The Johns Hopkins Hospital
Fiscal Year 2016
Community Benefits Report
Narrative

THE JOHNS HOPKINS HEALTH SYSTEM
FISCAL YEAR 2016 COMMUNITY BENEFITS REPORT
THE JOHNS HOPKINS HOSPITAL

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I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS

1. Primary Service Area

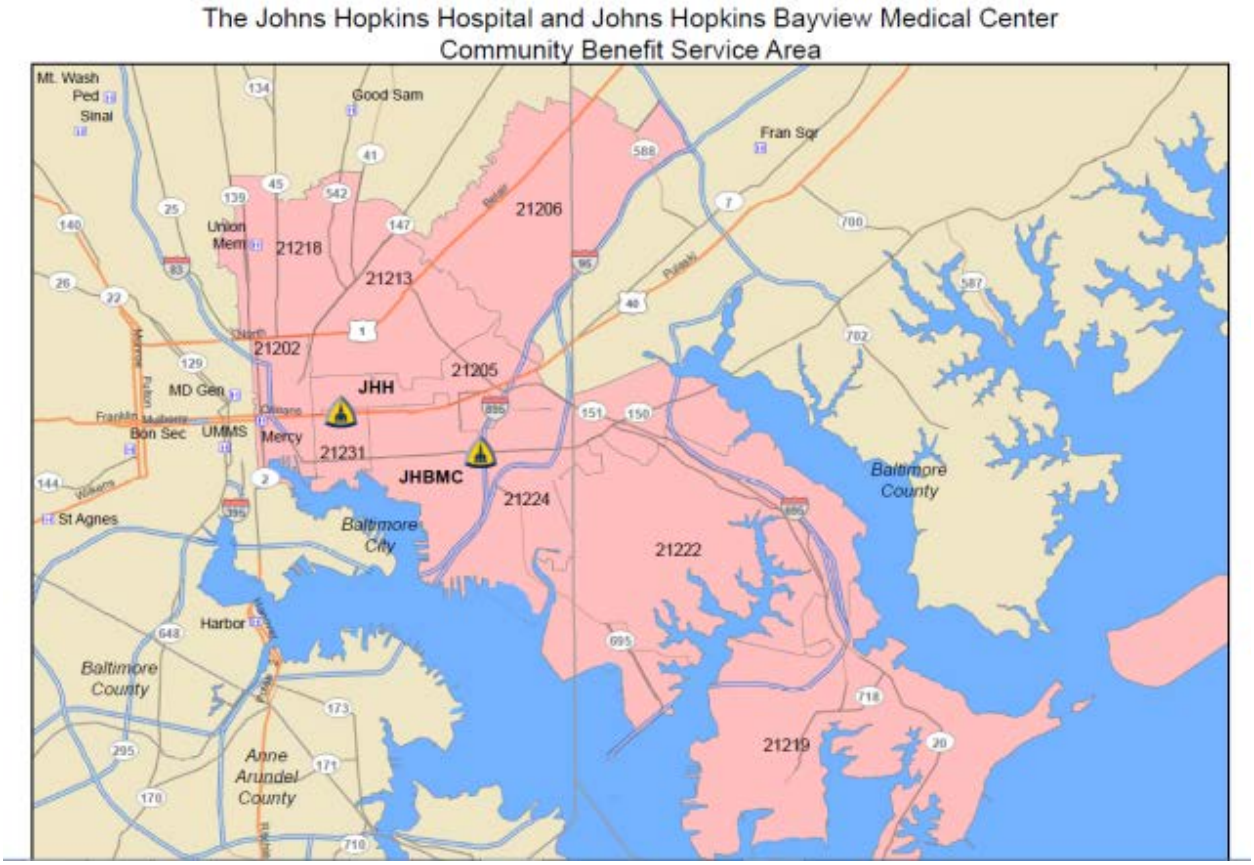
Table I

		Data Source
Bed Designation	1,129 acute beds	MHCC
Inpatient Admissions	48,554	JHM Market Analysis and Business Planning
Primary Service Area zip codes	21213, 21224, 21205, 21218, 21206, 21202, 21231, 21222, 21215, 21217, 21234, 21216, 21207, 21229, 21212, 21117, 21228, 21239, 21221, 21208, 21230, 21045, 21044, 21223, 21214, 21220, 21042, 21201, 21225, 21043, 21236, 21122, 21244, 21061, 21209, 21237, 21211, 21093, 21227, 21136, 21157, 21287, 21075, 21784, 21740, 21133, 21401, 21144, 20723, 21060, 21403, 21210, 21014, 21009, 21030, 21146, 21040, 21085, 21113, 20707, 21703, 21701, 21804, 21286, 21015, 20854, 21046, 21702, 21771, 21001	HSCRC
All other Maryland hospitals sharing primary service area	Laurel Regional Hospital, Upper Chesapeake Medical Center, Howard County General Hospital, Baltimore Washington Medical Center, Northwest Hospital Center, Carroll Hospital Center, University of Maryland Medical Center Midtown, University of Maryland Medical Center, Mercy Medical Center, University of Maryland Rehabilitation & Orthopaedic Institute, Mount Washington Pediatric Hospital, Sinai Hospital, Medstar Union Memorial Hospital, Bon Secours Hospital, Johns Hopkins Bayview Medical Center, Medstar Harbor Hospital, Saint Agnes Hospital, Franklin Square Hospital Center, Medstar Good Samaritan Hospital, Anne Arundel Medical Center, Frederick Memorial Hospital, Meritus Medical Center, Chesapeake Rehabilitation Hospital	JHM Market Analysis and Business Planning
Percentage of uninsured patients by county	Anne Arundel 0.3% Baltimore 0.6% Carroll 0.3% Charles 0.3% Dorchester 0.7% Frederick 0.7% Harford 0.3% Howard 0.3% Montgomery 0.3% Prince George's 0.4%	Review of discharge data: JHM Market Analysis and Business Planning

	St. Mary's	0.3%	
	Washington	1.5%	
	Worcester	0.4%	
	Baltimore City	0.8%	
Percentage of patients who are Medicaid recipients by county	Allegany	21.6%	Review of discharge data: JHM Market Analysis and Business Planning
	Anne Arundel	20.5%	
	Baltimore	29.0%	
	Baltimore City	52.2%	
	Calvert	16.2%	
	Caroline	33.0%	
	Carroll	15.1%	
	Cecil	38.0%	
	Charles	9.9%	
	Dorchester	46.4%	
	Frederick	17.4%	
	Garrett	25.5%	
	Harford	18.7%	
	Howard	15.1%	
	Kent	48.1%	
	Montgomery	14.2%	
	Prince George's	22.2%	
	Queen Anne's	19.8%	
	Somerset	50.0%	
	St. Mary's	20.1%	
	Talbot	30.0%	
	Washington	29.2%	
	Wicomico	46.0%	
	Worcester	33.6%	
Percentage of patients who are Medicare beneficiaries by county	Allegany	50.0%	Review of discharge data: JHM Market Analysis and Business Planning
	Anne Arundel	22.9%	
	Baltimore	46.5%	
	Baltimore City	34.8%	
	Calvert	16.4%	
	Caroline	15.0%	
	Carroll	29.3%	
	Cecil	34.3%	
	Charles	10.1%	
	Dorchester	24.1%	
	Frederick	41.5%	
	Garrett	33.3%	
	Harford	33.5%	
	Howard	29.3%	
	Kent	47.4%	
	Montgomery	38.0%	
	Prince George's	33.1%	
	Queen Anne's	41.9%	
	Somerset	20.0%	
	St. Mary's	10.0%	

	Talbot	63.3%	
	Washington	23.9%	
	Wicomico	29.5%	
	Worcester	39.4%	

2. Community Benefits Service Area (CBSA)



A. Description of the community or communities served by the organization

In 2015, the Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) merged their respective Community Benefit Service Areas (CBSA) in order to better integrate community health and community outreach across the East and Southeast Baltimore City and County region. The geographic area contained within the nine ZIP codes includes 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, and 21231. This area reflects the population with the largest usage of the emergency departments and the majority of recipients of community contributions and programming. Within the CBSA, JHH and JHBMC have focused on certain target populations such as the elderly, at-risk children and adolescents, uninsured individuals and households, and underinsured and low-income individuals and households.

The CBSA covers approximately 27.9 square miles within the City of Baltimore or approximately thirty-four percent of the total 80.94 square miles of land area for the city and 25.6 square miles in Baltimore County. In terms of population, an estimated 304,276 people live within CBSA, of which the population in City ZIP codes accounts for thirty-eight percent of the City's population and the population in County ZIP codes accounts for eight percent of the County's population (2014 Census estimate of Baltimore City population, 622,793, and Baltimore County population, 826,925).

Within the CBSA, there are three Baltimore County neighborhoods - Dundalk, Sparrows Point, and Edgemere. Baltimore City is truly a city of neighborhoods with over 270 officially recognized neighborhoods. The Baltimore City Department of Health has subdivided the city area into 23 neighborhoods or neighborhood groupings that are completely or partially included within the CBSA. These neighborhoods are Belair-Edison, Canton, Cedonia/Frankford, Claremont/Armistead, Clifton-Berea, Downtown/Seton Hill, Fells Point, Greater Charles Village/Barclay, Greater Govans, Greenmount East (which includes neighborhoods such as Oliver, Broadway East, Johnston Square, and Gay Street), Hamilton, Highlandtown, Jonestown/Oldtown, Lauraville, Madison/East End, Midtown, Midway-Coldstream, Northwood, Orangeville/East Highlandtown, Patterson Park North & East, Perkins/Middle East, Southeastern, and The Waverlies.

The Johns Hopkins Hospital is in the neighborhood called Perkins/Middle East, and the neighborhoods that are contiguous to Perkins/Middle East include Greenmount East (including Oliver, Broadway East, Johnston Square, and Gay Street), Clifton-Berea, Madison/East End, Patterson Park North & East, Fells Point, Canton, and Jonestown/Oldtown. Residents of most of these neighborhoods are primarily African American, with the exceptions of Fells Point, which is primarily white, and Patterson Park North & East, which represents a diversity of resident ethnicities. With the exceptions of Fells Point, Canton, and Patterson Park N&E, the median household income of most of these neighborhoods is significantly lower than the Baltimore City median household income. Median income in Fells Point, Canton, and Patterson Park N&E skews higher, and there are higher percentages of white households having higher median incomes residing in these neighborhoods. In southeast Baltimore, the CBSA population demographics have historically trended as white middle-income, working-class communities, Highlandtown, Southeastern, Orangeville/E. Highlandtown; however, in the past few decades, Southeast Baltimore has become much more diverse with a growing Latino population clustered around Patterson Park, Highlandtown, Orangeville/E. Highlandtown. Median incomes in these neighborhoods range from significantly below the City median in Southeastern to well above the median in Highlandtown. In Baltimore County, largely served by JHBMC, Dundalk, Sparrows Point, and Edgemere have been predominantly white with increasing populations of Hispanic and African American residents.

Neighborhoods farther north of the Johns Hopkins Hospital include Belair-Edison, Cedonia/Frankford, Claremont/Armistead, Clifton-Berea, Greater Charles Village/Barclay, Greater Govans, Hamilton, Lauraville, Midtown, Midway-Coldstream, Northwood, and The Waverlies. Residents of these neighborhoods are racially more diverse than in the neighborhoods closest to JHH and median household incomes range from significantly above the median to close to the median household income for Baltimore City.

Since the end of the Second World War, the population of Baltimore City has been leaving the city to the surrounding suburban counties. This demographic trend accelerated in the 1960s and 1970s, greatly affecting the neighborhoods around the Johns Hopkins Hospital and JHBMC. As the population of Baltimore City dropped, there has been a considerable disinvestment in housing stock in these neighborhoods. Economic conditions that resulted in the closing or relocation of manufacturing and

industrial jobs in Baltimore City and Baltimore County led to higher unemployment in the neighborhoods around the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, and social trends during the 1970s and 1980s led to increases in substance abuse and violent crime as well.

Greater health disparities are found in these neighborhoods closest to the Hospitals compared to Maryland state averages and surrounding county averages. The June 2012 Charts of Selected Black vs. White Chronic Disease SHIP Metrics for Baltimore City prepared by the Maryland Office of Minority Health and Health Disparities highlights some of these health disparities including higher emergency department visit rates for asthma, diabetes, and hypertension in blacks compared to whites, higher heart disease and cancer mortality in blacks than whites, higher rates of adult smoking, and lower percentages of adults at a healthy weight.

B. CBSA Demographics

Table II

		Data Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231 ZIP codes where the most vulnerable populations reside include 21202, 21205, 21213, and parts of 21206, 21218, 21219, 21222, 21224 and 21231	JHM Market Analysis & Business Planning
Median household income within the CBSA	CBSA average household income: $62,770 Median household income: $41,819 (Baltimore City) Median household income: $66,940 (Baltimore County)	2016 Truven and U.S. Census Bureau, 2014 American Community Survey
Percentage of households with incomes below the federal poverty guidelines within the CBSA	All families: 19.5% Married couple family: 7.1% Female householder, no husband present, family: 32.3% Female householder with related children under 5 years only: 38.4% All people: 24.2% Under 18 years: 34.6%	U.S. Census Bureau, 2014 American Community Survey http://factfinder2.census.gov

	Related Children under 5 years: 36.2% (Baltimore City, 2014) All families: 6.2% Married couple family: 3.0% Female householder, no husband present, family: 15.8% Female householder with related children under 5 years only: 21.8% All people: 9.1% Under 18 years: 11.7% Related Children under 5 years: 12.4% (Baltimore County, 2014)	
For the counties within the CBSA, what is the percentage of uninsured for each county?	10.2% Baltimore City 5.4% Baltimore County	2016 Truven
Percentage of Medicaid recipients by County within the CBSA	35.8% Baltimore City 22.3% Baltimore County	2016 Truven
Life expectancy by County within the CBSA	74.1 years at birth (Baltimore City, 2012-2014) 79.4 years at birth (Baltimore County, 2012-2014) 79.8 years at birth (Maryland, 2012-2014) Baltimore City by Race White: 76.8 years at birth Black: 72.3 years at birth Baltimore County by Race White: 79.5 years at birth Black: 78.4 years at birth	Maryland Vital Statistics Annual Report 2014 http://dhmh.maryland.gov/vsa
Mortality rates by County within the CBSA (including race and ethnicity where data are available).	Crude death rates per 100,000 in 2014 Baltimore City All: 977.7 White: 930.0 Black: 1042.3 AAPI: 208.8	Maryland Vital Statistics Annual Report 2014 and County Health Rankings 2016

	Hispanic: 142.6 Baltimore County All: 965.4 White: 1201.1 Black: 607.0 AAPI: 219.0 Hispanic: 142.5 Age-adjusted death rates for leading causes of death per 100,000 population in 2014 Baltimore City Heart disease: 236.9 Cancer: 208.5 Cerebrovascular: 48.3 Chronic lower respiratory: 35.0 Accidents: 34.6 Baltimore County Heart disease: 174.5 Cancer: 168.4 Cerebrovascular: 40.5 Chronic lower respiratory: 31.4 Accidents: 28.7 Premature Deaths (YPLL; years of potential life lost before age 75 per 100,000 population) Baltimore City: 11,207 deaths and 12,200 YPLL Rate Baltimore County: 8,637 deaths and 6,500 YPLL Rate	
Infant mortality rates within your CBSA	All: 8.4 per 1,000 live births White: 5.4 per 1,000 live births Black: 9.7 per 1,000 live births (Baltimore City, 2015) All: 6.1 per 1,000 live births White: 4.7 per 1,000 live births Black: 9.8 per 1,000 live births (Baltimore County, 2015) All: 6.7 per 1,000 live births	Maryland Vital Statistics Infant Mortality in Maryland, 2015 http://dhmh.maryland.gov/vsa

	(Maryland, 2015)	
Access to healthy food	25% of Baltimore City residents live in a food deserts (approximately 155,311 people) 30% of all school age children in Baltimore City live in a food desert Percentages of Baltimore City population living in food deserts by race/ethnicity: 34% African Americans 11-18% Hispanic/AAPI/other 8% White ZIP codes 21202, 21205, 21213, and parts of 21231 are most affected by the food deserts in Baltimore City	http://mdfoodsystemmap.org/2015-baltimore-city-food-access-map/
Access to transportation	Percentage of households with No Vehicle Available 30.3% Baltimore City 8.1% Baltimore County Elderly Population (65+) Percentage by County 12% Baltimore City 16% Baltimore County Disabled Population Potentially Requiring Transportation Assistance Percentage by County 12% Baltimore City 10% Baltimore County	The Transit Question: Baltimore Regional Transit Needs Assessment Baltimore Metropolitan Council, 2015
Education Level/Language other than English spoken at home	Education (Baltimore City): H.S. degree or higher: 80.9% Bachelor's degree or higher: 27.7%	U.S. Census Bureau, Quickfacts, 2014

	Language other than English spoken: 8.8% (Baltimore City, 2014) Education (Baltimore County): H.S. degree or higher: 90.2% Bachelor's degree or higher: 36.0% Language other than English spoken: 13.1% (Baltimore County, 2014)	
CBSA demographics, by sex, race, ethnicity, and average age	Total population: 305,197 Sex Male: 149,160/48.9% Female: 156,037/51.1% Race White non-Hispanic: 125,835/41.2% Black non-Hispanic: 139,612/45.7% Hispanic: 22,645/7.4% Asian and Pacific Islander non-Hispanic: 8,798/2.9% All others: 8,257/2.7% Age 0-14: 54,511/17.9% 15-17: 9,982/3.3% 18-24: 30,036/9.8% 25-34: 56,185/18.4% 35-54: 79,577/26.1% 55-64: 37,281/12.2% 65+: 37,625/12.3% Education Level (Pop. Age 25+) Less than H.S.: 12,979/6.2% Some H.S.: 27,695/13.1% H.S. Degree: 71,138/33.8% Some College: 50,448/ 23.9% Bachelor's Degree or Greater: 48,408/23.0%	2016 Truven

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?

