JOHNS HOPKINS COMMUNITY PHYSICIANS

Fiscal Year 2020 Annual Report

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A Message from the President

Steven Kravet, M.D., M.B.A.

Welcome to the Fiscal Year 2020 Annual Report of Johns Hopkins Community Physicians (JHCP). To put it bluntly, FY20 was not easy. It presented all of us with challenges – professional, clinical, and personal – that we continue to overcome *together*. This report provides a platform for sharing the stories of success and achievement across our organization from that tumultuous year.

Johns Hopkins Community Physicians is a diverse group of more than 1500 health care heroes. The more than 500 providers and affiliates on our team include primary care and specialty-care physicians, nurse practitioners, physician assistants and surgeons. Our practices and administrative spaces extend across the state of Maryland and Washington, D.C. The geographic footprint of our organization is vast and continues to grow.

COVID-19 fundamentally changed the way we deliver care to our patients. We have adopted new practices to maintain the safety of our teams and communities with strength and determination. In this report, you will read stories about JHCP's pivot to telemedicine, recruitment and hiring efforts for the Baltimore Convention Center Field Hospital, a new Mentorship Program from our Diversity Council and much, much more.

While we cannot include every story and accomplishment of FY20 in this report, I hope that the resolve, resilience and creativity of our entire organization is reflected in the few that we selected. To me, these stories prove that no trial is too great for our staff and providers to overcome and that no challenge can disrupt our focus of providing excellent patient-centered care.

My most sincere thank you to our patients, staff, providers, Board Members, friends and supporters for contributing to our unprecedented year.

All my best,

Steven J. Kravet, M.D., M.B.A.
President
Johns Hopkins Community Physicians

Rising to the Occasion: JHCP's COVID-19 Response in FY20

The COVID-19 pandemic changed the way we all live and work. In the latter half of Johns Hopkins Community Physicians' (JHCP) fiscal year 2020, COVID-19 shifted priorities for employees across the organization as they responded to the public health crisis. Some refocused their efforts to bolster administrative support for practices, some transformed workflows that would change the way care is delivered, while some donned personal protective equipment (PPE) on the frontlines and dedicated themselves to the health and safety of patients in a whole new way. No matter the role, each member of the JHCP team rose to the occasion with unyielding determination, selfless service and unwavering strength.

Johns Hopkins Community Physicians is a team of health care heroes.

Below is a small collection of COVID-19-related efforts from fiscal year 2020.

The Incident Command Team

Led by vice president of practice operations and chief operating officer, Melissa Helicke, and vice president of medical affairs, Ray Zollinger, the JHCP Incident Command Team (ICT) was established on March 10, 2020, to provide a coordinated and efficient approach to leadership, communication and decision-making in response to the COVID-19 pandemic. The centralized, multidisciplinary team ensured harmonization with Johns Hopkins Medicine efforts, and supported JHCP practices, providers and staff. Representatives from central operations, education and training, human resources, information systems, marketing and communications, patient safety and regulatory compliance made up the team. Many of JHCP's COVID-19-related achievements found their roots in the ICT, including but not limited to:

- Development and implementation of ambulatory entrance screening processes
- Safely reopening practices in accordance with COVID-19 Safety Auditor implementation
- Bilateral communications strategies (weekly director meetings, weekly practice leadership meetings, an internal ICT dial-in help line and an internal email help line) and daily COVID-19 update newsletter
- The pivot to telemedicine
- Supported a phone line for the Baltimore community to call for advice and care related to COVID-19 (340 calls taken and patients supported)

COVID-19 Safety Auditors

Before beginning to safely increase in-person appointments at our practices at the end of fiscal year 2020, the COVID-19 Safety Auditor (CSA) role was created. Each location required a CSA, who would receive training and actively monitor PPE usage, hand hygiene, physical distancing and enhanced environmental cleaning and disinfection at least four times per shift. The CSA documents and submits a report of their findings, following a detailed checklist. Patient safety program administrator Amanda Cullison analyzed reports and followed-up with any concerns. By the end of FY20, more than 180 JHCP employees were trained as CSAs to ensure the safety of our patients and our teams.

JHCP Go-Team

A dedicated group of JHCP clinical staff, led by director of operations and nurse practitioner Kimberly Zeren, brought the JHCP mission "bring Johns Hopkins Medicine to our communities" to life. In May 2020, the "Go-Team" collected specimens for COVID-19 testing from 335 collective patients at three long-term care facilities. Later, team members would also be deployed to serve the Latinx community in Howard County. We commend this team for supporting our communities and for supporting the reduction of COVID-19 testing barriers when it was needed most.

Supporting the Baltimore Convention Center Field Hospital

Both the JHCP human resources and credentialing teams played pivotal roles in the development of the Baltimore Convention Center Field Hospital, by managing the hiring and credentialing processes for all hospitalist providers. In a matter of mere weeks, the human resources team recruited and hired 100 providers and the credentialing team put into practice an Emergency Disaster Privileging Plan to credential 166 medical staff and providers.

- Read the Human Resources story
- Read the Credentialing story

Supply Chain and Personal Protective Equipment

Led by Nicole Weyant, project administrator for central operations, efforts to streamline supply chain activities included, but were not limited to:

- Developed a centralized JHCP supply chain for COVID-19 supplies to ensure conservation and adequate supply at each JHCP location
- Deployed personal protective equipment (PPE) kits to each JHCP employee
- Deployed plexiglass barriers to each location, as requested
- By the numbers:
    - 967 PPE kits distributed
    - 1100 N95 masks ordered
    - 185 plexiglass barriers ordered and deployed

Going Digital – From In-Person Visits to Telemedicine

JHCP Information Systems deployed:

- 200 laptops
- 450 webcams
- 575 headsets

To support the safety of our patients and teams, by the end of fiscal year 2020 the majority of patient encounters were completed through video and phone visits. In fact, the pivot to telemedicine happened nearly overnight. This endeavor, lead by the Johns Hopkins Medicine Office of Telemedicine, was a team effort from the start. Nearly all administrative departments had a hand in supporting the effort, and staff and providers at all JHCP locations worked tirelessly to convert appointments from in-person to telemedicine visits and to learn new workflows and technologies to make the process as smooth and convenient for patients as possible.

- Read the Education & Training story
- Read the Information Systems story

Primary Care Clinical Innovation

Johns Hopkins Community Physicians (JHCP) is dedicated to transforming the way that care is delivered through the development of innovative and high value primary care models. Overseen by JHCP chief of primary care clinical innovation, Michael Albert, these programs are designed to provide exceptional experience and wrap-around care for the segments of patients they serve, with a majority of models focused on patients that need additional time and attention. JHCP's clinical innovations are a vital step towards expanding upon value-based care. Many programs flourished in fiscal year 2020. See summaries below.

DPC | JHOME | PAPC | MESH | SHARP

Direct Primary Care

Direct Primary Care (DPC) is fundamentally changing the delivery of primary care. Launched in January, 2019, this practice is part of a series of innovative primary care models in the JHCP platform. The DPC practice offers Johns Hopkins Health System employees an opportunity to connect with a primary care provider through extended hours and virtual services. Each primary care provider manages a smaller patient panel, allowing the provider more time to meet with their patients and promote a personalized care experience to employees. Led by two providers in fiscal year 2020, Norman Dy and Carolyn Le, the practice continued to achieve success in its second year. DPC's longstanding integration of video, telephonic and MyChart delivered

care, in addition to standard in-person medical care, helped it seamlessly care for its patients through the COVID-19 pandemic. The majority of DPC patients engaged with the team, often multiple times, in a very challenging 2020. Despite these challenges, DPC was ranked at the top of JHM primary care practices in both CAPHS scores and quality metrics in 2020. The program expanded its enrollees by 25 percent in fiscal year 2020, and hopes to extend that trend into the future.

Johns Hopkins Home Based Primary Care

Johns Hopkins Home Based Primary Care (JHOME) is an innovation in primary care that also features "right-sized" panels. Its major point of differentiation lies in its name – it is home-based. JHOME had served home-bound elderly patients for decades as part of the Bayview geriatric academic program, before transitioning to Johns Hopkins Health System in 2019, under the direction of Johns Hopkins Home Care Group and Johns Hopkins Community Physicians. The multidisciplinary provider team, comprised of one physician and three nurse practitioners, ensures that home-bound geriatric patients have access to seamless primary care. In fiscal year 2020, the program's panel doubled in size and its Johns Hopkins Medicare Advantage panel also grew rapidly. The JHOME team pivoted quickly to telemedicine visits during the COVID-19 pandemic, while still performing essential house calls safely.

Priority Access Primary Care

Priority Access Primary Care (PAPC) is an innovative primary care model that employs a small, "right-sized" panel approach to provide more comprehensive care to a select subset of medically complex Medicaid patients in East Baltimore. Patients have 24/7 direct phone access to their provider and behavioral health resources are embedded in the program. With smaller panels, providers offer extended office visits and are fully available via phone to their patients, specialists and coordinating hospitals. Templates are fully open to meet the needs of their patients. The program, currently located at East Baltimore Medical Center, has continued to demonstrate great outcomes and positive results for its patients. Fiscal year 2020 saw the program maintain its 55 to 60 percent reduction in emergency department visits and hospitalizations for its high-risk patients.

Multidisciplinary Empowerment for Sustainable Health

The Multidisciplinary Empowerment for Sustainable Health (MESH) is modeled after PAPC with small panels of high-risk patients, managed by a multidisciplinary team. The major difference between the programs is that MESH was developed for Medicare and Medicare Advantage patients and is located at JHCP's Bayview General Internal Medicine practice. MESH began in fiscal year 2019 and is led by office medical director and director of primary care services at Bayview, Heather Agee. Like PAPC, MESH frees its providers from volume-based care and has also resulted in multiple positive outcomes. In its second year, MESH solidified team-based and care management processes and embedded behavioral health services into its offerings. The MESH program, coordinating actively with JHOME to manage high-risk patients who are not homebound or home-limited, saw its panel size grow to 130 patients in fiscal year 2020 and achieved a 40 percent reduction in emergency department visits.

