

**The Johns Hopkins Hospital
Fiscal Year 2015
Community Benefits Report
Narrative**



JOHNS HOPKINS
M E D I C I N E

**THE JOHNS HOPKINS HEALTH SYSTEM
FISCAL YEAR 2015 COMMUNITY BENEFITS REPORT
THE JOHNS HOPKINS HOSPITAL**

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I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS

1. Primary Service Area

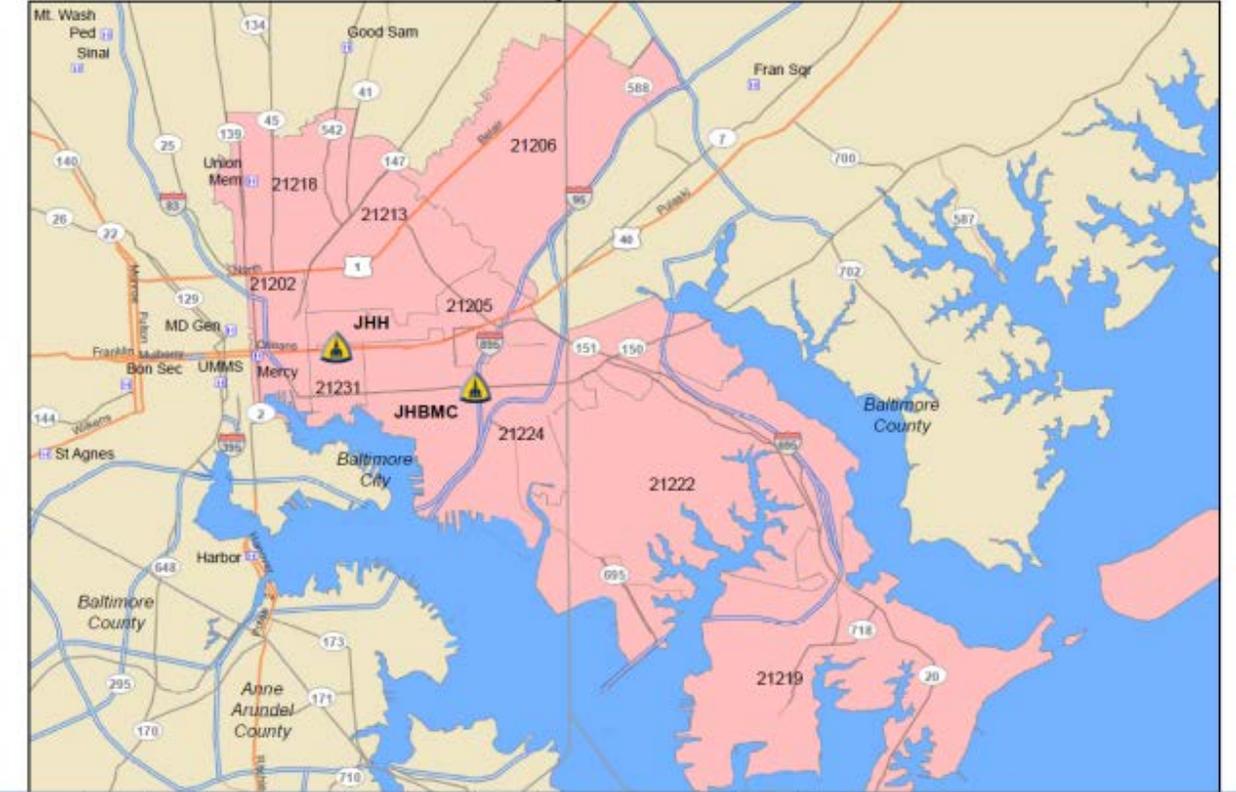
Table I

		Data Source
Bed Designation	1,082 acute beds	MHCC
Inpatient Admissions	50,217	JHM Market Analysis and Business Planning
Primary Service Area zip codes	21213, 21205, 21224, 21218, 21202, 21206, 21231, 21217, 21215, 21222, 21234, 21216, 21212, 21229, 21223, 21207, 21043, 21239, 21208, 21221, 21220, 21228, 21044, 21225, 21045, 21201, 21230, 21244, 21122, 21042, 21061, 21214, 21236, 21237, 21093, 21209, 21075, 21133, 21136, 21227, 21157, 21287, 21784, 21740, 21401, 21211, 21040, 21060, 21144, 21113, 21014, 20723, 21804, 21030, 21015, 21210, 21146, 21204, 21009, 21701, 21403, 21742, 21502, 20707, 21771, 21702, 20854, 21801, 21046	HSCRC
All other Maryland hospitals sharing primary service area	Laurel Regional Hospital, Upper Chesapeake Medical Center, Howard County General Hospital, Baltimore Washington Medical Center, Northwest Hospital Center, Carroll Hospital Center, University of Maryland Medical Center Midtown, University of Maryland Medical Center, Mercy Medical Center, Greater Baltimore Medical Center, UM Saint Joseph Medical Center, James Lawrence Kernan Hospital, Mount Washington Pediatric Hospital, Sinai Hospital, Medstar Union Memorial Hospital, Bon Secours Hospital, Johns Hopkins Bayview Medical Center, Medstar Harbor Hospital, Saint Agnes Hospital, Franklin Square Hospital Center, Medstar Good Samaritan Hospital, Anne Arundel Medical Center, Western Maryland Regional Medical Center, Frederick Memorial Hospital, Meritus Medical Center, Peninsula Regional Medical Center, Chesapeake Rehabilitation Hospital	JHM Market Analysis and Business Planning
Percentage of uninsured patients by county	Anne Arundel 0.2% Baltimore 0.5% Carroll 0.1% Frederick 0.1% Harford 0.1%	JHM Market Analysis and Business Planning

	Howard	0.3%	
	Montgomery	0.3%	
	Prince George's	0.6%	
	Washington	0.8%	
	Wicomico	0.3%	
	Baltimore City	0.9%	
Percentage of patients who are Medicaid recipients by county	Anne Arundel	20.6%	JHM Market Analysis and Business Planning
	Baltimore	30.9%	
	Carroll	18.9%	
	Frederick	16.7%	
	Harford	18.7%	
	Howard	18.4%	
	Montgomery	11.6%	
	Prince George's	19.7%	
	Washington	24.5%	
	Wicomico	42.5%	
	Baltimore City	52.7%	

2. Community Benefits Service Area (CBSA)

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center
Community Benefit Service Area



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

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

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

Within the CBSA, there are three Baltimore County neighborhoods - Dundalk, Sparrows Point, and Edgemere. The Baltimore City Department of Health has subdivided the city area into 23 neighborhoods or neighborhood groupings that are completely or partially included within the CBSA. These neighborhoods are Belair-Edison, Canton, Cedonia/Frankford, Claremont/Armistead, Clifton-Berea, Downtown/Seton Hill, Fells Point, Greater Charles Village/Barclay, Greater Govans, Greenmount East, Hamilton, Highlandtown, Jonestown/Oldtown, Lauraville, Madison/East End, Midtown, Midway-Coldstream, Northwood, Orangeville/East Highlandtown, Patterson Park North & East, Perkins/Middle East, Southeastern, and The Waverlies.

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

Neighborhoods farther north of the Johns Hopkins Hospital include Belair-Edison, Cedonia/Frankford, Claremont/Armistead, Clifton-Berea, Greater Charles Village/Barclay, Greater Govans, Hamilton,

Lauraville, Midtown, Midway-Coldstream, Northwood, and The Waverlies. Residents of these neighborhoods are racially more diverse than in the neighborhoods closest to JHH and median household incomes range from significantly above the median to close to the median household income for Baltimore City.

