

**The Johns Hopkins Hospital  
Fiscal Year 2014  
Community Benefits Report  
Narrative**



**JOHNS HOPKINS**  
M E D I C I N E

**THE JOHNS HOPKINS HEALTH SYSTEM  
FISCAL YEAR 2014 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	1,060	HSCRC
Inpatient Admissions	49,903	JHM Market Analysis and Business Planning
Primary Service Area zip codes	20707 20715 20723 20854 20878 20902 20904 21001 21009 21014 21015 21030 21040 21042 21043 21044 21045 21060 21061 21075 21093 21113 21117 21122 21133 21136 21144 21146 21157 21201 21202 21204 21205 21206 21207 21208 21209 21210 21211 21212 21213 21214 21215 21216 21217 21218 21220 21221 21222 21223 21224 21225 21227 21228 21229 21230 21231 21234 21236 21237 21239 21244 21286 21287 21401 21403 21502 21701 21702 21703 21740 21771 21784	HSCRC
All other Maryland hospitals sharing primary service area	Upper Chesapeake Medical Center, Howard County General Hospital, Baltimore Washington Medical Center, Northwest Hospital Center, Carroll Hospital Center, Maryland General Hospital, University of Maryland Medical Center, Mercy Medical Center, Greater Baltimore Medical Center, UM Saint Joseph Medical Center, James Lawrence Kernan Hospital, Mount Washington Pediatric Hospital, Sinai Hospital, Union Memorial Hospital, Bon Secours Hospital, Johns Hopkins Bayview Medical Center, Harbor Hospital, Saint Agnes Hospital, Franklin Square Hospital Center, Good Samaritan Hospital, Anne Arundel Medical Center, Frederick Memorial Hospital, Washington County Hospital, Chesapeake Rehabilitation Hospital, Eastern Neuro Rehabilitation Hospital, Western Maryland Regional Medical Center	JHM Market Analysis and Business Planning
Percentage of uninsured patients by county	Anne Arundel 8.00% Baltimore 9.33% Carroll 6.44% Frederick 7.75% Harford 6.54% Howard 6.97%	2009-2012 American Community Survey via CHNA.org

	Montgomery 11.80%	
	Prince George's 15.39%	
	Washington 10.14%	
	Wicomico 12.87%	
	Baltimore City 13.99%	
Percentage of patients who are Medicaid recipients by county	Anne Arundel 10.04%	2009-2012 American Community Survey via CHNA.org
	Baltimore 13.50%	
	Carroll 8.11%	
	Frederick 10.61%	
	Harford 11.16%	
	Howard 6.91%	
	Montgomery 10.64%	
	Prince George's 16.12%	
	Washington 19.21%	
	Wicomico 21.57%	
	Baltimore City 33.36%	

2. Community Benefits Service Area (CBSA)

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

The Hospital considers its Community Benefit Service Area (CBSA) as specific populations or communities of need to which the Hospital allocates resources through its community benefits plan. The Hospital uses geographic boundary and target population approaches to define its CBSA. The CBSA is defined by the geographic area contained within the following seven ZIP codes: 21213, 21205, 21224, 21218, 21202, 21231 and 21206. As JHH is an urban hospital, the JHH community focus has traditionally been on residents of neighborhoods and/or entities that operate in proximity to the Hospital. The seven ZIP codes included in the JHH CBSA best capture this proximal relationship. Within the CBSA, JHH has 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. In terms of population, an estimated 237,411 people live within CBSA, accounting for thirty-eight percent of the City's population (2013 Census estimate of Baltimore population, 622,104) Within the CBSA, the City Department of Health has subdivided the 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, 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 Hospital is in the neighborhood called Perkins/Middle East, and the neighborhoods that are contiguous to Perkins/Middle East include Greenmount East, Clifton-Berea, Madison/East End, Patterson Park North & East, Fells Point, 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 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 and Patterson Park N&E skews higher, and there are higher percentages of white households having higher median incomes residing in these neighborhoods.

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 Hospital. 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 led to higher unemployment in the neighborhoods around the Hospital, 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 Hospital 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.

Neighborhoods farther north of the 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 the Hospital and median household incomes range from significantly above the median to close to the median household income for Baltimore City.

B. CBSA Demographics

Table II

		Data Source
Community Benefits Service Area (CBSA)	21213, 21205, 21224, 21218, 21202, 21231, 21206	JHM Market Analysis & Business Planning
CBSA demographics, by sex, race, ethnicity, and average age	Total population: 237,411  Sex Male: 116,211/48.9% Female: 121,200/51.1%  Race White non-Hispanic: 74,853/31.5% Black non-Hispanic: 131,425/55.4%	2014 Nielsen Co. 2014 Thomson Reuters

	<p>Hispanic: 18,369/7.7%</p> <p>Asian and Pacific Islander non-Hispanic: 7,073/3.0%</p> <p>All others: 5,691/2.4%</p> <p>Age</p> <p>0-14: 42,009/17.7%</p> <p>15-17: 8,148/3.4%</p> <p>18-24: 27,054/11.4%</p> <p>25-34: 44,839/18.9%</p> <p>35-54: 62,754/26.4%</p> <p>55-64: 26,948/11.4%</p> <p>65+: 25,659/10.8%</p>	
Median household income within your CBSA	Average household income: \$57,512	2014 Nielsen Co. 2014 Thomson Reuters
Percentage of households (families and people) with incomes below the federal poverty guidelines within your CBSA (past 12 months)	<p>All families: 17.7</p> <p>Married couple family: 5.9%</p> <p>Female householder, no husband present, family: 29.6%</p> <p>Female householder with related children under 5 years only: 38.50%</p> <p>All people: 22.4%</p> <p>Under 18 years: 31.9%</p> <p>Related Children under 5 years: 33.2%</p> <p>(Baltimore City, 2012)</p>	U.S. Census Bureau, 2012 American Community Survey <a href="http://factfinder2.census.gov">http://factfinder2.census.gov</a>
Please estimate the percentage of uninsured people within your CBSA	17.9%	2014 Nielsen Co. 2014 Thomson Reuters
Percentage of Medicaid recipients within your CBSA	37.6%	2014 Nielsen Co. 2014 Thomson Reuters
Life expectancy and crude deaths within your CBSA	<p>73.9 years at birth (Baltimore City, 2012)</p> <p>79.2 years at birth (Baltimore County, 2012)</p> <p>79.5 years at birth (Maryland, 2012)</p> <p>6,224 deaths (Baltimore City, 2012)</p> <p>7,612</p>	Maryland Vital Statistics Annual Report 2012 <a href="http://dhmh.maryland.gov/vsa">http://dhmh.maryland.gov/vsa</a>

	(Baltimore County, 2012) 44,110 (Maryland, 2012)	
Infant mortality rates within your CBSA	All: 9.7 per 1,000 live births White: 3.4 per 1,000 live births Black: 12.6 per 1,000 live births (Baltimore City, 2012)  All: 5.3 per 1,000 live births (Baltimore County, 2012)  All: 6.3 per 1,000 live births (Maryland, 2012)	Maryland Infant Mortality Report, 2013 <a href="http://dhmh.maryland.gov/vsa">http://dhmh.maryland.gov/vsa</a>
Language other than English spoken at home	8.9% (Baltimore City, 2013)	U.S. Census Bureau, Quickfacts, 2013
Access to healthy food	Baltimore City food deserts map	Johns Hopkins Bloomberg School of Public Health, Center for a Livable Future <a href="http://www.jhsph.edu/bin/k/o/BaltimoreCityFoodEnvironment.pdf">http://www.jhsph.edu/bin/k/o/BaltimoreCityFoodEnvironment.pdf</a>  Baltimore City Food Policy Task Force <a href="http://www.baltimorecity.gov/Portals/0/agencies/planning/public%20downloads/USDA%20Presentation%201.0_sm.pdf">http://www.baltimorecity.gov/Portals/0/agencies/planning/public%20downloads/USDA%20Presentation%201.0_sm.pdf</a>

## 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?

Yes  
 No

Provide date here. 03/12/13 (mm/dd/yy)

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/2013\\_needs\\_assessment.pdf](http://www.hopkinsmedicine.org/the_johns_hopkins_hospital/about/in_the_community/_docs/2013_needs_assessment.pdf)

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

Yes  
 No

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

See Appendix 5

### III. COMMUNITY BENEFITS ADMINISTRATION

1. Is Community Benefits planning part of your hospital's strategic plan?

Yes  
 No

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.  Ronald R. Peterson, President
  - ii.  Ronald J. Werthman, CFO/Treasurer and VP, Finance
  - iii.  John Colmers, VP, Health Care Transformation and Strategic Planning
  - iv.  Ed Beranek, Senior Director, Regulatory Compliance
- b. Clinical Leadership
  - i.  Physicians
  - ii.  Nurses
  - iii.  Social Workers
- c. Community Benefits Department/Team
  - i.  Individuals (please specify FTEs)  
JHH CBR Team –Sherry Fluke (0.30 FTE), Sharon Tiebert-Maddox (0.40 FTE),  
William Wang (0.20 FTE)
  - ii.  Committee (please list members)

JHHS Community Benefit Reporting Work Group

- o The Johns Hopkins Hospital
  - Sherry Fluke, Financial Manager, Govt. & Community Affairs (GCA)
  - Sharon Tiebert-Maddox, Director, Strategic Operations, GCA
  - William Wang, Associate Director, Strategic Operations, GCA
- o Johns Hopkins Bayview Medical Center
  - Gayle Johnson Adams, Director, Community and Govt. Relations
  - Patricia A. Carroll, Community Relations Manager
  - Kimberly Moeller, Director, Financial Analysis

- Linda Stewart, Community Relations Coordinator
- Howard County General Hospital
  - Cindi Miller, Director, Community Health Education
  - Fran Moll, Manager, Regulatory Compliance
  - Scott Ryan, Senior Revenue Analyst
- Suburban Hospital
  - Eleni Antzoulatos, Program Coordinator, Community Health and Wellness
  - Joan Hall, Director, Financial Planning, Budget, & Reimbursement
  - Michelle Hathaway, Cardiovascular Health Promotions Coordinator, Community Health and Wellness
  - Patricia Rios, Supervisor, 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
  - Mark Long, Director, External Affairs
  - Mike McCoy, Associate CFO, Finance Department
- All Children’s Hospital
  - Jeff Craft, Administrative Director, Finance
  - Mary Mahoney, Director, Marketing
  - Alizza Punzalan-Randle, Community Relations Manager
- Johns Hopkins Health System
  - Janet Buehler, Director of Tax
  - Desiree de la Torre, Assistant Director, Healthy Policy Planning
  - Bonnie Hatami, Senior Tax Accountant
  - Anne Langley, Director, Health Policy Planning
- iii.   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.