Small High Acuity/Risk Panel

SHARP (Small High Acuity/Risk Panel) also saw significant growth in its second year. This program utilizes a multidisciplinary, team-based approach. The model features a nurse practitioner that works at the center of a pod of several primary care providers (PCP), supporting them in the management of each of their highest-risk patients. This embedded, small-panel "co-PCP" enhances and adds to the standard level of care of a single full-panel PCP, allowing for more comprehensive care including extended visits, increased access, virtual services and care coordination. Starting as a pilot at JHCP's White Marsh location, SHARP expanded to EBMC, Westminster and Hagerstown locations during fiscal year 2020. The program added four nurse practitioners to its arsenal, for a total of six, and grew its panel from 200 to well over 600 patients. SHARP adapted to the COVID-19 pandemic by providing much needed telemedicine support to some of the more complex patients in their practices.

The Stories of Fiscal Year 2020

Adult Primary Care
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Cardiology
Central Operations
Credentialing
Diversity Council
Education & Training
Finance
Gyn/Ob
Hospital Medicine
Human Resources
Information Systems
Marketing & Communications
Maryland Suburbs
National Capital Region
Neurology | Medical Specialty
Patient Experience
Pediatric Medicine
Quality & Transformation
Research
Risk, Safety & Service

Adult Primary Care

Engaging the Entire Team: More Energizing Than Your Morning Coffee

Improving quality metrics has been a focus for departments and services across Johns Hopkins Community Physicians (JHCP), and in fiscal year 2020, leaders in adult primary care made progress with one method in particular: engagement of the entire care team.

According to JHCP's chief of internal medicine and primary care clinical innovation, Michael Albert, and chief of family medicine, Steven Blash, there are many benefits with a team-based approach to quality improvement. A major benefit is psychological: Teamwork makes big asks more manageable — it takes the onus off of one person, and distributes the workload. "Engaging everyone and working collaboratively is energizing," Albert notes. "Knowing that I have a team that is also invested in quality improvement scores is motivating and gives us the best chance of success." The more touchpoints with the patient, the more likely we are to capture quality outcomes, like hypertension and diabetes control, annual well visits and colorectal cancer screenings. The team-based approach can also ensure that every member of the care team is working at the top of their license.

One of the easiest and most effective ways to engage the whole team is through daily huddles. Blash says he and a member of his medical assistant (MA) team have a five-minute huddle every morning before patient care begins. They use the time to review the day's appointments and who may be a candidate for a mammography, or who might need an A1C test for diabetes control. He says the meetings require a bit of preparation time, but that they are more than worth it, likening them to morning cups of coffee. "They are a centering experience for the day," he says, "a time to re-focus and make a game plan." He notes that his MAs often initiate the huddles, keeping him on track. Albert and Blash have noticed providers holding more morning huddles with their teams during the past year — a testament to their effectiveness.

A new method, similar to having the morning meetings, that emerged during fiscal year 2020 is holding a Secure Chat — a secure instant messaging function built into JHCP's electronic medical records system (EMR), Epic. Before Secure Chat, teams could use the messaging capability in their in-basket, but those messages would easily get buried among others. This new function increases real-time communication, and makes messages easy to find. Albert explains that Secure Chat has created another avenue for care teams to connect and collaborate — this is especially impactful during the COVID-19 pandemic, since physical distancing is required in practices. Other developments in team-based care in JHCP, like nonprescriber initiated patient orders (NIPOs), have also supported team involvement in recent years. For requests that do not require medical decision making (for example, when a patient requests a mammogram), staff can generate the referral without waiting for a provider's signature.

These systematic approaches to team-based care are important, but each practice is different. Often, the most impactful workflow and protocol changes are unique to certain sites. For example, JHCP's Canton Crossing location achieved high quality metrics in colorectal cancer screening with a Cologuard workflow — staff members are empowered to find eligible patients and enter orders for co-signature. Another example comes from Greater Dundalk, where leaders, staff members and providers have collectively agreed on standards for hypertension control. If a patient has elevated blood pressure, staff members can schedule an appointment on an agreed-upon interval to have the patient return for a blood pressure follow-up. Says Greater Dundalk practice administrator Nicole Oliver, "It would never be possible for our site to improve the care we provide our patients and in turn see positive movement in

our quality metrics without the engagement of the *entire* team. Everyone plays a crucial role and must be engaged in helping take the best care of our patients."

When staff members, in addition to providers, emphasize the importance of screenings and tests in an organized way, they not only boost quality metrics but also "send a powerful message of trust and confidence" to patients, notes Blash. "Our patients know that the entire team cares about bettering their health — it enhances connectiveness and a sense of community."

The future of primary care will inevitably bring a shift of focus from volume to value — from how many patients we see to how well we take care of them. Albert and Blash say that is a reason to embrace the team-based care approach. Success is not easily produced in a silo — together, our teams improve quality of care for our patients.

Baltimore North

An Exercise in Collaboration & Coordination to Benefit Our East Baltimore Community

Ask any administrative department within Johns Hopkins Community Physicians (JHCP) what their top five projects were of fiscal year 2020 and they will all have one in common: the partnership with Baltimore Medical System (BMS) to transition East Baltimore Medical Center (EBMC) into a Federally Qualified Health Center (FQHC). The Baltimore north region's largest project of fiscal year 2020 was also one of the most impactful.

For decades, EBMC has proudly delivered high-quality health care services to its community. Over time, it became difficult to keep up with the needs of its patient population. In order to take the best care of this community, EBMC needed access to services that JHCP was not able to provide: community health workers, behavioral health specialists, clinical nutritionists, certified dieticians and care managers. "These services are greatly needed in this patient population," says Mike Cole, Baltimore north senior director of operations and strategic initiatives. "After a lot of thought and evaluation," he says, "Johns Hopkins Medicine determined that the best way to provide the services would be to partner with an FQHC."

Johns Hopkins Medicine chose to align with BMS. Cole explains, "it was clear that the [FQHC] that most aligned with the mission, vision and values of Johns Hopkins Community Physicians was BMS." BMS is the largest FQHC in the Baltimore region and would have the ability to receive federal government grants to fund the greatly needed services. Partnering was a win-win: JHCP would be able to continue to offer the same high-quality care that patients have come to know and expect, and they would have access to additional resources through BMS. "The partnership would allow more underinsured and uninsured patients to affordably access care and medication at EBMC," explains Mike Albert, chief of internal medicine and primary care clinical innovation. But it would not be easy. "The transition of EBMC from JHCP to BMS, while maintaining Johns Hopkins Medicine employment and identity for all staff and providers, is one of the largest challenges undertaken in recent years," Albert says.

With a decision made, the real work began — eighteen months' worth, to be exact. With the support of the Office of Johns Hopkins Physicians (OJHP), teams of representatives from BMS, Baltimore City, and

JHCP, along with other Johns Hopkins Medicine leaders, planned to implement the transition. Conversations were had surrounding changes to business platforms, electronic medical records systems, financial platforms, branding and marketing, as well as many other areas. They also had to build awareness of the change internally. To manage such a project, twelve workgroups were developed to cover topics from information systems, to credentialing, government affairs to pharmacy. Approximately fifty individuals made this project a part of their daily work, and many more worked behind the scenes.

The transition went live at the end of the fiscal year, on June 4, 2020, with a small group of key project members staffing a command center. “That helped immensely,” Cole says. “The goal was to address unforeseen issues in real-time for the first week.” One unforeseen hurdle was a global pandemic, hitting just months before go-live. The workgroups quickly adapted by converting meetings and staff workflow trainings to virtual platforms, keeping the plan on track.

“With a lot of hard work from a lot of knowledgeable people,” Cole says, “we were able to bring this project to fruition. We all have one common goal: serving our East Baltimore community.”

Cardiology

Collaboration: The Heartbeat of Success

Johns Hopkins Community Physicians’ (JHCP) Heart Care section has quality, growth and expansion on the mind. That is why in fiscal year 2020, while simultaneously exceeding all patient safety and satisfaction targets at each of its Heart Care practices, JHCP cardiology leadership set out to collaborate with Sibley Memorial Hospital (SMH) to develop a more robust cardiovascular service program.

Leaders at SMH began to recognize that their hospitalists and community partners had a need for extra cardiology service support; echocardiogram and EKG readings, consultations and other urgent services. “More often than not, cardiology-related interventions need to be addressed immediately or in real-time,” says Harry Bigham, JHCP regional medical director for cardiology. JHCP cardiologists had already been covering evening and weekend shifts at SMH, so a solution was not farfetched. To enhance collaboration and support, JHCP would assign a provider to cover weekday hours at SMH. This coverage would be in addition to assistance from a team of dedicated community cardiologists.

Bigham and Angela Pilarchik, JHCP director of operations, explain that outcomes have been positive. “We feel that Sibley hospitalists are able to get readings, consultations and medical decisions faster, and we have helped to reduce length-of-stay for patients,” Pilarchik says. Another indirect benefit: the collaboration presented an opportunity for Mark Milner, JHCP ECHO director, to work in tandem with Genci Sallabanda, non-invasive cardiovascular supervisor at SMH, to develop a set of standard protocols to apply for and receive accreditation for the hospital’s echocardiography lab.

In addition to JHCP Heart Care leaders, the collaboration is also positive in the eyes of Sibley leadership: “It’s been a great addition,” adds Caroline Shafa, vice president of operations for SMH. “We value all of our partnerships that bring high-quality care to our cardiology program — this has been a great collaboration for enhancing it.”

While the expanded collaboration just started in FY 20, JHCP Heart Care has already made improvements to their efforts. When they first started covering weekday shifts, the team was piecing

provider schedules together. It soon became apparent that continuity of care was important to both patients and providers. Now, individual JHCP cardiologists are scheduled for three to five days in a row, which is a huge patient-satisfier. It has also enhanced care. “It’s helpful for one provider to make a patient evaluation, decide on a treatment plan, follow it through and be able to adapt it where necessary,” explains Bigham.

JHCP Heart Care leadership views the success of this collaboration as a sign of things to come. “We've been working really hard to integrate with the entire health system more and more,” Bigham says. This example of expansion into another Johns Hopkins Medicine member organization is a great springboard for the future growth and expansion of JHCP Heart Care.