Since the end of the Second World War, the population of Baltimore City has been leaving the city to the surrounding suburban counties. This demographic trend accelerated in the 1960s and 1970s, greatly affecting the neighborhoods around the Johns Hopkins Hospital and JHBMC. As the population of Baltimore City dropped, there has been a considerable disinvestment in housing stock in these neighborhoods. Economic conditions that resulted in the closing or relocation of manufacturing and industrial jobs in Baltimore City and Baltimore County led to higher unemployment in the neighborhoods around the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, and social trends during the 1970s and 1980s led to increases in substance abuse and violent crime as well.

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

B. CBSA Demographics

Table II

		Data Source
Community Benefits Service Area (CBSA)	21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231	JHM Market Analysis & Business Planning
CBSA demographics, by sex, race, ethnicity, and average age	<p>Total population: 304,276</p> <p>Sex Male: 148,582/48.8% Female: 155,694/51.2%</p> <p>Race White non-Hispanic: 122,915/41.4% Black non-Hispanic: 139,602/45.9% Hispanic: 21,801/7.2% Asian and Pacific Islander non-Hispanic: 8,701/2.9% All others: 8,257/2.7%</p>	2015 Truven

	<p>Age</p> <p>0-14: 54,696/18.0%</p> <p>15-17: 10,357/3.4%</p> <p>18-24: 31,725/10.4%</p> <p>25-34: 54,784/18.0%</p> <p>35-54: 79,559/26.1%</p> <p>55-64: 36,478/12.0%</p> <p>65+: 36,677/12.1%</p>	
Median household income within your CBSA	Average household income: \$60,305	2015 Truven
Percentage of households (families and people) with incomes below the federal poverty guidelines within your CBSA (past 12 months)	<p>All families: 19.1%</p> <p>Married couple family: 6.3%</p> <p>Female householder, no husband present, family: 32.3%</p> <p>Female householder with related children under 5 years only: 39.2%</p> <p>All people: 23.8%</p> <p>Under 18 years: 34.1%</p> <p>Related Children under 5 years: 36.0%</p> <p>(Baltimore City, 2013)</p> <p>All families: 6.0%</p> <p>Married couple family: 3.0%</p> <p>Female householder, no husband present, family: 15.0%</p> <p>Female householder with related children under 5 years only: 21.9%</p> <p>All people: 8.9%</p> <p>Under 18 years: 11.3%</p> <p>Related Children under 5 years: 12.6%</p> <p>(Baltimore County, 2013)</p>	<p>U.S. Census Bureau, 2013 American Community Survey</p> <p>http://factfinder2.census.gov</p>
Please estimate the percentage of uninsured people within your CBSA	11.2%	2015 Truven
Percentage of Medicaid recipients within your CBSA	37.2%	2015 Truven

<p>Life expectancy and crude deaths within your CBSA</p>	<p>73.9 years at birth (Baltimore City, 2013) 79.4 years at birth (Baltimore County, 2013) 79.6 years at birth (Maryland, 2012)</p> <p>Baltimore City by Race White: 76.5 years at birth Black: 72.2 years at birth</p> <p>Baltimore County by Race White: 79.6 years at birth Black: 78.1 years at birth</p>	<p>Maryland Vital Statistics Annual Report 2013 http://dhmh.maryland.gov/vsa</p>
<p>Infant mortality rates within your CBSA</p>	<p>All: 10.4 per 1,000 live births White: 7.1 per 1,000 live births Black: 12.8 per 1,000 live births (Baltimore City, 2014)</p> <p>All: 6.9 per 1,000 live births White: 3.1 per 1,000 live births Black: 14.6 per 1,000 live births (Baltimore County, 2014)</p> <p>All: 6.5 per 1,000 live births (Maryland, 2014)</p>	<p>Maryland Vital Statistics Infant Mortality in Maryland, 2014 http://dhmh.maryland.gov/vsa</p>
<p>Language other than English spoken at home</p>	<p>8.8% (Baltimore City, 2013) 13.1% (Baltimore County, 2013)</p>	<p>U.S. Census Bureau, Quickfacts, 2013</p>
<p>Access to healthy food</p>	<p>Baltimore City food deserts map</p>	<p>Johns Hopkins Bloomberg School of Public Health, Center for a Livable Future http://www.jhsph.edu/bin/k/o/BaltimoreCityFoodEnvironment.pdf</p> <p>Baltimore City Food Policy Initiative http://archive.baltimorecity.gov/portals/0/agencies/planning/public%20downloads/Baltimore%20Food%20Environment%20info-map%20handout.pdf</p>

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

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.

http://www.hopkinsmedicine.org/the_johns_hopkins_hospital/about/in_the_community/_docs/jhh-chna-implementation-strategy.PDF

III. COMMUNITY BENEFITS ADMINISTRATION

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

Yes
 No

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

The commitment of Johns Hopkins' leadership to improving the lives of its nearest neighbors is illustrated by the incorporation of Community Benefit metrics at the highest level in the Johns

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

Reference:

JHM Strategic Plan 2014-2018

Performance Goal #1: “Ensure that all financial operations, performance indicators and results support the strategic priorities, as well as the individual entity requirements”

Strategy: Create a mechanism to capture the value of community benefit and ensure that it supports strategic goals, and achieve compliance with community benefit standards

Tactic: Continue to use the community benefit advisory council to align reporting and investment decisions across member organizations

2. What stakeholders in the hospital are involved in your hospital community benefits process/structure to implement and deliver community benefits activities? (Place a check to any individual/group involved in the structure of the CB process and provide additional information if necessary)
 - a. Senior Leadership
 - i. Ronald R. Peterson, President
 - ii. Ronald J. Werthman, CFO/Treasurer and Senior VP, Finance
 - iii. John Colmers, Senior VP, Health Care Transformation and Strategic Planning
 - iv. Ed Beranek, VP, Revenue Cycle Management and Reimbursement

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

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

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

- c. 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)

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

- ii. X Committee (please list members)
- iii.

JHHS Community Benefit Reporting Work Group

- The Johns Hopkins Hospital
 - Sherry Fluke, Financial Manager, Govt. & Community Affairs (GCA)
 - Sharon Tiebert-Maddox, Director, Strategic Initiatives, GCA
 - William Wang, Associate Director, Strategic Initiatives, GCA
- Johns Hopkins Bayview Medical Center
 - Patricia A. Carroll, Community Relations Manager
 - Kimberly Moeller, Director, Financial Analysis
 - Selwyn Ray, Director, Community Relations
- Howard County General Hospital
 - Elizabeth Edsall-Kromm, Senior Director, Population Health and Community Relations
 - Cindi Miller, Director, Community Health Education
 - Fran Moll, Manager, Regulatory Compliance
 - Scott Ryan, Senior Revenue Analyst
- Suburban Hospital
 - Eleni Antzoulatos, Coordinator, Health Promotions and Community Wellness, Community Health and Wellness
 - Sara Demetriou, Coordinator, Health Initiative and Community Relations, Community Health and Wellness
 - Lucas McCormley, Senior Financial Analyst, Financial Planning, Budget, and Reimbursement
 - Alan Poole, Senior Financial Analyst, Financial Planning, Budget, and Reimbursement
 - Patricia Rios, Supervisor, Community Health Improvement, Community Health and Wellness
 - Monique Sanfuentes, Director, Community Health and Wellness
 - Sezelle Gabriel Banwaree, Department Director, Finance and Treasury
- Sibley Memorial Hospital
 - Marissa McKeever, Director, Government and Community Affairs

- Marti Bailey, Director, Sibley Senior Association and Community Health
 - Cynthia McKeever, Manager, Finance Decision Support
 - Honora Precourt, Community Program Coordinator
- All Children’s Hospital
 - Jeff Craft, Administrative Director, Finance
 - 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
 - Sandra Johnson, Vice President, Revenue Cycle Management
 - Anne Langley, Director, Health Policy Planning

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

iv. 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.