_X__Yes
____No

JHH conducted and published the 2016 Community Health Needs Assessment, which was approved by the JHH Board of Trustees on 06/10/16.

If you answered yes to this question, provide a link to the document here.

http://www.hopkinsmedicine.org/the_johns_hopkins_hospital/about/in_the_community/_docs/chna-implementation-strategy-2016.pdf

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?

_X__Yes
___No

The JHH Board of Trustees approved the 2016 Implementation Strategy on 06/10/16.

If you answered yes to this question, provide the link to the document here.

http://www.hopkinsmedicine.org/the_johns_hopkins_hospital/about/in_the_community/_docs/chna-implementation-strategy-2016.pdf

III. COMMUNITY BENEFITS ADMINISTRATION

1. Is Community Benefits planning part of your hospital's strategic plan? If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

   _X_Yes
   ___No

   Community Benefit planning is an integral part of the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center's strategic plan through an annual Strategic Objectives planning process that involves evaluating the Hospital's progress at meeting two community health goals and defines metrics for determining progress. The ability to meet the goals for these objectives is part of the performance measurement for each hospital and is tied to the annual executive compensation review.

   The commitment of Johns Hopkins' leadership to improving the lives of its nearest neighbors is illustrated by the incorporation of Community Benefit metrics at the highest level in the Johns Hopkins Medicine Strategic Plan. JHM consists of JHU School of Medicine and the Johns Hopkins

Health System, which includes education and research in its tri-partite mission (Education, Research and Healthcare). Even at this cross entity level (JHU and JHHS) Community Benefit activities and planning go beyond hospital requirements and expectations and are a core objective for all departments, schools and affiliates.

Reference:
JHM Strategic Plan 2014-2018
Performance Goal #1: "Ensure that all financial operations, performance indicators and results support the strategic priorities, as well as the individual entity requirements"
Strategy: Create a mechanism to capture the value of community benefit and ensure that it supports strategic goals, and achieve compliance with community benefit standards
Tactic: Continue to use the community benefit advisory council to align reporting and investment decisions across member organizations

2. What stakeholders in the hospital are involved in your hospital community benefits process/structure to implement and deliver community benefits activities? (Place a check to any individual/group involved in the structure of the CB process and provide additional information if necessary)

    a. Senior Leadership
        i. _X_ Ronald R. Peterson, President
        ii. _X_ Ronald J. Werthman, CFO/Treasurer and Senior VP, Finance
        iii. _X_John Colmers, Senior VP, Health Care Transformation and Strategic Planning
        iv. _X_Ed Beranek, VP, Revenue Cycle Management and Reimbursement

    Senior leadership directs, oversees and approves all community benefit work including the allocation of funds that support community outreach directed at underserved and high-need populations in the CBSA. This high level review and evaluation sets the priorities of the hospital's outreach work and ensures the effective, efficient usage of funds to achieve the largest impact in improving the lives of those who live in the communities we serve. This group conducts the final review and approval of the final report's financial accuracy to the hospitals' financial statements, alignment with the strategic plan and compliance with regulatory requirements.

    b. Clinical Leadership
        i. _X_ Physicians
        ii. _X_ Nurses
        iii. _X_ Social Workers

    Individual clinical leaders along with administrators make decisions on community benefit programs that each department supports/funds through their budget. Clinical leaders will also identify and create strategies to tackle community health needs that arise in the CBSA and oversee department programs for content accuracy, adherence to department protocols and best practices.

c. Population Health Leadership and Staff
    i. _X__ Patricia M.C. Brown, Senior VP, Managed Care and Population Health
    ii. _X__ Amy Deutschendorf, VP, Care Coordination and Clinical Resource Management

Population health leadership is involved in the process of planning the 2016 JHH Community Health Needs Assessment and Implementation Strategy by providing input, feedback and advice on the identified health needs and health priorities.

d. Community Benefits Department/Team
    i. _X_ Individuals (please specify FTEs)
    JHH CBR Team –Sherry Fluke (0.30 FTE), Sharon Tiebert-Maddox (0.40 FTE), William Wang (0.20 FTE)

The Community Benefit Team interacts with all groups in the hospital performing community benefit activities. They educate, advocate and collaborate with internal audiences to increase understanding, appreciation and participation of the Community Benefit report process and community outreach activities. Team members collect and verify all CB data, compile report, provide initial audit and verification of CBR financials and write CBR narrative. Throughout the year, the CB team attends local and regional community health conferences and meetings, represents the Hospital to external audiences, and works with community and JHH clinical leaders to identify promising projects or programs that address CBSA community health needs.

    ii. _X_ Committee (please list members)
    iii. ___ Department (please list staff)
    iv. ___ Task Force (please list members)
    v. ___ Other (please describe)

JHHS Community Benefit Reporting Work Group

- The Johns Hopkins Hospital
    - Sherry Fluke, Financial Manager, Govt. & Community Affairs (GCA)
    - Sudanah Gray, Budget Analyst, GCA
    - Sharon Tiebert-Maddox, Director, Strategic Initiatives, GCA
    - William Wang, Associate Director, Strategic Initiatives, GCA

- Johns Hopkins Bayview Medical Center
    - Patricia A. Carroll, Community Relations Manager
    - Kimberly Moeller, Director, Financial Analysis
    - Selwyn Ray, Director, Community Relations

- Howard County General Hospital
    - Elizabeth Edsall-Kromm, Senior Director, Population Health and Community Relations
    - Cindi Miller, Director, Community Health Education
    - Fran Moll, Manager, Regulatory Compliance
    - Scott Ryan, Senior Revenue Analyst

- Suburban Hospital
  - Eleni Antzoulatos, Coordinator, Health Promotions and Community Wellness, Community Health and Wellness
  - Sara Demetriou, Coordinator, Health Initiative and Community Relations, Community Health and Wellness
  - Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget, and Reimbursement
  - Kate McGrail, Program Manager, Community Health and Wellness
  - Patricia Rios, Manager, Community Health Improvement, Community Health and Wellness
  - Monique Sanfuentes, Director, Community Health and Wellness

- Sibley Memorial Hospital
  - Marti Bailey, Director, Sibley Senior Association and Community Health
  - Courtney Coffey, Community Health Program Manager
  - Cynthia McKeever, Manager, Finance Decision Support
  - Marissa McKeever, Director, Government and Community Affairs
  - Honora Precourt, Community Program Coordinator

- All Children's Hospital
  - Jill Pucillo, Accounting Manager
  - Alizza Punzalan-Randle, Community Engagement Manager

- Johns Hopkins Health System
  - Janet Buehler, Senior Director, Tax Compliance
  - Bonnie Hatami, Senior Tax Accountant
  - Sandra Johnson, Vice President, Revenue Cycle Management
  - Anne Langley, Director, Health Policy Planning

The JHHS Community Benefit Workgroup convenes monthly to bring Community Benefit groups together with Tax, Financial Assistance, and Health Policy staff from across the Health System to coordinate process, practice, and policy. Workgroup members discuss issues and problems they face in community benefit reporting, regulatory compliance to state and federal community benefit requirements, and technical aspects of administering and reporting community benefit systems. When needed, a designated representative from the group contacts the governing agency for clarification or decision regarding the issues in question to ensure that all hospitals reports are consistent in the interpretation of regulations.

vi. _X_ Other (please describe)

JHM Community Benefits Advisory Council

Description: The Community Benefits Advisory Council is comprised of hospital leadership and is responsible for developing a systematic approach that aligns community benefit objectives with JHM strategic priorities. The Advisory Council meets quarterly to discuss how JHM intends to fulfill both its mission of community service and its charitable, tax-exempt purpose.

- John Colmers, Senior Vice President, Health Care Transformation and Strategic Planning, Johns Hopkins Health System [Chairperson, CBAC]
- Kenneth Grant, Vice President, Supply Chain, The Johns Hopkins Health System
- Dan Hale, Special Advisor, Office of the President, Johns Hopkins Bayview Medical Center
- Anne Langley, Senior Director, Health Policy Planning and Community Engagement
- Marissa McKeever, Director, Government and Community Affairs, Sibley Memorial Hospital
- Adrian Mosley, Community Health Administrator, The Johns Hopkins Hospital
- Monique Sanfuentes, Director of Community Health and Wellness, Suburban Hospital
- Jacqueline Schultz, Executive Vice President and Chief Operating Officer, Suburban Hospital
- Sharon Tiebert-Maddox, Director, Strategic Initiatives, Johns Hopkins Government and Community Affairs

3. Is there an internal audit (i.e., an internal review conducted at the hospital) of the community benefits report?
    a. Spreadsheet (Y/N) Yes
    b. Narrative (Y/N) Yes

    There are several levels of audit and review in place at Johns Hopkins. Members of the CBR team conduct the initial review of accuracy of information submissions, analyze financial data variances year over year, review reports for data inconsistencies and/or omissions and contact program reporters to verify submitted information and/or provide additional details. The CBR team meets with senior hospital finance leadership to discuss, review and approve the CBR financial reports. The CBR team also meets with the senior compliance officer to review and audit for regulatory compliance. After hospital specific audit/review is completed the JHHS Community Benefit Workgroup attends a meeting with all of the JHHS CFOs to review system wide data and final reports to the Health System president. In the final review meeting before submission, the hospital CFOs present to the health system president and discuss strategic alignment, challenges and opportunities discussed during the CBR process.

4. Does the hospital's Board review and approve the completed FY Community Benefits report that is submitted to the HSCRC?
    a. Spreadsheet (Y/N) Yes
    b. Narrative (Y/N) Yes

    Prior to its submission to the HSCRC, the Community Benefit Report (CBR) is reviewed in detail by the CFO and the president of the Johns Hopkins Hospital, and the president of the Johns Hopkins Health System. Although CBR approval by the Board of Trustees is not a legal requirement, the completed report is presented and reviewed by the JH Board of Trustees Joint Committee on External Affairs and Community Engagement.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

a. Does the hospital organization engage in external collaboration with the following partners:

__X___ Other hospital organizations
__X___ Local Health Department
__X___ Local health improvement coalitions (LHICs)
__X___ Schools
__X___ Behavioral health organizations
__X___ Faith based community organizations
__X___ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete).

The list of participants below represent the persons and organizations that provided 30 to 60 minutes interviews with the CHNA consultant to discuss community needs. The second list of Community Organizations and Partners that Assisted in Primary Data Collection represent organizations that provided representatives for focus group sessions and the community health forum as well as assisted in community survey distribution/collection.

List of CHNA Interviewees

Name	Organization
Albury, Pastor Kay	St. Matthew United Methodist Church
Bates Hopkins, Barbara	The Johns Hopkins University, Center for Urban Environmental Health
Benton, Vance	Patterson High School
Bone, Lee	The Johns Hopkins University, Bloomberg School of Public Health
Burke, Camille	Baltimore City Health Department
Cooper, Glenn	G. Cooper Construction & Maintenance Company
Dittman, Pastor Gary	Amazing Grace Lutheran Church
Evans, Janice	The Johns Hopkins Community Advisory Board Community College of Baltimore County; Dundalk Campus
Ferebee, Hathaway	Baltimore's Safe and Sound Campaign
Foster, Katrina	Henderson-Hopkins School
Gavriles, John E.	Greektown Community Development Corporation
Gehman, Robert	Helping Up Mission
Gianforte, Toni	Maryland Meals on Wheels
Guy Sr., Pastor Michael	St. Philip's Evangelical Lutheran Church
Hammett, Moses	Center for Urban Families

Hemminger, Sarah	Thread
Heneberry, Paula	The Johns Hopkins Hospital, Pediatric Social Work
Hickman, Rev. Debra	Sisters Together and Reaching, Inc.
Hobson, Carl	Millers Island Edgemere Business Association Hob's Citgo Service & Car Wash
Holupka, Scott	Greater Dundalk Communities Council
Krysiak, Carolyn	The Johns Hopkins Bayview Medical Center Board Emeritus Trustee
Land-Davis, Veronica	Roberta's House
Leavitt, Dr. Colleen	East Baltimore Medical Center
Lief, Isaac	Baltimore CONNECT
Lindamood, Kevin	HealthCare for the Homeless
Long, Katie	Friends of Patterson Park
Mays, Tammy	Paul Laurence Dunbar High School
McCarthy, William	Esperanza Center Catholic Charities Board member
McDowell, Grace	Edgemere Senior Center
McFadden, Senator Nathaniel	Maryland State Senator
McKinney, Fran Allen	Office of Congressman Elijah Cummings
Menzer, Amy	Dundalk Renaissance Corporation
Miles, Bishop Douglas I.	Koinonia Baptist Church and BUILD
Mosley, Adrian	The Johns Hopkins Health System, Office of Community Health
Mueller, Dr. Denisse M.	East Baltimore Medical Center
Nelson, Gloria	Maryland Department of Human Resources
Pastrikos, Father Michael L.	St. Nicholas Greek Orthodox Church
Phelan-Emrick, Dr. Darcy	Baltimore City Health Department
Prentice, Pastor Marshall	CURE (Clergy United for Renewal of East Baltimore) Zion Baptist Church
Purnell, Leon	Men and Families Center
Redd, Sam	Operation Pulse
Rosario, David	Latino Providers Network
Ryer, D. Christopher	South East Community Development Corporation
Sabatino, Jr., Ed	Historic East Baltimore Community Action Coalition, Inc.
Salih, Hiba	International Rescue Committee Baltimore Resettlement Center
Schugam, Larry	Baltimore Curriculum Project
Scott, Pastor Dred	Sowers of the Seed
Stansbury, Carol	The Johns Hopkins Hospital, Department of Medical & Surgical Social Work
Sutton, Shirley	Baltimore Medical System, Inc.

