

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