- Gayle Adams, Director of Community Relations and Government Affairs, Johns Hopkins Bayview Medical Center
- Deidra Bishop, Director, East Baltimore Community Affairs, Johns Hopkins University
- Jay Blackman, Executive Vice President and Chief Operating Officer, Howard County General Hospital

- John Colmers\*, Vice President, Health Care Transformation and Strategic Planning, Johns Hopkins Health System
- Kenneth Grant, Vice President of General Services, The Johns Hopkins Hospital
- Dan Hale, Special Advisor, Office of the President, Johns Hopkins Bayview Medical Center
- Mark Long, Director, External Affairs, Sibley Memorial Hospital
- Adrian Mosley, Community Health Administrator, The Johns Hopkins Hospital
- Cindy Rose, Vice President of Marketing, Branding, and Community Relations, All Children's 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, Financial Operations, Johns Hopkins Government and Community Affairs

\*Chairperson

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
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

#### **IV. 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 CHNA 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.

##### **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 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 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 Implementation Strategy is attached as Appendix 5.

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 2014 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, Wilmer Diabetic Retinopathy Screening, and the Harriet Lane Youth Fitness Circle. In the tables below, these initiatives are described in greater detail.

Initiative 1. Health Leads

<p><b>Identified Need</b></p>	<p>Access to Healthcare</p> <p>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%).</p> <p>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.</p>
<p><b>Hospital Initiative</b></p>	<p>Health Leads Family Resource Desk – JHH Harriet Lane Clinic</p>
<p><b>Primary Objective</b></p>	<p>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.</p>
<p><b>Single or Multi-Year Initiative Time Period</b></p>	<p>Multi-year</p>
<p><b>Key Partners in Development and/or Implementation</b></p>	<p>Health Leads Baltimore, Johns Hopkins Bayview Medical Center, Johns Hopkins University</p>
<p><b>How were the outcomes evaluated?</b></p>	<p>Measurable goals like clients served, success rate of needs solved, time to case closure, client follow-up, and % of volunteers with Health Leads experience are tracked by the program and measured against Health Leads national data.</p>
<p><b>Outcome (Include process and impact measures)</b></p>	<p><b><u>Health Leads Outcomes:</u></b></p> <p>For FY14, the top presenting needs were as follows:</p>

<b>Bayview Children's Medical Practice</b>	<b>Bayview Comprehensive Care Practice</b>	<b>Harriet Lane Clinic</b>
Health (27%)	Food (19%)	Employment (25%)
Food (24%)	Utilities (15%)	Housing (15%)
Commodities (12%)	Housing (13%)	Utilities (11%)
Financial (11%)	Health (12%)	Child-Related (10%)
Adult Education (9%)	Transportation (11%)	Health (9%)
Child-Related (7%)	Commodities (8%)	Food (8%)
Utilities (4%)	Employment (8%)	Commodities (6%)

<b>Clients Served</b>	<b>Bayview Children's Medical Practice</b>	<b>Bayview Comprehensive Care Practice</b>	<b>Harriet Lane Clinic</b>
Unique Clients	609	217	493

*Total: 1319*

<b>Client Race/Ethnicity</b>	<b>Bayview Children's Medical Practice</b>	<b>Bayview Comprehensive Care Practice</b>	<b>Harriet Lane Clinic</b>
American Indian	0%	4%	1%
Asian	0%	1%	0%
Black or African American	6%	39%	92%
Decline to State	0%	2%	0%
Hispanic	91%	1%	3%
Native Hawaiian or PI	0%	0%	0%
White	3%	53%	5%
<b>Grand Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

The three Family Help Desks within the Johns Hopkins Health System served 1,319 unique clients/families in FY14, with 86 Johns Hopkins University students volunteering 25,056 hours (equivalent of 12 FTE). Under the leadership of 3 Program Managers, students served on Leaderships teams and participated in weekly professional development trainings in order to better work with families.

	<b>% of 10 day followup</b>	<b>% solved at least 1 need</b>	<b>Days to closure</b>
HL National	95%	59%	61
HL Midatlantic	83%	60%	57

		BCCP	100%	59%	70
		BCMP	100%	69%	47
		HLC	75%	63%	54
		<p>Overall, for the metrics tracked by HealthLeads nationally and regionally, the Johns Hopkins HealthLeads desks metrics are in line with regional and national metrics with good performance on % of clients with 10 day follow-up (HLC drop in ten day follow-up attributed to drop off in December), slightly better performance in % of clients with at least one need solved by the HealthLeads referral. Days to closure for the BCCP desk are slightly higher than the national and regional average. 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.</p>			
<b>Continuation of Initiative</b>		Yes, JHH is continuing to support its partnership with Health Leads Baltimore.			
<b>Total Cost of Initiative for Current FY</b>	<b>Direct Offsetting Revenues from Restricted Grants</b>	Total Cost \$110,427	Restricted Grants \$0		

Initiative 2. The Access Partnership (TAP)

<b>Identified Need</b>	<p>Access to Healthcare</p> <p>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%).</p> <p>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 in order to bring</p>
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	primary care to uninsured and/or financially needy residents and to provide access to specialty care.
<b>Hospital Initiative</b>	The Access Partnership (TAP)
<b>Primary Objective</b>	<p>The Access Partnership, or TAP, of Johns Hopkins Medicine is a program designed to improve access to effective, compassionate, evidence-based primary and specialty care for uninsured and underinsured patients residing in the East Baltimore community surrounding The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) with demonstrated financial need.</p> <p>TAP ensures access to continuity of care for East Baltimore residents. Before TAP, uninsured and underinsured patients residing in East Baltimore neighborhoods struggle to obtain care for their chronic and acute illnesses early in the disease process. Even when patients were able to obtain primary care – not always a simple proposition – referrals for diagnostic tests, specialty consultations, or surgery often went uncompleted as patients had no way to pay for them. This access problem frustrated local primary care physicians and hospitalists’ efforts to care for their patients as much as it impeded patients’ deep aspirations to manage their health. For the past four years, TAP has opened up new opportunities for partnership among patients, physicians, and frontline clinic staff. A TAP Navigator determines if patients are eligible for the program, and the TAP Medical Reviewer evaluates all specialty referrals to determine whether the medical issue can be managed in the primary care setting rather than through diagnostic testing or specialty consultation. Eligible patients meet the following criteria:</p> <ul style="list-style-type: none"> <li>• Enrolled in primary care at a participating primary care clinic at Johns Hopkins or in the Baltimore community;</li> <li>• Uninsured or Underinsured with demonstrated financial need; and</li> <li>• Reside in zip code area 21202, 21205, 21213, 21219, 21222, 21224, or 21231, or additionally, for patients who are beneficiaries of the high risk prenatal charity care program at the Johns Hopkins Bayview Medical Center, in zip code area 21206, 21221, or 21237.</li> </ul> <p>The program operates across five Johns Hopkins primary care locations and three primary care locations in the Baltimore community:</p> <ul style="list-style-type: none"> <li>• At Johns Hopkins: (1) East Baltimore Medical Center (EBMC); (2) John Hopkins Outpatient Center (JHOC) Adult Medicine Clinic; (3) JHBMC General Internal Medicine Clinic; (4) JHBMC Children’s Medical Practice; and (5) JHBMC Comprehensive Care Practice.</li> <li>• In the Baltimore community: (1) Chase Brexton Health Services; (2) The Esperanza Center; and (3) Healthcare for the Homeless.</li> </ul>
<b>Single or Multi-Year Initiative Time Period</b>	Multi-year

<p><b>Key Partners in Development and/or Implementation</b></p>	<p>Johns Hopkins Medicine, Johns Hopkins Health System, and the Johns Hopkins Clinical Practice Association are critical partners in the implementation of TAP. Additional partners are Chase Brexton Health Services, Esperanza Center, and Healthcare for the Homeless.</p>
<p><b>How were the outcomes evaluated?</b></p>	<p>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.</p>
<p><b>Outcome (Include process and impact measures)</b></p>	<p><b>TAP Outcomes:</b>  From its inception May 1, 2009 through June 30, 2014, the TAP program has provided medical services to 3,732 patients residing in eligible zip codes and has processed 9,124 specialty referrals across five Johns Hopkins clinical locations. In FY14 there were 806 patients seen and 2,170 referrals made. This was an increase of 27.5% compared to patients seen in FY13 and 6.4% increase compared to referrals in FY13.</p> <p>In addition, TAP has provided 4,074 primary care visits to 1,237 patients at 3 rate-regulated clinic sites at Johns Hopkins: the Medical Clinic at JHOC; the JHBMC General Internal Medicine clinic; and the JHBMC Children’s Medical Practice. In FY14 there were 1,246 primary care visits and 286 patients seen. This was a 9.6% increase in primary care visits in FY13 and there was no percentage change in patients seen compared to FY13.</p> <p>The top ZIP codes for patients by residence are 21224 (41.2% of overall patients), 21213 (15.4%, 21205 (14.5%) and 21222 (9.5%).</p> <p>TAP has improved access to care for uninsured people living in the East Baltimore community. Both JHH and JHBMC already care for many of these patients every day through the emergency department and as hospital admissions. TAP takes a proactive approach to managing uninsured patients who live in the area surrounding the hospitals. Through this program, we provide access to primary and specialty care efficiently and effectively to uninsured patients. Primary care clinicians are able to provide comprehensive care to their patients, and as a result, many patients develop alliances with their doctors that will facilitate improved health literacy, improved health outcomes, and reduced health disparities.</p> <p>Since January 1, 2014, 80-90 percent of the patients enrolled in TAP are the uninsurable (undocumented are not eligible for state or federal assistance) of which may be Latino or Hispanic. In the previous fiscal year, the percentage of uninsurable was in the range of 35-40 percent. TAP provides navigators that have linguistic competency in Spanish and all brochures and program information is also available in Spanish.</p> <p>Due to the demonstrated need, efforts are being made to expand TAP and add more ZIP codes to its coverage area. Additionally, new partners are expected to</p>

	be added to the TAP eligible clinics including Baltimore Medical System – Highlandtown.		
<b>Continuation of Initiative</b>	Yes, TAP is a continuing commitment of JHH.		
<b>Total Cost of Initiative for Current FY</b>	<b>Direct Offsetting Revenues from Restricted Grants</b>	Total Cost \$53,919	Restricted Grants \$0

