

Planning for the Future of Population Health: The Johns Hopkins Medicine Experience

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Johns Hopkins Medicine (JHM) recently underwent a significant evolution of its population health delivery with the introduction of a new Office of Population Health (OPH).¹⁻³ A transition of various programs and functions from across JHM became housed within a centralized, provider-integrated office. The principal goal was to improve coordination across the continuum of care and integration among physician groups, hospitals, home care, and other delivery and financing constructs of JHM. In doing so, OPH aligns longitudinal, measurement-based care that can ultimately serve all patients and payers in delivering a patient-centered care model as a population health services organization (PHSO) advances execution on health outcomes. There had been 3 stages: (1) building a hybrid clinical and administrative organizational structure; (2) establishing initial priorities for development, performance management, and execution; and (3) advancing a multistakeholder strategic planning process to formalize objectives for the next few years. As others around the country seek to look critically at their population health infrastructure and strategic development, we hope this approach may prove useful.

Building the Foundation

The vision for a new centralized OPH originated with JHM senior leadership to advance provider-based integration and performance. A search process identified a chief population health officer and vice president of population health, reporting to the health system president, with an understanding of the local Johns Hopkins and community landscape and with expertise on improving care coordination and value in care delivery. The reporting structure can be important in navigating the complexity of population health delivery and financing in an academic health system context.^{4,5} After reviewing various population health models around the country, this leader identified a hybrid structure of clinical and administrative disciplines. OPH established a provider-led senior leadership governance to hold it accountable and to provide insights and guidance. Executive directors for administration and for clinical services were identified through national search processes to oversee respective domains. Ambulatory care management and

ABSTRACT

Johns Hopkins Medicine underwent a significant evolution with a new Office of Population Health (OPH), inclusive of a hybrid clinical and administrative structure, to optimally align expertise with care delivery functions. Initial priorities included identification of high-risk patients to receive care management, integrated behavioral health, and wraparound supports to address social determinants of health. A cross-functional care team provides multidisciplinary support for primary care practice patient needs, and efforts through the Baltimore Metropolitan Diabetes Regional Partnership have helped accelerate scaling of evidence-based diabetes prevention and management programs across the state. Through a multistakeholder process, OPH and partners developed a 3-year strategic plan, with guiding stars of reducing avoidable utilization and disparities in care. The plan prioritized (1) generation of a data and analytics road map, (2) advanced population management clinical services for priority populations, (3) improved performance on value-based care programming, and (4) enhanced health system coordination. With a new OPH, Johns Hopkins Medicine is better positioned to execute on value-based initiatives in support of its patients.

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TAKEAWAY POINTS

In this article, we review an evolution of population health management organization at Johns Hopkins Medicine with the purpose of establishing the following:

- ▶ A new structural foundation to enable improved execution across clinical and administrative population health disciplines.
- ▶ Initial priorities around high-risk patient management inclusive of care management with wraparound support services to help address social determinants of health.
- ▶ A multiyear strategic plan with guiding stars focused on reducing avoidable utilization and health disparities and advancing strategies in data analytics, clinical services, value-based care, and health system coordination.

for both the CDC Diabetes Prevention Program and American Diabetes Association Diabetes Self-Management Training. Although there is focus on meeting scale target objectives, there is also interest in finding a mechanism to deliver these services beyond the Medicare population as they are beneficial universally. The Maryland Primary Care Program includes a Care Transformation Organization to provide value-added care transformation services to primary care practices.⁷

behavioral health (BH) resources, a project management team and supportive services from the health plan, and a cadre of community health workers (CHWs) supported through a Maryland job creation initiative were realigned within this emerging structure. Several existing initiatives were funded through the state of Maryland, and an incremental financing model spanning JHM entities enabled development of a foundation that could be scaled toward payer-agnostic capabilities.

Establishing Clinical and Administrative Pillars

The clinical services delivery aligns a cross-functional care team (CFCT) deployed to provide supportive services to high-risk/high-utilizing populations, development of a transitional-based care platform, and community health activities. The CFCT includes care management professionals, BH licensed clinical social workers with psychiatry oversight, pharmacists, and CHWs working as an interprofessional collaborative. OPH is engaged in operational redesign to optimize deployment and engagement of the CFCT model to outperform targets set forth on value-based care arrangements, as well as a more seamless postacute care transition. Within a community health pillar, OPH focuses on promoting health equity through social needs screening and referral, partnership with community-based organizations, and a CHW team deployed through a whole-person care model. An administrative services pillar incorporates budgeting, financial accountability and sustainability, project and performance management, policies and procedures, and other support functions. Finally, the analytics and evaluation pillar is multidisciplinary and insight driven, designed to surface new knowledge and advance solutions toward real-time analytics, inclusive of population segmentation, predictive risk, and the ability to evaluate impact and value generation.

