Director’s Message

We have reached a tipping point,” says John Colmers, senior vice president for health care transformation and strategic planning at Johns Hopkins Medicine, in an interview with John McKiel (MHA Class of 2019).

Mr. Colmers was describing the newest iteration of Maryland’s CMS waiver, which permits the state to establish its own rate-setting system for healthcare providers, and he gives an interesting perspective on the future of health care in Maryland. The most significant aspect of the new waiver, in addition to the fact that it is a 10-year agreement, is the focus placed on the total cost of care. The implications, Mr. Colmers indicates, are that health systems need “to focus their attention on the patients that are in front of them and [pay] attention a bit more to those with multiple chronic illnesses, … the focus [being] to provide the best care that you can and in the most compassionate and efficient way possible.” With the shift to the total cost of care, efficiency is a critical focal point to be sure, but the most distinctive feature of this newer waiver is the enhanced focus on what happens to patients outside the four walls of the health system. Mr. Colmers points out that “in particular for those patients who are the most vulnerable because of multiple conditions and are going to end up being more expensive, [there is a need] to begin wrapping around services for [them], so as

Faculty Q&A / John Colmers

As reported in earlier editions of Management Rounds, students in the Hopkins MHA program are introduced to the Maryland model of health care shortly after they arrive in Baltimore. In this edition of MR, we share with you what has been happening in Maryland via our Q&A with John Colmers. Before joining Hopkins, Mr. Colmers was secretary of the Maryland Department of Health and Mental Hygiene (2007–11) and held various positions within the state, including commissioner of the Health Services Cost Review Commission (2013–17).

MR: Mr. Colmers, as someone who has been involved in the development and evolution of the Maryland model, can you speak a bit about how the current Maryland all-payer model came to fruition?

JC: Maryland has had an all-payer hospital rate-setting system since 1977. For most of its existence, the system focused its attention on holding down only hospital costs. In those earlier years, however, there was no constraint on overall hospital spending. That waiver was continued as long as the state held the rate of increase in Medicare payments per admission to a level lower than the rate of increase in Medicare payments per admission nationally, as measured from January 1, 1981. It was becoming increasingly difficult to pass that old test, due to steps that were being taken in Maryland to reduce unnecessary admissions and readmissions. As the unnecessary admissions were reduced, the remaining admissions became more expensive. Thus, the payment per admission in Maryland was increasing more rapidly. We began negotiating with the federal government for a new demonstration program.

MR: How did the state perform under the previous five-year waiver?

JC: The 2014 model had a number of performance measures on which the state has performed quite well:

- Maryland had to hold hospital spending per capita for all payers to a rate of increase of 3.58 percent or less. In fact, the rate of increase in Maryland over the first three years was 1.53 percent.
- Maryland had to produce $300 million in cumulative savings over the five-year demonstration. Over the first three years, Maryland hospitals produced $586 million in Medicare hospital savings, and by the end of the five-year period, estimated savings will be well over $1 billion.
- The state was also required to reduce hospital readmissions for Medicare
Team Earns Third Place in UAB Case Competition

What would you do with a 54-bed hospital in rural Tennessee, which had an average daily census of just 11 patients and was hemorrhaging money? That’s what Comprehensive Care Consulting, the team from JHU’s MHA program, had to determine at this year’s University of Alabama–Birmingham Case Competition.

The team of second-year students—Sandi Wetzel, Staci Hodge and Tolga Babur—had three weeks to develop their strategy and create their presentation. It meant lots and lots of late nights and weekends, lots of strategies considered and abandoned, and near panic when the team wasn’t sure of its strategy just a day before the deadline. And, of course, they still had to work at their day jobs as administrative residents.

Their hard work was rewarded, however, when the team survived all three rounds of presentations and came in third out of 41 teams. The judges praised the team’s innovative—yet workable—solutions, detailed financial projections and high-quality presentation. In fact, one of the judges, who was the CEO of the hospital’s parent corporation, told the team privately that she was going to explore several of the team’s ideas.