Initiative 3. You Gotta Have Heart Collaboration

<b>Identified Need</b>	<p>Cardiovascular Disease</p> <p>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)</p> <p>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 100,000population). 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.</p> <p>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.</p>
<b>Hospital Initiative</b>	You Gotta Have Heart Collaboration
<b>Primary Objective</b>	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 manikin and DVD instruction.
<b>Single or Multi-Year Initiative Time Period</b>	Multi-year
<b>Key Partners in Development and/or Implementation</b>	<p>Key partners in the development include the Johns Hopkins Health System’s Office of Community Health, the Johns Hopkins Hospital’s CPR Office, and Phase I partners: Memorial Baptist Church, Zion Baptist Church, New Shiloh Baptist Church of Turners Station, and St. Martin Church of Christ.</p> <p>Phase II partners are Transforming Life Church, Huber Memorial, Ark Church, and Beth-El Temple.</p>
<b>How were the outcomes measured?</b>	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.
<b>Outcome (Include process and impact measures)</b>	<p>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.</p> <p>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.</p> <p>All areas of measure to indicate willingness and readiness showed statistically significant pre and post training responses. In addition, 98% 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.</p> <p>To date, the program has trained 600 families in Hands Only CPR (approximately 200 additional families received training in FY14). Phase I trainers have provided sessions on request to local community groups, while Phase II trainers were being recruited and trained in delivery of the curriculum. Twenty five new trainers started in the summer of 2014. The lead trainer has scheduled and conducted an observed teaching session to demonstrate proficiency in the delivery of the curriculum. AED training will be scheduled when the deliverables of the partnership have been met (i.e. a minimum of 100 families trained at each site).</p> <p>Phase II has resulted in a change in the curriculum for laypersons based on field</p>

	experience and input from the Phase I instructors. Changes do not impact content, but only help with the delivery. These changes also support uniformity in instruction. An additional change has been to delete the requirement of certification of the lay instructor. While certification continues to be offered through the CPR Office at JHH, it is done after the mastery of the Hands Only teaching. Initial laypersons often confused the requirements of Hands Only with the “over-teaching” of Advanced CPR.		
<b>Continuation of Initiative</b>	Phase II should be completed by June 2015. Funding will determine the continuance beyond Phase II.		
<b>Total Cost of Initiative for Current FY</b>	<b>Direct Offsetting Revenues from Restricted Grants</b>	Total Cost \$26,021	Restricted Grants \$0

Initiative 4. Wilson House

<b>Identified Need</b>	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).
<b>Hospital Initiative</b>	Wilson House
<b>Primary Objective</b>	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.
<b>Single or Multi-Year Initiative Time Period</b>	Multi-year
<b>Key Partners in Development and/or Implementation</b>	Alcohol and Drug Abuse Administration, Behavioral Health Systems Baltimore
<b>How were the outcomes</b>	The Wilson House operates 24 hours per day. During the day residents typically participate in intensive outpatient services at the Broadway Center. During

<b>evaluated?</b>	<p>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.</p> <p>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.</p>		
<b>Outcome (Include process and impact measures)</b>	<p>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.</p> <p>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.</p>		
<b>Continuation of Initiative</b>	Yes, this is a continuing initiative		
<b>Total Cost of Initiative for Current FY</b>	<b>Direct Offsetting Revenues from Restricted Grants</b>	Total Cost \$273,582	Restricted grants \$223,945

Initiative 5. Broadway Center for Addiction Substance Abuse Program

<b>Identified Need</b>	<p>Mental Health/Substance Abuse</p> <p>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</p>
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	<p>blacks and 8.5% in whites (per 100,000 population).</p> <p>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.</p>
<b>Hospital Initiative</b>	Broadway Center for Addiction
<b>Primary Objective</b>	<p>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.</p> <p>In FY14 the program experienced significant cuts to grant funding. Despite the financial setback, the Broadway Center was able to maintain critical services for nearly 100 patients and their families in the surrounding underserved community.</p>
<b>Single or Multi-Year Initiative Time Period</b>	Multi-year
<b>Key Partners in Development and/or Implementation</b>	Behavioral Health System Baltimore (BHSB), House of Ruth, Dayspring, Beans and Bread, Zion Baptist Church, Helping Up Mission
<b>How were the outcomes evaluated?</b>	The senior management team uses a set of statistical tools and reports to understand trends and uncover problems. Reports are monitored weekly, and typically include statistical information on toxicology results, patient utilization and retention, and patient safety and patient satisfaction data.
<b>Outcome (Include process and impact measures)</b>	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.
<b>Continuation of</b>	Yes, this is a continuing initiative.

<b>Initiative</b>			
<b>Total Cost of Initiative for Current FY</b>	<b>Direct Offsetting Revenues from Restricted Grants</b>	Total Cost \$588,681	Restricted Grants \$148,328

Initiative 6. Supportive Housing for Male Substance Abuse Patients

<b>Identified Need</b>	<p>Mental Health/Substance Abuse</p> <p>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.</p>		
<b>Hospital Initiative</b>	Supportive Housing for Male Substance Abuse Patients		
<b>Primary Objective</b>	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.		
<b>Single or Multi-Year Initiative Time Period</b>	Multi-year		
<b>Key Partners in Development and/or Implementation</b>	Helping Up Mission		
<b>How were the outcomes evaluated?</b>	Evaluations in the form of monthly meetings with program team. Annual review of all Day Hospital programs with Department Chairman. Annual contract to provide housing is reviewed yearly.		
<b>Outcome (Include process and impact measures)</b>	Regular monitoring and management of housing census by Broadway Center staff and leadership.		
<b>Continuation of Initiative</b>	Yes, this is a continuing initiative.		
<b>Total Cost of</b>	<b>Direct Offsetting</b>	Total Cost \$653,126	Restricted Grants \$0

<b>Initiative for Current FY</b>	<b>Revenues from Restricted Grants</b>		
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Initiative 7. Harriet Lane Youth Fitness Circle

<b>Identified Need</b>	Nearly 20% of America’s adolescents are obese and the number is on the rise. The prevalence of childhood obesity is high among all racial and ethnic minority groups; however, studies have shown that Hispanics and non-Hispanic blacks are disproportionately affected. According to the CDC, in 2011-2012, obesity prevalence was higher among Hispanics (22.4%) and non-Hispanic black youth (20.2%) than non-Hispanic white youth (14.1%). The “Youth Fitness Circle” for overweight adolescents was developed twelve years ago at the Children’s Center to address the growing need for intervention among our population of young people. Currently the program is by patient-referral only. We would like to expand services to the East Baltimore community but are prevented from doing so due to limited funding. This program is unique in that it provides comprehensive services to the youth without significant fees usually required for such services. Ultimately, the Youth Fitness Circle was developed with the aims of addressing the growing issue in the Baltimore community.
<b>Hospital Initiative</b>	Harriet Lane Youth Fitness Circle
<b>Primary Objective</b>	<p>The program initiative is to recruit overweight patients currently from the Harriet Lane Clinic with the goal of promoting physical well-being and building opportunities for longitudinal mentorship. Through physical, nutritional and emotional education, the Youth Fitness Circle addresses the issue of adolescent obesity in the Baltimore community.</p> <p>The primary objective of the Youth Fitness Circle is improved knowledge regarding healthy nutritional and exercise lifestyles, which in turn is expected to lead to positive lifestyle changes. Outcomes are measured using end of session questionnaires. Secondary outcome include weight stabilization or loss. Anthropometric measures are obtained at the onset and conclusion of the program.</p>
<b>Single or Multi-Year Initiative Time Period</b>	The fitness circle is an on-going initiative. Adolescents participate in two exercise and educational interactive sessions per week spanning an 8-week period. Educational and exercise sessions are repeated quarterly. The sessions are aimed at building knowledge of healthy nutrition and exercise lifestyles. Awareness is expected to lead to positive lifestyle changes, such as improved diet and exercise, in participants.
<b>Key Partners in Development and/or</b>	None

<b>Implementation</b>			
<b>How were the outcomes evaluated?</b>		Initiatives were evaluated by Questionnaire and Anthropometric measures	
<b>Outcome (Include process and impact measures)</b>		<p>Our primary goal was to improve knowledge regarding healthy nutritional and exercise lifestyles, which in turn is expected to lead to positive lifestyle changes. Through open-ended questionnaire responses, adolescents expressed individual health benefits of the program. Participant's responses are as follows:</p> <p>"It benefitted me by helping me be healthy. My diet has not changed. Yes, "I am exercising more. Yes, I am confident."</p> <p>"I stopped drinking sodas and started reading labels."</p> <p>"My diet has changed a little bit and I will exercise more."</p> <p>"This program helped me gain no more weight since I started."</p> <p>"I feel as though it helped me exercise more."</p> <p>"I feel really good."</p> <p>"I learned better and easier exercises and I opened up a little to making friends."</p> <p>Secondary outcome: Of the participants that were present for both initial and last session anthropometric measurements, 60% of participants either maintained their initial weight or lose weight.</p> <p>Aside from our primary and secondary objectives, participants also expressed improvements in self-esteem, building meaningful relationships with peers and mentors. This is an important finding as studies have shown that overweight children suffer from stigmatization and poor self-esteem.</p> <p>"I liked that you don't have to be shy."</p> <p>"I liked meeting new people and the staff."</p> <p>"I liked Mr. Dave and the other group members. I get along very well with them."</p> <p>"I learned a lot of stuff."</p> <p>"I benefitted because I like to play and meet new people."</p> <p>In addition to the positive findings listed above, 100% of participants expressed a desire to participate in the next Youth Fitness Circle session.</p>	
<b>Continuation of Initiative</b>		Yes, this is a continuing initiative.	
<b>Total Cost of Initiative for Current FY</b>	<b>Direct Offsetting Revenues from Restricted Grants</b>	Total Cost \$20,068  Not included is approximately 200 hours each for four pediatrics medical fellows.	Restricted Grants \$0