Sweeney, Brian	Highlandtown Community Association
Szanton, Dr. Sarah	The Johns Hopkins University, School of Nursing
Guerrero Vazquez, Monica	Latino Family Advisory Board/Johns Hopkins Centro SOL

Community Organizations and Partners that Assisted in Primary Data Collection (Surveys, Focus Groups, Community Health Forum)

	Community Organizations and Partners
1.	Amazing Grace Lutheran Church
2.	Baltimore City Council
3.	Baltimore City Health Department
4.	Baltimore CONNECT
5.	Baltimore County Department of Health
6.	Baltimore Curriculum Project
7.	Baltimore Medical System, Inc.
8.	Baltimoreans United in Leadership Development (BUILD)
9	Baltimore's Safe and Sound Campaign
10.	Bayview Community Association
11.	Bea Gaddy Family Center
12.	Berea East Side Community Association
13.	Breath of God Lutheran Church
14.	C.A.R.E. Community Association Inc.
15.	Catholic Charities
16.	Center for Urban Families
17.	Centro de la Comunidad
18.	Clergy United for Renewal of E. Baltimore (CURE)
19.	Community College of Baltimore County, Dundalk Campus
20.	Dayspring Programs
21.	Dundalk Renaissance Corporation
22.	Earl's Place/United Ministries
23.	East Baltimore Medical Center
24.	Edgemere Senior Center
25.	Esperanza Center
26.	Franciscan Center
27.	Friends of Patterson Park
28.	G. Cooper Construction & Maintenance Company
29.	Greater Dundalk Alliance

30.	Greater Dundalk Communities Council (GDCC)
31.	Greektown Community Development Corporation
32.	Health Care for the Homeless
33.	Helping Up Mission
34.	Henderson-Hopkins School
35.	Highlandtown Community Association
36.	Historic East Baltimore Community Action Coalition, Inc.
37.	Hob's Citgo Service & Car Wash
38.	Humanim Inc.
39.	International Rescue Committee (IRC), Baltimore Resettlement Center
40.	Johns Hopkins Center for Substance Abuse Treatment and Research
41.	Johns Hopkins Community Advisory Board
42.	Johns Hopkins Community Health Partnership (J-CHIP)
43.	Johns Hopkins Health System
44.	Johns Hopkins HealthCare
45.	Johns Hopkins Hospital Broadway Center for Addictions
46.	Johns Hopkins University Bloomberg School of Public Health
47.	Johns Hopkins University School of Medicine
48.	Johns Hopkins University School of Nursing
49.	Koinonia Baptist Church
50.	Latino Family Advisory Board/Johns Hopkins Centro SOL
51.	Latino Providers Network
52.	Light of Truth
53.	Marian House
54.	Maryland Department of Human Resources
55.	Maryland New Directions
56.	Meals on Wheels of Central Maryland
57.	Men & Families Center
58.	Millers Island Edgemere Business Association (MIEBA)
59.	Operation Pulse
60.	Parkview Ashland Terrace
61.	Patterson High School
62.	Patterson Park Neighborhood Association
63.	Paul Laurence Dunbar High School
64.	Roberta's House
65.	Sacred Heart Church
66.	Sisters Together and Reaching Inc. (STAR)

67.	South East Community Development Corporation
68.	Sowers of the Seed
69.	St. Matthew United Methodist Church
70.	St. Nicholas Greek Orthodox Church
71.	St. Philip's Evangelical Lutheran Church
72.	THREAD
73.	Turner Station Conservation Team
74.	United States Congressman Maryland's 7th District
75.	United States Senator Maryland's District 45
76.	Zion Baptist Church

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?

____yes __X___ No

The Baltimore County LHIC includes a representative from JHBMC Community Relations. The LHIC in Baltimore City has been reconvened by the Health Department. JHBMC and JHH are represented on the Baltimore City LHIC by the JHHS Senior Director of Health Planning and Community Engagement.

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

__X___yes _____ No

The LHIC in Baltimore City has been reconvened by the Health Department. JHH has a representative on the Baltimore City LHIC. The Baltimore County LHIC also has a JHH representative through the JHBMC Community Benefit team.

V. HOSPITAL COMMUNITY BENEFITS PROGRAM AND INITIATIVES

1. Brief introduction of community benefits program and initiatives, including any measurable disparities and poor health status of racial and ethnic minority groups.

Health Disparities in Baltimore City

The JHH CHNAs conducted in 2013 and 2016 identified in Baltimore City a number of health disparities, which refer to differences in occurrence and burden of diseases and other adverse health conditions between specific population groups. For example, there may be differences in health measures between

males and females, different racial groups, or individuals with differing education or income levels. Health disparities are preventable occurrences that primarily affect socially disadvantaged populations.

Disparity ratios are based on 2008 data through the 2010 Baltimore City Health Disparities Report Card. They were obtained by dividing the rate of the comparison group by the reference group rate. For example, to calculate a gender disparity, the female rate (comparison group) is divided by the male rate (reference group). There are data limitations concerning disparities among Latino, Asian, Pacific Islander and Native American/Alaskan Native residents, but this is not indicative of an absence of health disparities among these groups.

The Healthy Baltimore 2020 Report released in August 2016 identifies four main strategic priorities for the City: behavioral health, violence prevention, chronic disease, and life course and core services. The Report also identified key disparities that will be targeted for reduction by the Baltimore City Health Department and its partners. Under behavioral health, the objectives are to reduce disparity in the rate of black and white overdose death, rate of drug, alcohol, and mental health ED visits by ZIP code, and the disparity in black and white children with unmet medical needs. As part of the violence prevention component, the objectives are to reduce disparity between the rates of black vs. white child fatality, reduce disparity in percent of children who have access to vision care as compared between top-performing quartile and bottom-performing quartile of schools, and reduce disparity in absenteeism rates between black and white students.

For chronic disease, the objectives are to reduce the disparity between percent of black and white youth/adults/pregnant women who smoke cigarettes, reduce the disparity between percent of black and white residents who are obese, reduce the disparity between rate of black and white elevated blood-lead levels among children who are tested for lead, reduce the disparity between percent of black and white seniors/children living in a food desert, and reduce the disparity in the mortality rate for cardiovascular disease between black and white. Lastly, for life course and core services the objectives are to reduce the gap between black and white infant mortality rate, reduce the incidence rate of new HIV cases amongst highly vulnerable populations (e.g., LGBTQ community; youth; black), reduce the gap between rate of fatal falls for black vs. white elderly adults, reduce disparity between white vs. non-white teen birth rates, and reduce disparity between black and white life expectancy and between CSAs (Community statistical areas).

Health Disparities in Baltimore County

The health disparities in Baltimore County mirror those in Baltimore City and Maryland overall. It is the ratios that vary significantly. The DHMH Office of Minority Health and Health Disparities Report of June 2012 comparing Black vs. White disparities in the Baltimore Metro Jurisdictions (Baltimore County, Baltimore City and Anne Arundel) examined SHIP indicators including, Heart Disease Mortality, Cancer Mortality, Diabetes ED visits, Hypertension ED visits, Asthma ED Visits, Adults at Healthy Weight and Adult Cigarette Smoking. In all three jurisdictions the Black rates are typically 3 to 5 fold higher than the White Rates. Data for Baltimore County is not available with detail at the neighborhood or ZIP code level and when viewed in the aggregate, the data for the area in Southeast Baltimore contained in the JHBMC/JHH CBSA is diluted by the inclusion of many affluent areas in this large county. For that reason, in this report, the detailed information for the hospitals CBSA in Baltimore City will be described in more detail.

Mortality, Illness and Infant Health

There are health differences in mortality by location, gender, race and education level. People with a high school degree or less who live in Baltimore City are 2.65 times more likely to die from all causes than people with a bachelor's degree or more.

Baltimore City residents are 10.48 times more likely to die from HIV compared to Maryland residents. Blacks are 7.70 times more likely to die from HIV than whites. Men are 2.12 times more likely to die from HIV compared to women.

Individuals with a high school degree or less are 11.51 times more likely to die from HIV compared to individuals with a bachelor's degree or more.

Homicide is 5.05 times more likely to occur among Baltimore City residents compared to Maryland residents. Blacks are 5.99 times more likely to be involved in a homicide compared to whites. Homicide also occurs more frequently among men compared to women (disparity ratio = 7.06) and people with a high school degree or less compared to people with a bachelor's degree or more (disparity ratio = 13.60).

Infant mortality is 1.96 times more likely to occur in blacks compared to whites.

Health Status

There are differences in health status by race, gender, education level and household income. In Baltimore City, blacks are twice as likely to be obese compared to whites. People with a high school degree or less are also twice as likely to be obese compared to people with a bachelor's degree or more. Individuals with a household income less than $15,000 are 2.39 times more likely to be obese compared to individuals with a household income of $75,000 or more.

Diabetes occurs more frequently in people with a high school degree or less compared to people with a bachelor's degree or more (disparity ratio = 2.49), and in people with a household income less than $15,000 compared to people with a household income of $75,000 or more (disparity ratio = 3.67).

Child asthma is 5.97 times more likely to occur in blacks compared to whites.

Healthy Homes and Communities

In Baltimore City, there are differences in community safety and food and energy insecurity by race, gender, education level and household income. Men are 2.54 times more likely to be exposed to violence compared to women. People with a high school degree or less are more than three times as likely to be exposed to violence compared to people with a bachelor's degree or more. Blacks are 3.47 times more likely to report living in a dangerous neighborhood compared to whites. People with a high school degree or less are 5.12 times as likely to report living in a dangerous neighborhood compared to people with a bachelor's degree or more. Individuals with an income level below $15,000 are 14.17 times more likely to report living in a dangerous neighborhood than individuals with an income of $75,000 or more.

Food insecurity is 2.84 times higher among people with a high school degree or less compared to people with a bachelor's or more. People with a household income lower than $15,000 are 5.81 times more likely to have food insecurity compared to people with an income of $75,000 or more.

Energy insecurities occur more frequently among individuals with an income below $15,000 compared to individuals with an income of $75,000 or more (disparity ratio = 3.32).

Health Care

There are differences in health insurance coverage and health care needs by race, gender, education and household income. Blacks are twice as likely to lack health insurance compared to whites. Residents with a high school degree or less are also twice as likely to lack health insurance compared to residents with a bachelor's degree or more. People with an income less than $15,000 are 3.81 times more likely to lack health insurance compared to people with an income of $75,000 or more.

Individuals with a high school degree or less are 2.22 times more likely to report unmet health care needs compared to individuals with a bachelor's degree or more. Unmet health care needs are 5.23 times more likely to be reported by people with an income below $15,000 compared to people with an income of $75,000 or more. Blacks are 3.68 times more likely to report unmet mental health care needs compared to whites. People with a high school degree or less are 3.67 times more likely to report unmet mental health care needs compared to people with a bachelor's degree or more.

Community Benefit Initiatives

The 2016 JHH Implementation Strategy for the CHNA spells out in considerable detail ways that JHH intends to address the multiple health needs of our community in our ten priority areas. As the hospital begins to use this valuable tool, the Implementation Strategy itself should be considered a dynamic document and may change as JHH gains experience in implementing programs and measuring outcomes.

The Johns Hopkins Hospital community benefit program included numerous initiatives that support the Hospital's efforts to meet the needs of the community. These initiatives are decentralized and use a variety of methods to identify community needs. Over 300 programs and initiatives were carried out or supported by administrative, clinical, and operational departments at The Johns Hopkins Hospital. Community health programs and initiatives undertaken during FY 2016 include: Health Leads, The Access Partnership, You Gotta Have Heart Collaboration, Broadway Center for Addiction Substance Abuse program, Housing Support for Male Substance Abuse Patients, Wilson House, Camp SuperKids, and the Baltimore Population Health Workforce Collaborative. In the tables below, these initiatives are described in greater detail.

Initiative 1. Health Leads

Identified Need	Access to Healthcare Percentages of residents who reported having unmet medical needs in 2009 in the Baltimore City Health Disparities Report Card (2010 edition) reflected a greater number of African Americans (19.8%) than whites (8.3%) reporting unmet needs in the past year. In the 2013 edition of the Report Card, the disparity had declined with African Americans reporting 16.51% had unmet healthcare needs while whites at 14.89% had higher unmet healthcare needs. Strikingly, disparity remained quite high in those with less than a high school education (40.36%) and with incomes below $15,000 per year (20.48%). Social determinants of health are critical factors in determining the broader picture of health disparity. The 2010 Baltimore City Health Disparities Report Card showed that there are significant disparities by socioeconomic status, race and ethnicity, gender, and education level within social determinants of health such as exposure to violence, food insecurity, energy insecurity, lack of pest-free housing, lead exposure, and access to safe and clean recreation spaces.
Hospital Initiative	Health Leads Family Resource Desk – JHH Harriet Lane Clinic
Total Number of People within Target Population	Estimated individuals and families in the JHH CBSA with household income below $50,000 per year is 63,681 (Truven, 2016).
Total Number of People Reached by Initiative	Unique clients served in FY 2016: Harriet Lane Clinic: 1,111 Bayview Children's Medical Practice: 1,014 Bayview Comprehensive Care Practice: 438
Primary Objective	Health Leads provides preventative referrals to government and community resources to enable families and individuals to avert crises and access critical help such as food, clothing, shelter, energy security, and job training. It serves as an important supplement to the medical care that doctors provide, since many of the underlying wellness issues of patients and families is related to basic needs that doctors may not have time or access to research.
Single or Multi-Year Initiative **Time Period**	Multi-year initiative has been ongoing effort at Johns Hopkins Hospital since 2006.
Key Partners in Development and/or Implementation	External: Health Leads Baltimore Internal: Johns Hopkins Bayview Medical Center, Johns Hopkins University

How were the outcomes evaluated?

Health Leads does not keep baseline health related data about its clients. As their efforts to better integrate with the EMR continue, however, it may be possible to conduct pre and post analyses to determine if working with Health Leads affects a patients' probability of achieving a certain outcome. Health Leads has conducted such a study at an out-of-state partner hospital and initial findings indicate a positive correlation between Health Leads intervention and meaningful medical benefits. Additionally, Health Leads is currently designing evaluation initiatives with two other partner health systems.

Measurable goals like clients served, success rate of needs solved, time to case closure, client follow-up, and % of volunteers with Heath Leads experience are tracked by the program and measured against Heath Leads national data.

Outcome (Include process and impact measures)

Health Leads Outcomes:

For FY16, the top presenting needs were as follows:

Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
Health (30%)	Health (24%)	Health (18%)
Food (29%)	Food (19%)	Employment (15%)
Commodities (13%)	Housing (17%)	Housing (13%)
Financial (8%)	Utilities (9%)	Commodities (12%)
Child-Related (6%)	Transportation (9%)	Child-related (11%)
Other (6%)	Commodities (8%)	Food (7%)
Adult Education (5%)	Employment (6%)	Utilities (6%)

Clients Served	Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
Unique Clients	1,014	438	1,111

Total: 2,563

Client Race	Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
American Indian or Alaska Native	0%	5%	0%
Asian	0%	1%	0%

Black or African American	3%	36%	93%
Decline to State	1%	2%	1%
Other	29%	3%	1%
Native Hawaiian or Other Pacific Islander	0%	1%	0%
White	67%	55%	2%
Grand Total	100%	100%	100%
Client fill-out rate	75%	82%	64%

Ethnicity	**Bayview Children's Medical Practice**	**Bayview Comprehensive Care Practice**	**Harriet Lane Clinic**
Hispanic	95%	4%	5%
Non-Hispanic	5%	94%	94%
Decline to state	0%	2%	1%
Grand Total	100%	100%	100%
Client fill-out rate	94%	77%	60%

	% of 10 day followup	% solved at least 1 need	Days to closure
HL National	88%	65%	55
HL Midatlantic	85%	72%	62
BCCP	88%	64%	50
BCMP	82%	78%	64
HLC	86%	75%	72

Overall, for the metrics tracked by HealthLeads nationally and regionally, the Johns Hopkins HealthLeads desks metrics are in line with regional and national metrics. As part of a continual process for improving HealthLeads, Program Managers meet with clinicians and attend rounds on a weekly basis to better coordinate referrals.

Health Leads does not utilize specific population health targets. However, the vision and mission reflect the public health literature that ties unmet resource needs to increases in risk for negative medical outcomes in children and adults. Motivated by this research, as well as the day-in and day-out struggles of clients, Health Leads envisions a healthcare system that addresses all patients' basic resource needs as a standard part of quality care. Health Leads' mission is to catalyze this healthcare system by connecting

		patients with the basic resources they need to be healthy, and in doing so, build leaders with the conviction and ability to champion quality care for all patients. One key development in FY16 is progress in the ability to document social needs in EPIC. In close collaboration with JHM's EPIC team, Health Leads has built a tool to integrate social resource notes into the patient EMR. Additionally, Health Leads and Hopkins have recently collaborated to offer more flexible weekend trainings each semester for Advocates to be regularly trained as part of the on-boarding process with Health Leads in Baltimore. As a result, all three Hopkins desks are fully integrated into the EMR, providing clinical communication documentation and tracking the social needs of patient families over time. Two desks are also receiving social needs referrals via EPIC. Health Leads is experimenting nationally with tools and technologies to increase the scale of its impact and plans to bring these to JHM once they have incorporated lessons from the pilot phase into the program model. Most immediately, these include greater use of automated resource connection information for patients and the use of acuity indexes to steer our human resources towards the patients most likely to benefit from it or at greatest risk for a negative health outcome.	
Continuation of Initiative		Yes, JHH is continuing to support its partnership with Health Leads Baltimore.	
Total Cost of Initiative for Current FY	**Direct Offsetting Revenues from Restricted Grants**	Total Cost $231,551	Restricted Grants $0

Initiative 2. The Access Partnership (TAP)

Identified Need	Access to Healthcare Percentages of residents who reported having unmet medical needs in 2009 in the Baltimore City Health Disparities Report Card (2010 edition) reflected a greater number of African Americans (19.8%) than whites (8.3%) reporting unmet needs in the past year. In the 2013 edition of the Report Card, the disparity had declined with African Americans reporting 16.51% had unmet healthcare needs while whites at 14.89% had higher unmet healthcare needs.