- 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
- Elizabeth Edsall Kromm, Sr. Director, Population Health and Community Relations, Howard County General Hospital
- Kenneth Grant, Vice President, Supply Chain, The Johns Hopkins Health System
- Dan Hale, Special Advisor, Office of the President, Johns Hopkins Bayview Medical Center
- Amy Maguire, Vice President, Government, Community and Corporate Relations, All Children’s Hospital
- Marissa McKeever, Director, Government and Community Affairs, Sibley Memorial Hospital
- Adrian Mosley, Community Health Administrator, The Johns Hopkins Hospital

- Monique Sanfuentes, Director of Community Health and Wellness, Suburban Hospital
- Jacqueline Schultz, Executive Vice President and Chief Operating Officer, Suburban Hospital
- Sharon Tiebert-Maddox, Director, 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

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

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

Prior to its submission to the HSCRC, the Community Benefit Report (CBR) is reviewed in detail by the CFO, CEO and the president of Johns Hopkins Health System. Although CBR approval by the Board of Trustees is not a legal requirement, the completed report is presented and reviewed by the JH Board of Trustees Joint Committee on External Affairs and Community Engagement. The Community Health Needs Assessment and Implementation Strategy incorporated in the CBR were approved by the Board on March 12, 2013. Update reports are given to the Board of Trustees Joint Committee on External Affairs and Community Engagement to review and comment. The report includes highlights of activities, programs and impact made in the ten JHH health priority areas identified in the CHNA and Implementation Strategy.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

- Other hospital organizations
- Local Health Department

- Local health improvement coalitions (LHICs)
- Schools
- Behavioral health organizations
- Faith based community organizations
- Social service organizations

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

Organization	Name of Key Collaborator	Title	Collaboration Description
Ark Church	J.L. Carter	Pastor	Participated in focus group
Baltimore City Council	Warren Branch, Robert Curran, James Kraft, Brandon Scott, Carl Stokes	City Council member	Interviewed
Baltimore City Health Department	Osiris Barbot	Commissioner	Interviewed
Baltimore City Health Department	Peter Beilenson	Former Commissioner	Interviewed
Baltimore Community Foundation	Thomas Wilcox	President	Interviewed
Baltimore Healthcare Access	Angela Burden	Staff	Participated in focus group
Baltimore Medical Systems Inc.	Jay Wolfovsky	CEO	Participated in focus group
Catholic Charities	Sabree Akinyele Diane Shannon	Staff	Participated in focus group
Centro de la Comunidad	Nelson Ortega	Executive Director	Participated in focus group
Esperanza Center	Evelyn Rosario	Former Director	Hosted Latino health focus group and interviewed
Family League of Baltimore	Gena O'Keefe	Director, Healthy Communities Initiative	Interviewed
Greektown Community Development Corp.	Jason Fillippou	Director	Participated in focus group
Healthcare for the Homeless	Kevin Lindamood	CEO	Interviewed

Helping Up Mission	Robert Gehman	Executive Director	Interviewed
Koinonia Baptist Church	Douglas Miles	Bishop	Participated in focus group
JH Community Physicians	Steve Kravet	President	Interviewed
Johns Hopkins University Bloomberg School of Public Health	Michael Klag	Dean	Interviewed
Johns Hopkins University School of Nursing	Martha Hill	Former Dean	Interviewed
Julie Community Center	Sister Bobby English		Interviewed
Latino Providers Network	Luis Navas-Migueloa	Member	Participated in focus group
Meals on Wheels Central Maryland	Michelle McDonald	Staff	Participated in focus group
Operation PULSE	Sam Redd	Director	Participated in focus group
Peoples Community Health	Patricia Cassett	CEO	Participated in focus group
St. Philip's Evangelical Lutheran Church	Michael Guy, Sr.	Pastor	Participated in focus group
Waverly Main Street	Regina Boyce	President	Participated in focus group
Zion Baptist Church	Marshall Prentice	Pastor	Participated in focus group

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

_____yes No

Currently the LHIC in Baltimore City is being reorganized by the Health Department. JHH has participated in the LHIC in the past and will participate with the LHIC when meetings begin again. JHH will participate in the Baltimore County LHIC either directly with representation or through JHBMC Community Benefit team.

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

_____yes No

Currently the LHIC in Baltimore City is being reorganized by the Health Department. JHH has participated in the LHIC in the past and will participate with the LHIC when meetings begin again. JHH will participate in the Baltimore County LHIC either directly with representation or through JHBMC Community Benefit team.

V. HOSPITAL COMMUNITY BENEFITS PROGRAM AND INITIATIVES

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

Health Disparities in Baltimore City

The JHH 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.

Health Disparities in Baltimore County

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

Mortality, Illness and Infant Health

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

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

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

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

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

Health Status

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

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

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

Healthy Homes and Communities

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

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

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

Health Care

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

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

Community Benefit Initiatives

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

The Johns Hopkins Hospital community benefit program included numerous initiatives that support the Hospital's efforts to meet the needs of the community. These initiatives are decentralized and use a variety of methods to identify community needs. Over 300 programs and initiatives were carried out or supported by administrative, clinical, and operational departments at The Johns Hopkins Hospital. Community health programs and initiatives undertaken during FY 2015 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, and Camp SuperKids. In the tables below, these initiatives are described in greater detail.

Initiative 1. Health Leads

<p>Identified Need</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>Hospital Initiative</p>	<p>Health Leads Family Resource Desk – JHH Harriet Lane Clinic</p>
<p>Total Number of People within Target Population</p>	<p>Estimated individuals and families in the JHH CBSA with household income below \$50,000 per year is 66,073 (Truven, 2015).</p>
<p>Total Number of People Reached by Initiative</p>	<p>604 unique clients served in FY 2015</p>
<p>Primary Objective</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>Single or Multi-Year Initiative Time Period</p>	<p>Multi-year initiative has been ongoing effort at Johns Hopkins Hospital since 2006.</p>
<p>Key Partners in Development and/or Implementation</p>	<p>Health Leads Baltimore, Johns Hopkins Bayview Medical Center, Johns Hopkins University</p>
<p>How were the outcomes evaluated?</p>	<p>Health Leads does not keep baseline health related data about its clients. As their efforts to better integrate with the EMR continue, however, it may be possible to conduct pre and post analyses to determine if working with</p>

Health Leads affects a patients' probability of achieving a certain outcome. Health Leads has conducted such a study at an out-of-state partner hospital and initial findings indicate a positive correlation between Health Leads intervention and meaningful medical benefits.

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

Outcome (Include process and impact measures)

Health Leads Outcomes:

For FY15, the top presenting needs were as follows:

Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
Health (31%)	Food (20%)	Health (18%)
Food (29%)	Health (17%)	Employment (17%)
Commodities (9%)	Housing (16%)	Housing (17%)
Adult Education (7%)	Utilities (12%)	Child-Related (10%)
Financial (7%)	Transportation (10%)	Commodities (8%)
Child-Related (5%)	Commodities (8%)	Food (7%)
Employment (4%)	Employment (6%)	Utilities (6%)

Clients Served	Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
Unique Clients	732	272	604

Total: 1608

Client Race/Ethnicity	Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
American Indian or Alaska Native	0%	5%	0%
Asian	0%	1%	0%
Black or African American	4%	36%	93%
Decline to State	0%	2%	1%
Hispanic	91%	0%	3%

Native Hawaiian or Other Pacific Islander	0%	1%	0%
White	4%	55%	2%
Grand Total	100%	100%	100%
Client fill-out rate	59%	33%	41%

	% of 10 day followup	% solved at least 1 need	Days to closure
HL National	95%	61%	53
HL Midatlantic	93%	67%	59
BCCP	95%	70%	60
BCMP	89%	69%	52
HLC	95%	61%	66

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

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

The most significant barrier to improving the value of the Health Leads program is limited access to EMR training for volunteer Advocates. In close collaboration with JHM's EPIC team, Health Leads has built a tool to integrate social resource notes into the patient EHR. However, the current EPIC training options are not convenient for most of the volunteer student Advocates. As a result, utilization of the promising EPIC innovation is months behind schedule and Health Leads is not yet able to easily integrate social needs screening results into patient EHRs.