Initiative 8. Wilmer Diabetic Retinopathy Screening Program

<b>Identified Need</b>	Diabetes
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	<p>Rates of diagnosed diabetes are higher in African American adults of all ages when compared to non-Hispanic whites, and rates of diabetes are higher in both Hispanic and African American women (41% and 84% more likely to be diabetic) according to Health Equity data from the Office of Minority Health and Health Disparities (MHHD). This increases the likelihood that as a diagnosed diabetic ages, some of the complications of the chronic disease, such as retinopathy may begin to develop.</p> <p>Twenty-five years ago it was established that patients with diabetes should have a routine yearly dilated retina examination by an ophthalmologist familiar with the laser management of diabetic retinopathy; the nationwide NIH multi-center clinical trial had established that laser photocoagulation could reduce vision loss and prevent blindness by judicious institution of laser treatment; this treatment often needed to be applied at an early stage of the diabetic retinopathy before symptoms appeared.</p>
<b>Hospital Initiative</b>	Wilmer Diabetic Retinopathy Screening Program
<b>Primary Objective</b>	<p>This treatable prevention of vision loss from diabetic retinopathy provided management for the dreaded diabetic complication, vision loss and blindness. It became clear to healthcare providers at Wilmer just over two decades ago, in 1992, that many patients with diabetes would not seek yearly routine screening because of its expense when there was a lack of adequate medical insurance. Consequently, the Retina Division of the Wilmer Institute began a program offering free screening for diabetic retinopathy, providing a unique opportunity, particularly encouraging referral from the Baltimore low cost medical clinics, such as Healthcare For The Homeless, Shepherd’s Clinic, Esperanza Center, and several others clinics. The free diabetic retinopathy screening program is unique in the Baltimore/Washington area and, to our knowledge, is also unavailable elsewhere in the United States. The cost of the management of the free screening and laser management that uses senior retina ophthalmology care at the Wilmer Institute is, in part, underwritten by the Diabetes Research and Wellness Foundation.</p>
<b>Single or Multi-Year Initiative Time Period</b>	Multi-year
<b>Key Partners in Development and/or Implementation</b>	Diabetes Research and Wellness Foundation, Healthcare for the Homeless, Shepherd’s Clinic, Esperanza Center
<b>How were the outcomes evaluated?</b>	<p>In the past year, over 300 patients with diabetes were examined, with about 16% with diabetic retinopathy, of whom 1/3 were sufficiently advanced to receive necessary laser treatment.</p> <p>The outcomes of the screening and laser treatment are evaluated by noting the number/percentage of patients who are seen who did not know that they had</p>

	diabetic retinopathy.	
<b>Outcome (Include process and impact measures)</b>	<p>Since the rate of diabetic blindness is not kept in Baltimore City, the decline in numbers would not be known; however, it is clear that, for a patient who has regular follow-up examination, it would be vanishingly rare for such a person to become totally blind in 2014, whereas this was a common occurrence in previous decades before the results of the NIH studies of laser photocoagulation for diabetic retinopathy were known.</p> <p>There are no city health department statistics or DHMH statistics that would be useful to show the effect of the retinopathy screening program for identifying patients who would be totally without care until vision loss; sometimes serious vision loss would bring these patients without insurance to an emergency room.</p>	
<b>Continuation of Initiative</b>	Yes, this is a continuing initiative.	
<b>Total Cost of Initiative for Current FY</b>	<b>Direct Offsetting Revenues from Restricted Grants</b>	<p>Total Cost \$259,362</p> <p>Restricted Grants \$60,000</p>

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

The overarching goal in conducting the Community Health Needs Assessment was to identify health needs perceived by the community as important and, consequently, to assess the comprehensiveness of JHH's strategies in addressing these needs. Although community health needs assessments can point out underlying causes of good or poor health status, health providers and health related organizations—primary users of information found in CHNAs—are not usually in a position to affect all of the changes required to address a health issue. For example, the ability to reduce poverty, improve educational attainment or affect employment cannot be achieved by a health system alone. However addressing primary public health issues often includes active measures that address the broader social determinants of health. For example two programs highlighted in this report, the Wilson House and Broadway Center for Addiction have a holistic approach to care delivery, addressing medical, psychiatric, social service and social needs through comprehensive, on-site, integrated program services to meet the health needs of mental health and substance abuse. The Supportive Housing for Male Substance Abuse Patients Program (also highlighted in this report) was designed to meet the daily living needs of patients in treatment for substance abuse. By addressing these needs the program addresses the extended issues related to substance abuse as identified in the City Health Department's Health Baltimore 2015 report i.e. family/community disruption, crime, homelessness and health care utilization. The JHH CHNA does not separate social determinant health needs from primary direct health needs as it is felt that these needs are integrated into all areas of care.

For the purpose of identifying health needs for JHH, a health priority is defined as a medical condition or factor that is central to the state of health of the residents in the CBSA. With this in mind, a modified matrix based on Fowler and Dannenberg's Revised Decision Matrix was developed to glean priorities from the primary and secondary data collected. This matrix is a tool used in health program planning intervention strategies, and uses a ranking system of "high," "medium" and "low" to distinguish the strongest options based on effectiveness, efficiency and sustainability, among others. As some of these categories did not directly apply to this portion of the CHNA, we tailored the matrix to serve our needs, listing health priorities and ranking them within the context of data collected.

An exhaustive list of health concerns was compiled based on the health profile, surveys, interviews, focus groups and discharge data; other sources were taken into account when applicable, for example, the Maryland State Health Improvement Process (SHIP) measures, Baltimore City's Healthy Baltimore 2015, and a PowerPoint presentation given by the chair of the Department of Medicine, Dr. Myron Weisfeldt. In total more than 300 individuals were consulted through interviews, focus groups and surveys. From the extensive list of health concerns mentioned across the multiple data sources, larger categories of health concerns were created. For example, high blood pressure and cholesterol, as well as other health issues related to the cardiovascular system, were collapsed into "cardiovascular disease." Additionally, those concerns that did not fall within the identified definition of a health priority, social determinants of health for example, were put aside to be discussed in conjunction with the health priorities that they aligned with.

For each data source, every health concern was assigned a rank of "high," "medium" or "low" taking into consideration the frequency of mention, perceived importance within the community and substantial differences in secondary data between the CBSA, Baltimore City and Maryland. Once the ranks were assigned in each data source category, a composite rank was selected taking into account all source ranks. Some health concerns had conflicting ranks across the multiple sources. The merits of the

available data sources and the perceived importance of the health concern in the qualitative data were discussed by the Carnahan Group, Inc. team in order to develop a composite rank.

Health needs identified in the CHNA falling in the “high” or “medium” rank were listed as health priorities. The 10 health priorities for the JHH include asthma, cancer, cardiovascular disease, diabetes, health care (access and availability), infectious disease, maternal child health, mental health, obesity, and substance abuse. Health concerns falling within the “low” category were eliminated due to lack of substantive supporting evidence. Some health concerns that were "high" or "medium" ranking but considered to be outside the hospital's ability to impact meaningfully include homicide and teen pregnancy. Other concerns such as tobacco use, food access and availability, and exercise were included as social determinants that impact health priorities such as cardiovascular disease, diabetes, or obesity. Some of the "medium" or “low” rank concerns such as sickle cell disease, vision care, and prostate cancer are addressed through existing hospital programs or through JHU School of Medicine programs. Health concerns in the "low" category included poor air quality, domestic violence, child abuse and neglect, and lead exposure. Domestic violence, child abuse and neglect, and violent crime are complex issues involving behavioral and social factors outside the CHNA’s focus on health needs where the hospital can have a more direct and meaningful impact. Poor air quality, other than being addressed as a contributing factor to asthma, and lead exposure were considered to be a wider regional concern and a concern that is being addressed through federal/state environmental programs.

There was no prioritization within the list of ten identified direct health needs as it was felt they were all identified as critical needs in the community. Health Department data revealed that there were differing priorities in several geographic areas contained in the broader survey and therefore it would be inequitable to the population served to rank any critical need over another for the purpose of the report guidelines.

## **V. 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 2014, JHH paid a total of \$8.9 million in subsidies to physicians for the following patient services for on-call coverage in the emergency department:

Hospitalist (Med/Surg, Peds, Oncol, L&D)	\$4,561,606
Intensivist – Anesthesia	\$ 808,325
On call – Trauma	\$ 672,353
On call – Anesthesia	\$2,038,562
On call – MRI	\$ 488,198
On call – PICU Expansion	\$ 362,467

## **APPENDIX 1**

### **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.

JHH will publish the availability of Financial Assistance on a yearly basis in local newspapers and will post notices of availability at patient registration sites, Admissions/Business Office, the Billing Office and at the emergency department within JHH. Notice of availability 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.

JHH (financial counselor/patient financial services representative, Social Services Department personnel and/or medical assistance/Medicaid eligibility technician) will provide patients with assistance in determining eligibility for and making application to a variety of special entitlement programs that provide financial assistance both toward payment of medical bills and general expenses. The Finance Department, in conjunction with the Social Services Department, will interview patients to determine potential eligibility for Maryland Medical Assistance as well as other special programs, including but not limited to: Kidney Disease program, out-of-state Medicaid, special Health Services Cost Review Commission (HSCRC)-sponsored cancer screening and treatment programs, and Maryland Children's Health Services.

**APPENDIX 2**

**FINANCIAL ASSISTANCE POLICY  
SPECIAL ENTITLEMENT ADVOCACY POLICY**

 <b>JOHNS HOPKINS</b> MEDICINE JOHNS HOPKINS HEALTH SYSTEM	<b>The Johns Hopkins Health System          Policy &amp; Procedure</b>	<i>Policy Number</i>	FIN034A
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**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, also 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. 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.

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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	<p>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:</p> <ul style="list-style-type: none"> <li>(a) Serious jeopardy to the health of a patient;</li> <li>(b) Serious impairment of any bodily functions;</li> <li>(c) Serious dysfunction of any bodily organ or part.</li> <li>(d) With respect to a pregnant woman: <ul style="list-style-type: none"> <li>1. That there is inadequate time to effect safe transfer to another hospital prior to delivery.</li> <li>2. That a transfer may pose a threat to the health and safety of the patient or fetus.</li> <li>3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.</li> </ul> </li> </ul>
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	<p>Medical treatment that is necessary to treat an Emergency Medical Condition.</p> <p>Medically necessary care for the purposes of this policy does not include Elective or cosmetic procedures.</p>
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.

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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.

### 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 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).

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- 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).
  - 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 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.

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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. 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.
15. 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

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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.

- 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.

**REFERENCE<sup>1</sup>**

**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

**RESPONSIBILITIES - JHH, JHBMC**

Financial Counselor (Pre-Admission/Admission/In-House/Outpatient) Customer Service	Understand current criteria for Assistance qualifications.
Collector Admissions Coordinator	Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form.
Any Finance representative designated to accept applications for Financial Assistance	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.

<sup>1</sup> 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.

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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

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**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 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) 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.

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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**

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range					
1	\$ 22,980	\$ 25,278	\$ 27,576	\$ 29,874	\$ 32,172	\$ 34,470	
2	\$ 31,020	\$ 34,122	\$ 37,224	\$ 40,326	\$ 43,428	\$ 46,530	
3	\$ 39,060	\$ 42,966	\$ 46,872	\$ 50,778	\$ 54,684	\$ 58,590	
4	\$ 47,100	\$ 51,810	\$ 56,520	\$ 61,230	\$ 65,940	\$ 70,650	
5	\$ 55,140	\$ 60,654	\$ 66,168	\$ 71,682	\$ 77,196	\$ 82,710	
6	\$ 63,180	\$ 69,498	\$ 75,816	\$ 82,134	\$ 88,452	\$ 94,770	
7	\$ 71,220	\$ 78,342	\$ 85,464	\$ 92,586	\$ 99,708	\$ 106,830	
8*	\$ 79,260	\$ 87,186	\$ 95,112	\$ 103,038	\$ 110,964	\$ 118,890	
**amt for each mbr	\$8,040	\$8,844	\$9,648	\$10,452	\$11,256	\$12,060	
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 \$52,000  
 # of Persons in Family 4  
 Applicable Poverty Income Level 47,100  
 Upper Limits of Income for Allowance Range \$56,520 (60% range)  
 (\$50,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

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## 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
- Primary Adult Care Program (PAC) 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.

