Johns Hopkins Bayview Medical Center
Fiscal Year 2017
Community Benefits Report
Narrative

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

THE JOHNS HOPKINS HEALTH SYSTEM
FISCAL YEAR 2017 COMMUNITY BENEFITS REPORT
JOHNS HOPKINS BAYVIEW MEDICAL CENTER

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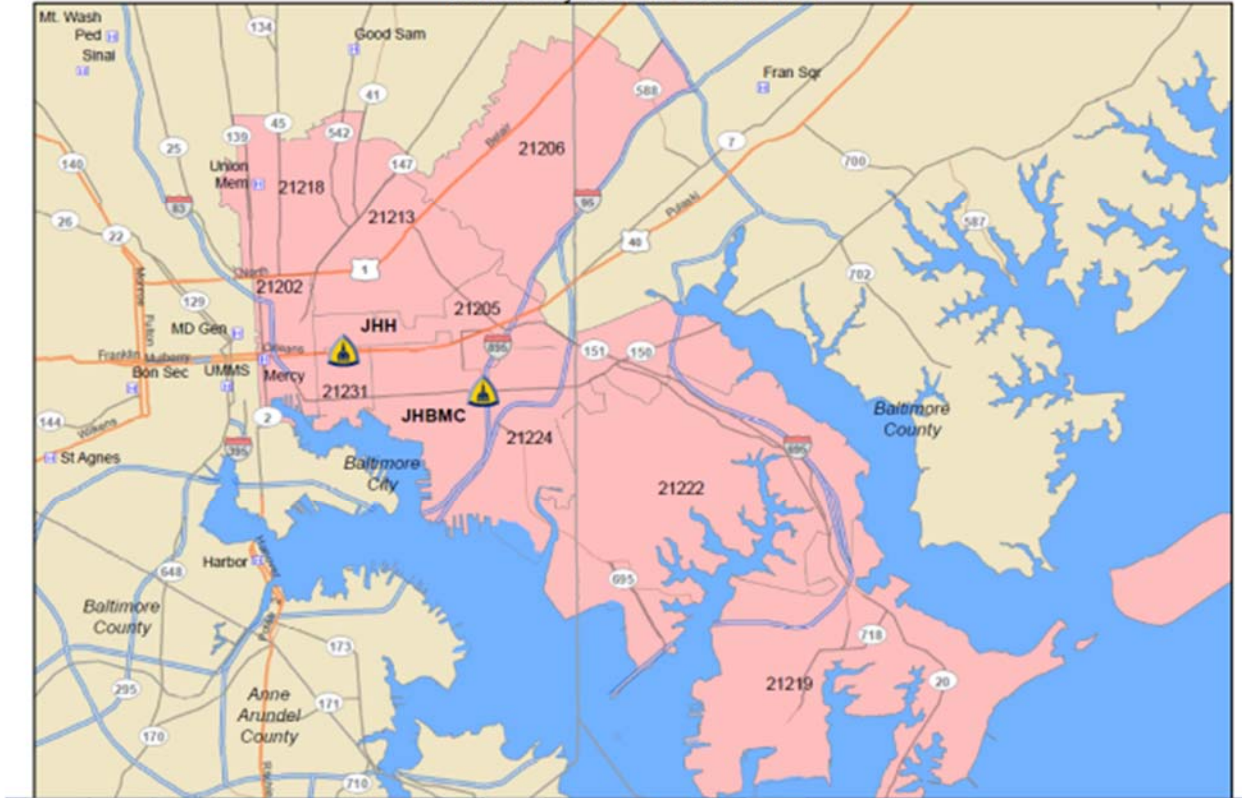
I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS

1. Primary Service Area

Table I

		Data Source
Bed Designation	440 licensed beds	MHCC
Inpatient Admissions	19,451	JHM Market Analysis and Business Planning
Primary Service Area zip codes	21222, 21224, 21206, 21221, 21213, 21205, 21219, 21220, 21237, 21234	HSCRC
All other Maryland hospitals sharing primary service area	Johns Hopkins Hospital Medstar Franklin Square Hospital Center	JHM Market Analysis and Business Planning
Percentage of hospital's uninsured patients	Total 2.1%	Review of discharge data: JHM Market Analysis and Business Planning
Percentage of hospital's patients who are Medicaid recipients	Total 34.0%	Review of discharge data: JHM Market Analysis and Business Planning
Percentage of hospital's patients who are Medicare beneficiaries	Total 39.8%	Review of discharge data: JHM Market Analysis and Business Planning

2. Community Benefits Service Area (CBSA)



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

In 2015, the Johns Hopkins Bayview Medical Center (JHBMC) and The Johns Hopkins Hospital (JHH) 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, JHBMC and JHH 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 305,895 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 (2016 Census estimate of Baltimore City population, 620,961, and Baltimore County population, 831,026).