Central Operations

Health Equality Through Language Services

A review of Johns Hopkins Community Physicians (JHCP) central operations’ fiscal year 2020 achievements indicates that there is nothing they cannot do: from supporting practice builds and expansions, to employing online scheduling functionality, to implementing multiple new systems and workflows. One area of focus that received a lot of attention in fiscal year 2020 was Language Services.

According to federal and state laws, Joint Commission Standards and Johns Hopkins policy, equal access and communication assistance will be provided to all patients with communication needs and those assisting them in the provision of care. That is because language access plays a major role in patient safety. “It ensures that all patients understand and can actively participate in their care,” says central operations project manager Danielle Scott. In addition to unifying workflows with Johns Hopkins Medicine Language Services, the central operations team completed three main initiatives: the creation of a bilingual patient access specialist position, deployment of additional hardware options for practices and the development of interpreter request workflow documentation for video visits.

The first tactic employed for improving Language Services was the recruitment of two bilingual patient access specialists for the Central Scheduling Intake (CSI) team. This allowed CSI to create a dedicated line for Spanish-speaking patients. Any time another patient access specialist or a practice received a call from a Spanish-speaking patient, they could transfer them directly to this dedicated line, allowing patients to schedule or cancel appointments, request prescription refills or enquire about test results in their preferred language. Scott and Kathy Picarelli, director of central operations and practice operations improvement, note that this reduced hold times and was much quicker than waiting to reach an interpreter from Cyracom, the interpretation services contractor used by Johns Hopkins Medicine. This has been a huge patient satisfier. “We always say that our CSI agents are the first voice and first impression of JHCP,” says Scott. How impactful it is that that first voice is now available in Spanish.

One of the two original bilingual patient access specialists, Geraldine Baltazar-Mitchell, who now serves as a bilingual medical office assistant at East Baltimore Medical Center (EBMC), says that in her previous role, she helped Spanish-speaking patients establish trust and access high-quality care. “I loved when new patients called and said they were referred by a family member or friend who recently established care,” she says. “I could always tell how satisfied the last patient was with their experience by the compliments that were given by the new patients.”

Another focus by the central operations team was the deployment of additional hardware to practices, namely cordless phones used for interpreter interactions. The phones come in pairs – one for the provider or medical staff member, the other for the patient. Cyracom is on speed dial for connecting with an interpreter. These phones have been distributed to four practices: Odenton, Remington, Heart Care Bethesda and EBMC. "The cordless phones are a critical part of our workflows among the medical assistants, medical office assistants and providers," says Paul McDermott, administrative supervisor at EBMC. They have been an increasingly useful resource since the start of the pandemic, he explains, because one of their translation carts has been dedicated to a front entrance screening station. "These language services and translation options provide peace of mind for our patients," he says. "Our patients know they are being understood [and Cyracom] also provides a level of comfort and security to our team members."

Finally, as use of video visits greatly increased, central operations partnered with Language Services to create a workflow for incorporating interpreters into video visits. Maggie Kim, project administrator for central operations, explained the simple process that would allow video interpretation for American Sign Language, Spanish, Mandarin, Russian, Arabic, Nepali, French, Korean, Hindi and Urdu. All a medical staff member has to do is schedule the appointment, get the video visit room link and submit a request form to the Language Services team, she says. Phone-only interpretation was also made available.

"We have a responsibility not to discriminate or exclude patients from treatment based on their language-service needs," says Picarelli. These initiatives, along with others, like management of the qualified bilingual staff program, video remote interpretation (VRI) carts and other projects in collaboration with centralized Johns Hopkins Medicine Language Services, have a huge impact on patient safety, patient satisfaction and overall health equity.

Credentialing

From Plan to Action: Emergency Disaster Privileging

Coincidentally, in fiscal year 2020, Johns Hopkins Community Physicians (JHCP) credentialing manager Deborah Brazil completed an Emergency Disaster Privileging Plan. It turns out that it was just in time for a global pandemic. "I've never experienced anything like this – everything really fell into place," Brazil says.

The story begins a few years ago, when Brazil attended a National Association Medical Staff Services (NAMSS) conference and found herself in a seminar about disaster planning. Thrown back into her busy every-day work, she did not give it another thought until May 2019, when the Baltimore government's computer systems were compromised by an aggressive ransomware attack. What if something similar were to infect their credentialing software? She was reminded of the conference she had attended years before, and discovered that JHCP did not have an emergency privileging plan. "This bothered me, because there would be significant delays for patient care if a disaster occurred," she says.

Brazil prioritized the development of an emergency plan, with no idea that a global pandemic would emerge just a few months later. It was completed and approved in December 2019. To her surprise, Brazil's newly approved plan was operationalized just a few months later in March 2020, when the

COVID-19 pandemic required an expedited hiring process for providers and staff for the Baltimore Convention Center Field Hospital, set to open in mid-April.

Mark Phillips, family practice provider at White Marsh and JHCP Credentialing committee chair, worked with legal counsel and field hospital leadership to put the plan into action. This took a few weeks, as the team had to develop new delineation of privileges documents (DOPs), which match each provider's clinical privileges with their documented training; integral for maintaining patient safety. Says Phillips, "We were excited to be able to contribute to the efforts on [behalf] of the State of Maryland, Johns Hopkins Medicine and the University of Maryland to create a field hospital at the Baltimore Convention Center [in order] to assist hospitals throughout the state [that were] contending with the surges of patients from the COVID-19 pandemic."

Altogether, the Emergency Disaster Privileging Plan supported the credentialing of 166 medical staff and providers in a matter of weeks. Under the plan, providers were credentialed in between one to five days. By comparison, the typical full-scale credentialing process takes 90 days. How was the turnaround time shortened so significantly? Brazil explains that for this amended emergency plan, they focused on the basics. "We verified licenses and board certifications and checked on national databases for any legal claims. If they were to come onboard as full-time JHCP providers, they would then go through the regular credentialing process, including a 54-page application, a complex DOP and peer review and referencing."

Says Phillips, "It was an impressive team effort that shows what great people and expertise we have in Johns Hopkins Medicine and at JHCP to so quickly and effectively meet the needs created by a national emergency." Brazil credits the successful implementation to a number of people: Mark Phillips and the JHCP Credentialing committee, the JHCP Credentialing team, the JHCP Human Resources Department for their hiring support, the Johns Hopkins Health System Centralized Credentialing Office, field hospital leaders Drs. Eric Howell, Mindy Kantsiper and Alexandra Loffredo, and the Johns Hopkins Medicine legal team.

"I like to say that we are the gatekeepers of patient safety," Brazil says. "With the Emergency Disaster Privileging Plan, we were able to streamline and expedite our process to meet the needs of the community, without compromising quality and safety."

Diversity Council

Mentorship: Growth, Opportunity and Development

The Johns Hopkins Community Physicians (JHCP) Diversity Council has a hand in many projects and initiatives, and in fiscal year 2020, development of a JHCP mentorship program was a significant undertaking.

Melissa Helicke, chief operating officer, vice president of practice operations and JHCP Diversity Council co-leader, says there is ample literature about the positive impact that mentors can have on a person's professional development. Although it is open for all to participate, the mentorship program aims to help underrepresented minorities connect with mentors who can help with career growth and professional development. Ultimately, the Diversity Council's vision is to provide deliberate connections for mentees to progress into senior positions so that the diversity of JHCP's leadership team better

reflects the diversity of our employees and patients. “We believe it is important to have diversity of thought and experience at all levels of the organization, including the director and executive levels,” Helicke says.

After researching similar projects from other Johns Hopkins Medicine member organizations and other academic health systems, the mentorship program workgroup laid out the basics of the program. In defining roles, the group decided that practice administrators, office medical directors and managers who supervise could be eligible mentees. Eligible mentors would be selected from director-level positions and above. The workgroup promoted the program during JHCP leadership meetings and reviewed candidate applications. Five pairs of mentors and mentees comprised the inaugural year’s program. Mentees could choose their mentor in a speed-dating-like event during a kickoff meeting. “This allowed mentees to choose someone who they felt connected with, and someone whose experiences match their career interest,” says Lashardian Byers, an operational education project administrator in the Department of Education and Training and a project workgroup member.

The workgroup created an extensive list of resources and tools for participants. The team wanted to provide structure and direction, but also wanted to ensure that relationships would be formed naturally, and not forced, which the group learned is important during its preliminary research. To do so, the workgroup developed meeting outlines to guide conversations. Pairs were not required to turn in these worksheets and tools, but could use them as they deemed fit.

Helicke says this project is unique because it was developed by a diverse, grass-roots team. Workgroup members are employed at all levels of the organization, and they brought different perspectives to light during the program’s development.

After its first few months, both Byers and Helicke had positive impressions of the mentorship program’s impact. Its participants do, too. Office medical director and mentee Stephen Martin says he joined the program to get connected with a mentor beyond his day-to-day interactions. “The program has helped me to verbalize some of my personal and professional thoughts and goals,” he says. Martin’s mentor supported him as he developed and presented a plan to expand office space at his practice. Martin continues, “Through the mentorship program, JHCP can continue to promote and encourage leadership and help foster new relationships among the leaders we currently have.”

Program leaders agree, and they have visions of expanding the program to continue to promote professional growth and representation on JHCP’s leadership teams.

Education and Training

Virtually Everywhere: Telemedicine and the Department of Education and Training

Projects abounded for Johns Hopkins Community Physicians’ (JHCP) department of education and training (DET) in fiscal year 2020, but their work to support telemedicine was particularly impactful across JHCP and the Johns Hopkins Health System. The COVID-19 pandemic completely changed the way health care is delivered; to mitigate risk of spreading the virus, there was a rapid transition from in-person appointments to video visits, nearly overnight. JHCP practices pivoted from providing practically no virtual care, to more than half of encounters being completed as video or phone visits by mid-March

2020. By April, more than three quarters of appointments were categorized as telehealth, and the majority of visits continued to be categorized as video visits through the end of the fiscal year in June.

A transition so drastic required support from all JHCP departments, and the DET made telemedicine support a priority. Their efforts were two-fold: on one hand, they developed, disseminated and trained staff members and providers on team-based workflows and on the other, they provided real-time support to patients and employees by creating a Video Visit Support Team (VVST).