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**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.

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

 <b>JOHNS HOPKINS</b> M E D I C I N E <hr/> JOHNS HOPKINS HEALTH SYSTEM	<b>The Johns Hopkins Health System          Policy &amp; Procedure</b>	<i>Policy Number</i>	FIN034A
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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.

 <b>JOHNS HOPKINS</b> MEDICINE JOHNS HOPKINS HEALTH SYSTEM	<b>The Johns Hopkins Health System          Policy &amp; Procedure</b>	<i>Policy Number</i>	FIN034A
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**MEDICAL HARDSHIP FINANCIAL GRID**

Upper Limits of Family Income for Allowance Range

1	\$ 34,470	\$ 45,960	\$ 57,450
2	\$ 46,530	\$ 62,040	\$ 77,550
3	\$ 58,590	\$ 78,120	\$ 97,650
4	\$ 70,650	\$ 94,200	\$ 117,750
5	\$ 82,710	\$ 110,280	\$ 137,850
6	\$ 94,770	\$ 126,360	\$ 157,950
7	\$ 106,830	\$ 142,440	\$ 178,050
8*	\$ 118,890	\$ 158,520	\$ 198,150
Allowance to Give:	50%	35%	20%

\*For family units with more than 8 members, add \$12,060 for each additional person at 300% of FPL, \$16,080 at 400% at FPL; and \$20,100 at 500% of FPL.



**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	_____
<b>Total</b>	_____

***II. Liquid Assets***

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

***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 _____
<b>Total</b>		_____

***IV. Monthly Expenses***

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

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 recibiendo 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 no es residente de Maryland, en que estado vive? Si o No
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 no, fecha en que se desempleó. Si o No  
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.

\_\_\_\_\_  
Applicant's signature

Date: \_\_\_\_\_

\_\_\_\_\_  
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 Médicas 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.

\_\_\_\_\_  
Firma del Aplicante

Fecha: \_\_\_\_\_

\_\_\_\_\_  
Relación al Paciente

\_\_\_\_\_  
Para Uso Interno: Revisado Por: \_\_\_\_\_ Fecha: \_\_\_\_\_

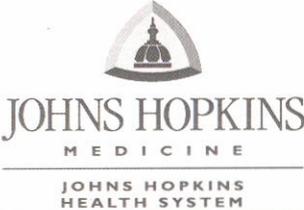
Ingresos: \_\_\_\_\_ 25% de ingresos= \_\_\_\_\_

Deuda Médica: \_\_\_\_\_ Porcentaje de Subsidio: \_\_\_\_\_

Reducción: \_\_\_\_\_

Balance Debido: \_\_\_\_\_

Monto de Pagos Mensuales: \_\_\_\_\_ Duración del Plan De Pago: \_\_\_\_\_ meses

 <p><b>JOHNS HOPKINS</b> M E D I C I N E JOHNS HOPKINS HEALTH SYSTEM</p>	<p><b>The Johns Hopkins Health System Policy &amp; Procedure</b></p>	<p><i>Policy Number</i></p>	<p>FIN054</p>
	<p><i>Subject</i></p>	<p><i>Effective Date</i></p>	<p>12-01-11</p>
	<p>SPECIAL ENTITLEMENT ADVOCACY PROGRAM</p>	<p><i>Page</i></p>	<p>1 of 5</p>
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**POLICY**

**This policy applies to The Johns Hopkins Health System Corporation (JHHS) and the following affiliated entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc. (JHBMC), Johns Hopkins Community Physicians (JHCP), Howard County General Hospital (HCGH), Suburban Hospital (SH), All Children’s Hospital, Inc. (ACH), Kids Home Care, Inc. (KHC), Pediatric Physician Services, Inc. (PPS), West Coast Neonatology, Inc. (WCN).**

**Purpose**

To establish guidelines and procedures for assisting patients with issues regarding eligibility and applications for special entitlement programs, as a means of meeting their financial obligations to JHHS or its affiliates.

Each JHHS affiliate will provide patients with assistance in determining eligibility for and making application to a variety of special entitlement programs that provide financial assistance both toward payment of medical bills and general expenses. The Finance Department, Admissions, Patient Accounts or Social Work in conjunction with the Social Services Department, will interview patients to determine potential eligibility for Medical Assistance as well as other special programs that are available for adults or children at the Federal or State level.

Since consideration for the JHHS Financial Assistance Program requires that where appropriate, an application be submitted to and rejected by the Medical Assistance Program before JHHS charity funds can be used, each hospital-based affiliate will provide funding for onsite Income Maintenance Technicians or outsourced contracted staff to process and approve Medical Assistance applications submitted by patients. To facilitate this process, a signed limited power of attorney may be obtained from each patient/guarantor who is applying for either Maryland Medical Assistance or an out-of-state Medicaid program. Hospital-based staff or outsourced contracted staff will also assist any patients who continue to require additional help in complying with the documentation requirements of the State's program once these patients have concluded their treatment at the JHHS facility.

**REFERENCES**

**JHHS Finance Policies and Procedures Manual**

Policy No. FIN034 - JHHS Financial Assistance Program

Policy No. FIN044 - Inpatient Admission & Financial Responsibility

**RESPONSIBILITIES**

Financial Counselor/Patient  
Financial Services Representative  
(or affiliate equivalent)

Screen patient to determine eligibility for entitlement programs.

Contact Social Services Department for assistance in obtaining necessary information from patient and/or family as appropriate.

Determine the best program to meet patient's needs and assist patient in completing necessary applications

- a. Obtain application for in-state Medical Assistance and schedule appointment with on-site Eligibility Technician or off-site caseworker, as appropriate.

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- b. Require eligible out-of-state patients to apply with the applicable state's Medicaid program. (Assistance may be provided)
- c. Assist or direct patient in applying for other suitable entitlement programs.

Social Services Department  
Personnel (or affiliate equivalent)

Provide required documentation to applicable programs regarding medical bills.

Document relevant financial information in patient's records.

On-site Medical Assistance/  
Medicaid Eligibility Technician (or  
affiliate equivalent)

Assist Patient Financial Services personnel in obtaining necessary patient financial information as required.

Receive and evaluate application for Medical Assistance and notify patient and provider of outcome; complete all required documentation of approved cases.

**SPONSOR**

Senior Director, Patient Finance (JHH, JHHS, JHBMC)  
Senior Director of Finance (JHCP)  
Director of Revenue Cycle (HCGH)  
Corporate Director, Patient Financial Services (SH)  
Director, Patient Accounts (ACH)

**REVIEW CYCLE**

Three (3) years

**APPROVAL**



Vice President of Finance/CFO and Treasurer, JHHS

12-1-11  
Date

**PROCEDURES (JHH, JHBMC, JHCP, HCGH, SH)**

- 1. Financial Counselor/Patient Financial Services (or affiliate equivalent)
  - a. Screen patient for need for various entitlement programs. Contact Department of Social Services for assistance in obtaining necessary information from patient and/or family as appropriate.
  - b. Determine which program best addresses the patient's situation. Currently available programs include but are not limited to:

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- 1) Maryland Medical Assistance
  - 2) Kidney Disease Program
  - 3) HSCRC Cancer Screening and Treatment Program
  - 4) Maryland Children's Health Service
- c. Assist patient as necessary in the completion of application to Maryland Medical Assistance Program. Require patient who may be eligible for out-of-state Medicaid programs to apply to the applicable state for benefits.
  - d. For Maryland residents applying for Maryland Medical Assistance, set up an interview for the patient with onsite Eligibility Technician or off-site caseworker to review completed application.
  - e. Provide required documentation (e.g., treatment plans, staging forms, medical records, discharge summaries, etc.), to applicable programs.
  - f. Refer patient as necessary to appropriate department for applications to other special programs and follow up with program concerning status of application. Act as liaison between patient and program to ensure completion of application process.
  - g. Document relevant financial information in patient's records.
  - h. Consider utilizing outside collection agent for any patient who is uncooperative or non-compliant with the application process.
2. Social Services Department Personnel (or affiliate equivalent)
    - a. As required, provide assistance to Patient Financial Services Department personnel in obtaining required information from patient and/or family and determining suitable entitlement programs.
  3. Onsite Medicaid Eligibility Technician/Financial Counselor (or affiliate equivalent)
    - a. Conduct face-to-face interviews with Maryland residents applying for Medical Assistance.
    - b. Evaluate application to determine if Federal guidelines for granting assistance are met.
    - c. Notify the patient and the provider regarding the outcome of the eligibility process.
    - d. State worker only:
      - Enter the Medicaid recipient number and eligibility dates for approved applications into the State's computer records.

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**PROCEDURES (ACH, KHC, PPS, WCN)**

1. Financial Counselor/Patient Financial Services
  - a. Screen patient for need for financial assistance program needs. Contact Social Work Services for assistance in obtaining necessary information from guarantor, patient and or family, as appropriate.
  - b. Determine which program best addresses the patient's situation. Currently available programs include, but are not limited to:
    - 1) Florida Medical Assistance
    - 2) Florida Healthy Kids
    - 3) Children's Medical Services
    - 4) SSI
  - c. Assist guarantor/patient as necessary in the completion of application to Florida Medicaid. Ensure that all needed documentation is readily available or provide assistance to ensure we are able to obtain all necessary documents, such as birth certificates, proof of income.
  - d. For Florida residents applying for Florida Medicaid, submit completed application electronically to Department of Children & Family Services (DCF).
  - e. Refer patient/guarantor to vendor for completion of eligibility process.
  - f. Document relevant financial information in patient's financial record.
  - g. Consider utilizing outside collections for any guarantor/patient who is uncooperative or non compliant with the application process.
2. Social Work Services Personnel
  - a. As required, provide assistance to Admissions and Patient Accounts personnel in obtaining required information from guarantor/patient or family members. As needed, assist in helping to arrange meeting with guarantor/patient or family members and Patient Accounts staff or outside Vendor staff.
3. Outside Vendor
  - a. Conduct face to face interviews with Florida residents

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applying for Florida Medicaid.

- b. Determine which program best addresses the patient's situation. Currently available programs include, but are not limited to:
  - 1) Florida Medical Assistance
  - 2) Florida Healthy Kids
  - 3) Children's Medical Services
  - 4) SSI
- c. Evaluate applications to determine if Federal and state guidelines for granting assistance are met.
- d. Assist guarantor/patient as necessary in the completion of application to Florida Medicaid. Ensure that all needed documentation is readily available or provide assistance to ensure we are able to obtain all necessary documents, such as birth certificates, proof of income.
- e. For Florida residents applying for Florida Medicaid, submit completed application electronically to Department of Children & Family Services (DCF).
- f. Provide any additional required documentation (e.g. treatment plans, staging forms, medical records, physician attestations, discharge summary) to applicable program.
- g. Refer guarantor/patient as necessary to appropriate department for applications to other special programs and follow up with program concerning status of application. Act as liaison between guarantor/patient and program to ensure completion of application process.
- h. After 30 days, contact DCF to determine the status of any pending application. Ensure Florida Medicaid Management Information System (FMMIS) and eligibility has been updated and Medicaid number assigned.
- i. Notify the guarantor/patient and the provider regarding the outcome of the eligibility process.
- j. Document relevant financial information in patient's financial record.