	Strikingly, disparity remained quite high those with less than a high school education (40.36%) and with incomes below $15,000 per year (20.48%). The top goal as identified in Baltimore City Health Department's Healthy Baltimore 2015 report is to increase the quality of health care for all citizens, specifically reducing emergency department utilization rates, decrease hospitalization rates for chronic conditions, and decrease the number of city residents with unmet medical needs. As part of a dialogue initiated in 2007 among East Baltimore faith leaders and Johns Hopkins leadership, efforts were made to improve access to health care for the large uninsured population in East Baltimore. From these conversations, TAP was created primarily to improve access to outpatient specialty care to uninsured and/or financially needy residents and to provide access to primary care in certain situations.
Hospital Initiative	The Access Partnership (TAP)
Total number of people in the target population	27,927 estimate of uninsured population in ZIP codes eligible for TAP (JHM Market Analysis and Business Planning)
Total number of people reached by initiative	Since program's inception in 2009, 2,245 patients have received primary care through TAP More than 5,386 patients have received outpatient specialty care through TAP, totaling 13,798 specialty referrals.
Primary Objective	The Access Partnership (TAP) of Johns Hopkins Medicine (JHM) is a mission-driven charity program designed to improve access to effective, compassionate, evidence-based primary and specialty care for uninsured and underinsured patients residing in the community surrounding The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC). TAP's Eligibility Requirements: • Uninsured or underinsured with demonstrated financial need • Enrolled in primary care at a participating primary care clinic at Johns Hopkins or in the Baltimore community • Household income of less than 200% of the Federal Poverty Level • Reside in: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231, or 21052 TAP provides access to comprehensive primary care at three hospital-based clinics located in the East Baltimore community: • JHBMC Children's Medical Practice (CMP) • JHBMC General Internal Medicine (GIM) • JHH John Hopkins Outpatient Center (JHOC)

	There are several community clinic partners that participate in the TAP program through panels of primary care physicians. TAP does not track primary care access at these sites, which include: • Baltimore Medical Systems (Belair Edison, Highlandtown and Middlesex locations) • East Baltimore Medical Center • Chase Brexton Health Care • Health Care for the Homeless • The Esperanza Center The number of patients served is the program's primary measurable outcome. TAP's ZIP code catchment area is aligned with the JHH/JHMBC Community Benefit Service Area. There are no provisions in TAP that would enable the program to measure improvements in health status. The goal of The Access Partnership is to improve access to outpatient specialty care for patients who do not have access to state or federal health insurance programs.
Single or Multi-Year Initiative Time Period	This program has been active from 2009 to date, and is now in its eighth year.
Key Collaborators in Delivery	Internal: Johns Hopkins Medicine, Johns Hopkins Health System, and the Johns Hopkins Clinical Practice Association are critical partners in the implementation of TAP. External: Additional partners are Chase Brexton Health Services, Esperanza Center, Healthcare for the Homeless, and Baltimore Medical System Inc.
Impact/Outcome of Hospital Initiative	Patient data such as demographics, eligibility, enrollment and referrals are tracked on a monthly basis. Program metrics are monitored and reviewed on a monthly basis and statistical data and trends are summarized in quarterly reports.
Evaluation of Outcome	**<u>TAP Outcomes:</u>** Since inception May 1, 2009, the TAP program has provided medical services to more than 5,386 patients and processed 13,798 specialty referrals. During Fiscal Year 2015 and Fiscal Year 2016, TAP provided 2,843 primary care visits at three rate-regulated clinic sites at Johns Hopkins: JHBMC Children's Medical Practice, JHBMC General Internal Medicine and JHH Johns Hopkins Outpatient Center. The top ZIP codes for patients currently enrolled in TAP are 21224 (68 percent), 21222 (10 percent) and 21205 (9 percent). JHH and JHBMC care for these patients every day in their emergency departments and through hospital admissions, where eligible patients are

		referred to TAP for follow-up care. TAP takes a proactive approach to managing and navigating primary and specialty care for eligible uninsured patients. Participating primary care clinicians are able to provide comprehensive care to patients, and as a result, TAP patients have the opportunity to develop alliances with their providers that can help facilitate improved health literacy, improved health outcomes, and reduced health disparities. Prior to the implementation of the ACA, the percentage of undocumented patients enrolled in the program ranged from 35-40 percent. Since January 1, 2014, approximately 90 percent of patients enrolling in TAP are undocumented residents who are ineligible for state or federal health insurance programs. These patients are matched with bilingual (English/Spanish) navigators who help with scheduling and attending appointments. TAP's navigators ensure that patients receive timely appointments and work closely with program staff to resolve issues that arise. Program brochures and materials are also available in Spanish. There are uninsured patients served by participating community-based clinics who live outside of TAP's eligible ZIP codes but need access to specialty care. TAP receives requests to expand the program's ZIP code catchment area but TAP staff are not aware of other barriers—at this time there are no additional clinics requesting to participate. TAP has grown steadily but carefully since its inception, ensuring access to care for East Baltimore residents. Early on, TAP's leadership met with the University of Maryland Medical System and MedStar Union Memorial; TAP recommended a collaborative approach to addressing access to outpatient specialty care for uninsured residents in each hospital's neighboring geographic area. At that time, there was no interest in expanding the initiative outside of Johns Hopkins. TAP staff are open to continuing this dialogue.	
Continuation of Initiative		Yes, TAP is a continuing commitment of JHH.	
Expense	**Direct Offsetting Revenues from Restricted Grants**	Total Cost $61,413	Restricted Grants $0

Initiative 3. You Gotta Have Heart Collaboration

Identified Need	Cardiovascular Disease In 2006, the American Heart Association (AHA) showed that there is a racial gap in home CPR intervention rates. Only 20% of African Americans who suffered cardiac arrest at home received CPR by bystanders or loved ones versus 33% for whites. The white survival rate of 30% surpassed the 17% survival rate for African American cardiac arrest victims. The premature death rate from major cardiovascular disease was higher in blacks compared to whites in Baltimore City data from Healthy Baltimore 2015 (347.9 vs. 289.7 age-adjust rate per 100,000 population) Healthy Baltimore 2015 data also reflects racial disparities in many areas of cardiovascular health. The rate of emergency department discharges for hypertension related episodes in 2010, show s that African Americans had 576.1 visits compared to 94.3 visits (per 100,000 population). Hospitalization rates reflected the same for hypertension and cardiovascular related issues with a rate of 136.6 for blacks as compared to 15.0 for whites. CPR training by the AHA is traditionally 4-6 hours long and is largely attended by professionals whose jobs require certification. The training is viewed as highly technical and intimidating and does not reach lay persons who are most likely to witness a cardiac arrest at home or other public locations, including houses of worship.
Hospital Initiative	You Gotta Have Heart Collaboration
Total number of people in the target population	304,276 total population in the CBSA of which 46% (139,602 are African American).
Total number of people reached by initiative	1,200 people trained in hands only CPR, the first 600 received the full training with AED and use of practice dummies
Primary Objective	Through a partnership with the Johns Hopkins Hospital CPR Office, the faith communities will utilize a train-the-trainer model to teach core skills of CPR to 400 families utilizing the AHA's personal learning program called CPR Anytime. This 22 minute "hands only" method is learned through a personal training dummy and DVD instruction.
Single or Multi-Year Initiative Time Period	Multi-year project that started in 2012
Key Partners in Development and/or Implementation	Key internal partners in the development include the Johns Hopkins Health System's Office of Community Health, the Johns Hopkins Hospital's CPR Office, and Medicine for the Greater Good (JHM resident volunteer program).

	External: Phase I partners: Memorial Baptist Church, Zion Baptist Church, New Shiloh Baptist Church of Turners Station, and St. Martin Church of Christ. Phase II partners are Transforming Life Church, Huber Memorial, Ark Church, and Beth-El Temple. Phase III partners are First Baptist Church of Baltimore, Garden of Prayer Christian Church, Turnaround Tuesday Jobs Training Program, and the American Heart Association.
How were the outcomes measured?	The project has been evaluated using a model developed by O. Lee McCabe, Ph.D. Evaluation of the program feasibility and effectiveness is organized around the three concepts in the everyday expression "ready, willing, and able." Participants are measured on a comprehensive index of success in effectively completing the CPR Anytime training and demonstrating technique and understanding of CPR. After establishing that the program works to address the CPR Anytime components of "ready, willing, and able" the program has discontinued the evaluation component. Outcomes are limited to participant satisfaction with the training.
Outcome (Include process and impact measures)	Outcome measures include assessment of the physical skill attainment through a "certification" process of core skills, and the self-empowerment and response probability developed through confidence, assessment of characteristics of willingness (or being predisposed in mind to respond), and an assessment of whether the individual is likely to be available for a prompt and effective response by perceiving that she or he has the human and material support needed. Using objective written tests provided to 241 program participants, we were able to demonstrate statistically significant improvements in all items of proficiency. The greatest magnitude of change in the pre and post-test items were in the domains of depth of chest compressions, compression types and timing, and how to prompt others to call for help. All areas of measure to indicate willingness and readiness showed statistically significant pre and post training responses. In addition, 95% of all program participants rated their satisfaction level with the lay instruction as extremely satisfied on the areas of relevance of program and quality of the program. To date, the program has trained 1200 families in Hands Only CPR. Phase I trainers have provided sessions on request to local community groups. While Phase III did not result in new trainers being trained, the inclusion of Medicine for the Greater Good as a partner expanded the availability of student and medical volunteer trainers to meet the need for day time trainings. AED training was conducted for 14 CPR champions and new AED equipment was placed in two additional sites.

Continuation of Initiative		The program will continue to be offered in the coming year utilizing the base of volunteers available. More diverse community settings are targeted such as public housing tenants associations and public library settings.	
Total Cost of Initiative for Current FY	**Direct Offsetting Revenues from Restricted Grants**	Total Cost $29,414	Restricted Grants $0

Initiative 4. Wilson House

Identified Need	Mental Health/Substance Abuse As identified in the City Health Department's Healthy Baltimore 2015 report, substance abuse represents a health challenge for Baltimore because it is related to so many other issues the city faces such as family/community disruption, crime, homelessness, and health care utilization. Additionally, Baltimore 2015 data shows racial/ethnic disparity in the rate of unmet mental health care needs exists in Baltimore City with an incidence rate of 33.4% in blacks and 8.5% in whites (per 100,000 population).
Hospital Initiative	Wilson House
Total number of people in the target population	Estimated 45,133 individuals over age 12 with alcohol or illicit drugs disorder in past year for the Baltimore City region (SAMHSA, 2010-2012, National Survey on Drug Use and Health).
Total number of people reached by initiative	47 women in FY 2016
Primary Objective	The JHH Broadway Center provides supportive housing through slots located at our state-certified halfway house for women recovering from substance abuse – the Wilson House. The Wilson House is specifically designed to enhance peer-support and independent living for women in recovery. The facility provides women a home-like, non-institutional, stable, structured living environment, which promotes ongoing addiction treatment. The house provides 14 beds which are partially funded through an ADAA block grant. The maximum length of stay is 180 days.
Single or Multi-Year Initiative Time Period	Multi-year

Key Partners in Development and/or Implementation	External: Alcohol and Drug Abuse Administration, Behavioral Health Systems Baltimore
How were the outcomes evaluated?	The Wilson House operates 24 hours per day. During the day residents typically participate in intensive outpatient services at the Broadway Center. During evening hours, the residents are given time for personal matters (e.g., washing clothes, bathing, and phone calls). Regular house meetings allow residents to discuss house-related concerns and issues, and promote a cooperative approach to halfway house living. A certified Addiction Counselor conducts a group counseling session which promotes pro-social leisure time use and teaches sober lifestyle skills. The house creates an exceptional opportunity to link intensive day treatment services with recovery housing. We are able to more closely monitor progress in treatment outcomes for women enrolled in our program when services are closely linked to supervised housing. The Wilson House supports ongoing collaborative relationships between the East Baltimore faith community and the Johns Hopkins Hospital.
Outcome (Include process and impact measures)	The senior management team uses a set of statistical tools and reports to understand trends and uncover problems. Program leadership also attend quarterly meetings with Behavioral Health Systems Baltimore to review goals and outcomes for women residing at the Wilson House. Data is monitored weekly, and typically include statistical information on toxicology results, patient utilization and retention. In addition, program leadership participated as active members of the Baltimore City Substance Abuse Directorate. The Directorate is a non-profit organization comprised of Baltimore City substance abuse providers who work collectively to address issues facing people with substance use disorders. In FY 2016 the Wilson House served 47 women with substance use disorders. During this time period, they focused on an initiative to retain women in the house for a longer period of time. The goal was to have the women more prepared for re-entry into independent living situations. Housing staff began to work with residents to secure preventative medical appointments, obtain employment or other meaningful activities. The average length of stay during FY 2016 was 126.17 days. This data includes all residents entering the house and represents a very high standard of average retention, testifying to the residents' satisfaction with the house, the staff, and the services the Wilson House provides. It is important to note that in order to increase the length of stay for residents, the house staff and Broadway Center counselors and case managers work on "aftercare from the day of admission." That is, if a resident finds safe and therapeutic housing at any point during her Wilson House episode, the staff typically support discharge, even if only after a few weeks or a couple months.

		During FY 2016, Wilson House successfully discharged 62% of the residents into stable independent living situations, achieving their objective for retaining successfully at least half of the women in the very high-need, high-severity population served at the hospital-based treatment program.	
Continuation of Initiative		Yes, this is a continuing initiative	
Total Cost of Initiative for Current FY	**Direct Offsetting Revenues from Restricted Grants**	Total Cost $293,090	Restricted grants $241,560

Initiative 5. Broadway Center for Addiction Substance Abuse Program

Identified Need	Mental Health/Substance Abuse As identified in the City Health Department's Healthy Baltimore 2015 report, substance abuse represents a health challenge for Baltimore because it is related to so many other issues the city faces such as family/community disruption, crime, homelessness, and health care utilization. Additionally, Baltimore 2015 data shows racial/ethnic disparity in the rate of unmet mental health care needs exists in Baltimore City with an incidence rate of 33.4% in blacks and 8.5% in whites (per 100,000 population). Interventions that are comprehensive and continuous provide the best chance for successful treatment. The Broadway Center for Addiction Substance Abuse program, formerly known as PAODD (Program for Alcoholism and Other Drug Dependencies), was designed to offer this high-level of integrated treatment program.
Hospital Initiative	Broadway Center for Addiction
Total number of people in the target population	Estimated 45,133 individuals over age 12 with alcohol or illicit drugs disorder in past year for the Baltimore City region (SAMHSA, 2010-2012, National Survey on Drug Use and Health).
Total number of people reached by initiative	53 people in FY 2016
Primary Objective	The Johns Hopkins Hospital Broadway Center offers comprehensive treatment services for persons experiencing acute or chronic substance use problems. The program has a holistic approach to care delivery, addressing medical, psychiatric, social service and social network needs through

	comprehensive, on-site, integrated program services. The major categories of services provided are screening/assessment, intensive outpatient (IOP), and standard outpatient (SOP). Service enhancements are abundant, highly utilized, and include ambulatory detoxification, psychiatric assessment and treatment, basic medical assessment and treatment, case management, and opioid maintenance. Treatment services focus on establishing alcohol and drug abstinence and stabilizing health and living situations. Patients are educated about the nature and consequences of addiction. A cognitive/behavioral treatment curriculum teaches patients the necessary skills to stop substance use. Specific services include: individual therapy, group education and therapy, urinalysis testing for drug monitoring, Breathalyzer testing for alcohol monitoring, and case management.
Single or Multi-Year Initiative **Time Period**	Multi-year
Key Partners in Development and/or Implementation	External: Behavioral Health System Baltimore (BHSB), House of Ruth, Dayspring, Beans and Bread, Zion Baptist Church, and Helping Up Mission
How were the outcomes evaluated?	The Broadway Center for Addiction focuses on establishing alcohol and drug abstinence and stabilizing health and living situations. Patients are educated about the nature and consequences of addiction. IOP service delivery operates in close collaboration with the JHH halfway housing for women and with near-by men's recovery housing in East Baltimore (Helping Up Mission). Meals are provided on-site at the treatment program. NA meetings are hosted daily after treatment hours to support recovery. Patients receive treatment 2.5-3 hours/day for 4-5 days/week, with a minimum of 9 hours of clinical services scheduled each week. Patients at this treatment level also begin to work on longer-term goal setting, including such areas as job training, GED completion, and family reunification – goals continued after eventual stabilization and transfer to a standard outpatient level of care. Individual treatment sessions are scheduled at least once weekly, and treatment plans are reviewed every four weeks. Transfer to a less restrictive level of care typically occurs only after approximately 4 weeks of drug-free status and good treatment adherence. The number of weeks until achievement of this goal varies from patient to patient, but is typically 4 to 12 weeks. FY 2016 quality improvement goals of the Broadway Center included reducing substance use and maintain the percentage of positive tox screens to less than 25% and increasing patient satisfaction scores. Data for both initiatives are below.