Health Leads is experimenting nationally with tools and technologies to increase the scale of its impact and plans to bring these to JHM once they have incorporated lessons from the pilot phase into the program model. Most immediately, these include greater use of automated resource

		connection information for patients and the use of acuity indexes to steer our human resources towards the patients most likely to benefit from it or at greatest risk for a negative health outcome. In the future, Health Leads may also deploy self-help options such as clinic-based kiosks and a patient-centered website.	
Continuation of Initiative		Yes, JHH is continuing to support its partnership with Health Leads Baltimore.	
Total Cost of Initiative for Current FY	Direct Offsetting Revenues from Restricted Grants	Total Cost \$115,372	Restricted Grants \$0

Initiative 2. The Access Partnership (TAP)

Identified Need	<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 for 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 primarily to improve access to outpatient specialty care to uninsured and/or financially needy residents and to provide access to primary care in certain situations.</p>
Hospital Initiative	The Access Partnership (TAP)

Total number of people in the target population	29,398 estimate of uninsured population in ZIP codes eligible for TAP (JHM Market Analysis and Business Planning)
Total number of people reached by initiative	4,270 people for specialty referrals 1,446 people for primary care
Primary Objective	<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 struggled 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 six years, TAP has opened up new opportunities for partnership among patients, physicians, and frontline clinic staff. Once a primary care physician at one of eight participating sites identifies a need for additional care and makes a referral, 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"> • Enrolled in primary care at a participating primary care clinic at Johns Hopkins or in the Baltimore community; • Uninsured or Underinsured with demonstrated financial need; and • Reside in ZIP code area 21202, 21205, 21213, 21219, 21222, 21224, 21231, 21218, or 21052, 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. <p>The program operates across four Johns Hopkins primary care locations and four primary care locations in the Baltimore community:</p> <ul style="list-style-type: none"> • 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. • In the Baltimore community: (1) Chase Brexton Health Services; (2) The Esperanza Center; (3) Healthcare for the Homeless; and (4) Baltimore Medical Systems-Highlandtown.

	<p>Number served is primary measurable outcome. ZIP codes expanded significantly and BMS added as a participating site. There are no provisions in the program that would allow us to measure improvements in health status. Goal is to improve access to outpatient specialty care and TAP consider the number of people served, number of visits, growing geographic area eligible, and growing number of participating sites all measures of success.</p>
Single or Multi-Year Initiative Time Period	<p>This program has been active from 2009 to date.</p>
Key Collaborators in Delivery	<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, Baltimore Medical System Inc.</p>
Impact/Outcome of Hospital Initiative	<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>
Evaluation of Outcome	<p><u>TAP Outcomes:</u></p> <p>From its inception May 1, 2009 through March 31, 2015, the TAP program has provided medical services to 4,270 patients residing in eligible zip codes and has processed 10,541 specialty referrals across five Johns Hopkins clinical locations.</p> <p>Through Q2 FY2015, TAP has provided 5,027 primary care visits to 1,446 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.</p> <p>The top ZIP codes for patients served by residence since program inception are 21224 (44.7% of overall patients), 21213 (13.4%), 21205 (13.7%) and 21222 (9.1%).</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 residents are not eligible for state or federal assistance) of which many are Latino or Hispanic. Prior to the implementation of the ACA, the percentage of assumed undocumented residents was in the range of 35-40 percent. TAP provides navigators that have linguistic competency in Spanish and all brochures and program information are also available in Spanish.</p> <p>There are always patients served by participating clinics but living outside of the eligible ZIP codes who need care and TAP receives many requests to expand our geographic area. TAP staff are not aware of other barriers—there are no additional clinics requesting to participate at this time, and TAP staff have no reports of patients not getting access to primary or outpatient specialty care. The navigators ensure that patients get timely appointments and notify TAP staff so that they can address any barriers as they arise.</p> <p>TAP has grown steadily but carefully since its inception, ensuring access to care for Baltimore neighbors. Early on, TAP met with other hospitals in the city and suggested that they all work together, with each hospital providing similar access in their immediate geographic area. Specifically, TAP met with UMMS and MedStar Union Memorial. At that time, there was no interest in expanding this initiative outside of Hopkins. TAP is certainly open to working to expand to other hospitals if they are interested.</p>	
Continuation of Initiative		Yes, TAP is a continuing commitment of JHH.	
Expense	Direct Offsetting Revenues from Restricted Grants	Total Cost \$32,826	Restricted Grants \$0

Initiative 3. You Gotta Have Heart Collaboration

Identified Need	<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</p>
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	<p>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, shows that African Americans had 576.1 visits compared to 94.3 visits (per 100,000 population). Hospitalization rates reflected the same for hypertension and cardiovascular related issues with a rate of 136.6 for blacks as compared to 15.0 for whites.</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>
Hospital Initiative	You Gotta Have Heart Collaboration
Total number of people in the target population	304,276 total population in the CBSA of which 46% (139,602) are African American.
Total number of people reached by initiative	800 people trained in hands only CPR, the first 600 received the full training with AED and use of practice dummies
Primary Objective	Through a partnership with the Johns Hopkins Hospital CPR Office, the faith communities will utilize a train-the-trainer model to teach core skills of CPR to 400 families utilizing the AHA’s personal learning program called CPR Anytime. This 22 minute “hands only” method is learned through a personal training dummy and DVD instruction.
Single or Multi-Year Initiative Time Period	Multi-year project that started in 2012
Key Partners in Development and/or Implementation	Key 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. Phase II partners are Transforming Life Church, Huber Memorial, Ark Church, and Beth-El Temple. Additional partners will be identified in the future to continue the training program.
How were the outcomes measured?	The project has been evaluated using a model developed by O. Lee McCabe, Ph.D. Evaluation of the program feasibility and effectiveness is organized around the three concepts in the everyday expression “ready, willing, and able.” Participants are measured on a comprehensive index of success in effectively completing the CPR Anytime training and demonstrating technique and understanding of CPR.

Outcome (Include process and impact measures)		<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 800 families in Hands Only CPR. 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 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.</p>	
Continuation of Initiative		Phase II should be completed by June 2015. Funding will determine the continuance beyond Phase II, but the goal is to reach an additional 400 people in FY16-17.	
Total Cost of Initiative for Current FY	Direct Offsetting Revenues from Restricted Grants	Total Cost \$30,219	Restricted Grants \$0

Initiative 4. Wilson House

Identified Need	<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 blacks and 8.5% in whites (per 100,000 population).</p>
Hospital Initiative	Wilson House
Total number of people in the target population	Estimated 45,133 individuals over age 12 with alcohol or illicit drugs disorder in past year for the Baltimore City region (SAMHSA, 2010-2012, National Survey on Drug Use and Health).
Total number of people reached by initiative	45 women in FY 2015
Primary Objective	<p>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.</p>
Single or Multi-Year Initiative Time Period	Multi-year
Key Partners in Development and/or Implementation	Alcohol and Drug Abuse Administration, Behavioral Health Systems Baltimore
How were the outcomes evaluated?	<p>The Wilson House operates 24 hours per day. During the day residents typically participate in intensive outpatient services at the Broadway Center. During evening hours, the residents are given time for personal matters (e.g., washing clothes, bathing, and phone calls). Regular house meetings allow residents to discuss house-related concerns and issues, and promote a cooperative approach to halfway house living. A certified Addiction Counselor conducts a group counseling session which promotes pro-social leisure time use and teaches sober lifestyle skills.</p> <p>The house creates an exceptional opportunity to link intensive day treatment services with recovery housing. We are able to more closely monitor</p>