The team-based training efforts, led by Mindy Berger, program manager for clinical informatics, were integral to the successful transition. The biggest challenge, Berger explains, was keeping up with the rapid advances in technology. “It was a new way to provide care, so it was a challenge for everyone: providers, staff members and patients,” she says.

The basic workflow that she and her colleagues promoted involved the entire care team. Starting with scheduling, staff members ensure that the patient has a MyChart account and outline the steps for joining their future visit. Next, practice staff members reach out to patients in advance of their appointment to review the eCheck-in process. At the time of the appointment, practice staff members virtually “room” the patient to make sure all technology is working and to collect clinical data. After that, the provider joins the call to complete the visit. The DET set out to standardize this process and put the workflow in writing to make it easier for the team to follow. The two most important things, says Berger, were to “continue to focus on our patients and their relationship with our team, and to maintain the same quality of care.”

The team used a myriad of tactics to effectively train staff and providers:

- They developed a one-pager that outlined the whole team-based process, with links to multiple training videos and tip sheets.
- They created videos of the patient-view for staff members to reference while walking patients through the process.
- They provided informational webinars that were available for staff members and providers from JHCP and the Johns Hopkins University School of Medicine (SOM).
- They held training webinars for each individual JHCP practice.

Major sources of information for training materials and workflow development were the practices themselves. “A lot of it was crowdsourced, as sites began sharing their best practices,” says Berger. “Our team collected and synthesized them all, and used them to create new recommendations.” Another source of information was the VVST.

The DET dedicated a team of individuals to support patients, staff and providers in real-time using a support line. According to education project manager George Margetas, the VVST was originally created to support JHCP providers only, so that they did not have to wait in the long queues that were forming in the general Johns Hopkins Medicine IT support pool. Eventually they began collaborating with the Epic Help Desk to help manage their queues, then they opened their own support line for any patient or Johns Hopkins provider to call. The VVST soon expanded its ranks to include members from IT, the SOM and even a few JHCP practice staff members who were trained and helped tackle the massive call volumes.

Altogether, the VVST supported 2,300 requests over a period of five months — a combination of help desk tickets, calls to their hotline and emails. Their resolution rate was nearly 70 percent, with many of the unresolved issues being due to technology restraints. Lashardian Byers, operational project

administrator, recounts that most of the calls involved troubleshooting telemedicine visits in real-time, as patients and providers connected to appointments. “This was a huge patient-satisfier,” Byers says. “They knew that someone was there to help them get connected to the care they need during the pandemic.” In fact, 80 percent of cases involved VVST members working directly with patients.

More than 60 percent of calls came from other Johns Hopkins Medicine member organizations, while 37 percent were isolated to JHCP. “This endeavor was spearheaded by the JHCP Education and Training department, but it was really a group effort,” Margetas says. “It’s an overall win for JHCP and for the Johns Hopkins Health System as a whole.” Adds Byers, the DET’s telemedicine efforts, both through team-based training and the VVST, were a collaboration in pursuit of supporting JHCP’s practices and Johns Hopkins Medicine departments so that — even through a pandemic — they could continue to do what they do best: deliver excellent care to our patients.

A Deeper Dive: Developing Education for Patients and Clinicians

Judy Greengold, family nurse practitioner at JHCP’s Fulton practice, recognized a need for both patient and provider education. Partnering with the department of education and training and Johns Hopkins Office of Telemedicine, Greengold and team rapidly developed and launched innovative educational offerings. Together they created instructional videos for patients introducing video visits and explaining the process around them. They also convened a Telemedicine Education Consortium, with representation from across Johns Hopkins Medicine. This group developed a new training course titled “Clinical Skills in Telemedicine,” which focuses on techniques for physical examination via telemedicine visits. “The consortium draws on the experiences of providers from all specialties to study, cultivate and promote the highest clinical standards in telemedicine,” says Greengold. The clinician-facing curriculum includes modules for chest, abdominal, ENT, neurological and general medical examinations. Johns Hopkins clinicians can view the videos on the Office of Johns Hopkins Physicians telemedicine education page.

Finance

Where There’s a Plan, There’s a Way

They say that behind every great athlete is a great coach; behind every great film, a great director. By that logic, behind every great Johns Hopkins Community Physicians (JHCP) project, is a great business plan.

Fiscal year 2020 was marked by achievement for JHCP’s finance team: they made successful use of the new Johns Hopkins Medicine financial decision support system, EPSi, improved benchmarking capabilities and re-projected financial targets due to the COVID-19 pandemic. But one accomplishment that could impact the organization for years to come is the enhancement and acceleration of business planning and modelling.

Improvement in the process was born from necessity; beginning in the previous fiscal year and lasting throughout FY 2020, the finance department worked on fourteen business plans. These included new practice openings in Urbana and Brandywine, expansions at Hagerstown and Germantown and Green

Spring Station's practice relocation. "There's a lot of effort and information that go into these plans, and with so many under our belt in such quick succession, we feel like we're ahead of the curve," says chief financial officer Jim Clauter. "Each time a business plan is developed and completed, it informs our future business plans and our models become more and more accurate." This is because the team is able to see the actual outcomes in comparison to the expectations that are in the plans and are able to enhance the data upon which the planning models are based.

What exactly is a business plan, and what is its role in project management? Assistant director of decision support, Angela Temple, who spends much of her time developing JHCP's business plans, explains that "when there is a new idea, we need to lay out what the financial ramifications will be." The ultimate goal is to be able to present accurate data to leadership to make "go or no-go" decisions. From office expansions, to new lines of service, to implementation of new technology into practice, business planning and modelling is a major step in the approval process for all of JHCP's significant projects, Temple says.

It is a major step, and a complex one. For example, projections of revenues and expenses in a new practice build plan are determined by many factors including assumptions for patient demand, the importance of brand name recognition in the specific area, estimated encounters, ease of provider recruitment, payor mix, staffing costs, and much, much more — pages and pages of synthesized data. "This process is always supported by a group," Temple says, "there is a constant feedback loop with external stakeholders like Johns Hopkins Real Estate and the Office of Johns Hopkins Physicians, and internal JHCP stakeholders such as project leads, practice operations and regional leaders and executive leadership."

After working on so many plans during FY 2020, Clauter and Temple say that the business planning process will only continue to be streamlined. "Our modelling tools have improved, and we have a much better understanding of what data we need, and where to pull it from," Temple says. The business planning process will continue to evolve in support of JHCP growth and innovation to meet our mission of providing patient-centered care.

Gyn/Ob

Minimally Invasive Surgeries for Maximum Patient Satisfaction

Johns Hopkins Community Physicians' (JHCP) Gyn/Ob leadership always has their sights set on the future. One specific emphasis for fiscal year 2020, and beyond, is on minimally invasive surgery (MIS). In FY 2020, the team focused on training providers on universal MIS skills.

With substantial improvements in technology over the past fifteen years, minimally invasive surgeries have become normalized, gradually replacing the need for open surgeries, explains Francisco Rojas, then chief of Gyn/Ob, and provider at JHCP locations in Howard County and Odenton. As its name suggests, and in contrast to open surgeries, most minimally invasive surgeries require a small incision of only about five millimeters and employ the use of small instruments, including a camera, and, often, robotics. Laparoscopy, which takes place in the abdomen or pelvis, is the most common form of MIS used for the Gyn/Ob specialty.

There are multiple surgeries that are often done laparoscopically today. One of them is tubal ligation, more commonly referred to as "getting your tubes tied." The laparoscopic version of the surgery has the same contraceptive results, with less risk of future complications. Ovarian cyst removal is also performed laparoscopically, as is removal of suspect tissues. Hysterectomies, or the removal of the uterus, historically performed using midline, abdominal incisions, are also commonly performed laparoscopically. Laparoscopy is also often used for diagnostic examinations, in search of sources of pain. This provides a major benefit as patients no longer have to undergo major surgery for a diagnostic procedure.

In addition to laparoscopy, hysteroscopy is the other form of MIS most common to Gyn/Ob. Instead of using small incisions, hysteroscopies are performed through the body's natural openings for examinations, removal of polyps or diagnostics for abnormal bleeding.

Typically, MIS is performed using robotics, manipulated by a console with joysticks. Technology has improved significantly. When MIS was first introduced, the camera view was in two dimensions, which greatly limited depth perception, but over the past few years, developments have allowed for three-dimensional viewing. "This has essential replaced the human eye," Rojas says. According to him, the beauty of these robotic instruments is that they provide magnification of small structures and illumination, improving the quality and precision of surgeries.

MIS has many benefits beyond improving quality of surgeries. Open abdomen surgeries create much larger wounds that take more time to heal and are more likely to become infected. Smaller incisions also mean that recovery time after MIS is much shorter — between three to four weeks at most, while open surgeries take at least four to six weeks. In some cases, patients may be able to function somewhat normally after a few days of recovery. Post-surgery, laparoscopic patients often spend less time in the hospital, as well, which has another impact: a reduction in medical costs and expenses. While initial investment in MIS instruments and technology is pricey, it is balanced by these medical cost reductions, as well as its other non-monetary impacts.

"Minimally invasive techniques are now a standard of care," Rojas says. "If you do not incorporate them into practice today, you'd be considered a dinosaur." That is precisely why it was the focus of JHCP's Gyn/Ob department in FY 2020. Previously, only a handful Gyn/Ob providers were certified in MIS. By the end of the fiscal year, the entire group of Gyn/Ob surgeons, fifteen in total, became certified. "Looking to the future, we realized that having only a few providers trained would not work," Rojas explains. They began offering courses for their existing team, and made MIS a focus when hiring new providers. "Finally, we can say that all of our surgeons are minimally invasive trained and they can perform these surgeries on a regular basis," he says.

"Our physicians are in a unique spot," continues Rojas, "because they have to combine medical skills with surgical skills." The great thing about Johns Hopkins Medicine is that JHCP's Gyn/Ob providers have direct access to experts and resources in all fields. "We can invite those surgeons to work with us," he says. "Combining those skills and knowledge with our MIS techniques, we can complete much more complicated surgeries."

With a focus on cutting edge practices, technology and expansion, and with the resources of Johns Hopkins Medicine, the future looks bright for JHCP Gyn/Ob.