Outcome (Include process and impact measures)		The Broadway Center continued to see improvements in treatment adherence to care and overall health for participants. Additionally, a majority of patients strongly agreed that they are better able to deal with problems as a result of treatment received.	
Continuation of Initiative		Yes, this is a continuing initiative.	
Total Cost of Initiative for Current FY	**Direct Offsetting Revenues from Restricted Grants**	Total Cost $279,677	Restricted Grants $137,217

Initiative 6. Supportive Housing for Male Substance Abuse Patients

Identified Need	Mental Health/Substance Abuse As identified in the City Health Department's Healthy Baltimore 2015 report, substance abuse represents a health challenge for Baltimore because it is related to so many other issues the city faces such as family/community disruption, crime, homelessness, and health care utilization. Interventions that are comprehensive and continuous provide the best chance for successful treatment. The Supportive Housing program was designed to help meet the daily living needs of patients in treatment for substance abuse.
Hospital Initiative	Supportive Housing for Male Substance Abuse Patients
Total number of people in the target population	Estimated 45,133 individuals over age 12 with alcohol or illicit drugs disorder in past year for the Baltimore City region (SAMHSA, 2010-2012, National Survey on Drug Use and Health).
Total number of people reached by initiative	250 men in FY 2016
Primary Objective	The Department of Psychiatry pays for supportive housing (including transportation to and from housing, and meals) for male patients in treatment at the Johns Hopkins Broadway Center for Addiction. Long-term residential recovery housing provides stable living conditions for men struggling with drug and alcohol addiction.
Single or Multi-Year Initiative Time Period	Multi-year
Key Partners in Development and/or Implementation	External: Helping Up Mission

How were the outcomes evaluated?		The Johns Hopkins Hospital currently provides financial support to the Helping Up Mission (HUM), contracted to provide up to 48 male recovery beds for patients enrolled in the Broadway Center. All patients are required to maintain excellent attendance and progression in treatment goals at the Broadway Center. Transportation is provided between the HUM and the Broadway Center multiple times per day. The maximum length of stay is 6 months. When not engaged in services at the Broadway Center, patients have access to a wide array of HUM services and programming, such as GED courses, computer literacy classes, faith services, peer support groups, art therapy, physical fitness equipment, a state of the art patient library, and much more. Men that reside at the HUM receive services daily at the Broadway Center. Although, there was no specific quality improvement projects developed for the HUM, residents were included in the Broadway Center initiatives.	
Outcome (Include process and impact measures)		Regular monitoring and management of housing census by Broadway Center staff and leadership.	
Continuation of Initiative		Yes, this is a continuing initiative.	
Total Cost of Initiative for Current FY	**Direct Offsetting Revenues from Restricted Grants**	Total Cost $562,126	Restricted Grants $0

Initiative 7. Camp SuperKids

Identified Need	Childhood asthma is an identified condition with high disparity in Baltimore City with 33.7% of children having ever been diagnosed with asthma compared to the Maryland rate of 17.3% (Baltimore City Health Disparities Report Card 2013). According to the DHMH Maryland Asthma Control Program report on Asthma in Baltimore City, "while asthma is one of the most common illnesses among children, there is little reliable county level data on the prevalence of asthma in children." However, 2009 Baltimore City emergency department data shows that the asthma emergency department visit rate per 10,000 in Baltimore City is higher for children of all age group than the Maryland rate (0-4 years 510.6 vs 195.6; 5-17 years 313.2 vs 114.7; <18 years 36.2 vs 136.1).
Hospital Initiative	Camp SuperKids

Total number of people in the target population	The 2013 CDC BRFSS data on child asthma reports a child lifetime asthma prevalence rate of 15.6% for Maryland. The 2013 estimate of the number of children currently in Maryland with child asthma is 138,988. There is no estimate available for the number of children in Baltimore City with child asthma.
Total number of people reached by initiative	Twelve children in FY15 from the JHH Community Benefit Service Area
Primary Objective	Camp Superkids is a week-long residential summer camp for children with asthma, ages seven-and-a-half to twelve. It's held at Summit Grove Camp, located in New Freedom, Pennsylvania, just over the Maryland border. While attending this summer camp, children enjoy a full range of traditional camp activities, such as swimming, arts & crafts, archery, Zumba, outdoor team-building skills and more. They learn how to manage their asthma, through identifying triggers, talking about medications, learning breathing techniques and lung anatomy; increase confidence in their ability to manage asthma; are provided knowledge to make independent and positive health choices. Additionally, children gain a strong support system of friends with asthma and positive reinforcement from adults who volunteer their valuable time and services. Children at the camp are attended to by registered nurses, a physician assistant, respiratory therapists and other non-medical personnel who are on-site the entire week.
Single or Multi-Year Initiative **Time Period**	The Johns Hopkins Hospital will continue to sponsor Camp SuperKids spots for children from the JHH CBSA.
Key Partners in Development and/or Implementation	Internal: Johns Hopkins Bayview Medical Center
How were the outcomes evaluated?	In an effort to see how much campers learn and to make needed changes to the focus and education components of Camp SuperKids, the staff administer a pre- and post-camp test each year on the first and last days of the camp. Campers are given the test on a one-on-one basis by asking the questions in an interview style and recorded by the child's camp counselor (with no prompting). The test administered in FY2016 was provided by the Children's Asthma Camp Consortium, "What do you know about asthma?" It is divided into three sections, Asthma and the Body, Asthma and You, and Asthma Tools. Each section has a mix on Yes-No and multiple choice questions, and there are a total of 43 questions.

Outcome (Include process and impact measures)		The primary goal is for children to learn more about their asthma and to learn ways to cope with the disease and manage it on a daily basis. 2016 test results indicated that the average score on the pre-test was 74.7%, and post-test was 80.4%. 80% of campers showed an improvement in test score from pre to post test, whereas 11% of campers scored lower on the post-test and 9% of campers had the same score. Additionally, the program will be exploring a health care provider survey as a follow-up assessment of how the children gained from the camp learning experience. Anecdotally, providers (pediatrician and social worker) have remarked positively about the camp experience. "Children with uncontrolled asthma face many challenges that effect their ability to breathe well, be active, and have the same experiences as other children without asthma. The biggest challenge is often understanding how to recognize and manage symptoms. The team at Camp SuperKids breaks down the key components of asthma management (symptoms, medications, prevention, self care) into an easily understandable educational format that is fun at the same time. Patients of mine that have gone to asthma camp come back with a clearer understanding of how to monitor their symptoms and use their medications properly. These children now spend more time with their friends experiencing normal day to day physical activities and play than they do managing their asthma attacks." "This camp builds confidence, improves social skills, teaches children about their asthma, medications and gives them information to share with their families. It also allows children that never have had a camp experience, because of parents' fears of their illness, a medically safe and fun experience."	
Continuation of Initiative		Yes, this is a continuing initiative.	
Total Cost of Initiative for Current FY	**Direct Offsetting Revenues from Restricted Grants**	Total Cost $15,000	Restricted Grants $0

Initiative 8. Baltimore Population Health Workforce Collaborative

Identified Need	Unemployment, along with the need to earn a living wage, is one of the greatest challenges facing Baltimore City residents. The April 2015 unemployment rate in the city was 7.4%, compared to the statewide rate of 4.9%, with some areas facing unemployment rates as high as 17% (DLLR 2015). These numbers do not take into account people who have given up hope of finding permanent employment or those who are underemployed.

	The healthcare industry is one of Baltimore's fastest growing industry sectors. According to the Baltimore Region Talent Development Pipeline study (2013), the healthcare industry will add 20,000 new jobs between 2012 and 2020. Thirty-six percent of these jobs will not require a college education, but will require training beyond high school.
Hospital Initiative	Baltimore Population Health Workforce Collaborative
Total number of people in the target population	Targeted neighborhoods are those in hospital Community Benefit Service Areas (CBSA) that have higher poverty and unemployment rates than Baltimore City overall. BPHWC will focus on the following 24 zip codes representing CBSA's of the 9 partner hospitals: 21201, 21202, 21205, 21206, 21207, 21211, 21213, 21214, 21215, 21216, 21217, 21218, 21221, 21222, 21223, 21224, 21225, 21226, 21227, 21229, 21231and 21239. The highest poverty communities to be specifically targeted include: a) the west side communities of Penn-North, Harlem Park, Sandtown-Winchester, Greater Rosemont, Upton/Druid Heights, Southern Park Heights, Pimlico/Arlington; b) the east side communities of Clifton-Berea, Madison East End, Oldtown-Middle East and Belair-Edison; c) the southern communities of Cherry Hill, Brooklyn, Curtis Bay; d) the northeast communities of Waverly, Greenmount East, Govans and Northwood; and e) the southeast Baltimore County communities of Essex, Dundalk, and Rosedale.
Total number of people reached by initiative	The BPHWC application was approved on October 19, 2016. In FY17, total number of people reached by the BPHWC will be reported.
Primary Objective	BPHWC is designed to provide the training needed to fill new health care jobs, while also improving the health of high poverty communities BPHWC will target high poverty communities throughout Baltimore City to recruit, train, and hire residents for 198 newly established entry level core jobs over three years. Individual hospitals will establish 35 other new positions related to BPHWC, to include social workers, care coordinators, for a total of 233 new jobs. The BPHWC application was approved on October 19, 2016.
Single or Multi-Year Initiative **Time Period**	This is a multi-year initiative, running from FY17 to FY19.
Key Partners in Development and/or Implementation	Internal: Johns Hopkins Bayview Medical Center External: HSCRC, LifeBridge Sinai, Medstar Franklin Square Medical Center, Medstar Good Samaritan, Medstar Harbor Hospital, Medstar Union Memorial Hospital, UMMC, UM Midtown, Baltimore Alliance for Careers in Healthcare, Baltimore Area Health Education Center, Bon Secours Community Works,

	BUILD Turnaround Tuesday, Center for Urban Families, Community College of Baltimore County, Mission Peer Recovery Training, Penn North
How were the outcomes evaluated?	When the BPHWC is up and running in FY17, the effectiveness will be evaluated along seven goals. The goals and objectives of the project, along with performance measures, include: Goal 1: Establish 68 new CHW positions across BPHWC over 3 years Objective 1.1: Provide on-boarding and essential skills training to the CHW candidates through Turnaround Tuesday (TAT), CFUF, or Penn North, based on the competencies defined by the Legislative Workgroup on Workforce Development, and 160 hours of occupational skills training to CHW candidates through BAHEC. Objective 1.2: Recruit 68 CHWs who have completed 160 hours of CHW training. Objective 1.3: Provide ongoing job coaching/mentoring to CHWs to maximize job retention Objective 1.4: Deploy CHWs to various ambulatory, community-based and home-based settings to serve chronic disease patients in targeted high poverty communities. Goal 2: Establish 21 new PRS positions across BPHWC over 3 years Objective 2.1: Provide, to those PRS candidates who have completed onboarding/essential skills training through TAT, (CFUF) or Penn North Recovery, 50 hours of training to PRS candidates through Mission Peer Recovery Training (MPRT), a training program approved by the Maryland Addictions Professional Certification Board. Objective 2.2: Recruit 21 new PRSs who have completed 50 hours of PRS training. Objective 2.3: Provide ongoing job coaching/mentoring to PRSs to maximize job retention Objective 2.4: Deploy PRSs to various ambulatory, community-based and home-based sites serving chronic disease patients in targeted high poverty communities. Goal 3: Establish 61 new CNA positions and 28 half-time CNA/GNA positions over 3 years Objective 3.1: Provide Maryland Board of Nursing approved training to CNA candidates through Community College of Baltimore County (CCBC) Objective 3.2: Recruit 61 new full-time CNAs and 28 half-time CNAs over 3 years (JHH) Objective 3.3: Provide job coaching/mentoring to CNAs/GNAs to maximize job retention Goal 4: Establish 15 Peer Outreach Specialist (POS) positions over 3 years serving HIV and Hepatitis C patients at JHH, who will be provided internal training through JHH.

		Goal 5: Establish a pool of qualified candidates for CHW, PRS and CNA occupational skills training, through an on-boarding process provided TAT, CFUF, and Penn North to identify, screen (background, experience, education, physical) and provide essential services to the targeted workforce development population. Objective 5.1: Provide essential skill classes through TAT, CFUF or Penn North that prepare trainees to enter hard skills training for CHW, PRS and CAN/GNA. Objective 5.2: Develop, with each essential skills trainee, an individual workforce development plan with short and long term career goals, including how to address barriers. Objective 5.3: Assign to those trainees who successfully complete essential skills training a job coach/mentor who will provide job coaching during and after the hiring process. Goal 6: Establish a Job Retention Program that involves technical job coaching through BACH, job mentoring through TAT, and career development coaching through hospital coaches Objective 6.1: Assign roving BACH job coaches to BPHWC sites to provide on-site job coaching related to technical aspects of the job. Objective 6.2: Assign TAT job mentors to provide job coaching/mentoring related to barriers/problems that may interfere with continued employment. Goal 7: Increase patient/family awareness of chronic illness prevention/management, to reduce ED visits/admissions/readmissions for patients served by CHWs, PRSs, CNAs-GNAs Objective 7.1: Assign/deploy CHWs, PRSs and CNAs/GNAs to care teams/settings serving chronic disease patients with high rates of potentially avoidable inpatient and ED utilization. Objective 7.2: Track potentially avoidable utilization, including 30- day hospital readmissions, of the patients directly affected by programs where CHWs/PRSs/CAN-GNAs are deployed.	
Outcome (Include process and impact measures)		In FY16, the BPHWC proposed and advocated for the creation of the Population Health Work Force Support for Disadvantaged Areas program. Outcome measures will be reported in FY17.	
Continuation of Initiative		Yes, this is a continuing initiative.	
Total Cost of Initiative for Current FY	**Direct Offsetting Revenues from Restricted Grants**	Total Cost $23,423	Restricted Grants $0

Initiative 9. – Mary Harvin Transformation Center

Identified Need(s)	Behavioral Health; Employment and Education; Housing; Safety and Security; Chronic Disease; Access to Care.
Hospital Initiative	The Mary Harvin Transformation Center (MHTC) partnership A new program, the Mary Harvin Transformation Center partnership completed a startup and planning phase in FY16. The center will serve as a central venue where The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, in collaboration with Southern Baptist Church and other neighborhood churches and community organizations, will offer programs and resources that address many of the needs identified in the Community Health Needs Assessment (listed above). The Mary Harvin Transformation Center is located in the center of some of the poorest and most distressed neighborhoods in the CBSA, with residents facing significant social and economic barriers and experiencing major health disparities. For example, only 10 percent of the residents have a bachelor's degree or greater, while almost 20 percent do not have even a high school diploma; and almost 40 percent of the households have an annual income of $25,000 or less. Given these circumstances, it is not surprising that the life expectancy of residents in these neighborhoods is less than 68 years, well below that of the overall life expectancy for Baltimore City (73.8 years) and dramatically below that of neighborhoods just a few miles away.
Total number of people in the target population	Primary – 90 senior residents living at the facility Secondary – 45,632 All Community members (all ages) living in the two closest zip codes (21205 and 21213) to the center (source 2010-2014 American Community Survey)
Total number of people reached by initiative	FY16 was a startup and planning year. The MOU and lease were signed in June 2016 and the center was opened and programming commenced in August 2016. Thus the total number of people reached/served through the program will be reported in the FY17 CBR.
Primary Objective	Provide health education and services as part of a growing interfaith community partnership. Become an integral part of the community and build trust with community residents. Objectives: • Improve educational opportunities for residents • Improve employment opportunities for residents • Support initiatives of community partners to improve housing options • Collaborate with Baltimore City Police Department and other community partners to offer safer opportunities for residents to engage in healthful activities