	<p>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>	
<p>Outcome (Include process and impact measures)</p>	<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> <p>In FY 2015 the Wilson House served 45 women with substance use disorders. During this time period, they focused on an initiative to retain women in the house for a longer period of time. The goal was to have the women more prepared for re-entry into independent living situations. Housing staff began to work with residents to secure preventative medical appointments, obtain employment or other meaningful activities.</p> <p>The average length of stay during FY 2015 was 79.4 days, which is 88% of the 90-day goal. This data includes all residents entering the house and represents a very high standard of average retention, testifying to the residents’ satisfaction with the house, the staff, and the services the Wilson House provides. It is important to note that in order to increase the length of stay for residents, the house staff and Broadway Center counselors and case managers work on “aftercare from the day of admission.” That is, if a resident finds safe and therapeutic housing at any point during her Wilson House episode, the staff typically support discharge, even if only after a few weeks or a couple months.</p> <p>During FY 2015, Wilson House successfully discharged 56% of the residents into stable independent living situations, achieving their objective for retaining successfully at least half of the women in the very high-need, high-severity population served at the hospital-based treatment program.</p>	
<p>Continuation of Initiative</p>	<p>Yes, this is a continuing initiative</p>	
<p>Total Cost of Initiative for</p>	<p>Direct Offsetting Revenues from</p>	<p>Total Cost \$278,244</p>
		<p>Restricted grants \$241,560</p>

Current FY	Restricted Grants		
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Initiative 5. Broadway Center for Addiction Substance Abuse Program

Identified Need	<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 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>
Hospital Initiative	Broadway Center for Addiction
Total number of people in the target population	Estimated 45,133 individuals over age 12 with alcohol or illicit drugs disorder in past year for the Baltimore City region (SAMHSA, 2010-2012, National Survey on Drug Use and Health).
Total number of people reached by initiative	112 people in FY 2015
Primary Objective	The Johns Hopkins Hospital Broadway Center offers comprehensive treatment services for persons experiencing acute or chronic substance use problems. The program has a holistic approach to care delivery, addressing medical, psychiatric, social service and social network needs through comprehensive, on-site, integrated program services. The major categories of services provided are screening/assessment, intensive outpatient (IOP), and standard outpatient (SOP). Service enhancements are abundant, highly utilized, and include ambulatory detoxification, psychiatric assessment and treatment, basic medical assessment and treatment, case management, and opioid maintenance. Treatment services focus on establishing alcohol and drug abstinence and stabilizing health and living situations. Patients are educated about the nature and consequences of addiction. A cognitive/behavioral treatment curriculum teaches patients the necessary skills to stop substance use. Specific services include: individual therapy, group education and therapy, urinalysis testing for drug monitoring, Breathalyzer testing for alcohol monitoring, and case management.

Single or Multi-Year Initiative Time Period		Multi-year	
Key Partners in Development and/or Implementation		Behavioral Health System Baltimore (BHSB), House of Ruth, Dayspring, Beans and Bread, Zion Baptist Church, Helping Up Mission	
How were the outcomes evaluated?		<p>The Broadway Center for Addiction focuses on establishing alcohol and drug abstinence and stabilizing health and living situations. Patients are educated about the nature and consequences of addiction.</p> <p>IOP service delivery operates in close collaboration with the JHH halfway housing for women and with near-by men's recovery housing in East Baltimore (Helping Up Mission). Meals are provided on-site at the treatment program. NA meetings are hosted daily after treatment hours to support recovery.</p> <p>Patients receive treatment 2.5-3 hours/day for 4-5 days/week, with a minimum of 9 hours of clinical services scheduled each week. Patients at this treatment level also begin to work on longer-term goal setting, including such areas as job training, GED completion, and family reunification – goals continued after eventual stabilization and transfer to a standard outpatient level of care. Individual treatment sessions are scheduled at least once weekly, and treatment plans are reviewed every four weeks. Transfer to a less restrictive level of care typically occurs only after approximately 4 weeks of drug-free status and good treatment adherence. The number of weeks until achievement of this goal varies from patient to patient, but is typically 4 to 12 weeks.</p> <p>FY 2015 quality improvement goals of the Broadway Center included reducing substance use and maintain the percentage of positive tox screens to less than 25% and increasing patient satisfaction scores. Data for both initiatives are below.</p>	
Outcome (Include process and impact measures)		The Broadway Center continued to see improvements in treatment adherence to care and overall health for participants. Additionally, a majority of patients strongly agreed that they are better able to deal with problems as a result of treatment received.	
Continuation of Initiative		Yes, this is a continuing initiative.	
Total Cost of Initiative for	Direct Offsetting Revenues from	Total Cost \$297,467	Restricted Grants \$137,217

Current FY	Restricted Grants		
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Initiative 6. Supportive Housing for Male Substance Abuse Patients

Identified Need	<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>
Hospital Initiative	Supportive Housing for Male Substance Abuse Patients
Total number of people in the target population	Estimated 45,133 individuals over age 12 with alcohol or illicit drugs disorder in past year for the Baltimore City region (SAMHSA, 2010-2012, National Survey on Drug Use and Health).
Total number of people reached by initiative	173 men in FY 2015
Primary Objective	The Department of Psychiatry pays for supportive housing (including transportation to and from housing, and meals) for male patients in treatment at the Johns Hopkins Broadway Center for Addiction. Long-term residential recovery housing provides stable living conditions for men struggling with drug and alcohol addiction.
Single or Multi-Year Initiative Time Period	Multi-year
Key Partners in Development and/or Implementation	Helping Up Mission
How were the outcomes evaluated?	The Johns Hopkins Hospital currently provides financial support to the Helping Up Mission (HUM), contracted to provide up to 48 male recovery beds for patients enrolled in the Broadway Center. All patients are required to maintain excellent attendance and progression in treatment goals at the Broadway Center. Transportation is provided between the HUM and the Broadway Center multiple times per day. The maximum length of stay is 6 months. When not engaged in services at the Broadway Center, patients have access to a wide array of HUM services and programming, such as GED courses, computer literacy classes, faith services, peer support groups, art

	<p>therapy, physical fitness equipment, a state of the art patient library, and much more.</p> <p>Men that reside at the HUM receive services daily at the Broadway Center. Although, there was no specific quality improvement projects developed for the HUM, residents were included in the Broadway Center initiatives.</p>		
Outcome (Include process and impact measures)	Regular monitoring and management of housing census by Broadway Center staff and leadership.		
Continuation of Initiative	Yes, this is a continuing initiative.		
Total Cost of Initiative for Current FY	Direct Offsetting Revenues from Restricted Grants	Total Cost \$622,089	Restricted Grants \$0

Initiative 7. Camp SuperKids

Identified Need	<p>Childhood asthma is an identified condition with high disparity in Baltimore City with 33.7% of children having ever been diagnosed with asthma compared to the Maryland rate of 17.3% (Baltimore City Health Disparities Report Card 2013). According to the DHMH Maryland Asthma Control Program report on Asthma in Baltimore City, “while asthma is one of the most common illnesses among children, there is little reliable county level data on the prevalence of asthma in children.” However, 2009 Baltimore City emergency department data shows that the asthma emergency department visit rate per 10,000 in Baltimore City is higher for children of all age group than the Maryland rate (0-4 years 510.6 vs 195.6; 5-17 years 313.2 vs 114.7; <18 years 36.2 vs 136.1).</p>
Hospital Initiative	Camp SuperKids
Total number of people in the target population	The 2013 CDC BRFSS data on child asthma reports a child lifetime asthma prevalence rate of 15.6% for Maryland. The 2013 estimate of the number of children currently in Maryland with child asthma is 138,988. There is no estimate available for the number of children in Baltimore City with child asthma.
Total number of people reached by initiative	Fifteen children in FY15