Hospital-Based Medicine

Hospital-Based Medicine: Equipped for Quality Improvement

Johns Hopkins Community Physicians' (JHCP) hospitalists see a wide range of patients at Johns Hopkins Medicine's various hospitals; in fact, they are touch points for nearly every patient that passes through the Johns Hopkins Health System's hospitals. In 2013, JHCP hospital-based medicine leadership wanted to develop a unified approach to measuring and improving quality for all hospitalists. They partnered with the Armstrong Institute for Patient Safety and Quality for guidance, and Project EQUIP (Excellence in Quality, Utilization, Integration and Patient care) was born.

Project EQUIP is a collaborative effort that reaches across five Johns Hopkins Medicine-affiliated hospitals: The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center (JHBMC), Howard County General Hospital, Sibley Memorial Hospital and Suburban Hospital. The goal is to engage all departments that feed into hospital-based care to evaluate and develop quality improvement initiatives.

Pat Wachter, administrator for JHCP's hospital-based medicine program and a lead for Project EQUIP, says that the program is unique because it is truly from the ground-up. "To me, that's the most important piece," she says. "It involves the people who honestly and sincerely do the work. It makes them dedicated to the cause — and we really do move the needle." The steering committee for the program, consisting primarily of unit directors, meets biweekly to review detailed data and executive requests, but every other week, front-line workgroup members come together to brainstorm ideas for how to improve metrics like length of stay, mortality and readmissions. Departments involved include case management, physical therapy, occupational therapy, respiratory therapy and many others — "anyone who affects how providers move through the continuum of care throughout our hospitals," Wachter says.

According to Wachter, a significant improvement to the program came in fiscal year 2020: Project EQUIP gained its own data analyst, Gurmehar Singh Deol, project manager for hospital-based medicine at JHBMC. He has made it possible to create individual provider dashboards — the biggest asset to the program, in Wachter's opinion. Individual providers are able to benchmark their performance, which leads to tangible data and outcomes. Hospitalists know that the data they are seeing is specific to them — rather than the hospital as a whole. "That's a lot of the reason why it's gained so much credibility among providers — because they know that it's their data," she says.

Eric Park and Atul Rohatgi, co-leaders for Project EQUIP at Suburban Hospital, could not agree more. Says Park, "The forum is a springboard for launching many of our quality improvement and quality assurance projects. It allows us to make sure that we are continuing to challenge ourselves to do better, and to maintain what we are already doing well." Rohatgi has similar sentiments. Provider-specific dashboards indicate opportunities for change. A major takeaway, in his opinion, is that people who are doing well in specific domains can offer insights and share ideas with others for how they can improve. "When we learn from each other, we can raise the overall quality of our care," Rohatgi says.

Before these individual dashboards were created thanks to Project EQUIP, hospitalists would have found it difficult to pull together their performance data from multiple sources. "Within the last year, the way data is visually aggregated for easy consumption and the automatic updates in the background has changed our practice for the better," Park added.

This specific data and inter-entity collaboration are the heartbeat of Project EQUIP. Explains Wachter, “It brings us all together as providers and support staff with a common goal: taking care of patients. It doesn’t matter what entity or department you’re a part of — we work as one.”

Human Resources

Human Resources: Making the Impossible Possible

The COVID-19 pandemic interrupted business as usual for every Johns Hopkins Community Physicians (JHCP) department, and the human resources (HR) team was no exception. Everyone at JHCP had to adjust their strategic goals, department priorities and daily tasks, and the JHCP HR team pivoted and lent their assistance in a powerful way.

In response to the concern that Baltimore hospitals would surpass maximum capacity, Johns Hopkins Medicine, in partnership with the University of Maryland Medical System and at the request of the state of Maryland, agreed to open and operate a field hospital at the Baltimore Convention Center. The field hospital provides services for recovering COVID-19 patients before they can be discharged, freeing up valuable hospital space for the most serious cases. On March 30, 2020, Johns Hopkins Health System human resources leadership tasked Leslie Rohde, JHCP senior director of human resources, and the JHCP HR team with the recruitment and hiring of providers to staff the field hospital just four short weeks before the 250-bed facility was slated to open on April 27.

The pressure was on, and the JHCP HR team came through, screening more than 300 applicants and hiring more than 100 providers in rapid succession to meet the late April deadline. The team members made it look easy, but it was no simple task — the tight turnaround time meant they could not use typical hiring processes and systems. “It typically takes months to recruit and onboard providers,” says Rohde. “We had to create all new systems and processes, which was very time consuming and labor intensive.” Adds Beth Wilson, HR manager, the process had to be completely streamlined for quick and efficient onboarding.

The team’s first step was to create a hiring database via OneDrive, which could be accessed by all onboarding stakeholders including HR, JHCP credentialing, field hospital medical leadership and occupational health. They could update the steps in the process for each candidate in real time. They also used DocuSign, through which they sent preemployment paperwork — for example, I-9 forms and criminal background check authorizations — and created unique emergency employment contracts. Allowing candidates to review, sign and send their paperwork back electronically was essential to streamlining the process. Another major workflow change resulted from the creation of a new email address specifically for field hospital applicants.

These process changes may seem straightforward, but the manual intervention and onboarding coordination of 100 providers required the entire team’s unwavering dedication. “It’s really important to highlight that Eileen Walters and Alisha McGowan volunteered to interview all of the candidates that came through,” notes Rohde. “They were basically working seven days a week, screening candidates and forwarding them to the field hospital medical leadership for further consideration.” Walters, physician recruiter, and McGowan, talent acquisition specialist, screened each candidate who submitted their curriculum vitae to the field hospital. Those who met the needs of the position were added to the hiring

database and interviewed by field hospital medical leadership, who made hiring decisions. Once all onboarding steps for a provider were checked off in the database, the provider was scheduled for orientation.

> *Helping staff the field hospital has been an incredibly rewarding experience — especially for someone like me who [isn't always] a "run into the fire" type! It's been amazing to be a part of this and to talk to hero after hero who've told me over and over again: "Get me in there." "I want to help." "I have the training and this is what I'm meant to be doing." "I need to support my colleagues and my community." Not to mention the nurse practitioner who told me, "They [patients] haven't had any family with them. I can sit with them and hold their hand and let them know they're cared for, and it will make a difference in their recovery." That one has me in tears every time I remember it. It's been an honor to help.* | Eileen Walters, physician recruiter

This entire operation would not have been possible without the support of many teams across multiple Johns Hopkins Medicine member organizations. "There was *a lot* of communication and cooperation from JHCP and non-JHCP departments," notes Wilson. Rohde says the project's impact on the HR team specifically was tremendous. "It was truly remarkable for the HR team to be really intimately engaged in what felt like the front lines of the COVID-19 crisis," she says. "We are not the providers, nurses or staff that are risking their health to work directly with patients, but for us in HR, it was an impactful way to contribute to the COVID-19 response, and to support Johns Hopkins Medicine and our community."

"Going from recruiting 25 physicians each year to 100 in a month? That's mission impossible," Rohde says. But she notes that from the very beginning, failing to meet the Johns Hopkins Health System's request was not an option, which makes it fair to say: The JHCP HR team makes the impossible possible.

Information Systems

Health Care from Anywhere: The Growth of Telemedicine

Johns Hopkins Community Physicians' (JHCP) Information Systems (IS) department aims to "provide excellent IT support and customer service for our users, enabling the best patient care" in everything they do. While IS projects were numerous in fiscal year 2020, one stands out, as its affects were felt across the country and across the world: support of JHCP and Johns Hopkins Medicine's telemedicine efforts.

In March 2020, as the global spread of COVID-19 rapidly gained momentum, JHCP practices had to quickly pivot from in-person appointments to virtual appointments. Embracing telemedicine was the best way to ensure staff, provider and patient safety, while maintaining the highest quality of care possible.

Director of IS Matthew Eyre defines telemedicine as any mode to provide patient care, other than being solely in-person, face-to-face. This definition includes telephone visits and MyChart messaging, as well as hybrid methods, like tele-consults, wherein, for example, a patient at a rural practice would have a consultation with a specialist in Baltimore, while in their provider's office. The focus for FY 20 efforts, though, was on video visits.

Johns Hopkins Medicine and JHCP's rapid transition from in-person to video visits was a mammoth achievement. JHCP providers and staff converted in-person appointments to video visits, practically overnight. From January 1, 2020, through March 11, only seven telemedicine visits had been conducted. From March 12 through the end of the month there were 15,342 telemedicine visits (split between video and phone). Finally, the total from March 12 through the end of the fiscal year's end in June is a staggering 143,436 telemedicine visits. That includes 125,850 video visits and 17,586 phone visits.

Although JHCP was preparing for increased use of telemedicine before the pandemic began, this immediate and drastic pivot to video visits provided no shortage of work for the IS team. They deployed about 500 headsets and 500 webcams to providers and staff over the course of eight weeks, and continue to do so. They also supported the education and training team's efforts by quickly setting up a phone line for the Video Visit Support Team. The IS team also had to ensure that all workstations were in compliance and prepared for the video visits platforms, coordinating and pushing out new software to desktops.

From the beginning, video visits needed to be as easy as possible for the patient, provider and support staff. With this and quality improvement in mind, the Johns Hopkins Medicine Office of Telemedicine and stakeholders decided to switch video visit platforms. The new platform minimized requirements on the patient-side, decreased complexity on the staff- and provider-side, and increased reliability and video visit capacities. Eyre and team had to ensure that all software was kept up-to-date to make the transition as seamless as possible for patients and providers. The transition would make sure that there were as few barriers as possible to accessing care, and would also maintain telemedicine standardization across JHCP practices and Johns Hopkins Medicine.

Eyre and his team view the drastic pivot to telemedicine as a positive change. He notes enhanced relationships and increased communication between the IS department and operational clinical staff, resulting in the team becoming more in-tune with practice workflows. They were also required to think creatively and become even more flexible. Eyre notes that the team's ability to leverage the equipment and infrastructure that they already had prepared led them to success.

He also humbly admits that such an endeavor was not without its fair share of failures. "Our providers were really, really resilient," he says. Luckily for JHCP, so are the teams, like IS, that support them.