		• Collaborate with churches and other community partners to offer mental health and substance abuse services • Enhance the capacity of patients to engage in self-care, thus addressing the need to prevent and/or effectively manage chronic conditions • Facilitate access to health services	
Single or Multi-Year Initiative Time Period		Multi-year/on-going	
Key Collaborators in Delivery		Southern Baptist Church Zion Baptist Church Israel Baptist Church Medicine for the Greater Good STAR/Sisters Together and Reaching BACH/Baltimore Alliance for Careers in Healthcare Baltimore City Police Department	
Impact/Outcome of Hospital Initiative		Partnerships established in FY16 include: • Southern Baptist Church • Zion Baptist Church • STAR/Sisters Together and Reaching	
Evaluation of Outcome		Partnerships established Programs offered Residents reached Participant feedback	
Continuation of Initiative		This will be a continuing initiative.	
Expense	**Direct Offsetting Revenues from Restricted Grants**	Total Cost $22,000	Restricted Grants $0

2. Description of the community health needs that were identified through a community needs assessment that were not addressed by the hospital

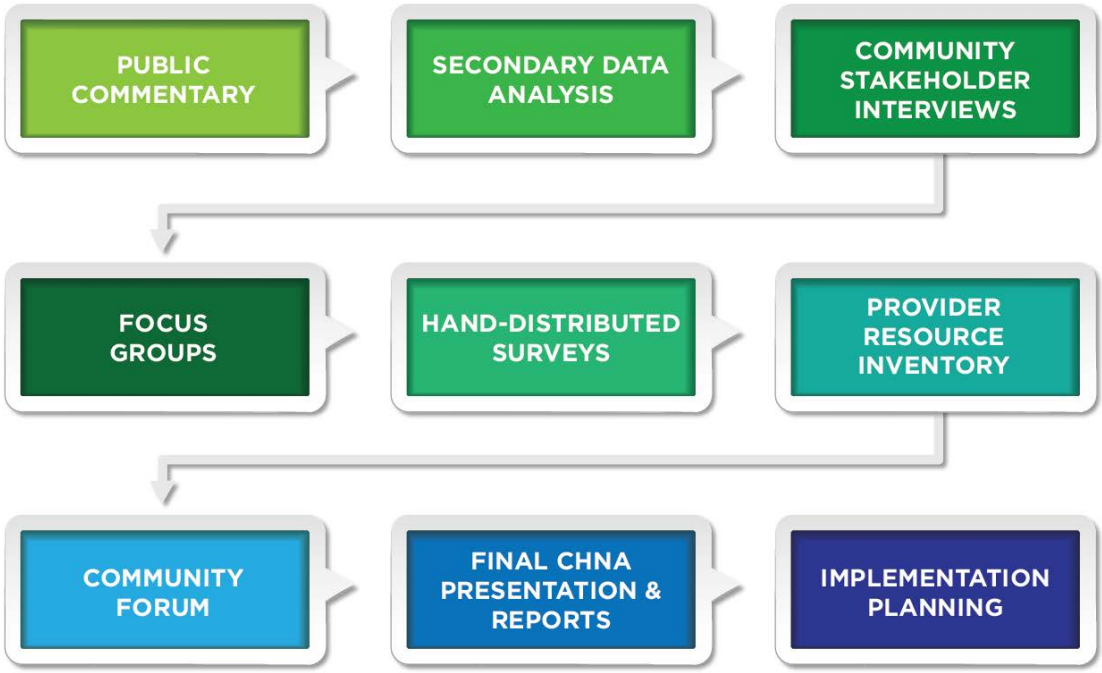
A comprehensive community-wide CHNA process was completed for Johns Hopkins Bayview Medical Center (JHBMC) and The Johns Hopkins Hospital (JHH), connecting public and private organizations, such as health and human service entities, government officials, faith-based organizations and educational institutions to evaluate the needs of the community. The 2016 assessment included primary and

secondary data collection that incorporated public commentary surveys, community stakeholder interviews, a hand-distributed survey, focus groups and a community forum.

Collected primary and secondary data brought about the identification of key community health needs in the region. An Implementation Strategy was developed that highlights, discussed and identifies ways the health system will meet the needs of the communities they serve.

The flow chart below outlines the process of each project component in the CHNA (See Flow Chart 2).

Flow Chart 2: CHNA Process



As part of the CHNA, public comments related to the 2013 CHNA and 2014 Implementation Plan completed on behalf of the Johns Hopkins Institutions were obtained. Requests for community comments offered community residents, hospital personnel and committee members the opportunity to react to the methods, findings and subsequent actions taken as a result of the previous CHNA and planning process.

Respondents were asked to review and comment on, via a survey, the 2013 CHNA report and the 2014 Implementation Plan adopted by the Johns Hopkins Institutions. The survey was strategically placed at JHH's security desk at the Wolfe Street entrance (e.g., Main Hospital Lobby) and at the security desk at the Billings Administration Lobby. At JHBMC, surveys were collected at the main hospital lobby and in the community relations office. The survey questionnaire was also emailed to the Executive Planning Committee, which includes representatives from JHH and JHBMC for review and comment collection.

There were no restrictions or qualifications required of public commenters. The collection period for the public comments began August 2015 and continued through early September 2015. In total, 21 surveys were collected and analyzed.

As part of the CHNA, telephone interviews were completed with community stakeholders in the community benefits service area to better understand the changing health environment. Community stakeholder interviews were conducted during September and October 2015.

Community stakeholders targeted for interviews encompassed a wide variety of professional backgrounds including: 1) public health expertise; 2) professionals with access to community health related data; and 3) representatives of underserved populations. The interviews offered community stakeholders an opportunity to provide feedback on the needs of the community, secondary data resources and other information relevant to the study.

The qualitative data collected from community stakeholders are the opinions, perceptions and insights of those who were interviewed as part of the CHNA process. A diverse representation of community-based organizations and agencies were among the 52 stakeholders interviewed.

Between the months of September and October 2015, Tripp Umbach facilitated six focus groups within the study area with at-risk populations. Targeted underserved focus group audiences were identified and selected with direction from hospital leadership based on their knowledge of their Community Benefits Service Area (CBSA). Tripp Umbach worked closely with community-based organizations and their representatives to schedule, recruit and facilitate focus groups within each of the at-risk communities. Participants were provided with a cash incentive, along with food and refreshments for their participation.

Tripp Umbach employed a hand-distribution methodology to disseminate surveys to individuals within the CBSA. A hand survey was utilized to collect input, in particular, from underserved populations. The hand survey, available in both English and Spanish, was designed to capture and identify the health risk factors and health needs of those within the study area. The hand survey collection process was implemented during September and October 2015.

Tripp Umbach worked with community-based organizations to collect and distribute the surveys to end-users in the underserved populations. Tripp Umbach's engagement of local community organizations was vital to the survey distribution process.

In total, 648 were used for analysis; 619 surveys were collected in English and 29 surveys were collected in Spanish. Information from the surveys played a critical role in identifying key concerns from a wide community constituent group.

As part of the CHNA process, a regional community planning forum was held at Breath of God Lutheran Church in Baltimore, MD, on December 7, 2015. Over 30 community leaders attended the event representing a variety of community organizations, health and human services agencies, health institutions and additional community agencies. Forum participants were invited to a four-hour community event where they reviewed all data collected throughout the comprehensive CHNA process, discussed the results and prioritized the needs. Forum participants were community stakeholders who

were interviewed, sponsored and recruited participants for the focus groups, and/or were instrumental in the hand-distributed survey process. Most importantly, forum participants provided critical feedback and prioritized key need areas for the CHNA.

At the community forum, Tripp Umbach presented results from secondary data analysis, community leader interviews, hand surveys and focus group results and used these findings to engage community participants in a group discussion. Upon review of primary and secondary data, participants broke into four groups to determine and identify issues that were most important to address in their community. Finally, the breakout groups were charged with prioritizing the needs and creating ways to resolve their community identified problems through concrete solutions in order to form a healthier community (this task was only completed if the breakout groups had sufficient time to brainstorm). During the final segment of the forum, all participants reassembled into one large group to discuss the prioritizations completed in each of the breakout groups. Interestingly, all breakout groups prioritized the needs in the same order. With a united voice a final list of needs was approved.

The following list identifies prioritized community health needs based upon input collected from forum participants. They are listed in order of mention.[1]

Prioritized Key Community Needs:

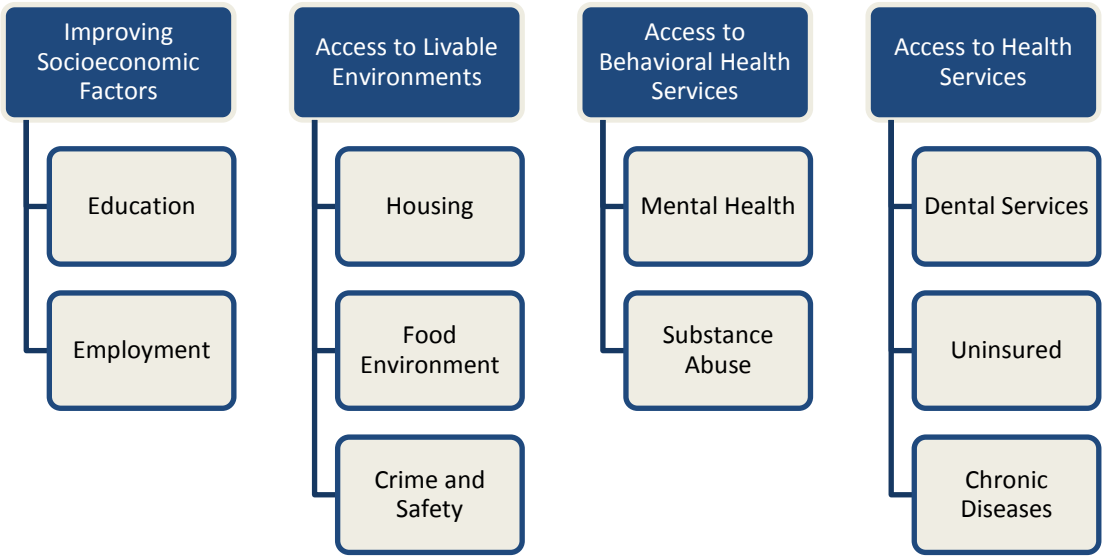
Education (4)
Employment (4)
Housing (3)
Mental health (2)
Food environment (2)
Substance abuse (2)
Crime and safety (1)
Health care/access (1)
Dental health (1)

It is important to note that forum participants expressed and discussed at great length the direct impact and associated effects between employment and education and how these specific factors directly or indirectly impact the socioeconomic factors and health needs of community residents.

Based upon feedback and input from the community leaders, community residents, project leadership, Executive Planning Committee and extensive primary and secondary data research, four CBSA priorities were identified. The key community needs were organized into broader areas and took into account the previous CHNA results of the Johns Hopkins Institutions (e.g., chronic diseases, substance abuse/addiction, obesity, access to care and mental health). The key need areas from the 2016 CHNA are aligned and merged with the previous CHNA needs and are depicted in the chart below. This grouping of the identified needs into broader categories results in the ability to include and address all identified key community needs and reflects the entwined connection the social determinants of health and population health have with impacting and improving direct health conditions.

[1] The number in parenthesis indicates the number of groups that identified the listed community need (e.g., if each of the four breakout groups mentioned the need, a (4) is shown).

2016 JHH/JHBMC CHNA Key Needs



3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health?

The Hospital has a number of programs that work toward the State's Health Improvement Process measures.

For the increase life expectancy goal and reduce hypertension related ED visit goal, the Hospital conducted stroke awareness, blood pressure screenings, and community CPR training activities.

For the goal to lower the PQI composite measure, the Hospital supports a pharmacist home-based medication management program and supports the JHCP EBMC primary care center in an otherwise underserved part of the Hospital CBSA. Additionally, the Hospital supports dialysis treatment and services as well as long-term care services for discharged patients who cannot afford these services.

For the goals related to diabetes-related ED visits, childhood obesity, and adults at a healthy weight, the Hospital conducted community health education events on healthy eating and healthy lifestyle, as well as coordinating adult walking groups and pediatric exercise programs.

For the goal to reduce hospital ED visits related to behavioral health, the Hospital supports a community psychiatry case management program for homeless individuals, a substance abuse and rehabilitation treatment center, a halfway house for women in recovery, and housing support for homeless men in recovery.

VI. PHYSICIANS

1. Description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

As stated in its Financial Assistance Policy, The Johns Hopkins Hospital is committed to providing medically necessary care to uninsured and underinsured patients with demonstrated financial need. We recognize, however, that specialty care, particularly outpatient, can be difficult to access for some uninsured patients with significant financial need despite the Hospital's stated policy. In FY2009, JHH implemented a program, The Access Partnership, to address these barriers to outpatient specialty care for uninsured patients living in the ZIP codes that surround the Hospital. The Access Partnership provides facilitation and coordination of specialty referrals for uninsured Hopkins primary care patients. Patients in the program receive support through the referral process with scheduling, appointment reminders, and follow-up. The Hospital provides specialty care as charity care, at no charge to the patient other than a nominal fee for participation in the program.

2. Physician subsidies

The Johns Hopkins Hospital provides subsidies to physicians for trauma on-call services that they would otherwise not provide to the hospital. In FY 2016, JHH paid a total of $9.526 million in subsidies to physicians for the following patient services:

Category of Subsidy	Explanation of Need for Service
Hospital-Based physicians with exclusive contract	As a state-designated Level I trauma center for Maryland, The Johns Hopkins Hospital provides subsidies to physicians for trauma on-call services that they would otherwise not provide to the Hospital. In FY16, the Hospital contributed $996,034 in Trauma On-call Coverage.
Non-Resident House Staff and Hospitalists	The Hospital staffs a team of hospitalists and intensivists to provide primary care for patients, working collaboratively alongside specialists and patients' primary care physician. In total, the Hospital provided $5,199,846 for support of hospitalist/intensivist physicians.
Coverage of Emergency Department Call	See above
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other – (provide detail of any subsidy not listed above – add more rows if needed)	On-call/Standby Anesthesia On-call/Standby Radiology On-call – GYN/OB

APPENDIX I

FINANCIAL ASSISTANCE POLICY DESCRIPTION

Description of how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's financial assistance policy.

JHHS hospitals publish the availability of Financial Assistance on a yearly basis in their local newspapers, and post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. These notices are at a reading comprehension level appropriate to the CBSA's population and is in English and in non-English languages prevalent in the CBSA.

Notice of availability is mentioned during oral communications. The hospital has multilingual staff to assist non-English speaking patients.

Notice of availability and financial assistance contact information is also prominently noted on patient bills and statements at a reading comprehension level appropriate to the CBSA's population. For Spanish speaking patients, when the hospital is aware of patient's limited language skills, statements and letters are sent in Spanish.

A Patient Billing and Financial Assistance Information Sheet is provided to inpatients before discharge and will be available to all patients upon request. This Information Sheet is at a reading comprehension level appropriate to the CBSA's population and is in English and in non-English languages prevalent in the CBSA.

Financial Assistance Applications and Medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and those patients are notified in writing as well as verbally.

Notice of availability of financial assistance is posted on each hospital website. The Financial Assistance Policy and Application and Medical Financial Hardship Application are posted on the hospital's website in English and in non-English languages that are prevalent to the CBSA's population. The application is printable.

JHHS has staff available to discuss and assist patients and/or their families with the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

APPENDIX II

Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014.

Effective January 1, 2015, JHHS expanded its definition of Medical Debt to include co-payments, co-insurance and deductibles of patients who purchased insurance through a Qualified Health Plan.

> In JHHS FAP a Qualified Health Plan is defined as:
> Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

At The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (JHBMC), the policy expanded eligibility for Financial Assistance. Previously, eligibility was limited to patients who were citizens of the United States of America or a permanent legal resident (must have resided in the USA for a minimum of one year). Effective January 1, 2015, this was expanded to include patients who reside within the geographic area described in the hospital's Community Health Needs Assessment. The ZIP codes for JHH and JHBMC are: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231, and 21052.

Notice of financial assistance availability was posted on each hospital's website and mentioned during oral communications. Policy was changed to state this is being done. This change is in response to IRS regulation changes.