What did the team recommend? First, stabilize the hospital by converting unused inpatient beds into an inpatient skilled nursing unit and an inpatient detox unit. Most creatively, acquire a local oncology physician practice and leverage the 340B program for drug purchases. Second, establish relationships with a local college and osteopathic medical school to rotate their health professions students through the hospital and its related practices (with the expectation that many students will choose to stay in the area after graduation). Third, pursue state and federal funding opportunities to enhance revenue, and attract and retain health professionals in the area.

The MHA program office is very proud of the team members and the work they did. They used the myriad of tools that they had learned in the first year, as well as the practical experience they had acquired in the second year.

What the Healthcare Industry Can Learn from the Music Industry

In the MHA strategic planning course, Doug Hough invites healthcare leaders to discuss the strategic challenges they face. After the leaders set out a current challenge, the students brainstorm about potential solutions. This year, the class met with Steven Kravet, MD, MBA, CEO of Johns Hopkins Community Physicians, and Sebastian Seiguer, CEO of emocha Mobile Health.

Doug shook up the format a bit this year when he also invited Lou Mann, former executive vice president of Capitol Records, senior vice president of marketing for MCA Records and senior vice president of sales for Arista Records.

Lou’s 35 years in the music business have given him a unique perspective on the dramatic impact of technology on the industry—from LPs to 8-track tapes to cassettes to CDs to MP3s to Napster to Spotify and Pandora. He discussed those trends, as well as the changes in the business model and how the “theory of the business” was playing out in the industry. In short, the role of “record companies” has been transformed from identifying and developing talent to being the “banker” for emerging and developed artists. The students then speculated on the future of the industry, the most interesting prediction being instant, high-quality recording of concerts delivered to attendees’ phones.

As it turns out, Lou also knows something about the healthcare business. His wife works in patient safety and quality at Greater Baltimore Medical Center, so he made sure students understood the parallels between the disruptions of the music business and health care.

In the last few minutes of the discussion, Doug let Lou tell fan stories and answer questions about his favorite (and not-so-favorite) artists, including Paul McCartney, Whitney Houston, Bonnie Raitt, and Garth Brooks.
Introducing Students to Innovative Health Services Partnerships

Hardly a week goes by without learning of a new acquisition, merger or partnership within health care. Soon after their arrival on campus, Hopkins MHA students learn how All Children’s Hospital in St. Petersburg, FL, joined the Johns Hopkins Health System as a fully integrated member. They learn about how emocha Mobile Health, founded on technology licensed from the Johns Hopkins University, is expanding its medication adherence application to opioid addiction. Responding to feedback from students who wanted to learn more about such initiatives, the MHA program introduced a new required course in 2017–18: Non-Traditional & Innovative Health Services Partnerships, taught by Mark Shaver, senior vice president for strategy at Welltower Inc.

Mark has a long history with both Johns Hopkins Medicine and the MHA program. Before joining Welltower in January, he was the vice president of business development and strategic alliances for Johns Hopkins Medicine. During his tenure at JHM, Mark cultivated key corporate partnerships with Under Armour, Premier Inc. and GE HealthCare, in addition to Welltower. He also led the effort to forge a strategic partnership and collaboration with Walgreens, which focused on chronic disease program development. For the past 12 years, Mark has been a mentor and resource to numerous MHA students.

The course, which was taught in fourth term, introduces nontraditional partnerships as an integral part of achieving a value-based healthcare system. Students examine growing trends in health care and basic principles and practices of nontraditional partnerships. They hear from industry leaders who have established partnerships with multinational corporate, investor and strategic entities focusing on clinical services, population health and health IT activities. Groups of students were assigned to recent collaborations such as CVS/Aetna and Anthem/Cigna and asked to present a description and analysis of the venture.

MHA Students Experience Five Days of Poverty

Master of Health Administration students recently joined healthcare leaders in the Leading Transformation for Value-Based Health Care executive education program for United Way of Central Maryland’s Walk a Mile Experience. It is a hands-on, half-day activity that simulates five days in the lives of diverse types of families living near or below the poverty line. Each participant is assigned a role: mother, father, teen, child in these families, all struggling to make ends meet under different scenarios. Despite its stylized nature—taking place in a conference room with tables and chairs arranged in a small “village”—the simulation drives home the point in a very personal way that health care is not the most pressing need for these families and underscores the importance of the social determinants of health to the well-being of populations.