<p>Primary Objective</p>	<p>Camp Superkids is a week-long residential summer camp for children with asthma, ages seven-and-a-half to twelve. It’s held at Summit Grove Camp, located in New Freedom, Pennsylvania, just over the Maryland border. While attending this summer camp, children enjoy a full range of traditional camp activities, such as swimming, arts & crafts, archery, Zumba, outdoor team-building skills and more. They learn how to manage their asthma, thereby decreasing the number and duration of asthma episodes; increase confidence in their ability to manage asthma; are provided knowledge to make independent and positive health choices. Additionally, children gain a strong support system of friends with asthma and positive reinforcement from adults who volunteer their valuable time and services. Children at the camp are attended to by registered nurses, a physician assistant, respiratory therapists and other non-medical personnel who are on-site the entire week.</p>
<p>Single or Multi-Year Initiative Time Period</p>	<p>2015 is the first year in which the Johns Hopkins Hospital provided sponsorship of fifteen Camp SuperKids spots for children from the East Baltimore CBSA.</p>
<p>Key Partners in Development and/or Implementation</p>	<p>Johns Hopkins Bayview Medical Center</p>
<p>How were the outcomes evaluated?</p>	<p>In an effort to see how much campers learn and to make needed changes to the focus and education components of Camp SuperKids, the staff administer a pre- and post-camp test each year on the first and last days of the camp. Campers are given the test on a one-on-one basis by asking the questions in an interview style and recorded by the child’s camp counselor (with no prompting).</p> <p>The test administered in FY2015 was provided by the Children’s Asthma Camp Consortium, “What do you know about asthma?” It is divided into three sections, Asthma and the Body, Asthma and You, and Asthma Tools. Each section has a mix on Yes-No and multiple choice questions, and there are a total of 43 questions.</p>
<p>Outcome (Include process and impact measures)</p>	<p>The primary goal is for children to learn more about their asthma and to learn ways to cope with the disease and manage it on a daily basis.</p> <p>2015 test results indicated that the average score on the pre-test was 80.7%, and post-test was 85.7%. 65% of campers showed an improvement in test score from pre to post test, whereas 15% of campers scored lower on the post-test and 19% of campers had the same score.</p>
<p>Continuation of Initiative</p>	<p>This program will be evaluated in FY16 to determine if it is the most effective way to address childhood asthma in the JHH CBSA.</p>

Total Cost of Initiative for Current FY	Direct Offsetting Revenues from Restricted Grants	Total Cost \$10,000	Restricted Grants \$0
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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.

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

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

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

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

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

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

VI. PHYSICIANS

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

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

2. Physician subsidies

The Johns Hopkins Hospital provides subsidies to physicians for trauma on-call services that they would otherwise not provide to the hospital. In FY 2015, JHH paid a total of \$9.05 million in subsidies to physicians for the following patient services for on-call coverage in the emergency department:

Hospitalist (Med/Surg, Peds, Oncol, Rad Peds)	\$3,915,975
Intensivist – PICU	\$820,450
On call – Trauma	\$684,793
On call – Anesthesia	\$2,069,140
On call – MRI	\$495,521
On call – PICU Expansion	\$367,904
On call – GYN/OB	\$700,311

APPENDIX I

FINANCIAL ASSISTANCE POLICY DESCRIPTION

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

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

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

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

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

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

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

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

APPENDIX II

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

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

In JHHS FAP a Qualified Health Plan is defined as:

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

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

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

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

For Medical Hardship: changed to include italicized verbiage.

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

Policy is being changed to add an Appendix and language advising that the Appendix lists physicians that provide emergency and medically necessary care at the hospitals and whether the doctor is covered under the hospital's Financial Assistance policy. The Appendix will be updated quarterly and will be posted on the hospital website. The policy and the website instruct patients to direct any questions they may have concerning whether a specific doctor has a financial assistance policy separate and apart from the hospital's policy. This change is in response to IRS regulation changes. Changes expected to be made and approved by the hospital board in December 2015.

APPENDIX III

FINANCIAL ASSISTANCE POLICY

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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, and will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

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

Definitions

Medical Debt

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

Liquid Assets

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

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qualified deferred compensation plans.

Elective Admission	A hospital admission that is for the treatment of a medical condition that is not considered an Emergency Medical Condition.
Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.
Emergency Medical Condition	<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"> (a) Serious jeopardy to the health of a patient; (b) Serious impairment of any bodily functions; (c) Serious dysfunction of any bodily organ or part. (d) With respect to a pregnant woman: <ol style="list-style-type: none"> 1. That there is inadequate time to effect safe transfer to another hospital prior to delivery. 2. That a transfer may pose a threat to the health and safety of the patient or fetus. 3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.
Emergency Services and Care	Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician which is necessary to relieve or eliminate the emergency medical condition, within the service capability of the hospital.
Medically Necessary Care	Medical treatment that is necessary to treat an Emergency Medical Condition. Medically necessary care for the purposes of this policy does not include Elective or cosmetic procedures.
Medically Necessary Admission	A hospital admission that is for the treatment of an Emergency Medical Condition.
Family Income	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.

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

PROCEDURES

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

For example:

- A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
 - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
 - A patient with a hospital account referred to a collection agency notifies the collection agency that he/she cannot afford to pay the bill and requests assistance.
 - A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.
2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Administrative staff, Customer Service, etc.
 3. Designated staff will meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
 - a. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income, (as defined by Medicaid regulations). To help applicants complete the process, we will provide a statement of conditional approval that will let them know what paperwork is required for a final determination of eligibility.
 - b. Applications received will be sent to the JHHS Patient Financial Services Department's dedicated Financial Assistance application line for review; a written determination of probable eligibility will be issued to the patient.
 4. To determine final eligibility, the following criteria must be met:
 - a. The patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its' designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. The Patient Profile Questionnaire (Exhibit B) is used to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

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- b. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.
 - c. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year).
 - d. All insurance benefits must have been exhausted.
5. To the extent possible, there will be one application process for all of the Maryland hospitals of JHHS. The patient is required to provide the following:
 - a. A completed Financial Assistance Application (Exhibit A) and Patient Profile Questionnaire (Exhibit B).
 - b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
 - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
 - d. A Medical Assistance Notice of Determination (if applicable).
 - e. Proof of U.S. citizenship or lawful permanent residence status (green card) if applicable.
 - f. Proof of disability income (if applicable).
 - g. Reasonable proof of other declared expenses.
 - h. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc...
6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive Medical Debt. Medical Debt is defined as out of pocket expenses excluding copayments, coinsurance and deductibles unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements for medical costs billed by a Hopkins hospital. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based upon JHMI guidelines.
 - a. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee for final evaluation and decision.
 - b. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee. This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Committee will have a final determination made no later than 30 days from the date the application was considered complete. The Financial Assistance Evaluation Committee will base its determination of financial need on JHHS guidelines.

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7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
8. Services provided to patients registered as Voluntary Self Pay patients do not qualify for Financial Assistance.
9. A department operating programs under a grant or other outside governing authority (i.e., Psychiatry) may continue to use a government-sponsored application process and associated income scale.
10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient make a good-faith payment at the beginning of the Financial Assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set forth in Appendix B, JHHS shall make a payment plan available to the patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may be extended.
11. **Presumptive Financial Assistance Eligibility.** There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patient's representative request an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.
12. Financial Assistance Applications may only be submitted for/by patients with open and unpaid hospital accounts.
13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Financial Assistance Evaluation Committee. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
14. Patients who receive coverage on a Qualified Health Plan and ask for help with out of pocket expenses (co-payments and deductibles) for medical costs resulting from medically necessary care shall be required to submit a Financial Assistance Application if the patient is at or below 200% of Federal Poverty Guidelines.