Previously patients had to apply for Medical Assistance as a prerequisite for financial assistance. JHHS added that the patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements.

For Medical Hardship: Medical Debt is defined as out of pocket expenses for medical costs for Medically Necessary Care billed by the Hopkins hospital to which the application is made, the out of pocket expenses mentioned above do not include co-payments, co-insurance and deductibles, unless the patient is below 200% of Federal Poverty Guidelines.

Policy was changed to add an Appendix and language advising that the Appendix lists physicians that provide emergency and medically necessary care at the hospitals and whether the doctor is covered under the hospital's Financial Assistance policy. The Appendix will be updated quarterly and is posted on the hospital website. The policy and the website instruct patients to direct any questions they may have concerning whether a specific doctor has a financial assistance policy separate and apart from the hospital's policy. This change is in response to IRS regulation changes.

APPENDIX III

FINANCIAL ASSISTANCE POLICY

JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Policy & Procedure	Policy Number	FIN034A
		Effective Date	01-01-15
	Subject: FINANCIAL ASSISTANCE	Page	1 of 23
		Supersedes	05-15-13

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc. Acute Care Hospital and Special Programs (JHBMC) and the Chronic Specialty Hospital of the Johns Hopkins Bayview Care Center (JHBCC).

Purpose

JHHS is committed to providing financial assistance to patients who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or excessive Medical Debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, and will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. Review for Medical Financial Hardship Assistance shall include a review of the patient's existing medical expenses and obligations (including any accounts placed in bad debt) and any projected medical expenses. Financial Assistance Applications and Medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted, so long as other requirements are met.

Definitions

Medical Debt

Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the Hopkins hospital to which the application is made. Out of pocket expenses do not include co-payments, co-insurance and deductibles unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements. Medical Debt does not include those hospital bills for which the patient chose to be registered as Voluntary Self Pay(opting out of insurance coverage, or insurance billing).

Liquid Assets

Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. A safe harbor of $150,000 in equity in patient's primary residence shall not be considered an asset convertible to cash. Equity in any other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non

qualified deferred compensation plans.

Elective Admission — A hospital admission that is for the treatment of a medical condition that is not considered an Emergency Medical Condition.

Immediate Family — If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.

Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, or other acute symptoms such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) Serious jeopardy to the health of a patient;

(b) Serious impairment of any bodily functions;

(c) Serious dysfunction of any bodily organ or part.

(d) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery.
2. That a transfer may pose a threat to the health and safety of the patient or fetus.
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency Services and Care — Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician which is necessary to relieve or eliminate the emergency medical condition, within the service capability of the hospital.

Medically Necessary Care — Medical treatment that is necessary to treat an Emergency Medical Condition. Medically necessary care for the purposes of this policy does not include Elective or cosmetic procedures.

Medically Necessary Admission — A hospital admission that is for the treatment of an Emergency Medical Condition.

Family Income — Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household.

Supporting Documentation — Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.

Qualified Health Plan	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified By the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximuim amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

PROCEDURES

1. An evaluation for Financial Assistance can begin in a number of ways:

   For example:

   - A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
   - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
   - A patient with a hospital account referred to a collection agency notifies the collection agency that he/she cannot afford to pay the bill and requests assistance.
   - A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.

2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Administrative staff, Customer Service, etc.

3. Designated staff will meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

   a. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income, (as defined by Medicaid regulations). To help applicants complete the process, we will provide a statement of conditional approval that will let them know what paperwork is required for a final determination of eligibility.
   b. Applications received will be sent to the JHHS Patient Financial Services Department's dedicated Financial Assistance application line for review; a written determination of probable eligibility will be issued to the patient.

4. To determine final eligibility, the following criteria must be met:

   a. The patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its' designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. The Patient Profile Questionnaire (Exhibit B) is used to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

b. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.

c. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year).

d. All insurance benefits must have been exhausted.

5. To the extent possible, there will be one application process for all of the Maryland hospitals of JHHS. The patient is required to provide the following:

a. A completed Financial Assistance Application (Exhibit A) and Patient Profile Questionnaire (Exhibit B).

b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).

c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.

d. A Medical Assistance Notice of Determination (if applicable).

e. Proof of U.S. citizenship or lawful permanent residence status (green card) if applicable.

f. Proof of disability income (if applicable).

g. Reasonable proof of other declared expenses.

h. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc...

6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive Medical Debt. Medical Debt is defined as out of pocket expenses excluding copayments, coinsurance and deductibles unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements for medical costs billed by a Hopkins hospital. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based upon JHMI guidelines.

a. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee for final evaluation and decision.

b. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee. This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Committee will have a final determination made no later than 30 days from the date the application was considered complete. The Financial Assistance Evaluation Committee will base its determination of financial need on JHHS guidelines.

7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

8. Services provided to patients registered as Voluntary Self Pay patients do not qualify for Financial Assistance.

9. A department operating programs under a grant or other outside governing authority (i.e., Psychiatry) may continue to use a government-sponsored application process and associated income scale.

10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient make a good-faith payment at the beginning of the Financial Assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set forth in Appendix B, JHHS shall make a payment plan available to the patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may be extended.

11. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patient's representative request an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.

12. Financial Assistance Applications may only be submitted for/by patients with open and unpaid hospital accounts.

13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Financial Assistance Evaluation Committee. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

14. Patients who receive coverage on a Qualified Health Plan and ask for help with out of pocket expenses (co-payments and deductibles) for medical costs resulting from medically necessary care shall be required to submit a Financial Assistance Application if the patient is at or below 200% of Federal Poverty Guidelines.

15. If a patient account has been assigned to a collection agency, and patient or guarantor request financial assistance or appears to qualify for financial assistance, the collection agency shall notify PFS and shall forward the patient/guarantor a financial assistance application with instructions to return the completed application to PFS for review and determination and shall place the account on hold for 45 days pending further instruction from PFS.

16. Beginning October 1, 2010, if within a two (2) year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $25. If the hospital documentation demonstrates the lack of cooperation of the patient or guarantor in providing information to determine eligibility for free care, the two (2) year period herein may be reduced to 30 days from the date of initial request for information. If the patient is enrolled in a means-tested government health care plan that requires the patient to pay-out-of pocket for hospital services, then patient or guarantor shall not be refunded any funds that would result in patient losing financial eligibility for health coverage.

17. This Financial Assistance policy does not apply to deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient. Johns Hopkins will file a claim in the decedents' estate and such claim will be subject to estate administration and applicable Estates and Trust laws.

18. JHHS Hospitals may extend Financial Assistance to residents with demonstrated financial need, regardless of citizenship, in the neighborhoods surrounding their respective hospitals, as determined by the hospital's Community Health Needs Assessment. The zip codes for JHH and JHBMC are: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231 and 21052. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. Financial Counselors will refer these patients to The Access Partnership program at Hopkins (see FIN057 for specific procedures).

REFERENCE[1]

JHHS Finance Policies and Procedures Manual
Policy No. FIN017 - Signature Authority: Patient Financial Services
Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

Code of Maryland Regulations COMAR 10.37.10.26, et seq
Maryland Code Health General 19-214, et seq
Federal Poverty Guidelines (Updated annually) in Federal Register

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1[1] NOTE: Standardized applications for Financial Assistance, Patient Profile Questionnaire and Medical Financial Hardship have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A, B and C.

RESPONSIBILITIES - JHH, JHBMC

Financial Counselor (Pre-Admission/Admission/In-House/ Outpatient) Customer Service Collector Admissions Coordinator Any Finance representative designated to accept applications for Financial Assistance	Understand current criteria for Assistance qualifications. Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form. On the day preliminary application is received, fax to Patient Financial Services Department's dedicated fax line for determination of probable eligibility. Review preliminary application, Patient Profile Questionnaire and Medical Financial Hardship Application (if submitted) to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments. If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review. Review and ensure completion of final application. Deliver completed final application to appropriate management. Document all transactions in all applicable patient accounts comments. Identify retroactive candidates; initiate final application process.
Management Personnel (Supervisor/Manager/Director)	Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies. Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.] Notices will not be sent to Presumptive Eligibility recipients.
Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent) CP Director and Management Staff	Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

SPONSOR

Senior Director, Patient Finance (JHHS)
Director, PFS Operations (JHHS)

REVIEW CYCLE

Two (2) years

APPROVAL

_____ _____

Sr. VP of Finance/Treasurer & CFO for JHH and JHHS Date

APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

1. Each patient requesting Financial Assistance must complete a JHM/Financial Assistance Application (also known as the Maryland State Uniform Financial Assistance Application) Exhibit A, and Patient Profile Questionnaire, Exhibit B. If patient wishes to be considered for Medical Financial Hardship, patient must submit Medical Financial Hardship Application, Exhibit C.

2. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.

3. The patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

4. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year)

5. Proof of income must be provided with the final application. Acceptable proofs include:
   (a) Prior-year tax return;
   (b) Current pay stubs;
   (c) Letter from employer, or if unemployed documentation verifying unemployed status; and
   (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.

6. Patients will be eligible for Financial Assistance if their maximum family (husband and wife, same sex married couples) income (as defined by Medicaid regulations) level does not exceed each affiliate's standard (related to the Federal poverty guidelines) and they do not own Liquid Assets *in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.

7. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify.

8. Patients who chose to become voluntary self pay patients do not qualify for Financial Assistance for the amount owed on any account registered as Voluntary Self Pay.

9. Financial Assistance is only applicable to Medically Necessary Care as defined in this policy. Financial Assistance is not applicable to convenience items, private room accommodations or non-essential cosmetic surgery. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is an "Elective Admission" or a "Medically Necessary Admission," the patient's admitting physician shall be consulted and the matter will also be directed to the physician advisor appointed by the hospital.

10. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days of the day when the application was satisfactorily completed and submitted.

11. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.

12. A determination of eligibility for Financial Assistance based on the submission of a Financial Assistance Application will remain valid for a period of six (6) months for all necessary JHM affiliate services provided, based on the date of the determination letter. Patients who are currently receiving Financial Assistance from one JHM affiliate will not be required to reapply for Financial Assistance from another affiliate.

13. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.

Exception

The Director of Patient Financial Services (or affiliate equivalent) may make exceptions according to individual circumstances.

FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 2/1/15

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	**$ 23,540**	$ 25,894	$ 28,248	$ 30,602	$ 32,956	$ 35,310
2	**$ 31,860**	$ 35,046	$ 38,232	$ 41,418	$ 44,604	$ 47,790
3	**$ 40,180**	$ 44,198	$ 48,216	$ 52,234	$ 56,252	$ 60,270
4	**$ 48,500**	$ 53,350	$ 58,200	$ 63,050	$ 67,900	$ 72,750
5	**$ 56,820**	$ 62,502	$ 68,184	$ 73,866	$ 79,548	$ 85,230
6	**$ 65,140**	$ 71,654	$ 78,168	$ 84,682	$ 91,196	$ 97,710
7	**$ 73,460**	$ 80,806	$ 88,152	$ 95,498	$ 102,844	$ 110,190
8*	**$ 81,780**	$ 89,958	$ 98,136	$ 106,314	$ 114,492	$ 122,670
**amt for each mbr	$8,320	$9,152	$9,984	$10,816	$11,648	$12,480
Allowance to Give:	100%	80%	60%	40%	30%	20%

*200% of Poverty Guidelines

** For family units with more than eight (8) members.

EXAMPLE:

Annual Family Income	$55,000
# of Persons in Family	4
Applicable Poverty Income Level	48,500
Upper Limits of Income for Allowance Range	$58,200 (60% range)

($55,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

Appendix A-1

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Active Medical Assistance pharmacy coverage
- QMB coverage/ SLMB coverage
- Homelessness
- Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
- Maryland Public Health System Emergency Petition patients
- Participation in Women, Infants and Children Programs (WIC)*
- Supplemental Nutritional Assistance program (SNAP) or Food Stamp eligibility *
- Households with children in the free or reduced lunch program*
- Low-income household energy assistance program participation*
- Eligibility for other state or local assistance programs which have financial eligibility at or below 200% of FPL
- Healthy Howard recipients referred to JHH
- Patient is deceased with no known estate
- The Access Partnership Program at Hopkins (see FIN057 for specific procedures)
- Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
- The Pregnancy Care Program at JHBMC (see FIN053 for specific procedures)

*These life circumstances are set forth in COMAR 10.37.10.26 A-2. The patient needs to submit proof of enrollment in these programs within 30 days of treatment unless the patient requests an additional 30 days.

APPENDIX B
MEDICAL FINANCIAL HARDSHIP ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance. This determination will be offered to all patients who apply for Financial Assistance.

Medical Financial Hardship Assistance is available for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom:

1.) Medical Debt incurred over a twelve (12) month period exceeds 25% of the Family Income creating Medical Financial Hardship; and
2.) who meet the income standards for this level of Assistance.

For those patients who are eligible for reduced cost care under the Financial Assistance criteria and also qualify under the Medical Financial Hardship Assistance Guidelines, JHHS shall apply the reduction in charges that is most favorable to the patient.

Medical Financial Hardship is defined as Medical Debt for medically necessary treatment incurred by a family over a twelve (12) month period that exceeds 25% of that family's income.

Medical Debt is defined as out of pocket expenses for medical costs for Medically Necessary Care billed by the Hopkins hospital to which the application is made, the out of pocket expenses mentioned above do not include co-payments, co-insurance and deductibles, unless the patient is below 200% of Federal Poverty Guidelines.

The patient/guarantor can request that such a determination be made by submitting a Medical Financial Hardship Assistance Application (Exhibit C), when submitting JHM/Financial Assistance Application, also known as the Maryland State Uniform Financial Assistance Application (Exhibit A), and the Patient Profile Questionnaire (Exhibit B). The patient guarantor must also submit financial documentation of family income for the twelve (12) calendar months preceding the application date and documentation evidencing Medical Debt of at least 25% of family income.

Once a patient is approved for Medical Hardship Financial Assistance, Medical Hardship Financial Assistance coverage shall be effective starting the month of the first qualifying service and the following twelve (12) calendar months. It shall cover those members of the patient's Immediate Family residing in the same household. The patient and the Immediate Family members shall remain eligible for reduced cost Medically Necessary Care when seeking subsequent care at the same hospital for twelve (12) calendar months beginning on the date on which the reduced cost Medically Necessary Care was initially received. Coverage shall not apply to Elective Admissions or Elective or cosmetic procedures. However, the patient or the patient's immediate family member residing in the same household must notify the hospital of their eligibility for the reduced cost medically necessary care at registration or admission.

General Conditions for Medical Financial Hardship Assistance Application:

1. Patient's income is under 500% of the Federal Poverty Level.
2. Patient has exhausted all insurance coverage.
3. Patient account balances for patients who chose to register as voluntary self pay shall not counted toward Medical Debt for Medical Financial Hardship Assistance.
4. Patient/guarantor do not own Liquid Assets *in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.
5. Patient is not eligible for any of the following:
   - Medical Assistance

- Other forms of assistance available through JHM affiliates

6. Patient is not eligible for The JHM Financial Assistance Program or is eligible but the Medical Financial Hardship Program may be more favorable to the patient.

7. The affiliate has the right to request patient to file updated supporting documentation.

8. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.

9. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the Medical Financial Hardship Assistance program, the patient is still required to file a JHHS Medical Financial Hardship Assistance Application but not to submit duplicate supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Medical Financial Hardship Assistance Application:

- Medical Debt incurred over the twelve (12) months preceding the date of the Financial Hardship Assistance Application at the Hopkins treating facility where the application was made.
- Liquid Assets (leaving a residual of $10,000)
- Family Income for the twelve (12) calendar months preceding the date of the Financial Hardship Assistance Application
- Supporting Documentation

Exception

The Director or designee of Patient Financial Services (or affiliate equivalent) may make exceptions according to individual circumstances.

Evaluation Method and Process

1. The Financial Counselor will review the Medical Financial Hardship Assistance Application and collateral documentation submitted by the patient/responsible party.