At the start of the activity, families huddle in the center of the room to go over their specific situations/crises and the resources they have going into that week. They are surrounded by tables represent-
Continued from page 1

patients to the national rate over five years. Over the course of the first four years, Maryland has met that goal.

MR: What are some of the major changes in the new Maryland waiver model?

JC: The new model will cover a 10-year period. As part of the negotiations, we were able to keep the original base year of 2013, so the savings that we have accrued thus far do not disappear. In this iteration of the model, the state will have to demonstrate by the end of 2023 annualized savings of $300 million in Medicare total cost of care (Part A and Part B). By the end of the fourth year of the current model, the Health Services Cost Review Commission, or HSCRC, estimates we are at about $140 million of annual savings. So we have $160 million in improvement still to make going forward. Additionally, there will be population health outcome measures, which are currently being finalized, and the federal government provided the state with some new tools to assist in aligning incentives between hospital and nonhospital providers.

MR: Following up on that, what challenges might the focus on total cost of care provide hospitals, given that some of the total cost of care does not fall within their control?

JC: The biggest challenge is aligning hospital incentives to control spending with these other providers, short of rate setting for these other providers, which is not in the plan at all. There are a couple of tools that we think will be very important in this alignment.

The first is the creation of a Medicare primary care medical home model. Medicare nationally has created a PCP Plus program for primary care physicians. It is designed to increase care coordination fees and additional support for primary care physicians with a focus on Medicare patients with multiple chronic conditions.

The second tool is a recognition by CMS of the Maryland model as an advanced alternative payment model. This will allow hospitals to encourage physicians to participate in approved care redesign programs.

MR: How does the new model incorporate population health measures at the state level?

JC: One of the features of the new model is an agreement between the state and the federal government that will measure a number of population health metrics. The federal government is willing to calculate and monetize the benefit of those improvements, and to use those calculations to offset any burdens that the state has for meeting the total cost-of-care target.

The state will propose a methodology to the federal government on how these improvements might be monetized, and the state would then encourage programs in those particular areas to bolster results.

MR: And do you anticipate that the focus on population health will have an impact on how healthcare organizations in the state deliver health care?

JC: I do think in general, whether it is because of the population health measures just discussed or the more general focus on total cost of care, the idea of hospitals forming partnerships is going to be more important than ever. Hospitals will likely be reaching outside their four walls to physicians, skilled nursing facilities, and other post-acute and community-based providers. I don’t anticipate that hospitals acting on their own will solve those problems, but they may serve as a catalyst in a community to address social determinants of health, such as housing, employment, or food safety.

MR: How might the new model impact safety net hospitals across the state of Maryland?

JC: In Maryland, for many years, there have been no hospitals of last resort. Since the inception of the HSCRC, hospital rates have included a provision for uncompensated care, so hospitals have always had an incentive to provide needed care to the uninsured. Moving forward, it will be interesting to see how hospitals are going to be partnering with community-based organizations and federally qualified health centers to provide care to the portion of the population that remains uninsured, which would include people who have decided not to avail themselves of care under the exchanges, people who have not enrolled themselves in Medicaid or people who, because of their immigration status, cannot enroll in Medicaid.

MR: One final question: How is Maryland becoming a model for other states? Furthermore, what are your views on the probability and potential impact of the model being expanded nationally?

JC: I am a firm believer in state flexibility and the ability of states on their own to decide how they might want to address the fundamental problem of the high cost of health care. The good news is that if we are successful here in Maryland, we will have done a remarkable job of bending the cost curve and making health care more affordable. While there are many things occurring with private employers, Medicare and Medicaid elsewhere in the country, they are not being done on an all-payer basis, and they do not have the laser focus that we are going to have here in Maryland. So the ways in which we are doing this, whether it is the partnerships we are developing in the care redesign programs that we have to date or if there are other care redesign activities that we develop, those may be more easily replicable in other jurisdictions.
Reflecting on My Tenure as an MAHCE Board Member

Staci Hodge, MHA Class of ’18  
Former Administrative Resident at LifeBridge Health, now LifeBridge’s Operations Manager of Pediatrics

During my first year in the MHA program, I was given the opportunity to be the student board member for the Maryland Association of Health Care Executives. MAHCE is the Maryland chapter of ACHE, the American College of Healthcare Executives. The local chapter plays an important role in educating and supporting healthcare executives, from those students looking to gain healthcare administration degrees to those well into their careers. From the start, I recognized the benefits of being part of this close-knit group of healthcare administrators. Not only were they welcoming and excited to bestow upon me many lessons of “growing up” in the industry, but their dedication to the enhancement of other administrators was quickly evident.