Baltimore is a city of neighborhoods with over 270 identified communities. For purposes of health data analysis, the Baltimore City Department of Health has organized these areas into 55 neighborhoods or neighborhood groupings of which 23 are completely or partially included within the CBSA. These neighborhoods are Belair-Edison, Canton, Cedonia/Frankford, Claremont/Armistead, Clifton-Berea, Downtown/Seton Hill, Fells Point, Greater Charles Village/Barclay, Greater Govans, Greenmount East (which includes neighborhoods such as Oliver, Broadway East, Johnston Square, and Gay Street), Hamilton, Highlandtown, Jonestown/Oldtown, Lauraville, Madison/East End, Midtown, Midway-Coldstream, Northwood, Orangeville/East Highlandtown, Patterson Park North & East, Perkins/Middle East, Southeastern, and The Waverlies.

Johns Hopkins Bayview Medical Center is located in east Baltimore City. The CBSA population demographics have historically trended as white middle-income, working-class communities; however, in the past few decades, Southeast Baltimore has become much more diverse with a growing Latino population clustered around Patterson Park and Highlandtown. In Baltimore County, Dundalk, Sparrows Point, and Edgemere have been predominantly white with increasing populations of Hispanic and African American residents. Many of these new residents come to JHBMC for their health care needs. Challenges for Hispanic families include poor access to primary care, need for prenatal care for women, unintentional injury- related deaths, and high rates of alcohol use among Latino men. To address these disparities Johns Hopkins Bayview has increased clinical services and developed new initiatives including more language interpretations for patient services, the Care-a-Van mobile health unit, the Children's Medical Practice and Centro Sol which provides outreach, education, mental health support and improved access to services.

The Johns Hopkins Hospital is in the neighborhood called Perkins/Middle East, and the neighborhoods that are contiguous to Perkins/Middle East include Greenmount East (including Oliver, Broadway East, Johnston Square, and Gay Street), Clifton-Berea, Madison/East End, Patterson Park North & East, Fells Point, Canton, and Jonestown/Oldtown. Residents of most of these neighborhoods are primarily African American, with the exceptions of Fells Point, which is primarily white, and Patterson Park North & East, which represents a diversity of resident ethnicities. With the exceptions of Fells Point, Canton, and Patterson Park N&E, the median household income of most of these neighborhoods is significantly lower than the Baltimore City median household income. Median income in Fells Point, Canton, and Patterson Park N&E skews higher, and there are higher percentages of white households having higher median incomes residing in these neighborhoods. 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.

Between the two hospitals, in southeast Baltimore City, 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.

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. The closure of Bethlehem Steel in Sparrow's Point had a particularly devastating impact on the residents of the Dundalk Peninsula, a large group of whom rely upon JHBMC for services.

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

B. CBSA Demographics

Table II

		Data Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231 ZIP codes where the most vulnerable populations reside include 21202, 21205, 21213, and parts of 21206, 21218, 21219, 21222, 21224 and 21231	JHM Market Analysis & Business Planning
Median household income within the CBSA	CBSA average household income: $64,946 Median household income: $42,241 (Baltimore City) Median household income: $67,095 (Baltimore County)	2017 Truven and U.S. Census Bureau, 2015 American Community Survey
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Baltimore City – 2015 All families: 19.0% Married couple family: 6.6% Female householder, no husband present, family: 32.1% Female householder with related children under 5 years only: 37.2% All people: 23.7% Under 18 years: 34.2% Related Children under 5 years: 34.3%	U.S. Census Bureau, 2015 American Community Survey http://factfinder2.census.gov

	Baltimore County – 2015 All families: 6.3% Married couple family: 3.1% Female householder, no husband present, family: 16.0% Female householder with related children under 5 years only: 24.5% All people: 9.4% Under 18 years: 12.1% Related Children under 5 years: 13.0%	
For the counties within the CBSA, what is the percentage of uninsured for each county?	10.3% Baltimore City 8.1% Baltimore County	2015 American Community Survey
Percentage of Medicaid recipients by County within the CBSA	43.9% Baltimore City 29.7% Baltimore County Data is for public coverage, not specifically Medicaid	2015 American Community Survey
Life expectancy by County within the CBSA	73.9 years at birth (Baltimore City, 2013-2015) 79.1 years at birth (Baltimore County, 2013-2015) 79.7 years at birth (Maryland, 2013-2015) Baltimore City by Race White: 76.9 years at birth Black: 72.0 years at birth Baltimore County by Race White: 79.1 years at birth Black: 78.0 years at birth	Maryland Vital Statistics Annual Report 2015 http://dhmh.maryland.gov/vsa
Mortality rates by County within the CBSA (including race and ethnicity where data are available).	Crude death rates per 100,000 in 2015 Baltimore City All: 1037.7 White: 1034.1 Black: 1145.2 AAPI: 271.5 Hispanic: 146.9 Baltimore County All: 978.7 White: 1281.5	Maryland Vital Statistics Annual Report 2015 and County Health Rankings 2016