Marketing & Communications

The Intranet: An Organization's Central Nervous System

One of Johns Hopkins Community Physicians (JHCP) marketing and communications' greatest achievements came at the beginning of fiscal year 2020, after years of cross-entity collaboration, discovery and design: the JHCP intranet redesign.

What is an intranet, and why is it important? According to Molly Jackson, marketing and communications manager, "an organization's intranet almost acts as its central nervous system." She continues, "it's a central repository where important documents and news are stored and shared for easy access." It also acts as a springboard for resources, tools and links that employees need to do their job. The team knew that in order to support JHCP's employees to the best of their ability, a redesign was in order. Like most company intranets, JHCP's previous one was functional, but the structure was not

purposeful, it was difficult to navigate, and the look was outdated. Jackson imagined improved function and design possibilities.

The process of redesigning an intranet is not as easy as it may seem – in fact, it is often cited as being more difficult than building one from scratch, when there was no previous site in place. To begin the process, the marketing and communications team's first step was to engage their central Johns Hopkins Medicine marketing colleagues and recruited the services of a web design vendor. Next, they embarked on a discovery period, surveying and speaking with employees of diverse roles about what they needed and wanted most out of an intranet.

Challenges abounded at the start of the process – the team had a wish list of a lot of great ideas, but many were simply not possible within the confines of the web platform's content management system. "The design process became an act of balancing expectations and reality to get the best end-product we could," Jackson recounts. Other challenges surfaced with vendor relations and stakeholder turnover, but the team remained steadfast, chipping away at the project slowly, but surely.

All along the way, the team had support from a robust workgroup, which included representation from nearly every job function and department. "If the JHCP Intranet was the central nervous system, the workgroup served as the brain. The individual contributions were pivotal to the successful launch of this project," Jackson says. Workgroup members brought feedback from their own experiences, as well as their department and peers. They were also responsible for filtering through what information and resources needed to be included from their job area. Caroline Lentz, assistant director of learning and development, is one of those workgroup members, representing the department of education and training. "I was able to present our department's needs to the workgroup and it was clear early on that they were complex," she says. "Working with others helped to define a cohesive vision for the intranet as a whole and it gave me an appreciation for the dedication and talent throughout JHCP."

After overcoming obstacles and spending months updating content, links and documents, the go-live day finally came at the beginning of FY 20. The completely revamped look and feel was a big change for some, but most users embraced it with open arms. The project's completion came in good timing, too, with the COVID-19 pandemic right around the corner. The intranet served as a source of truth at the beginning of the pandemic during FY 20, and beyond – the JHCP COVID-19 intranet page quickly became one of the most referenced pages on the entire Johns Hopkins intranet.

The new intranet template design itself also made waves – multiple entities across Johns Hopkins Medicine have converted their own intranets to the version that JHCP pioneered.

Even with the redesign now complete, the work is nowhere near over – maintenance of this new intranet is more intensive than ever. The results are worth it though. "The new intranet is a living site, compared to the old static one," Jackson says. "Our team will continually make updates and changes to make it as useful and easy as it can be. We want to support the teams that care for our patients."

Maryland Suburbs

In Pursuit of Bigger and Better Things

Melissa Blakeman, Johns Hopkins Community Physicians' (JHCP) Maryland suburbs regional medical director, and Karen Skochinski, JHCP operations director, had a few major goals for fiscal year 2020, but none more ambitious than to "ace" their quality metrics. And ace them, they did.

The region has seven adult sites with six quality measures each. Of those 42 metrics, 33 of them saw improvement. All seven adult primary care sites exceeded the quality target for well visits for patients age 65 and older, most of them by double digit margins. One site in particular, Annapolis, improved its score by 31% over the previous year.

Blakeman and Skochinski owe this remarkable success to a few factors. First, they encouraged their leaders to find ways to make quality improvement intrinsically motivating. A few examples are: look for small wins — starting with metrics they are close to meeting, so that changes can be felt; re-frame tasks to appeal to emotional motivations; and make the connection between providing great patient care and quality metrics — data that *proves* you are providing great care. One of Skochinski and Blakeman's goals in fiscal year 2019 was to strengthen their practice administrator (PA) and office medical director dyads, an endeavor they believe carried over into FY 2020, as much site leadership became more proactive and creative in its pursuit of meeting metrics.

The regional leadership duo also emphasizes the importance of the entire care team achieving metrics — not just providers. Skochinski often sits down with PAs *and* staff members to discuss how they can break their data down so that it is manageable. For example: Instead of a medical office assistant trying to tackle a 10-page list of patients to call, starting with just one page yields better results. They also note that metrics regarding wellness visits are great to focus on, because they often lead to capture of other measures, like mammogram metrics. When the entire team is engaged, staff members can proactively change patient appointment types or length to accommodate the services reflected in quality metrics. This ensures that no one is falling through the cracks. Bridget Akinbobola, practice administrator at JHCP's Glen Burnie site, says "providers work with their care team members to outreach to those patients who need gentle reminders. Ensuring patients complete their regular health maintenance is one of our top priorities."

Skochinski and Blakeman also credit the JHCP quality and transformation team, and their practices' quality improvement officers (QIOs), for being major catalysts for improvement. The data that the quality and transformation team provides is indispensable, and according to Blakeman, the biggest benefit of QIOs is that "direction is not just top-down. Having another staff member who is focused on quality improvement helps to encourage and engage all staff in the process."

Finally, JHCP's Tiger Team, a panel of experts with diverse knowledge who recommend solutions for improvement, was a tremendous help. Over the past few years, leadership and staff turnover has left a few practices in need of extra support. The multidisciplinary team showed up with new ideas and left the practices with renewed energy. Adds Skochinski, "The Tiger Team really knows how to drill down to specific issues that will help site leadership focus on key points and actionable items." A testament to the team's effectiveness, and to the focus and commitment of the practices, three sites in the Maryland suburbs region graduated from the services of the Tiger Team, and two more decreased their meeting frequency to bimonthly.

But beyond support for leadership, engaging the entire team, and the roles of QIOs and the Tiger Team, the stark improvement in quality scores for the Maryland suburbs region comes down to the dedication of its leaders, staff members and providers. Blakeman and Skochinski are confident in their teams: "There are always bigger and better things coming up," Blakeman says.

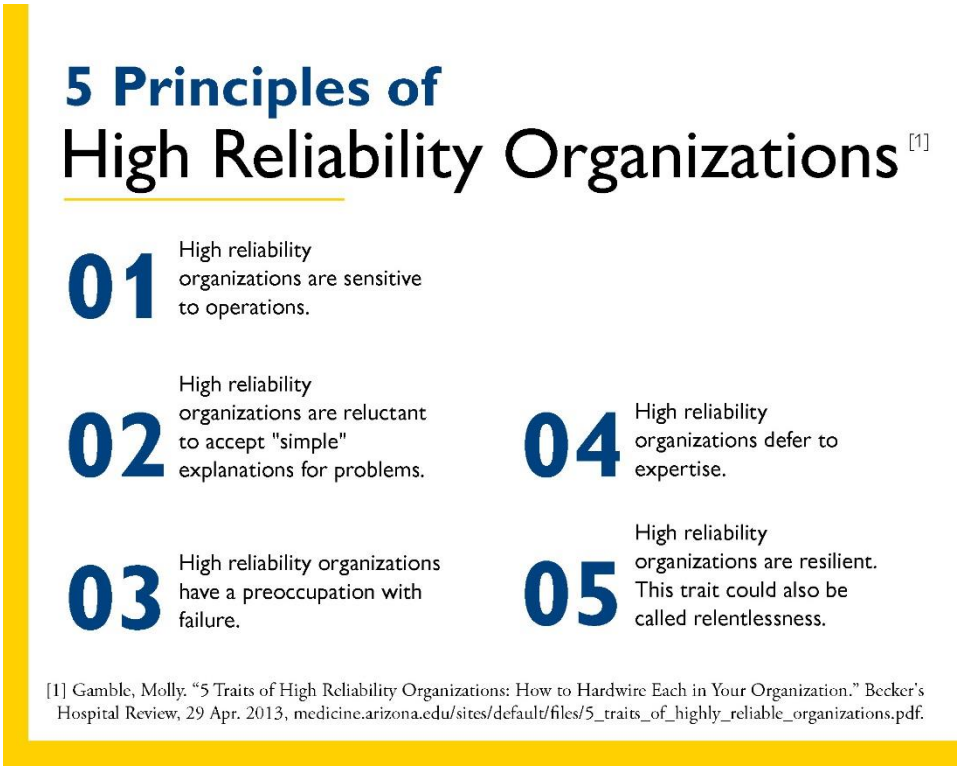
National Capital Region

HRO Principles: Pandemic Approved

Over the past few years, regional leaders of Johns Hopkins Community Physicians' (JHCP) National Capital Region (NCR), Bill Convey, then regional medical director, and Kimberly Zeren, director of operations, have navigated their leadership roles according to the five principles of Highly Reliable Organizations (HRO). With the COVID-19 pandemic affecting nearly every aspect of practice operations, fiscal year 2020 presented the NCR's leadership dyad with an even greater need for structured problem-solving.

Convey and Zeren had tried using other leadership ideologies, but landed on the HRO principles as their guiding compass because of their practicability, achievability and natural fit into their day-to-day operations. "The principles are realistic and applicable – not just fluff that sounds nice," Convey says. "We began applying them consistently throughout the region, specifically instilling them in their region's practice leadership dyads – practice administrators (PA) and office medical directors (OMD).

How have they gone about implementing? The most basic way was distributing a list to give the principles a formal structure, along with examples of situational applications, but far much more impactful than that, says Convey, is his and Zeren's embodiment of the principles. "We try to make it evident in our leadership styles, and more specifically, in the questions we ask, like, 'How is this going to fail?' and 'Who is the subject matter expert?'"



A shortcoming of many growing organizations is the disconnect between leadership and frontline operations. Curbing this pitfall, and exemplifying the first HRO principle – sensitivity to operations – Zeren will assume the roles of medical office assistant (MOA) or medical assistant when the need arises.