As student member, I had the opportunity to attend board meetings, volunteer at the MAHCE Annual All-Day event and even serve as moderator for a panel discussion about recognizing generational differences within a workforce and how health systems can support those differences. I have met wonderful, successful, hardworking healthcare careerists who have mentored me and supported me as I transitioned from student to administrator. What I realize as I reflect on my time as the student member, which ends in December, is that these relationships and programs are extremely valuable and important to our profession. MAHCE plays a critical role in keeping its members abreast of the constantly changing healthcare field; in Maryland it often feels like changes come weekly. In addition to hosting informational sessions on topics ranging from behavioral health to the opioid crisis and gender identity, MAHCE provides a two-day board of governors study session to help those of us looking to obtain our FACHE.

Having obtained my degree this past May, I reflect on this experience and realize how much I learned from being part of this organization. I encourage students and colleagues to take advantage of these resources.

The networking opportunities, the additional real-world education and my exposure to a range of administrative careers have helped me grow in this profession, even as I am just getting started.

Note from the Program Office: Beginning in AY18–19, the program will be paying for all incoming students to join the ACHE as student members. We believe the students should be active and engaged in the industry in which they will contribute. Congratulations to Staci on a successful year with MAHCE.

HPM Student Is a Winston Scholarship Recipient

Juliana Vigorito, a second-year student in the department’s Master of Science in Public Health program, is one of the 2018 recipients of the David A. Winston Health Policy Scholarships. The award recognizes excellence and achievement for students in master’s degree programs in health administration, health policy and public health.

Juliana earned her BA in public health from Johns Hopkins University and worked for the Patient-Centered Outcomes Research Institute and the Center for American Progress prior to matriculating in the MSPH Health Policy program last year. As a scholarship recipient, Juliana will be attending the Winston Symposium in Washington in late September.

During her time at JHSPH, Juliana has served as a teaching assistant and volunteered as a sex education instructor at a Baltimore City middle school. She was also a PHASE intern in the Office of Population Health Improvement at the Maryland Department of Health, where she focused on community health reporting by clinical and public health entities.

Earlier this summer Juliana, who is from New York, started her MSPH field placement as a strategy and business analyst at Maimonides Medical Center in Brooklyn, NY.
MHA Weekend, May 4–5, 2018

To some it is Cinco de Mayo; to others it’s Kentucky Derby weekend, to the MHA program it is THE weekend of the year. Faculty, students, preceptors and alumni have the opportunity to share and celebrate their accomplishments while enjoying each other’s company.

The weekend kicks off with the program’s annual case competition. Now in its 10th year, the case competition is the culminating activity for first-year MHA students. Eight teams present in the morning, and by noon the judges, all of whom are local health system executives or consultants, identify the top two teams. Department Chair Colleen Barry presided over the final round, which was judged by Dr. John Chessare, CEO and president of GBMC HealthCare, and Conan Dickson, senior director of business development and strategy at JHM, who is also a judge at the annual UAB Case Competition. By late afternoon, J&T Consulting Solutions (Justin Serrano, Victoria Ellsworth, Jordan Wuest and Tai Izawa) was identified as the winning team and received their award from Dr. Steve Kravet, president of Johns Hopkins Community Physicians, the sponsor of this year’s competition.

At 4:30, the president of Upsilon Phi Delta, Fadi Rammo, convened the annual meeting and inducted a record number of students and alumni. This year’s induction gift was Give and Take
by Adam Grant. The UPD Honor Award was presented later in the evening to Colin Ward, ’04, vice president of population health, Upper Chesapeake Health.