2. The Financial Counselor will then complete a Medical Financial Hardship Assistance Worksheet (found on the bottom of the application) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 2/1/15

# of Persons in Family	Income Level**		
# of Persons in Family	*300% of FPL	400% of FPL	500% of FPL
1	**$ 35,310**	$ 47,080	$ 58,850
2	**$ 47,790**	$ 63,720	$ 79,650
3	**$ 60,270**	$ 80,360	$ 100,450
4	**$ 72,750**	$ 97,000	$ 121,250
5	**$ 85,230**	$ 113,640	$ 142,050
6	**$ 97,710**	$ 130,280	$ 162,850
7	**$ 110,190**	$ 146,920	$ 183,650
8*	**$ 122,670**	$ 163,560	$ 204,450
Allowance to Give:	50%	35%	20%

*For family units with more than 8 members, add $12,480 for each additional person at 300% of FPL, $16,640 at 400% at FPL; and $20,800 at 500% of FPL.

Exhibit A

Johns Hopkins Hospital
3910 Keswick Road, Suite S-5100
Baltimore, MD 21211

JOHNS HOPKINS
MEDICINE

Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

Exhibit A

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____		Approximate value	_____
Automobile	Make _____	Year _____	Approximate value	_____
Additional vehicle	Make _____	Year _____	Approximate value	_____
Additional vehicle	Make _____	Year _____	Approximate value	_____
Other property			Approximate value	_____
		Total		_____

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? Yes No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant signature Date

_____

Relationship to Patient

Exhibit A

Johns Hopkins Bayview Medical Center
3910 Keswick Road, Suite S-5100
Baltimore, MD 21211

JOHNS HOPKINS
MEDICINE

Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

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List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____		Approximate value	_____
Automobile	Make _____	Year _____	Approximate value	_____
Additional vehicle	Make _____	Year _____	Approximate value	_____
Additional vehicle	Make _____	Year _____	Approximate value	_____
Other property			Approximate value	_____
		Total		_____

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? Yes No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant signature Date

_____

Relationship to Patient

Exhibit B

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #:_____

1. What is the patient's age? _____

2. Is the patient a U.S. citizen or permanent resident? Yes or No

3. Is patient pregnant? Yes or No

4. Does patient have children under 21 years of age living at home? Yes or No

5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No

6. Is patient currently receiving SSI or SSDI benefits? Yes or No

7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the following amounts? Yes or No

   Family Size:

   Individual: $2,500.00
   Two people: $3,000.00
   For each additional family member, add $100.00
   (Example: For a family of four, if you have total liquid assets of less than $3,200.00, you would answer YES.)

8. Is patient a resident of the State of Maryland? Yes or No
   If not a Maryland resident, in what state does patient reside? _____

1. Is patient homeless? Yes or No

10. Does patient participate in WIC? Yes or No

11. Does household have children in the free or reduced lunch program? Yes or No

12. Does household participate in low-income energy assistance program? Yes or No

13. Does patient receive SNAP/Food Stamps? Yes or No

14. Is the patient enrolled in Healthy Howard and referred to JHH Yes or No

15. Does patient currently have?
    Medical Assistance Pharmacy Only Yes or No
    QMB coverage/ SLMB coverage Yes or No
    PAC coverage Yes or No

16. Is patient employed? Yes or No
    If no, date became unemployed. _____
    Eligible for COBRA health insurance coverage? Yes or No

Exhibit B

SERVICIOS FINANCIEROS AL PACIENTE
CUESTIONARIO DEL PERFIL DEL PACIENTE

NOMBRE DEL HOSPITAL: _____

NOMBRE DEL PACIENTE: _____

DOMICILIO: _____
(Incluya Código Postal)

No. De Archivo Médico: _____

1. ¿Cual es la edad del paciente? _____
2. ¿Es el paciente un Ciudadano Americano o Residente Permanentet? Si o No
3. ¿Esta la paciente embarazada? SI o No
4. ¿Tiene el paciente hijos menores de 21 años viviendo en casa? SI o No
5. ¿Es el paciente ciego o potencialmente discapacitado por lo menos 12 meses o mas afectando su empleo? SI o No
6. ¿Esta el paciente en la actualidad reciviendo beneficios de SSI o SSDI? SI o No
7. ¿Tiene el paciente (y si casado, esposo/a) cuentas de banco o bienes convertibles a efectivo que no exceden las siguientes cantidades? SI o No

   Tamaño de Familia:

   Individual: $2,500.00
   Dos personas: $3,000.00
   Por cada miembro familiar adicional, agregar $100.00
   (Ejemplo: Para una familia de cuatro, si el total de sus bienes liquidas es menos que $3200.00 usted contestaría SI)

8. ¿Es el paciente residente del Estado de Maryland? SI o No
   Si no es residente de Maryland, en que estado vive? _____
9. ¿Is patient homeless? Si o No
10. ¿Participa el paciente en WIC? Si o No
11. ¿Tiene usted niños en el programa de lunche gratis o reducido? Si o No
12. ¿Su hogar participa en el programa de asistencia de energia para familia de ingresos bajos? Si o No
13. ¿El paciente recibet SNAP/Food Stamps (Cupones de alimentos? Si o No
14. ¿Esta el paciente inscrito en Healthy Howard y fue referido a JHH? Si o No
15. ¿Tiene el paciente actualmente?:
    - Asistencia Médica solo para farmacia? Si o No
    - Covertura de QMB / Covertura SLMB? Si o No
    - Covertura de PAC? Si o No
16. ¿Esta el paciente empleado? Si o No
    Si no, fecha en que se desempleó. _____
    Es elegible para covertura del seguro de salud de COBRA? Si o No

Exhibit C

MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #: _____

Date: _____

Family Income for twelve (12) calendar months preceding date of this application: _____

Medical Debt incurred at The Johns Hopkins Hospital (not including co-insurance, co-payments, or deductibles) for the twelve (12) calendar months preceding the date of this application:

Date of service	Amount owed
_____	_____
_____	_____
_____	_____
_____	_____

All documentation submitted becomes part of this application.

All the information submitted in the application is true and accurate to the best of my knowledge, information and belief.

_____ Date: _____
Applicant's signature

_____
Relationship to Patient

For Internal Use: Reviewed By:
_____ Date: _____

Income: _____ 25% of income= _____

Medical Debt: _____ Percentage of Allowance: _____

Reduction: _____

Balance Due: _____

Monthly Payment Amount: _____ Length of Payment Plan: _____ months

Exhibit C

APLICACION PARA DIFICULTADES MEDICAS FINANCIALES

NOMBRE DEL HOSPITAL: _____

NOMBRE DEL PACIENTE: _____

DOMICILIO: _____
(Incluya Código Postal)

No. DE ARCHIVO MEDICO :_____

FECHA: _____

Ingresos Familiares por doce (12) meses anteriores a la fecha de esta solicitud: _____

Deudas Mèdicas incurridas en el Hospital de Johns Hopkins (no incluyendo co-seguro, co-pagos, o (deducibles) por los doce (12) meses del calendario anteriores a la fecha de esta solicitud:

Fecha de Servicio	Monto Debido
_____	_____
_____	_____
_____	_____
_____	_____

Toda documentacion sometida sera parte de esta aplicación.

Toda la información sometida en la aplicación es verdadera y exacta a lo mejor de mi conocimiento, saber y enterder.

_____ Fecha: _____
Firma del Aplicante

_____
Relación al Paciente

Para Uso Interno: Revisado Por:
_____Fecha:_____

Ingresos: _____25% de ingresos=_____

Deuda Médica: _____Porcentaje de Subsidio: _____

Reducción: _____

Balance Debido: _____

Monto de Pagos Mensuales: _____ Duración del Plan De Pago: _____meses

PATIENT BILLING & FINANCIAL ASSISTANCE INFORMATION

YOUR RIGHTS AND RESPONSIBILITIES:

The Johns Hopkins Hospital makes every effort to see that your account is properly billed. You are responsible for making sure the insurance information provided to The Johns Hopkins Hospital is correct. However, we cannot guarantee payment from your insurance company. All unpaid charges on the statement will be your responsibility.

The Johns Hopkins Hospital provides a reasonable amount of its services free, or at a reduced charge to eligible persons who cannot afford to pay for medical care. Financial Assistance eligibility is based upon documented family circumstances and family size. Additionally, to qualify for this assistance, all other sources of payment must be exhausted, including Medical Assistance. In certain circumstances, Medical Financial Hardship Assistance may also be available. Financial Assistance Eligibility applications can be obtained by contacting Customer Service between 8:30 AM to 4:30 PM, Monday through Friday, at the numbers listed below.

If you have any questions concerning this bill and charges for services rendered by The Johns Hopkins Hospital, please call our Customer Service office between 8:30am to 4:30pm, Monday thru Friday at 443-997-0100 or toll-free at 1-800-757-1700.

Mail only payments to:

The Johns Hopkins Hospital
P.O. Box 537118
Atlanta, GA 30353-7118

Mail correspondence/insurance information directly to Customer Service:

The Johns Hopkins Hospital
3910 Keswick Road, Suite S-5100
Baltimore, MD 21211

For information concerning Maryland Medical Assistance Program contact your local Department of Social Services at 1-800-332-6347, TTY: 1-800-925-4434 or visit: www.dhr.state.md.us.

If any checks are returned due to NSF (Non-Sufficient Funds) or stop payment, the patient will be charged the maximum fee permitted under Maryland law.

HOSPITAL STATEMENTS DO NOT INCLUDE PHYSICIAN FEES OR CHARGES:

This statement represents only those charges for services billed through The Johns Hopkins Hospital. Services rendered by your doctors are billed separately. Questions concerning physician fees must be directed to the appropriate office. Please contact Johns Hopkins University Clinical Practice Association with questions concerning your physician's fees at (410) 933-1200, or toll-free at 1-800-657-0066.

If you need to contact The Johns Hopkins Hospital on matters not related to this statement, please call our general information number at (410) 955-5000.

Johns Hopkins is introducing another way to contact our Customer Service Department. You may now email us directly at: customerservice@jhmi.edu Questions regarding your account should include your account number, patient name, date of service, statement date, insurance information, and a description of the charges billed.

CHANGE OF NAME, ADDRESS, OR HEALTH INSURANCE INFORMATION (Please Print)

Name Change:	New Street Address		
City:	State:	Zip Code	New Phone Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Insured's Name:	Social Security: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Patient's DOB: / /	Relationship to Insured (circle one) Self Spouse Child Other

Insurance Company Name and Address:	Policy Number:	Group Number:

Effective Date:	Insurance Company Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Signed	Date	I authorize the release of medical information necessary to process this claim. I assign and authorize direct payment to this hospital of any insurance or other benefits otherwise payable to me or the patient.

641962M

APPENDIX IV

PATIENT INFORMATION SHEET

JOHNS HOPKINS
MEDICINE

THE JOHNS HOPKINS HOSPITAL
600 NORTH WOLFE STREET
BALTIMORE, MD 21287

PATIENT BILLING and FINANCIAL ASSISTANCE INFORMATION SHEET

Billing Rights and Obligations

Not all medical costs are covered by insurance. The hospital makes every effort to see that you are billed correctly. It is up to you to provide complete and accurate information about your health insurance coverage when you are brought in to the hospital or visit an outpatient clinic. This will help make sure that your insurance company is billed on time. Some insurance companies require that bills be sent in soon after you receive treatment or they may not pay the bill. Your final bill will reflect the actual cost of care minus any insurance payment received and/or payment made at the time of your visit. All charges not covered by your insurance are your responsibility.

Financial Assistance

If you are unable to pay for medical care, **you may qualify for Free or Reduced-Cost Medically Necessary Care** if you:

- Are a U.S. citizen or permanent resident living in the U.S. for a minimum of one year
- Have no other insurance options
- Have been denied medical assistance or fail to meet all eligibility requirements
- Meet specific financial criteria

If you do not qualify for Maryland Medical Assistance or financial assistance, you may be eligible for an extended payment plan for your medical bill.

Call: 410-955-5464

with questions concerning:

- Your hospital bill
- Your rights and obligations with regard to your hospital bill
- Your rights and obligations with regard to reduced-cost, medically necessary care due to financial hardship
- How to apply for free and reduced-cost care
- How to apply for Maryland Medical Assistance or other programs that may help pay your medical bills

For information about Maryland Medical Assistance

Contact your local department of Social Services

1-800-332-6347 TTY 1-800-925-4434

Or visit: www.dhr.state.md.us

Physician charges are not included in hospital bills and are billed separately.

1296 (9/10)

JOHNS HOPKINS
MEDICINE

THE JOHNS HOPKINS HOSPITAL
600 NORTH WOLFE STREET
BALTIMORE, MD 21287

HOJA INFORMATIVA SOBRE LA FACTURACIÓN DE PACIENTES Y LA ASISTENCIA FINANCIERA

Los derechos y obligaciones de la facturación

No todos los costos médicos son cubiertos por el seguro. El hospital hace todo lo posible para estar seguro de que usted reciba la factura correcta. Depende de usted proveer la información completa y precisa sobre su cobertura de seguro médico cuando le traen al hospital o cuando visita la clínica ambulatoria. Esto ayudará a asegurar que se manden las facturas a su compañía de seguros a tiempo. Algunas compañías de seguro requieren que se manden las facturas tan pronto como usted recibe el tratamiento, de lo contrario pueden no pagarlas. Su factura final reflejará el verdadero costo de su cuidado, menos cualquier pago que se haya recibido y/o hecho al momento de su visita. Todo cobro no cubierto por su seguro es responsabilidad suya.

Asistencia financiera

Si usted no puede pagar por su cuidado médico, es posible que califique para **cuidado médicamente necesario gratuito o de bajo costo** si usted:

- Es ciudadano Estadounidense ó residente permanente viviendo en los Estados Unidos por un periodo no menor a un año
- No tiene otras opciones de seguro
- Le ha sido negada la asistencia médica, o no cumple con todos los requisitos de elegibilidad
- Cumple con criterios financieros específicos.

Si usted no califica para la Asistencia Médica de Maryland o la asistencia financiera, es posible que sea elegible para un sistema de pagos extendidos para sus facturas médicas.

Llame a 410-955-5464

con sus preguntas referentes a:

- Su factura del hospital
- Sus derechos y obligaciones en cuanto a su factura del hospital
- Sus derechos y obligaciones de loque se refiere a la reducción de costo, al cuidado médico necesario debido a dificultades financieras
- Cómo inscribirse para cuidado gratuito o de bajo costo
- Cómo inscribirse para la Asistencia Médica de Maryland u otros programas que le puedan ayudar a pagar sus facturas médicas

Para más información sobre la Asistencia Médica de Maryland

Por favor llame a su departamento local de Servicios Sociales

1-800-332-6347 TTY 1-800-925-4434

O visite al: www.dhr.state.md.us

Los cobros de los médicos no se incluyen en las facturas del hospital, son facturados aparte.

1296 (9/10)

APPENDIX V

MISSION

VISION

VALUE STATEMENT

	The Johns Hopkins Health System Corporation/The Johns Hopkins Hospital **Corporate and Administrative Policy Manual** **Administration**	*Policy Number*	ADM002
		Effective Date	11/01/2012
		Approval Date	10/29/2012
	Subject **Mission, Vision, and Values**	*Page*	1 of 2
		Supercedes	11/01/2009

Keywords:

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I. POLICY

The purpose of this policy is to describe the mission, vision, and values for the Johns Hopkins Hospital and Johns Hopkins Medicine.

The Johns Hopkins Hospital (JHH)

JHH Mission Statement

The mission of The Johns Hopkins Hospital is to improve the health of the community and the world by setting the standard of excellence in patient care. Diverse and inclusive, The Johns Hopkins Hospital in collaboration with the faculty of The Johns Hopkins University supports medical education and research and provides innovative patient-centered care ro prevent, diagnose and treat human illness.

JHH Vision

The vision of The Johns Hopkins Hospital is to be the world's preeminent health care institution.

JHH Values

- Excellence & Discovery
- Leadership & Integrity
- Diversity & Inclusion
- Respect & Collegiality

Johns Hopkins Medicine (JHM)

JHM Mission Statement

The mission of Johns Hopkins Medicine is to improve the health of the community and the world by setting the standard of excellence in medical education, research and clinical care. Diverse and inclusive, Johns Hopkins Medicine educates medical students, scientists, health care professionals and the public; conducts biomedical research; and provides patient-centered medicine to prevent, diagnose and treat human illness.

JHM Vision

Johns Hopkins Medicine provides a diverse and inclusive environment that fosters intellectual discovery, creates and transmits innovative knowledge, improves human health, and provides medical leadership to the world.

JHM Values

- Excellence & Discovery
- Leadership & Integrity
- Diversity & Inclusion
- Respect & Collegiality

II. REVIEW CYCLE

Three (3) years

III. SPONSOR

President

IV. APPROVAL

PRESIDENT APPROVAL

_____

_____

Date