"The first principle is my favorite," Zeren explains. "So many times, leaders, including myself, will say, 'here's a task – now go do it,' without really considering the how, or the why; without operationalizing it." When new ideas or tasks are presented to practice leaders, Zeren and Convey will often ask the region's dyads to think through how their implementation will work and how it will fail. They are encouraged to put together their own workflows and are given time to allow them to evolve, rather than implementing next-day changes.

Convey emphasizes the second principle as being integral to problem-solving. Instead of writing off a problem with an easy explanation, Convey believes that for all problems at practices, the assumption should be made that it is a practice-level cultural issue – no matter how local or isolated the original issue is. With culture as a default, you can begin to work in from that higher level to solve problems. "Working this way," he says, "you often discover historical corollaries that point to the root of the problem."

While all five of them are applicable, another that Convey and Zeren find themselves referring to often is number four: deferring to expertise. An example they give of this principle in action is a site that is suddenly encountering issues checking patients in at the front desk. Leaders should not make decisions for remedies in a silo, but should defer to the expert: the MOA at the front desk who has been successfully checking in patients for years.

Derek Sauer and Kamal Deol, the PA/ OMD dyad at Montgomery Grove, also find meaning in the fourth principle. "Opinions matter," they say. "Soliciting opportunities from our diverse team of providers and clinical and administrative staff proactively predicts potential barriers to or enhancement of patient-centered care."

Perhaps worth mentioning is that the NCR had zero "high-focus" practices in FY 2020. While the application of HRO principles cannot be credited for this achievement, it certainly does not hinder the success. Convey and Zeren maintain that the principles are very fluid: they all work together within conversation, and they can be used to orient and navigate problem-solving.

Neurology

Safety, Convenience and Simplicity

Medical services across the country were disrupted by the COVID-19 pandemic in fiscal year 2020, and the Johns Hopkins Community Physicians (JHCP) neurology section had to pivot quickly in response.

The Sleep Disorder Center at Sibley Memorial Hospital was transitioned into space for patients with COVID-19. Displaced, the center's team had to adapt to the changing health care environment. While working on opening a sleep center in a different location, the team members ramped up their use of home sleep testing (HST), specifically for diagnosis and monitoring of sleep apnea.

The neurology department leadership chose to focus its efforts on WatchPAT — essentially a wristwatch worn by the patient overnight that monitors peripheral arterial tone to help detect sleep and respiratory events, as well as oxygen levels, heart rate, movement, snoring and body positions. With the safety of patients and staff members at top of mind, leadership created a workflow that limited in-person touch points. Carolyn Wang, JHCP medical director for the neurology section, explains that the singular technician completes a video visit with a prospective patient, teaches them how to set-up the device and then schedules them to pick up the device later in the day. The patient wears it overnight and delivers it back to the hospital the next day. "Like so many companies and services these days, we've employed curbside pickup and drop-off," Wang explains. "Patients are really pleased with this workflow— everyone feels like they are just a little bit safer, including our staff."

WatchPAT is easier to clean compared to other home sleep devices, including the ApneaLink Air, which the department put on the backburner to focus on safety. With only 12–15 WatchPAT devices active at one time, and only one technician, HST volumes doubled by the end of fiscal year 2020, and even tripled going into FY 2021. Wang notes that with limited resources, they are at full capacity. Increased volumes may also be a result of many local non-Johns Hopkins Medicine sleep centers closing. Wang says she is happy that Johns Hopkins has been able to provide this service, since there is such a great need in the community for the monitoring of sleep disordered breathing.

Even beyond COVID-19, Wang says HST technology will continue to be used. "There's always going to be a need for home sleep testing," she says, "particularly for our younger and healthier patients. It's convenient for them, and acts as a great screening tool to catch people who might not otherwise go for an in-person sleep study."

Sleep apnea screening is integral to the neurology specialty's work. According to Wang, sleep apnea has a prevalence up to 35% in populations with neurological conditions, including patients with neuromuscular diseases, Parkinson's disease, stroke and memory disorders. Perhaps more impactful than its benefit to cardiovascular health, treating sleep apnea directly improves quality of life — the impacts can be felt across all medical specialties and can boost overall health.

"If people don't get tested, they will never get diagnosed," notes Wang. That is why the safety, convenience and simplicity of HST — particularly during the COVID-19 pandemic — are so important to the pursuit of managing sleep apnea.

Patient Experience

Virtual Patient Feedback: The Compass that Guides Us

Fiscal year 2020 brought with it many changes. One that we can all relate to is the prevalence of video as a means of communication. Nearly everything went digital, from health care appointments to weddings, meetings to concerts. This virtual revolution also impacted our patient experience team at the end of FY20, very much for the better.

In 2018, Johns Hopkins Community Physicians (JHCP) practices created Patient and Family Advisory Councils (PFAC), wherein they would host patients and their family members for discussions on topics relevant to delivery, quality and safety of care. The goal was to get their insights on our operations or listen to their suggested changes, allowing them to refine our systems and processes. Says Keisha

Mullings-Smith, director of patient experience, "we want our patients to be present as we reflect on our current state and integrate their voices into our future state."

Over the program's first two years, practices noted that it was difficult for many patients to make time for in-person meetings at the practice due to their work schedules or child care. This often led to a population imbalance in PFAC attendance. "In the past, it was not uncommon for the majority of PFAC attendees for a family medicine practice to be retirees for the simple fact that they had the time and were more apt to come into the office," explains Mullings-Smith. This meant that practices were only hearing perspectives from one specific patient segment. In turn, the practices would only receive feedback on subject matters that affect them – for example: comorbidities that might not be prevalent in younger populations.

The transition to virtual events that accompanied the COVID-19 pandemic presented an excellent opportunity for the patient experience team to move PFACs to a virtual forum. With captive audiences at home, teams started noticing rising numbers of participants, with more diversity as well. In-person sessions would draw an average of five participants at medium-sized practices, but sites have seen that number double or even triple with the virtual switch.

PFACs make a difference. One example of a patient suggestion in action, Mullings-Smith recounts, was a pediatric practice separating their waiting room into a "sick" side and a "well" side. The impact is not only qualitative, though – there are also noticeable improvements in CG-CAHPS scores, JHCP's survey-based measure of patient-satisfaction. "In areas where we've hit plateaus, we took questions to our PFACs, and for the first time at JHCP we were able to achieve targets in all of our CG-CAHPS domains in FY 20."

Mullings-Smith is especially proud that each JHCP site held a virtual PFAC in FY 20. "That's really exciting," she says. "In particular, we've had some of our practices who previously had one or two per year, increase it to three or four per year, thanks to the virtual forum." This change has been a win for both patients, and the practices. Says Nicole Oliver, practice administrator in Greater Dundalk, "Our patients have found that attending a virtual PFAC is easier…and it has also made it easier for us to host meetings. Holding meetings virtually means that we have fewer disruptions to our clinic day and does not require us to hold meetings outside of office hours."

"PFACs offer us another opportunity to lead with the patient at the center," Mullings-Smith says. "It serves as our compass that guides our operations."

Pediatric & Family Medicine

An Ounce of Prevention Is Worth a Pound of Cure

Perhaps no endeavor is as important to pediatric medicine as maintaining high vaccination rates, a sentiment echoed by Johns Hopkins Community Physicians' (JHCP) pediatrics department.

Michael Crocetti, chief of pediatrics at JHCP, cites vaccinations as one of the greatest contributions to medicine during the 20th century. Many of the vaccine-preventable diseases that we now take for granted, such as polio and whooping cough, were major killers of children. "We have to remain

passionate about vaccination moving forward, because in order to keep those infections away, a certain percentage of the population needs to remain covered at all times," he says.

What is JHCP doing to emphasize the importance of vaccination? First, says Crocetti, is that timely vaccination has been made an institutional priority, evident in the JHCP vaccine statement. Organization leaders feel so strongly about the importance of vaccinations that in fiscal year 2020, a policy was developed concerning parents and guardians who decline to have children vaccinated.

Beyond the institutional level, staff members, providers and even JHCP's EMR, Epic, all play a role in maintaining vaccination levels among the pediatric patient population. Clinical decision support in Epic, in the form of systematic reminders and best practice alerts (BPAs), help staff members and providers track when patients are due for vaccinations — all based on national CDC guidelines. Medical assistants and medical office assistants also play an integral role in the timely vaccination of pediatric patients. As patients arrive to the practice, staff members review their chart in Epic to identify care gaps. If they are due for a vaccine, staff members can order the vaccine or note for the provider to do so. Front-line staff is also responsible for scheduling patients for their second or third doses, if needed. Finally, the provider's attitude and approach toward vaccines is one of the most influential components in vaccination success. "We are really, really lucky that we have provider buy-in," Crocetti says. "The clinician has to believe in the process and deliver the information in a confident, matter-of-fact way." According to Crocetti, evidence shows that hesitancy from providers leads to hesitancy from parents and guardians.

JHCP continues to maintain an extremely high mandatory vaccination completion rate, soaring year after year, with a percentage in the high 90s — proof that the approaches above work. One vaccination in particular saw great increases in compliance during FY 2020: the vaccination for HPV. There is a lot of room for the HPV completion rates to improve, says Crocetti, because it is not a school-mandated vaccination. Steve Blash, chief of family medicine, and pediatrics provider Tina Kumra lead a workgroup to improve compliance. A few tactics the group initiated include:

- A change in the vaccination recommendation that allows for completion of the HPV vaccine series with two immunizations by age 14 (three immunizations are still required if two vaccines are not administered before the child's 15th birthday)
- Greater attention to and emphasis on vaccination opportunities outside of traditional well-child health maintenance visits
- Better vaccine education for patients and families

Also, the CDC and its Advisory Committee on Immunization Practices recently decreased the recommended age criteria for the vaccine series from 11 to 9. "The HPV vaccine is unique in that it is intended to prevent reproductive cancers from developing later in life," Blash says. "Earlier vaccination in late childhood and early adolescence has been shown to significantly improve the individual's immunologic response and the overall efficacy of the vaccination." As a response, the group changed the age regarding the BPA in Epic that alerts providers and staff members about HPV vaccine candidacy to 9. All of these measures were effective — the calendar year 2019 saw a 20% increase in HPV vaccination completion over 2018. Blash and Kumra intend to continue efforts into fiscal year 2021 and beyond.