The Alumni/Preceptor Dinner started at 5:30 with a reception held by the School’s Wall of Wonder. The dinner, which celebrated the graduates of the Class of 2018, also served as a reunion for the Class of 1998. Speaking for the 20-year revelers, Aileen McShea Tinney, executive director of Keswick Community Health, shared some of her cohort’s memories and accomplishments with the audience. Jeff Collins, administrative director and director of external alliances at MedStar’s M12, spoke for the Class of 2008. Attendees from the classes of 2018 and 2019 received great lessons on the value of relationships from their alumni predecessors.

On Saturday morning, members of the Class of 2018 returned to campus to present their capstone papers to their classmates and program directors. Although attire was casual, the delivery and content of the presentations were completely professional. Among the outstanding talks were Chris Sulmonte’s “Moving Beyond a Unit: Transforming the Johns Hopkins Bio-Containment Unit into a Center of Excellence;” Jamison Kies’ “Care Management in an All-Payer Model, A Case Study at Greater Baltimore Medical Center;” and JulieAnn Fenstermaker’s “Hospital Occupancy Case Study.”
ing different services: grocery store/food bank, school, nonprofit community organizations, bank, employer, government agencies, which all have specific hours of service. At the start of each "day," a school bus circulates among the families to pick up school-aged children. Each 15-minute "day" brings such challenges as facing eviction because of inability to pay the rent; taking time off from work to apply for assistance, but with unreliable public transport; obtaining food; getting a sick child to health care while both parents are working full time; trading off the need for cash with the steep interest rates of payday loans. The number of challenges compressed into the 15-minute "days" creates enormous pressure on the participants to make decisions and trade-offs quickly.

At the conclusion of the five days, the participants gather for a debriefing session led by Lizzie Devereux, Walk a Mile’s director and facilitator from United Way. One of the key takeaways is a greater personal understanding of the three types of poverty highlighted by the Harvard economist Sendhil Mullainathan: lack of money, essential to any definition of poverty; lack of time, which follows from lacking money; and lack of mental bandwidth to cope with any decisions beyond those immediately facing them. This last deficiency causes hyperbolic discounting, the concept that MHA Associate Director Doug Hough has introduced to both cohorts, and makes payday loans a seemingly rational trade-off for these families in crisis.

The experience also highlights how health care falls well below the higher priorities of food, shelter and jobs. It underscores the fundamental role that social determinants of health—nutritional support, income support, housing and care coordination—play in the health of these low-income families, and it explains why these social determinants account for 80 percent of their health while acute care accounts for only 20 percent. Looking back on the experience, MHA student Kam Knab recalls, “On day 1, watching my “family” choose between a doctor’s appointment they couldn’t pay for or standing in line for subsidized food only to be turned away because the agency had closed for the day left me outraged. Over the course of the scenario, my outrage quickly turned into exhaustion and then into giving up. I thought to myself, as we inherit this system we must change it to be more patient-centered, equitable and compassionate.”

United Way of Central Maryland offers Walk a Mile Experiences to groups or organizations in the community with 30-80 participants. For more information, please contact Lizzie Devereux at elizabeth.devereux@uwcm.org.
Faculty Update: Where’s Wardo?

Ever played *Where in the World is Carmen Sandiego?* How about *Where’s Waldo?* The MHA program has its own version of these two geography games: *Where’s Wardo.* Since stepping down as MHA program director several years ago, Bill Ward has spent a good deal of his time on the road. He has visited exotic places like Palm Springs, Disney World, Maui and some not-so-exotic ones including Manchester, NH, Bismark, ND, and Missoula, MT. Why? Simple. Bill speaks all over the United States on clinical quality and patient safety.

Drawing on his experience in both hospital operations and finance, he tells his audience, mostly clinical providers, how to make the business case for improvements they know will benefit patient care. Some of this content has been shared in the lecture Bill delivers as part of the third term quality course taught by Sean Berenholtz and Chris Goeschel. But Bill’s road show is often longer and more interactive, including a mini three-act play used to illustrate how to make “the pitch” to executive row.

Soon after stepping down as director, Bill made a speech for the Association of Professionals in Infection Control and Epidemiology (APIC) at its annual educational conference in Anaheim, CA, just outside the gates to Disneyland. Since then, he has spoken at similar conferences and has also delivered daylong seminars at the intersection of finance and quality.