**APPENDIX 3**

**PATIENT INFORMATION SHEET**

## 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](http://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](mailto: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.		



# Patient Bill of Rights and Responsibilities

We want to encourage you, as a patient at The Johns Hopkins Hospital, to speak openly with your health care team, take part in your treatment choices, and promote your own safety by being well informed and involved in your care. Because we want you to think of yourself as a partner in your care, we want you to know your rights as well as your responsibilities during your stay at our hospital. We invite you and your family to join us as active members of your care team.

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## Your Rights

- YOU HAVE THE RIGHT to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
- YOU HAVE THE RIGHT to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
- YOU HAVE THE RIGHT to be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.
- YOU HAVE THE RIGHT to be told the names of your doctors, nurses, and all health care team members directing and/or providing your care.
- YOU HAVE THE RIGHT to have a family member or person of your choice and your own doctor notified promptly of your admission to the hospital.
- YOU HAVE THE RIGHT to have someone remain with you for emotional support during your hospital stay, unless your visitor's presence compromises your or others' rights, safety or health. You have the right to deny visitation at any time.
- YOU HAVE THE RIGHT to be told by your doctor about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment, including unexpected outcomes. You have the right to give written informed consent before any non-emergency procedure begins.
- YOU HAVE THE RIGHT to have your pain assessed and to be involved in decisions about treating your pain.
- YOU HAVE THE RIGHT to be free from restraints and seclusion in any form that is not medically required.
- YOU CAN EXPECT full consideration of your privacy and confidentiality in care discussions, exams, and treatments. You may ask for an escort during any type of exam.
- YOU HAVE THE RIGHT to access protective and advocacy services in cases of abuse or neglect. The hospital will provide a list of these resources.
- YOU, YOUR FAMILY, AND FRIENDS WITH YOUR PERMISSION, HAVE THE RIGHT to participate in decisions about your care, your treatment, and services provided, including the right to refuse treatment to the extent permitted by law. If you leave the hospital against the advice of your doctor, the hospital and doctors will not be responsible for any medical consequences that may occur.
- YOU HAVE THE RIGHT to agree or refuse to take part in medical research studies. You may withdraw from a study at any time without impacting your access to standard care.
- YOU HAVE THE RIGHT to communication that you can understand. The hospital will provide sign language and foreign language interpreters as needed at no cost. Information given will be appropriate to your age, understanding, and language. If you have vision, speech, hearing, and/or other impairments, you will receive additional aids to ensure your care needs are met.
- YOU HAVE THE RIGHT to make an advance directive and appoint someone to make health care decisions for you if you are unable. If you do not have an advance directive, we can provide you with information and help you complete one.
- YOU HAVE THE RIGHT to be involved in your discharge plan. You can expect to be told in a timely manner of your discharge, transfer to another facility, or transfer to another level of care. Before your discharge, you can expect to receive information about follow-up care that you may need.



JOHNS HOPKINS  
MEDICINE

THE JOHNS HOPKINS HOSPITAL

- YOU HAVE THE RIGHT to receive detailed information about your hospital and physician charges.
- YOU CAN EXPECT that all communication and records about your care are confidential, unless disclosure is permitted by law. You have the right to see or get a copy of your medical records. You may add information to your medical record by contacting the Medical Records Department. You have the right to request a list of people to whom your personal health information was disclosed.
- YOU HAVE THE RIGHT to give or refuse consent for recordings, photographs, films, or other images to be produced or used for internal or external purposes other than identification, diagnosis, or treatment. You have the right to withdraw consent up until a reasonable time before the item is used.
- IF YOU OR A FAMILY MEMBER NEEDS TO DISCUSS an ethical issue related to your care, a member of the Ethics Service is available by pager at all times. To reach a member, dial 410-283-6104. After three beeps, enter your phone number and then the pound sign (#). An Ethics Service member will return your call.
- YOU HAVE THE RIGHT to spiritual services. Chaplains are available to help you directly or to contact your own clergy. You can reach a chaplain at 410-955-5842 between 8am and 5pm weekdays. At other times, please ask your nurse to contact the chaplain on call.
- YOU HAVE THE RIGHT to voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your doctor, nurse manager, or a department manager. You may also contact the Patient Relations Department at 410-955-2273 or email [patientrelations@jhmi.edu](mailto:patientrelations@jhmi.edu).

If your concern is not resolved to your liking, you may also contact:

**Maryland Department of Health & Hygiene**

Office of Health Care Quality  
Hospital Complaint Unit  
Spring Grove Hospital Center  
Bland Bryant Building  
Catonsville, Maryland 21228  
410-402-8000

**The Joint Commission**

Office of Quality Monitoring  
One Renaissance Boulevard  
Oakbrook Terrace, IL 60181  
1-800-994-6610  
[complaint@jointcommission.org](mailto:complaint@jointcommission.org)

## Your Responsibilities

- YOU ARE EXPECTED to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer when it is required.
- YOU SHOULD PROVIDE the hospital or your doctor with a copy of your advance directive if you have one.
- YOU ARE EXPECTED to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
- YOU ARE EXPECTED to ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment, and service plan.
- YOU ARE EXPECTED to actively participate in your pain management plan and to keep your doctors and nurses informed of the effectiveness of your treatment.
- YOU ARE ASKED to please leave valuables at home and bring only necessary items for your hospital stay.
- YOU ARE EXPECTED to treat all hospital staff, other patients, and visitors with courtesy and respect; abide by all hospital rules and safety regulations; and be mindful of noise levels, privacy, and number of visitors.
- YOU ARE EXPECTED to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner.
- YOU HAVE THE RESPONSIBILITY to keep appointments, be on time, and call your health care provider if you cannot keep your appointments.

# Declaración de los derechos y responsabilidades del paciente

Como paciente del Hospital Johns Hopkins, queremos alentarle a que discuta abiertamente asuntos referentes a su cuidado con el equipo médico, que tome parte activa en su tratamiento, y que promueva su propia seguridad al estar bien informado e involucrado en su cuidado. Queremos que usted se conciba como un socio en su propio cuidado, y que conozca sus derechos así como también sus responsabilidades durante su estadía en el hospital. Le invitamos a usted y a su familia a que nos acompañen como miembros activos del equipo de cuidado.

## Sus Derechos

- **TIENE DERECHO** a recibir un cuidado considerado, respetuoso y compasivo sin importar su edad, género, raza, nacionalidad, religión, orientación sexual o limitaciones físicas.
- **TIENE DERECHO** a ser atendido en un ambiente seguro, exento de cualquier forma de abuso, abandono o maltrato.
- **TIENE DERECHO** a que le llamen por su nombre y a permanecer en un ambiente que mantenga la dignidad y que contribuya a una imagen propia positiva.
- **TIENE DERECHO** a que le digan los nombres de los médicos, enfermeras/os y otros miembros del equipo médico involucrados en su cuidado.
- **TIENE DERECHO** a que se le notifique lo más pronto posible a un miembro de su familia o a un representante de su elección y a su propio médico acerca de su hospitalización.
- **TIENE DERECHO** a que alguien permanezca con usted para brindarle apoyo emocional durante su estadía en el hospital, a menos que la presencia de su visitante comprometa sus derechos o los derechos, la seguridad o la salud de los demás. Tiene el derecho de negarse a recibir visitas en cualquier momento.
- **TIENE DERECHO** a que el médico le hable acerca de su diagnóstico y posible pronóstico, de los beneficios y de los riesgos del tratamiento, y del desenlace esperado del tratamiento, incluyendo los desenlaces no previstos. Tiene derecho a dar un consentimiento informado por escrito antes de que empiece cualquier procedimiento o tratamiento que no sea de emergencia.
- **TIENE DERECHO** a que le examinen su dolor y a estar involucrado en las decisiones acerca de cómo manejarlo.
- **TIENE DERECHO** a estar exento de sujetadores que le impidan el movimiento y de aislamiento innecesario desde un punto de vista médico.
- **TIENE DERECHO** a que se le considere su total privacidad y confidencialidad en las conversaciones acerca de su cuidado, de los exámenes y del tratamiento. Puede solicitar un acompañante durante cualquier examen.
- **TIENE DERECHO** a acceder a los servicios de protección y defensoría en casos de abuso o de abandono. El hospital le brindará una lista de recursos de defensoría y protección.
- **USTED, LOS MIEMBROS DE SU FAMILIA Y LOS AMIGOS QUE TENGAN SU AUTORIZACIÓN, TIENEN DERECHO** a participar en decisiones acerca de su cuidado, tratamiento y servicios, incluido el derecho a rehusarse al tratamiento hasta el punto permitido por la ley. Si usted se va del hospital en contra del consejo de su médico, el hospital y los médicos no son responsables por ninguna consecuencia médica que pueda ocurrir.
- **TIENE DERECHO** a acceder o a rehusarse a participar en cualquier estudio de investigación médica. En cualquier momento usted puede dejar de participar en el estudio sin que esto tenga un impacto en el acceso o la calidad del cuidado.
- **TIENE DERECHO** al tipo de comunicación que usted pueda comprender. El hospital brindará lenguaje de signos o servicios de interpretación para idiomas extranjeros sin costo adicional. La información ofrecida será apropiada para su edad, nivel de comprensión e idioma. Si tiene alguna limitación visual, auditiva, de lenguaje, y/u otro impedimento, recibirá ayudas adicionales para asegurar de que sus necesidades estén satisfechas.
- **TIENE DERECHO** a decidir sus últimas voluntades, y asignar a alguien, para que, si usted no puede, tome las decisiones acerca de su salud. Si no tiene una instrucción previa de sus últimas voluntades, le podemos ofrecer información y ayuda para completar una.
- **TIENE DERECHO** a hacer parte de su plan de dado de alta. Puede esperar que le informen a tiempo acerca de la necesidad de planear su dado de alta o transferencia a otra instalación o a otro nivel de cuidado. Antes de que le den de alta usted puede esperar que le den información acerca del cuidado de seguimiento que necesita.
- **TIENE DERECHO** a recibir información detallada acerca de los cobros hechos por su hospital y por el médico
- **PUEDE ESPERAR** que todas las comunicaciones y registros médicos sean confidenciales a menos que la divulgación esté permitida por la ley. Tiene derecho a ver y a obtener una copia de sus registros médicos y, si es necesario, a que le expliquen la información contenida en ellos. Puede añadir información a sus registros contactando a su coordinador/a. Una vez usted lo solicite, usted tiene derecho a recibir una lista de las personas a quienes se le reveló su información personal de salud.