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15. If a patient account has been assigned to a collection agency, and patient or guarantor request financial assistance or appears to qualify for financial assistance, the collection agency shall notify PFS and shall forward the patient/guarantor a financial assistance application with instructions to return the completed application to PFS for review and determination and shall place the account on hold for 45 days pending further instruction from PFS.
16. Beginning October 1, 2010, if within a two (2) year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding \$25. If the hospital documentation demonstrates the lack of cooperation of the patient or guarantor in providing information to determine eligibility for free care, the two (2) year period herein may be reduced to 30 days from the date of initial request for information. If the patient is enrolled in a means-tested government health care plan that requires the patient to pay-out-of-pocket for hospital services, then patient or guarantor shall not be refunded any funds that would result in patient losing financial eligibility for health coverage.
17. This Financial Assistance policy does not apply to deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient. Johns Hopkins will file a claim in the decedents' estate and such claim will be subject to estate administration and applicable Estates and Trust laws.
18. JHHS Hospitals may extend Financial Assistance to residents with demonstrated financial need, regardless of citizenship, in the neighborhoods surrounding their respective hospitals, as determined by the hospital's Community Health Needs Assessment. The zip codes for JHH and JHBMC are: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231 and 21052. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. Financial Counselors will refer these patients to The Access Partnership program at Hopkins (see FIN057 for specific procedures).

REFERENCE¹

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

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

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RESPONSIBILITIES - JHH, JHBMC

Financial Counselor (Pre-Admission/Admission/In-House/Outpatient) Customer Service Collector Admissions Coordinator Any Finance representative designated to accept applications for Financial Assistance

Understand current criteria for Assistance qualifications.
 Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form.
 On the day preliminary application is received, fax to Patient Financial Services Department's dedicated fax line for determination of probable eligibility.

Review preliminary application, Patient Profile Questionnaire and Medical Financial Hardship Application (if submitted) to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments.

If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review.

Review and ensure completion of final application.

Deliver completed final application to appropriate management.

Document all transactions in all applicable patient accounts comments.

Identify retroactive candidates; initiate final application process.

Management Personnel (Supervisor/Manager/Director)

Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies.

Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.]

Notices will not be sent to Presumptive Eligibility recipients.

Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent) CP Director and Management Staff

Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

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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 or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
4. The patient must be a United States of America citizen or permanent legal resident (must have resided in the U.S.A. for a minimum of one year)
5. Proof of income must be provided with the final application. Acceptable proofs include:
 - (a) Prior-year tax return;
 - (b) Current pay stubs;
 - (c) Letter from employer, or if unemployed documentation verifying unemployed status; and
 - (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
6. Patients will be eligible for Financial Assistance if their maximum family (husband and wife, same sex married couples) income (as defined by Medicaid regulations) level does not exceed each affiliate's standard (related to the Federal poverty guidelines) and they do not own Liquid Assets *in excess of \$10,000 which would be available to satisfy their JHHS affiliate bills.
7. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify.
8. Patients who chose to become voluntary self pay patients do not qualify for Financial Assistance for the amount owed on any account registered as Voluntary Self Pay.
9. Financial Assistance is only applicable to Medically Necessary Care as defined in this policy. Financial Assistance is not applicable to convenience items, private room accommodations or non-essential cosmetic surgery. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is an "Elective Admission" or a "Medically Necessary Admission," the patient's admitting physician shall be consulted and the matter will also be directed to the physician advisor appointed by the hospital.
10. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days of the day when the application was satisfactorily completed and submitted.

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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.

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FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES Effective 2/1/15						
# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	\$ 23,540	\$ 25,894	\$ 28,248	\$ 30,602	\$ 32,956	\$ 35,310
2	\$ 31,860	\$ 35,046	\$ 38,232	\$ 41,418	\$ 44,604	\$ 47,790
3	\$ 40,180	\$ 44,198	\$ 48,216	\$ 52,234	\$ 56,252	\$ 60,270
4	\$ 48,500	\$ 53,350	\$ 58,200	\$ 63,050	\$ 67,900	\$ 72,750
5	\$ 56,820	\$ 62,502	\$ 68,184	\$ 73,866	\$ 79,548	\$ 85,230
6	\$ 65,140	\$ 71,654	\$ 78,168	\$ 84,682	\$ 91,196	\$ 97,710
7	\$ 73,460	\$ 80,806	\$ 88,152	\$ 95,498	\$ 102,844	\$ 110,190
8*	\$ 81,780	\$ 89,958	\$ 98,136	\$ 106,314	\$ 114,492	\$ 122,670
**amt for each mbr	\$8,320	\$9,152	\$9,984	\$10,816	\$11,648	\$12,480
Allowance to Give:	100%	80%	60%	40%	30%	20%

*200% of Poverty Guidelines

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

EXAMPLE: Annual Family Income \$55,000
 # of Persons in Family 4
 Applicable Poverty Income Level 48,500
 Upper Limits of Income for Allowance Range \$58,200 (60% range)
 (\$55,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

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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
- 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, unless the patient is below 200% of Federal Poverty Guidelines.

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

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

General Conditions for Medical Financial Hardship Assistance Application:

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

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- Other forms of assistance available through JHM affiliates
6. Patient is not eligible for The JHM Financial Assistance Program or is eligible but the Medical Financial Hardship Program may be more favorable to the patient.
 7. The affiliate has the right to request patient to file updated supporting documentation.
 8. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.
 9. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the Medical Financial Hardship Assistance program, the patient is still required to file a JHHS Medical Financial Hardship Assistance Application but not to submit duplicate supporting documentation.

Factors for Consideration

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

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

Exception

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

Evaluation Method and Process

1. The Financial Counselor will review the Medical Financial Hardship Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Financial Counselor will then complete a Medical Financial Hardship Assistance Worksheet (found on the bottom of the application) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.



**The Johns Hopkins Health System
Policy & Procedure**

Subject

FINANCIAL ASSISTANCE

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MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES			

Effective 2/1/15			
# of Persons in Family	Income Level**		
# of Persons in Family	*300% of FPL	400% of FPL	500% of FPL
1	\$ 35,310	\$ 47,080	\$ 58,850
2	\$ 47,790	\$ 63,720	\$ 79,650
3	\$ 60,270	\$ 80,360	\$ 100,450
4	\$ 72,750	\$ 97,000	\$ 121,250
5	\$ 85,230	\$ 113,640	\$ 142,050
6	\$ 97,710	\$ 130,280	\$ 162,850
7	\$ 110,190	\$ 146,920	\$ 183,650
8*	\$ 122,670	\$ 163,560	\$ 204,450
Allowance to Give:	50%	35%	20%

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

Exhibit A

I. Family Income

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

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

II. Liquid Assets

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

III. Other Assets

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

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

IV. Monthly Expenses

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

Do you have any other unpaid medical bills? Yes No

For what service? _____

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

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

Applicant signature

Date

Relationship to Patient

Exhibit B

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #: _____

1. What is the patient's age? _____
2. Is the patient a U.S. citizen or permanent resident? Yes or No
3. Is patient pregnant? Yes or No
4. Does patient have children under 21 years of age living at home? Yes or No
5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No
6. Is patient currently receiving SSI or SSDI benefits? Yes or No
7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the following amounts? Yes or No

Family Size:

Individual: \$2,500.00

Two people: \$3,000.00

For each additional family member, add \$100.00

(Example: For a family of four, if you have total liquid assets of less than \$3,200.00, you would answer YES.)