Most recently, Bill has been putting together a series of articles (four to be exact) for APIC’s quarterly publication *Prevention Strategist.* Soon, he will be collaborating with APIC on an internet-based series of audio lessons for infection control practitioners.

Next time you are at the airport, you might want to play MHA’s game: *Where’s Wardo?* Let us know if you spot Bill during his or your travels.

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Do You Know How to Survive a Public Health Crisis?

If not, add *The Public Health Crisis Survival Guide: Leadership and Management in Trying Times* to your late-summer reading list. Written by Josh Sharfstein, MD, vice dean for public health practice and community engagement and director of the Bloomberg American Health Initiative, this book provides candid and real-world advice on how to lead when things go wrong. Using examples from his experiences at the local, state and federal levels, Josh lets readers know how to recognize, manage and communicate in a crisis; how to pivot from managing a crisis to advocating for long-term policy change; and how to create a sense of crisis to a long-standing problem in order to generate change. Tom Frieden, former CDC director and New York City health commissioner, describes the Survival Guide as “practical, thoughtful and well-written. Before taking a job in public health, read this book.”

Committed to developing the next generation of public health practitioners and leaders, Josh also brings his extensive knowledge and good humor to the classroom by teaching Public Health Policy in the summer to the entering MPH cohort as well as Crisis and Response in Public Health Policy and Practice in the third term.

You can follow Josh at https://twitter.com/drJoshS.
HPM Welcomes New Part-Time Management Faculty

Health Policy and Management does not have far to search in recruiting part-time professional faculty. The department has been successful in tapping into its alumni network as well as its relationships within Johns Hopkins Medicine, as evidenced by the following appointments.

When the MHA program formally introduced Lean Sigma into its management curriculum in 2016, the department reached out to Eric Hamrock, who has managed and led process improvement projects throughout Johns Hopkins Medicine since 2008. In his most recent position within JHM, Eric was responsible for corporate strategy, business development, managed care, physician relations, marketing and the Greater Baltimore Health Alliance, an accountable care organization. In the MHA program, one of John’s most important roles was that of faculty preceptor. Over the past nine years, he served as preceptor to 11 second-year MHA students, many of whom are still working within GBMC. This past fall, the School posted a news story titled “Brain Trust” that described how the partnership between the MHA program and GBMC has been mutually beneficial. Although John will acknowledge that “the village raises the resident at GBMC,” it was John who made this opportunity available to MHA students.

At this year’s alumni and preceptor dinner, John’s current residents, Jamison Kies and Lindsay McMurdie, spoke for all those who have received mentorship and guidance from John. Among the quotes for which John will be remembered are, “That’s the plan and we’re sticking to it,” “management by fact” and his favorite, “family first.”

Although the MHA program has lost John as preceptor, he will continue as teaching faculty within the Bloomberg School of Public Health, where he has taught the two-term Financial Management in Health Care class to the past 22 cohorts of MHA students. The MHA program and its students are not ready to retire John!
Daniel Webster Named First Bloomberg Professor of American Health

The School has appointed Daniel Webster, a member of the HPM faculty since 1992 and a leading national expert in gun violence prevention, as its first Bloomberg Professor of American Health. This endowed position is supported by the Bloomberg American Health Initiative which tackles five issues that compromise the nation’s health: addiction and overdose, environmental challenges, obesity and the food system, risks to adolescent health, and violence.

The Initiative was launched in 2016 with a $300 million gift from Bloomberg Philanthropies. As part of the Initiative, Webster, the director of the Johns Hopkins Center for Gun Policy and Research, will lead new educational, research and practice efforts to reduce violence in the United States.

“Evidence-driven public health approaches are critical to reversing the trend of gun violence in the United States,” said Bloomberg School Dean Ellen J. MacKenzie. “Naming Dr. Webster the first Bloomberg Professor of American Health underscores the Johns Hopkins Bloomberg School of Public Health’s continued commitment to addressing this pervasive threat to American lives and communities.”

Over the past 25 years, Webster’s research and policy analyses have helped shape local, state and federal policies on gun violence prevention. Nationally, his research on handgun purchaser licensing and background checks led to the introduction of federal legislation in the U.S. House and Senate in 2015, and was the basis for a national faith-based advocacy campaign. President Obama cited this research in his 2016 address to the nation on gun violence as evidence in support of universal background checks.