"We have a commitment to the community to provide the highest quality of health care, and part of that promise is to ensure that our patients are vaccinated on time," Crocetti says. This simple act will

significantly relieve the health care system's future disease burden. Adds Blash, "The old adage holds true: An ounce of prevention is worth a pound of cure."

Quality and Transformation

Tableau: Providing Direction and Driving Change

From synthesizing and organizing data sourced across the Johns Hopkins Health System, to monitoring metrics and supporting practices with quality improvement plans, the Johns Hopkins Community Physicians (JHCP) quality and transformation department is never without a constant stream of critically important work. That is why it is all the more impressive that in fiscal year 2020, the department maintained 19 Tableau dashboards — eight of which were developed in FY 2020 alone.

The quality and transformation department's work with Tableau is integral to the safety, management and improvement of quality and operations across JHCP and Johns Hopkins Medicine. A data visualization tool, Tableau presents a digestible way for end users to see and interpret metrics. As Pam Mercer, senior director of quality and transformation, says, it helps to tell the story of where we are and where we need to be.

Tableau's audience is far reaching — it extends from executive leadership to providers, local leaders and clinic staff members. Part of its beauty is that dashboards are transparent — they are helpful for benchmarking at the practice and provider levels. There are also comprehensive overview dashboards, which provide a high level, at-a-glance view of performance. Dashboards are sorted by four categories: safety, patient experience, outcomes and value. Mercer adds that Tableau serves as the organization's true north. "It's the first level of enacting change — for our team specifically, quality improvement analysts can look at the data and start working with individual practices who are struggling in certain domains."

Dashboards are diverse in the data they present, representing safety, quality outcome, patient experience and value metrics. Increasingly, the team develops dashboards to support specific projects and initiatives. Mercer and Sharon Svec, director of quality improvement data analytics, explain that new dashboards are born out of need, when a new question arises to understand performance or when priorities arise to reveal information gaps. The team creates dashboards for new or emerging programs. For example, a new one was created in FY 2020 to support the state's Maryland Primary Care Program, and others were developed in response to new health care needs. COVID-19 fits the bill for the latter — three out of the eight new dashboards developed in FY 2020 can, at least partially, trace their roots back to the pandemic: COVID-19 Safety Auditor, COVID patient characteristics and Telemedicine Patient Experience Surveys. These new dashboards have become integral to ensuring the safety of Johns Hopkins Medicine's patients and staff members.

The quality and transformation team is also focused on the maintenance and improvement of existing dashboards, specifically regarding automation. Svec says that when creating some of its early dashboards, the team had to rely on manual entry to meet tight turnaround times. "What we are doing now is working on the technical end to leverage Microsoft SQL Server, a database management software, so that Tableau can automatically refresh data on a scheduled timeline, saving a lot of manual intervention from our data analysts," Svec explains.

As automation processes continue to be developed, and more dashboards are created, the quality and transformation team will continue to drive change and excellence at JHCP, Johns Hopkins Medicine and beyond.

Research

Supporting Research to Enrich Lives

Even with a global pandemic affecting every aspect of their daily responsibilities, the Johns Hopkins Community Physicians (JHCP) research department still managed to back 53 actively enrolling projects and provide 24 letters of support – both increases over the previous fiscal year. One of their goals was to participate in at least two Patient-Centered Outcomes Research Institute (PCORI) or other large, patient-centered research initiatives. Astoundingly, they participated in nine. For example, RICH LIFE (Reducing Inequities in Care of Hypertension: Lifestyle Improvement for Everyone) received a one-year extension in fiscal year 2020.

The RICH LIFE Project was developed to address blood pressure and heart disease health disparities among Black and Hispanic populations. Co-principal investigator (PI) and professor in The Johns Hopkins University's Bloomberg School of Public Health, Jill Marsteller explains that these inequities exist across the country, often a symptom of extra pressures outside of the clinic and higher rates of negative social determinants of health, like access to health care, the ability to keep up with medication, financial pressures and access to healthy, affordable foods resulting from structural racism. Marsteller and co-PI Lisa Cooper, national expert in health care disparities and a physician at East Baltimore Medical Center, wanted to address this health inequity by comparing whether they could achieve better outcomes from clinics' efforts to address social needs, or if extra support from outside of the clinic setting would yield better results for patients who have trouble controlling their blood pressure.

Thirteen JHCP practices, along with several Federally Qualified Health Centers (located in the Baltimore region, with one in Pennsylvania), participated in the study. These locations were split into two arms: a control group and an intensive intervention group.

The control group carried on with usual care of their patients, while the intensive condition practices added a care manager and community health worker (CHW) to their care teams. They also had access to a panel of specialists for questions or advice.

In addition to the expanded care team for the intensive condition, the research team provided both groups with three extra resources. First, both groups had access to a new quality dashboard that separates data based on patient race and ethnicity. This allowed providers to look for trends in their own practice that may indicate differences in how they are managing hypertension across segments of their patient population. There was also a Johns Hopkins Health System-level education initiative focused on promotion of health equity. Finally, both the control and intensive practices received extra training and protocols for accurately measuring blood pressure. The study even provided automatic blood pressure monitoring devices for sites that did not already have them.

RICH LIFE is now in its sixth and final year; the first was mostly dedicated to planning, with four years of active implementation. Marsteller explains that during this final year, they will synthesize data from the past four years, gather their findings and interpret what they have learned. A unique part of their final year was the inclusion of the town hall-style meetings on September 9 and December 9, 2020, where

everyone who participated in the study could share their thoughts. The piece they have seen the most impact from and interest in is the incorporation of the care manager and CHW roles into practice.

These care team members served as a great resource to patients in the intensive condition of the study. Care managers, typically nurse-trained, can provide clinical advice and offer extra support to patients about medications and healthy eating. Community health workers, most of which are from the communities they serve, are not clinically trained, but are available to provide self-care motivation and training and connect patients to non-clinical resources in their communities – like transportation services, for example. In this way, the CHWs make connections related to social determinants of health. Both roles form solid relationships with patients.

Marsteller hopes that one of the study's biggest takeaways will be a general understanding that people are facing barriers that do not have anything to do with the clinical system. "Primary care providers are in a position where they want to do more to help their patients, but often they don't have the time or might not know how to connect patients to the resources they need," she says. To address these social determinants, sometimes patients need someone to actively support them beyond the clinical support of providers and that is where care managers and CHW teams can expand the way that primary care is delivered.

"We want to allow people who face greater challenges in their day-to-day lives to reach the same level of health outcomes by giving them the support and resources they need to get there," Marsteller says. In pursuit of health equity, the RICH LIFE team, supported by the JHCP research department, is enriching the lives of patients everywhere.

Risk, Safety & Service

JHCP's Tiger Team: Impact That Can't Be Tamed

With a global pandemic occupying its latter half, there is no question that fiscal year 2020 was a busy one for the Johns Hopkins Community Physicians (JHCP) Risk, Safety and Service (RSS) team. Beyond working around the clock to ensure the safety of JHCP patients, staff and providers, one achievement in particular stands out: maximizing the effectiveness of the Tiger Team.

The JHCP Tiger Team is a multidisciplinary group of five subject-matter experts who leverage their collective expertise to support practices that have faced numerous challenges. Areas of expertise include organizational development and engagement, risk management, patient experience, patient safety and nursing education. "As a team, we come together to think outside the box to develop and propose recommendations to solve the particular issues a practice might be facing," says organizational development and training consultant Alissa Putman.

The Tiger Team's current structure developed over time. Its roots can be traced back to a few years ago, when members of the education and training and RSS teams began visiting practices to address safety culture assessment scores. One by one, representatives from other disciplines began to join them. The team gained their formal name and structure in early 2018.

The main function of the team is to support high-focus sites. These sites may be identified in multiple ways. The foremost is through a review performed by the Johns Hopkins Medicine Armstrong Institute

for Patient Safety, which assesses and assigns risk levels based on metrics from three key assessments: the Patient Safety Culture assessment, the annual employee engagement survey and patient experience scores from CG-CAHPS surveys. Regional and central leadership, and members of the RSS team, may also identify practices as high-focus based on other operational or environmental factors. Proposed high-focus practices are then taken to the RSS committee to determine whether intervention is necessary.

According to Keisha Mullings-Smith, director of patient experience, the real highlight of the Tiger Team is the success and development of the practices that they served. "The dedication, time and effort of practice leadership and staff, and the act of actually following through on our recommendations and guidance, is really the most important piece," she notes. The Tiger Team meets monthly with high-focus practices' leadership to discuss pitfalls and develop improvement plans. Explains Amanda Cullison, patient safety program administrator, as they show growth, sites have the opportunity to extend the intervals between meetings, from monthly, to bi-monthly, to quarterly. "Eventually," Cullison says, "the ultimate goal is for practices to graduate out of the program." To put this work in perspective, the Tiger Team held 138 meetings in FY 20, with five practices graduating.

Danie Noble, practice administrator for pediatrics in Howard County, says that the Tiger Team was able to support her when she needed it most. "It was reassuring to have a table full of people that I consider experts in their fields, to help guide and advise me," she says. "I felt like I had a support system who sat and listened to me, and helped me to build a stronger team environment." Examples like Howard County pediatrics, that switch from high focus to high performance, are what proves that the process is worth the time and effort on both the parts of the Tiger Team members, and practice leadership. The proof that it is working, in Putman's eyes, is manifested in the response of non-high-focus sites. "There have been cases where other practices have heard what we've done and have asked to be added to the list," she recounts.

Noble's opinion of the Tiger Team represents exactly what they set out to do. "We want practices to know that they are not alone, and to recognize that it is a 'no judgement zone,'" says Mullings-Smith. "It shows that we care and that these evaluation tools are meaningful," adds Putman – at the end of the day, improving patient care is a mutual goal.

The magic behind why the Tiger Team works so well is that the team itself works so well together; they are all experts in their own right, but when they collaborate, they come up with a lot of creative solutions. Says Mullings-Smith, "we genuinely enjoy working together, we are genuinely concerned when our leaders face mounting pressures, and we are genuinely thrilled when they reach milestones."