- Si reporteros u otros miembros de los medios de comunicación solicitan hablar con usted, **TIENE DERECHO** a dar su consentimiento acerca del uso de grabadoras o fotografías. Usted tiene derecho de revocar su consentimiento hasta un tiempo razonable antes de que la grabación o las fotografías sean usadas.
- **SI USTED O UN MIEMBRO DE SU FAMILIA NECESITA DISCUTIR UN ASUNTO** ético relacionado con su cuidado, un miembro del Servicio de Ética está disponible todo el tiempo por beeper. Para localizar a uno de los miembros, marque 410-283-6104. Después de tres pitos, entre su número de teléfono y luego oprima el signo (#). Un miembro del servicio de ética le devolverá la llamada.
- **TIENE EL DERECHO** a recibir servicio pastoral. Hay capellanes disponibles para ayudarle directamente o para contactar a su propio clérigo. Puede localizar a un capellán en el 410-955-5842 de las 8 a.m. a las 5 p.m. durante los días de la semana. Fuera de este horario, por favor pídale a su enfermera que contacte al capellán de turno.
- **TIENE DERECHO** a expresar sus preocupaciones acerca del cuidado que está recibiendo. Si tiene un problema o queja, usted puede hablar con su doctor, enfermera jefe, o a un gerente de departamento. Puede comunicarse también con el Departamento de Relaciones de Pacientes al 410-955-2273 o enviar un correo electrónico a: [patientrelations@jhmi.edu](mailto:patientrelations@jhmi.edu).
- Si su queja no se resuelve satisfactoriamente, **TIENE DERECHO** a solicitar una revisión por parte de las siguientes organizaciones:

### Maryland Department of Health & Hygiene

Office of Health Care Quality  
Hospital Complaint Unit  
Spring Grove Hospital Center  
55 Wade Avenue  
Bland Bryant Building  
Catonsville, Maryland 21228  
410-402-8016 o a la línea gratis 1-877-402-82180

### The Joint Commission Office of Quality Monitoring

One Renaissance Boulevard  
Oakbrook Terrace, IL 60181  
1-800-994-6610 o  
[complaint@jointcommission.org](mailto:complaint@jointcommission.org)

## Sus responsabilidades

- **SE ESPERA QUE** brinde información completa y precisa, incluyendo su nombre completo, dirección, número de teléfono de la casa, fecha de nacimiento, número de seguro social (si aplica), aseguradora médica y empleador cuando se requiera.
- Si usted ha escrito sus últimas voluntades, **DEBE** darle al hospital o a su doctor una copia de las mismas.
- **SE ESPERA QUE** dé información correcta y completa acerca de su salud y su historia médica, incluyendo su condición actual, las enfermedades pasadas, hospitalizaciones, medicamentos, vitaminas, productos naturales y cualquier otro asunto concerniente a su salud, incluyendo los riesgos de seguridad percibidos.
- **SE ESPERA QUE** haga preguntas cuando no entienda la información o las instrucciones que se le dan. Si usted cree que no puede llevar a cabo su plan de tratamiento, usted tiene la responsabilidad de decirle a su médico. Usted es responsable por los resultados si no sigue el plan de servicio, cuidado y tratamiento.
- **SE ESPERA QUE** participe activamente en el manejo de su dolor y que mantenga a los médicos y a las enfermeras informados de la efectividad de dicho tratamiento.
- **SE LE PIDE** que deje sus objetos de valor en casa y que solamente traiga lo necesario para su estadía en el hospital.
- **SE ESPERA QUE** usted trate al personal del hospital, otros pacientes y visitantes con cortesía y respeto; que acate todas las reglas y regulaciones de seguridad y que sea consciente de los niveles de ruido, privacidad y número de visitantes.
- **SE ESPERA QUE** brinde información correcta y completa acerca del cubrimiento de su plan de seguro médico y que pague las facturas a tiempo.
- **USTED TIENE LA RESPONSABILIDAD** de asistir a sus citas médicas puntualmente, y de llamar a su proveedor de salud si no puede asistir.

**APPENDIX 4**

**MISSION**

**VISION**

**VALUE STATEMENT**

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

**Keywords:**

Table of Contents	Page Number
I. <a href="#">POLICY</a>	1
II. <a href="#">REVIEW CYCLE</a>	2
III. <a href="#">SPONSOR</a>	2
IV. <a href="#">APPROVAL</a>	2

**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 to 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*

	The Johns Hopkins Health System Corporation/The Johns Hopkins Hospital <b>Corporate and Administrative Policy Manual          Administration</b>	<i>Policy Number</i>	ADM002	
		<i>Effective Date</i>	11/01/2012	
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	<i>Subject</i>	<b>Mission, Vision, and Values</b>	<i>Page</i>	2 of 2
			<i>Supersedes</i>	11/01/2009

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

## Appendix 5

### JHH Implementation Strategy

	The Johns Hopkins Health System Corporation/The Johns Hopkins Hospital <b>Corporate and Administrative Policy Manual          Administration</b>	<i>Policy Number</i>	ADM002	
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*JHM Vision*

	The Johns Hopkins Health System Corporation/The Johns Hopkins Hospital <b>Corporate and Administrative Policy Manual          Administration</b>	<i>Policy Number</i>	ADM002	
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- Excellence & Discovery
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- Diversity & Inclusion
- Respect & Collegiality

**II. REVIEW CYCLE**

Three (3) years

**III. SPONSOR**

President

**IV. APPROVAL**

PRESIDENT APPROVAL

\_\_\_\_\_

\_\_\_\_\_  
Date

# The Johns Hopkins Hospital Implementation Strategy

In response to the  
JHH Community Health Needs Assessment

Fiscal Year 2013



JOHNS HOPKINS  
M E D I C I N E

## Introduction

The Johns Hopkins Hospital Implementation Strategy is a companion report to the JHH Community Health Needs Assessment (CHNA) as required by the Treasury Department (“Treasury”) and the Internal Revenue Service (IRS) in response to new regulations set forth in the Affordable Care Act (ACA).

The ACA, enacted on March 23, 2010, requires not-for-profit hospital organizations to conduct a CHNA once every three taxable years that meets the requirements the Internal Revenue Code 501(r) set forth by the ACA. It also requires each hospital to adopt an Implementation Strategy that addresses the community health needs identified in the CHNA.

The development of the CHNA and the Implementation Strategy was led by the Office of Government and Community Affairs (Tom Lewis, Vice President) and Redonda Miller (JHH Vice President for Medical Affairs) and involved the contributions of over 350 individuals through direct interviews, surveys and focus groups. Key stakeholder groups included but were not limited to, community residents, members of faith based organizations, health care providers, neighborhood association leaders, elected officials, health professionals, Johns Hopkins Medicine leadership and other experts both internal and external to Johns Hopkins.

The CHNA is a report based on epidemiological, qualitative and comparative methods that assesses the health issues in a hospital organization’s community and that community’s access to services related to those issues. The Implementation Strategy is a list of specific actions and goals that demonstrate how Johns Hopkins Hospital plans to meet the CHNA-identified health needs of the residents in the communities surrounding the hospital, i.e. the Community Benefit Service Area (CBSA). This Implementation Strategy has been prepared for approval by the JHH Board of Trustees.

### IRS Requirements

The requirements outlined by the Treasury and the IRS for the Form 990 Schedule H submission state that the Community Health Needs Assessment (CHNA) must contain:

- A separate written report for each hospital
- Description of the community served by the hospital, i.e. the Community Benefit Service Area (CBSA) and how that community is defined
- Description of the process and methods used to conduct the CHNA

- Information gaps that may impact ability to assess needs
- Identification of any collaborating partners
- Identification and qualifications of any third parties assisting with CHNA
- Description of how input from community was used
- Prioritized description of all community health needs identified through the CHNA
- Description of existing health care facilities within the community available to meet the needs identified

The Implementation Strategy which is developed and adopted by each hospital must address each of the needs identified in the CHNA by either describing how the hospital plans to meet the need or identifying it as a need not to be addressed by the hospital and why. Each need addressed must be tailored to that hospital's programs, resources, priorities, plans and/or collaboration with governmental, non-profit or other health care organization. If collaborating with other organizations to develop the implementation strategy, the organizations must be identified. The board of each hospital must approve the Implementation Strategy within the same fiscal year as the completion of the CHNA.

### **The Community We Serve**

For purposes of defining a Community Benefit Service Area (CBSA), JHH focused on specific populations or communities of need to which the hospital has historically allocated resources through its community benefits plan. The hospital uses geographic boundary and target population approaches to define its CBSA. The CBSA is defined by the geographic area contained within the seven ZIP codes surrounding JHH: 21202, 21205, 21206, 21213, 21218, 21224 and 21231. This area accounts for approximately 25% of the inpatient discharge population of the hospital, and most of the recipients of the hospital's community outreach projects and contributions reside in this area. Within this CBSA, JHH has 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.

### **Health Priorities**

From a broad list of health concerns gathered from primary (interviews, focus groups, surveys) and secondary (federal, state, local health databases) sources, larger categories of health concerns were identified. For example, high blood pressure and cholesterol, as well as other health issues related to the cardiovascular system, were collapsed into "cardiovascular disease." Those concerns that did not fall within the identified definition of a health priority, social determinants of health for example, were put aside to be discussed in conjunction with the health priorities that they aligned with.

As a result of the CHNA, the following ten health needs have been determined as the priorities in the JHH CBSA.

- Asthma
- Cancer
- Cardiovascular Disease
- Diabetes
- Health Care Access and Availability
- Infectious Disease (HIV/AIDS, STDs)
- Maternal and Child Health
- Mental Health
- Obesity
- Substance Abuse

### **Johns Hopkins Medicine Affiliate Hospitals**

Each of the Johns Hopkins Health System hospitals must submit a separate CHNA and board approved Implementation Strategy. While each report varies greatly due to the distinct characteristics and needs of each hospital's CBSA and the research and discovery process used to determine the community health needs, a workgroup of representatives from each of the JHHS hospitals collaborated to determine a consistent format and approach to the CHNA and Implementation Strategy.

### **Implementation Strategy Additional Notes**

The Implementation Strategy is not intended to be a comprehensive catalog of the many ways the needs of the community are addressed by each hospital but rather a representation of specific actions that the hospital commits to undertaking and monitoring as they relate to each identified need. Only a few internal and external partners have been included in the line item entries on the Implementation Strategy charts; however, many JHH clinical departments will be partnering in the collaborative efforts and specific actions that address the goals of "meeting the health needs of the community" whether that entails involvement in a clinical program or protocol or if it is an individual or group sharing knowledge in an educational outreach opportunity.