In Baltimore, Webster advises the Mayor’s Office, Police Department and Health Department on strategies to reduce gun violence. He co-chairs the advisory board for Safe Streets, a public health program to prevent shootings involving youth by changing behaviors and social norms related to gun violence. Webster has led Baltimore’s Homicide Review Commission and now leads the Johns Hopkins—Baltimore Collaborative for Violence Reduction, a partnership between Johns Hopkins, the Baltimore Police Department and the State’s Attorney’s Office to promote data-driven innovation to reduce violence and improve police-community relations.

Bloomberg Open House

Want to learn more about the Bloomberg School of Public Health and all its programs?

The Bloomberg School hosts an Open House each fall providing prospective master’s and doctoral students the opportunity to learn about our dynamic academic community. To learn more about the October 8 event, go to https://www.jhsph.edu/admissions/visit/open-house
Convocation 2018

The Class of 2018 is the largest in the School’s history. At Convocation, 153 doctoral degrees and 763 master’s degrees were awarded, with 25 new alums from the Master of Health Administration program. The ceremony took place on Tuesday, May 22. Although this was the 40th ceremony that Dr. Ellen MacKenzie, former HPM department chair, attended, it was the first one she presided over as dean.

This year’s Convocation speaker was Dr. Leana S. Wen, health commissioner of Baltimore City. Dr. Wen is on the front lines of the most pressing public health issues of our times, including urban violence, health disparities, food insecurity and a deepening opioid crisis. At Convocation, MacKenzie awarded Dr. Wen the Dean’s Medal for her work advancing health and social justice in Baltimore. The Dean’s Medal is the Bloomberg School’s highest honor and celebrates individuals who have made a significant contribution to the field of public health.

The Baltimore City Health Department, formed in 1793, is the oldest, continuously operating health department in the United States, and serves community members through education, policy/advocacy, direct service delivery and a number of programs and initiatives.

Administrative Residency Placements for the MHA Class of 2019

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<th>Name</th>
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<tr>
<td>Jesse Benza</td>
<td>JHM – Department of Medicine</td>
<td>Baltimore, MD</td>
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<td>Ian Cronin</td>
<td>Atlantic Health System</td>
<td>Morristown, NJ</td>
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<tr>
<td>Tyler Dunn</td>
<td>JHM – Office of Healthcare Transformation &amp; Strategic Planning</td>
<td>Baltimore, MD</td>
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<tr>
<td>Victoria Ellsworth</td>
<td>JHM – Financial Analysis Unit</td>
<td>Baltimore, MD</td>
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<tr>
<td>Natasha Fletcher</td>
<td>Temple Physicians Inc.</td>
<td>Philadelphia, PA</td>
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<td>Matthew Hersman</td>
<td>University of Maryland Medical Center, Midtown</td>
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<td>Jan Ingram</td>
<td>Booz Allen Hamilton</td>
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<td>Tai Izawa</td>
<td>JHM – Bayview/Department of Medicine</td>
<td>Baltimore, MD</td>
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<td>Christina Jameson</td>
<td>Deloitte Consulting, LLP</td>
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<td>Anam Khan</td>
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<td>Angel Khuu</td>
<td>Meridian Health Plan</td>
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<td>Blake Manion</td>
<td>Cigna Medical Group</td>
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<td>Miriam McBride</td>
<td>JHM – Office of Johns Hopkins Physicians/CPA</td>
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<td>Kingsley Mooney</td>
<td>Knowledge Capital Group</td>
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<td>Medstar – Institute for Innovation &amp; Emergency Physicians</td>
<td>Washington, DC</td>
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<td>Onyeka Okeke</td>
<td>University of Maryland Medical System, System Performance Improvement</td>
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<td>Justin Serrano</td>
<td>LifeBridge Health</td>
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<td>Travis Woodburn</td>
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<td>MD Anderson Cancer Center</td>
<td>Houston, TX</td>
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<td>Anna Ye</td>
<td>JHM – Capacity Command Center</td>
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<td>Maggie Zhang</td>
<td>Cigna Medical Group</td>
<td>Phoenix, AZ</td>
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<td>Andrew Zimmerman</td>
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