OPH oversees various care transformation programs funded through the state of Maryland via its unique all-payer financing model and has incorporated these initiatives within a broader framework toward delivery of PHSO services. As an example, there is a \$43 million 5-year partnership between Johns Hopkins Health System and the University of Maryland Medical Center to support improved diabetes prevention and management known as the Baltimore Metropolitan Diabetes Regional Partnership (BMDRP).⁶ The BMDRP is seeking to dramatically increase referrals and enrollment

Initial Priorities and Strategic Planning

OPH established initial priorities to meet enterprise needs, including (1) high-risk/high-utilization patient identification and connection to care management resources; (2) development of CFCT workflows; (3) collaboration with the Office of Diversity, Inclusion and Health Equity related to social determinants of health (SDOH) data collection and response; (4) BH intervention refinement; and (5) the development of a 3-year strategic plan.

Being able to identify newly high-risk/high-utilizing patients to provide timely and appropriate care management along with wraparound support resources was an initial priority. Identification of risk was both retrospective (2 or more hospitalizations or observation stays, or 3 or more emergency department visits in the last 6 months) and prospective (an ACG risk score of > 0.5 for predicting hospitalization in the next 6 months), or by direct provider referrals. High-risk patient lists were generated every 2 weeks and shared with care management and other disciplines. To improve coordination, near-real-time patient lists were generated at the time of hospitalization to enable “in-reach” from ambulatory care teams to inpatient care teams. Clinical processes and workflow development also focused on interdisciplinary patient assessments and coordination among CFCT disciplines. Social needs screening leveraged the Epic SDOH wheel and the Findhelp (formerly Aunt Bertha) platform was selected to identify community resource support opportunities.

OPH simultaneously advanced a strategic planning process with dozens of representatives from across the enterprise. “Bending the utilization curve” and “reducing health disparities” were identified by stakeholders as 2 guiding stars for the process. Core areas of focus for the strategic plan included the following areas, for which concrete tactics were developed: (1) creation and execution of an analytics road map so that data-driven capabilities drive the work, (2) clinical service delivery to enable advanced population management for priority populations, (3) engagement and performance on value-based care programs that improve health and catalyze the health system journey to value, and (4) aligning health system goals and financial models across JHM entities related to population health activities (Table). In addition to these core areas of focus, the strategic planning process identified 4 priority areas that would require significant enterprise-wide collaboration to

advance, inclusive of all-payer care delivery, BH expansion, a postacute care road map, and implementation of cross-continuum care pathways for chronic conditions.

OPH now implements its strategic plan, following its analytics road map to identify priority populations and deploy its care model, while harmonizing population health activities across JHM and leveraging value-based care initiatives with a goal of improving health and optimizing performance. Within a complex and matrixed organization such as an academic health system, ensuring alignment with other centralized functions and individual delivery entities and departments can be challenging but, if prioritized and achieved, can dramatically improve synergies and reduce redundancy. This is particularly important at this time of financial challenge as health care emerges from the COVID-19 pandemic and OPH continues to evolve its operating model to achieve impact and build the PHSO toward all-payer care delivery. ■

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TABLE. Overview of JHM Office of Population Health Strategic Plan: Strategies and Tactics

1. Data analytics: data-driven population health to inform and guide our work
1.1. Implement the Data Analytics Roadmap to augment JHM's foundation for population health data analytics
1.2. Use population health data analytics to identify health disparities in our patient populations
2. Clinical services: advanced population health management for our priority populations
2.1. Create and implement a Clinical Services Roadmap to enhance our population health management interventions
2.2. Coordinate transitions of care initiatives to improve continuity of care
2.3. Expand community health services and partnerships with community organizations to reach JHM's patients from groups that have been historically disinvested
3. Value-based care: performance on value-based programs to make the case for new opportunities
3.1. Continuously improve our population health management capabilities and achieve Maryland Primary Care Program goals
3.2. Achieve Diabetes Prevention and Education Program goals
4. Health system coordination: aligning health system goals and interventions to support population health
4.1. Help JHM and its entities set population health goals
4.2. Develop the Office of Population Health's regional focus programs

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