8. Is patient a resident of the State of Maryland? Yes or No
If not a Maryland resident, in what state does patient reside? _____
1. Is patient homeless? Yes or No
10. Does patient participate in WIC? Yes or No
11. Does household have children in the free or reduced lunch program? Yes or No
12. Does household participate in low-income energy assistance program? Yes or No
13. Does patient receive SNAP/Food Stamps? Yes or No
14. Is the patient enrolled in Healthy Howard and referred to JHH? Yes or No
15. Does patient currently have?
 Medical Assistance Pharmacy Only Yes or No
 QMB coverage/ SLMB coverage Yes or No
 PAC coverage Yes or No
16. Is patient employed? Yes or No
 If no, date became unemployed. _____
 Eligible for COBRA health insurance coverage? Yes or No

Exhibit B

SERVICIOS FINANCIEROS AL PACIENTE
CUESTIONARIO DEL PERFIL DEL PACIENTE

NOMBRE DEL HOSPITAL: _____

NOMBRE DEL PACIENTE: _____

DOMICILIO: _____
(Incluya Código Postal)

No. De Archivo Médico: _____

1. ¿Cual es la edad del paciente? _____
2. ¿Es el paciente un Ciudadano Americano o Residente Permanentet? Si o No
3. ¿Esta la paciente embarazada? SI o No
4. ¿Tiene el paciente hijos menores de 21 años viviendo en casa? SI o No
5. ¿Es el paciente ciego o potencialmente discapacitado por lo menos 12 meses o mas afectando su empleo? SI o No
6. ¿Esta el paciente en la actualidad 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 o No
Si no, fecha en que se desempleó. _____
Es elegible para covertura del seguro de salud de COBRA? SI o No

Exhibit C

MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #: _____

Date: _____

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

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

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

All documentation submitted becomes part of this application.

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

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 FINANCIAIES

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 Apicante

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

APPENDIX IV

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.

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

HOSPITAL STATEMENTS DO NOT INCLUDE PHYSICIAN FEES OR CHARGES:

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

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

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

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

Name Change:		New Street Address		
City:		State:	Zip Code	New Phone Number (____) _____
Insured's Name:	Social Security: _____ - _____	Patient's DOB: / /	Relationship to Insured (circle one) Self Spouse Child Other	
Insurance Company Name and Address:			Policy Number:	Group Number:
Effective Date:	Insurance Company Phone Number: (____) _____			
Signed	Date	I authorize the release of medical information necessary to process this claim. I assign and authorize direct payment to this hospital of any insurance or other benefits otherwise payable to me or the patient.		



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.

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.



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- 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.

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

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 animarle a discutir abiertamente con el equipo de atención médica los asuntos referentes a su cuidado, a tomar parte activa en su tratamiento, y a promover su propia seguridad al estar bien informado e involucrado en su cuidado. Queremos que usted se considere 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 atención.

Sus Derechos

- TIENE DERECHO a recibir un cuidado considerado, respetuoso y compasivo en un ambiente seguro 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, descuido o maltrato.
- TIENE DERECHO a que le llamen por su nombre y a estar en un ambiente que preserve la dignidad y que contribuya a una autoimagen positiva.
- TIENE DERECHO a que le digan los nombres de los médicos, enfermeras/os y de todos los miembros del equipo médico involucrados en su cuidado.
- TIENE DERECHO a que se 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 ingreso al hospital.
- 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 y la salud de los demás. Tiene el derecho de negarse a recibir visitas en cualquier momento.
- TIENE DERECHO a que su médico le hable acerca de su diagnóstico y pronóstico posible, de los beneficios y 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 se dé inicio a 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 que no sea considerado necesario desde un punto de vista médico.
- TIENE DERECHO a la protección total de su privacidad y confidencialidad durante las conversaciones acerca de su cuidado, los exámenes y su tratamiento. Puede solicitar un acompañante durante cualquier examen.
- TIENE DERECHO a acceder a los servicios de protección y defensa en casos de abuso o de descuido. El hospital le brindará una lista de estos recursos.
- 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 rehusar tratamiento hasta el punto permitido por la ley. Si usted se retira del hospital en contra del consejo de su médico, el hospital y los médicos no serán responsables por ninguna consecuencia médica que pueda ocurrir.
- TIENE DERECHO a aceptar 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 afecte su acceso al cuidado regular.
- TIENE DERECHO a un 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 que sus necesidades sean satisfechas.
- TIENE DERECHO a decidir sus últimas voluntades, y a asignar a alguien para que tome las decisiones referentes a su salud, en caso de que usted no lo pueda hacer. Si no tiene una instrucción previa de sus últimas voluntades, le podemos ofrecer información y ayuda para preparar una.



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- TIENE DERECHO a participar en su plan para el alta. Puede esperar que le informen a tiempo acerca de su alta o traslado a otra instalación o a otro nivel de cuidado. Antes del alta usted puede esperar que le den información acerca del cuidado de seguimiento que pueda necesitar.
- TIENE DERECHO a recibir información detallada acerca de los cobros hechos por su hospital y el médico.
- PUEDE ESPERAR que todas las comunicaciones e historia médica sean confidenciales, a menos que la divulgación esté permitida por la ley. Tiene derecho a ver u obtener una copia de su historia médica. Si desea añadir información a sus registros, puede comunicarse con el Departamento de Archivos Médicos por medio de su coordinador/a. Tiene derecho a recibir una lista de las personas a quienes se les divulgó su información personal de salud.
- TIENE DERECHO a dar su consentimiento, o a rehusarse al uso interno o externo de grabaciones, fotografías, películas u otro tipo de imágenes, con un propósito diferente a la mera identificación, diagnóstico o tratamiento. Tiene derecho a revocar su consentimiento, si lo hace durante un tiempo razonable antes de que dicho material sea utilizado.
- SI USTED O UN MIEMBRO DE SU FAMILIA NECESITA TRATAR un asunto ético relacionado con su atención médica, un miembro del Servicio de Ética está disponible a toda hora por localizador. Para comunicarse con un miembro, marque 410-283-6104. Después de tres timbres, 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 laborales. Fuera de este horario, tenga la bondad de pedirle a su enfermera que llame al capellán de turno.
- TIENE DERECHO a expresar sus preocupaciones acerca del cuidado que está recibiendo. Si tiene un problema o una queja, puede hablar con su médico, enfermera jefe o con el gerente del departamento. Puede comunicarse también con el Departamento de Relaciones con los Pacientes al 410-955-2273 o enviar un correo electrónico a: patientrelations@jhmi.edu
- Si su queja no se resuelve satisfactoriamente, también puede comunicarse con 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, MD 21228
410-402-8016 o a la línea gratis 1-877-402-8218

The Joint Commission

Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
1-800-994-6610
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 se aplica), aseguradora médica y empleador, cuando se requiera.
- DEBE darle al hospital o a su médico una copia de sus últimas voluntades, si cuenta con ellas.
- SE ESPERA QUE dé información correcta y completa acerca de su salud y su historia médica, incluyendo su condición actual, las enfermedades anteriores, 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 entiende la información o las instrucciones que se le dan. Si usted cree que no puede cumplir con su plan de tratamiento, usted tiene la responsabilidad de decírselo a su médico. Usted es responsable por los resultados si no cumple con el plan de cuidado, tratamiento y servicio.
- SE ESPERA QUE participe activamente en el manejo de su dolor y que mantenga a los médicos y enfermeras informados de la eficacia 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, a otros pacientes y visitantes con cortesía y respeto; que cumpla todas las reglas y normas de seguridad; y que sea consciente de los niveles de ruido, la privacidad y el número de visitantes.
- SE ESPERA QUE brinde información correcta y completa acerca la cobertura 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.

*Actualizada en inglés en octubre de 2011
Versión en español en diciembre de 2012*

APPENDIX V

MISSION

VISION

VALUE STATEMENT

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

Keywords:

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III. SPONSOR	2
IV. APPROVAL	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 Corporate and Administrative Policy Manual Administration	<i>Policy Number</i>	ADM002	
		<i>Effective Date</i>	11/01/2012	
		<i>Approval Date</i>	10/29/2012	
	<i>Subject</i>	Mission, Vision, and Values	<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