The following charts reflect the actions identified for measurement and tracking for the JHH Implementation Strategy.

**Johns Hopkins Hospital Implementation Strategy**

#	COMMUNITY HEALTH NEED	TARGET POPULATION	ACTION PLAN	GOAL(S)	PARTNERING ORGANIZATION(S)
1-1	Asthma	Children with asthma who reside in the CBSA	In accordance with the DHMH Asthma Action Plan, regarding pediatric asthma care, provide free spacers for metered dose asthma inhalers at the Harriet Lane Clinic to children diagnosed with asthma	Increase the consistency of care for children with asthma using inhalers	<b>External:</b> Maryland Department of Health and Mental Hygiene (DHMH) <b>Internal:</b> Harriet Lane Clinic; Office of East Baltimore Community Affairs; JH Office of Community Health (OCH)
1-2	Asthma	Children with asthma who reside in the CBSA	Become a partner in the JH Dept of Asthma and BCHD program to provide HEPA filters to families containing members who smoke and children with asthma	Decrease exposure to second hand smoke to children with asthma who live in the CBA	<b>External:</b> Baltimore City Health Department; JH School of Medicine <b>Internal:</b> Center for Childhood Asthma in the Urban Environment; Office of East Baltimore Community Affairs; JH Office of Community Health (OCH)
1-3	Asthma	CBSA residents diagnosed with asthma	Educate the community to keep their asthma clinic follow-up appointments which typically occur every 3 to 6 months until stable lung function	Improve the health of diagnosed asthma patients by increasing the number of patients who keep their follow-up appointments	<b>Internal:</b> Johns Hopkins Pediatric Clinic
2-1	Cancer	CBSA residents who are smokers	Increase CT scans for smokers	Increase early identification of suspicious nodules and thereby increase early cancer detection	<b>Internal:</b> Relevant JHH Clinical Departments
2-2	Cancer	Women ages 40-74 years living in the CBSA	Increase percentage of female population in CBSA receiving mammograms	Make progress towards the National Cancer Institute guidelines for breast cancer screenings	<b>Internal:</b> OB-GYN clinical care outlets (Procedure to be tracked in EPIC)
3-1	Cardiovascular Disease	CBSA residents	Increase the number of families who know how to perform CPR. (400 families will be receiving training through an outreach program with faith based organizations in FY14)	Reduce the health disparity in the CBSA of those receiving emergency bystander CPR by increasing the number of CBSA residents who have been trained to administer it	<b>External:</b> East Baltimore Faith Based Organizations <b>Internal:</b> JH Office of Community Health (OCH) - Gotta Have Heart Program

#	COMMUNITY HEALTH NEED	TARGET POPULATION	ACTION PLAN	GOAL(S)	PARTNERING ORGANIZATION(S)
3-2	Cardiovascular Disease	CBSA residents with undiagnosed cardiovascular problems	Increase community outreach to engage CBSA residents in education and screening for cardiovascular problems	Increase the number outreach programs on hypertension and other cardio vascular conditions to residents of the CBSA.	<b>External:</b> Isaiah Wellness Center, <b>Internal:</b> Community Chats (OCH); JHH Heart Hype; Stroke Center Community Outreach (JHH Cerebrovascular)
4-1	Diabetes	CBSA residents living with diabetes	Increase knowledge of and access to diabetes management programs in the CBSA through outreach programs at area schools, churches, community meetings	Increase number of educational outreach encounters in the CBSA	<b>External:</b> Comiendo Juntos; Isaiah Wellness Center <b>Internal:</b> JH Office of Diversity and Cultural Competence Urban Health Radio; JHOC Diabetes Center
4-2	Diabetes	CBSA residents living with diabetes	Increase education and participation in regular vision monitoring by CBSA patients	Increase number of retinopathy screenings	<b>Internal:</b> Wilmer Eye Center Diabetic Retinopathy screening program
4-3	Diabetes	CBSA residents living with diabetes	Increase education outreach opportunities and participation in diabetes management programs	Improve Hemoglobin HbA1c levels in diabetes patients	<b>External:</b> Isaiah Wellness Center <b>Internal:</b> JHOC Diabetes Center
5-1	Health Care (Access and Availability)	CBSA residents	Identify at risk patients upon admission to JHH or during visit to ED or JHH clinic and link to follow up care	Increase number of patients receiving post discharge and/or post visit follow-up care	<b>External:</b> JH Community Physicians (JHCP); JH Health Care LLC (JHHC); JH Home Care Group (JHHCG); Johns Hopkins Community Health Partnership (J-CHiP); <b>Internal:</b> The Access Partnership program (TAP)
5-2	Health Care (Access and Availability)	CBSA residents	Through prescription bridging programs and patient assistance programs help patients receive sustained access to needed medications	Increase the number of JHH patients receiving patient services from the JH outpatient pharmacy (prescription services, medication therapy management services and other pharmacy services)	<b>Internal:</b> Outpatient Medication Assistance Program (OMAP); Patient Assistance Program; Special Needs Program
5-3	Health Care (Access and Availability)	JHH medical staff	Provide annual training for all JHH medical staff on accessing and utilizing interpretive services	Increase skills and sensitivity of JHH medical staff in addressing the differing needs of diverse patient populations.	<b>External:</b> Esperanza Center, Latino Providers Network <b>Internal:</b> JHM Office of Diversity and Cultural Competence

#	COMMUNITY HEALTH NEED	TARGET POPULATION	ACTION PLAN	GOAL(S)	PARTNERING ORGANIZATION(S)
5-4	Health Care (Access and Availability)	CBSA residents	Offer a bedside delivery service to fill discharge prescriptions with assistance for uninsured residents	Increase access to medications for residents in the CBSA	<b>External:</b> Johns Hopkins Home Care Group (JHHCG) <b>Internal:</b> JHH Department of Pharmacy
5-5	Health Care (Access and Availability)	CBSA residents	Pilot a post-discharge home visit by a pharmacist to perform medication reconciliation and medication education	Increase access to pharmacist medication management assistance for residents in the CBSA	<b>External:</b> Johns Hopkins Home Care Group <b>Internal:</b> JHH Department of Pharmacy
6-1	Infectious Disease	CBSA residents at risk (i.e. intravenous drug users, MSM population, sexually active individuals)	Increase knowledge of and access to screening for HIV in CBSA residents at risk through community outreach and primary care intervention.	Increase number of HIV screenings among CBSA adults and adolescents.	<b>External:</b> Sisters Together and Reaching (STAR); ODCC Urban Health Radio  <b>Internal:</b> JH East Baltimore Medical Center
6-2	Infectious Disease	CBSA residents currently living with HIV	Increase access to care and linkage to medication assistance for HIV positive individuals in the CBSA	Increase number of patients who receive same day/next day care when receiving news of a positive HIV diagnosis	<b>Internal:</b> JH Moore Clinic; JHH HIV/AIDS Patient Emergency Fund
7-1	Maternal and Child Health	New mothers who reside in the CBSA	Through education and support care – teach the importance of breast feeding newborns for at least their first six months	Increase the number of women who breast feed at 6 weeks and 6 months post-delivery and become the first Maryland hospital to earn the World Health Organization (WHO) baby friendly designation	<b>External:</b> World Health Organization <b>Internal:</b> Baby Friendly Committee; JHH Wellstart program; Maternal Fetal Medicine clinic
7-2	Maternal and Child Health	New teenage mothers in the CBSA	Promote the use of LARC (Long Acting Reversible Contraception) among teenage new mothers	Increase the percentage of new teenage mothers who receive counseling on the benefits to maternal and child health from LARC before discharge	<b>Internal:</b> Baby Friendly Committee; JHH Wellstart program; Maternal Fetal Medicine clinic

#	COMMUNITY HEALTH NEED	TARGET POPULATION	ACTION PLAN	GOAL(S)	PARTNERING ORGANIZATION(S)
8-1	Mental Health	CBSA residents	Enhance access to community mental health services by providing early intervention, detecting and treating early-onset psychosis, offering walk-in clinic hours and mental health educational events	Increase the number of walk-in clinic patients served and educational events	<b>External:</b> Baltimore Mental Health Systems (BMHS); Health Care for the Homeless; Esperanza Center (Catholic Charities of Baltimore); Helping Up Mission <b>Internal:</b> East Baltimore Medical Center; PAODD Program for Alcohol and Other Dependent Drugs
8-2	Mental Health	CBSA residents seeking mental health and/or substance abuse services	Increase supportive housing census for individuals seeking services for mental health and/or substance abuse	Increase the number of persons who receive adequate housing who are receiving treatment for substance abuse and/or mental health disorders	<b>External:</b> Baltimore City Health Department; Helping Up Mission; Healthcare for the Homeless <b>Internal:</b> Broadway Center for Addiction; PATCH Psychogeriatrics Assessment and Treatment in City Housing
9-1	Overweight/Obesity	CBSA residents	Expand access to local healthy food options to residents in food deserts	Increase the percentage of CBSA residents who have access to a food retail outlet that sells a variety of healthy foods	<b>External:</b> HEBCAC and Santoni's EB Supermarket Shuttle; BaltiMarket Virtual Grocery; JHM Community Farmers' Market <b>Internal:</b> Office of East Baltimore Community Affairs
9-2	Overweight/Obesity	Johns Hopkins Hospital physicians	Require physicians measure the body mass index (BMI) of their adult patients and provide educational opportunities for physicians to increase self-efficacy discussing behavioral interventions	Increase the number of physicians who regularly measure the BMI of their adult patients	<b>Internal:</b> JHOC Clinics; Clinical Departments
9-3	Overweight/Obesity	CBSA residents	Expand community, childcare, and school-based programs focused on healthy eating habits and physical activity	Increase the number of CBSA residents who have participated in at least one program per year	<b>External:</b> Henderson Hopkins School; Youth Fitness Circle Harriet Lane Clinic; Playworks; Meals on Wheels <b>Internal:</b> JHH Pediatrics East Baltimore Health Fair; Office of East Baltimore Community Affairs

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10-1	Substance Abuse	Physicians who treat opioid dependence with buprenorphine	Provide training opportunity for physicians to become qualified to apply for an “X” number and subsequently prescribe buprenorphine	Increase the number of local physicians eligible to apply to the DEA to prescribe buprenorphine	Drug Addiction Treatment Act of 2000 (DATA 2000); professional organizations (e.g., AAAP, ASAM)
10-2	Substance Abuse	CBSA patients, eligible for J-CHiP, and who have an active substance abuse disorder and a history of high health care use	Targeted case management services provided through the J-CHiP program	Decrease the rate of use for inpatient medical services at JHH/JHBMC	<b>External:</b> JH HomeCare Group (JHHCG); Johns Hopkins Community Health Partnership (J-CHiP) program