	Black: 663.7 AAPI: 222.8 Hispanic: 164.1 Age-adjusted death rates for leading causes of death per 100,000 population in 2015 Baltimore City Heart disease: 241.1 Cancer: 194.2 Cerebrovascular: 50.5 Accidents: 35.8 Homicide: 35.5 Baltimore County Heart disease: 176.6 Cancer: 168.4 Cerebrovascular: 42.0 Chronic lower respiratory: 31.7 Accidents: 31.3 Premature Deaths (YPLL; years of potential life lost before age 75 per 100,000 population) Maryland: 6,400 YPLL Rate Baltimore City: 12,300 YPLL Rate (ranked 24th of 24 counties) Baltimore County: 6,500 YPLL Rate	
Infant mortality rates within your CBSA	Baltimore City - 2015 All: 8.4 per 1,000 live births White: 4.4 per 1,000 live births Black: 9.7 per 1,000 live births Baltimore County - 2015 All: 6.1 per 1,000 live births White: 4.1 per 1,000 live births Black: 9.9 per 1,000 live births Maryland - 2015 All: 6.7 per 1,000 live births	Maryland Vital Statistics Infant Mortality in Maryland, 2015 http://dhmh.maryland.gov/vsa
Access to healthy food	25% of Baltimore City residents live in a food deserts (approximately 155,311 people) 30% of all school age children in Baltimore City live in a food desert	http://mdfoodsystemmap.org/2015-baltimore-city-food-access-map/

	Percentages of Baltimore City population living in food deserts by race/ethnicity: 34% African Americans 11-18% Hispanic/AAPI/other 8% White ZIP codes 21202, 21205, 21213, and parts of 21231 are most affected by the food deserts in Baltimore City Maryland Food insecurity: 13% Limited access to healthy foods: 3% Baltimore City Food insecurity: 24% Limited access to healthy foods: 1% Baltimore County Food insecurity: 13% Limited access to healthy foods: 3%	2017 County Health Rankings
Access to transportation	Percentage of households with No Vehicle Available 30.3% Baltimore City 8.1% Baltimore County Elderly Population (65+) Percentage by County 12% Baltimore City 16% Baltimore County Disabled Population Potentially Requiring Transportation Assistance Percentage by County 12% Baltimore City 10% Baltimore County	The Transit Question: Baltimore Regional Transit Needs Assessment Baltimore Metropolitan Council, 2015
Education Level/Language other than English spoken at home	CBSA Education Level (Pop. Age 25+) Less than H.S.: 12,727/6.0% Some H.S.: 26,337/12.4% H.S. Degree: 73,223/34.6% Some College: 48,879/ 23.1% Bachelor's Degree or Greater: 50,730/23.9%	2017 Truven; U.S. Census Bureau, Quickfacts, 2015

	Language other than English spoken: 8.9% (Baltimore City, 2015) Language other than English spoken: 13.6% (Baltimore County, 2015)	
CBSA demographics, by sex, race, ethnicity, and average age	Total population: 305,895 Sex Male: 149,414/48.8% Female: 156,487/51.2% Race White non-Hispanic: 124,940/40.8% Black non-Hispanic: 139,245/45.5% Hispanic: 23,622/7.7% Asian and Pacific Islander non-Hispanic: 9,547/3.1% All others: 8,541/2.8% Age 0-14: 54,752/17.9% 15-17: 9,871/3.2% 18-24: 29,376/9.6% 25-34: 56,782/18.6% 35-54: 79,172/25.9% 55-64: 37,518/12.3% 65+: 38,424/12.6% Household Income <$15K: 20,980/17.5% $15-25K: 13,030/10.9% $25-50K: 29,026/24.2% $50-75K: 20,438/17.0% $75-100K: 13,473/11.2% >$100K: 23,023/19.2%	2017 Truven
Healthy Behaviors	Maryland Adult smoking: 15% Adult obesity: 29% Physical inactivity: 22% Excessive drinking: 16% Baltimore City Adult smoking: 24%	2017 County Health Rankings

	Adult obesity: 34% Physical inactivity: 27% Excessive drinking: 17% Baltimore County Adult smoking: 13% Adult obesity: 29% Physical inactivity: 23% Excessive drinking: 15%	

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

_X__Yes
____No

Johns Hopkins Bayview Medical Center conducted and published the 2016 Community Health Needs Assessment, which was approved by the JHBMC Board of Trustees on 05/23/16.

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

http://www.hopkinsmedicine.org/johns_hopkins_bayview/community_services/health_needs_initiatives/community_health_needs_assessment.html

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

_X__Yes
___No

The JHBMC Board of Trustees approved the 2016 Implementation Strategy on 05/23/16.

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

https://www.hopkinsmedicine.org/johns_hopkins_bayview/_docs/community_services/jhbmc-chna-implementation-2016.pdf

III. COMMUNITY BENEFITS ADMINISTRATION

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

_X_Yes
___No

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

The commitment of Johns Hopkins' leadership to improving the lives of its nearest neighbors is illustrated by the incorporation of Community Benefit metrics at the highest level in the Johns Hopkins Medicine Strategic Plan. JHM consists of JHU School of Medicine and the Johns Hopkins Health System, which includes education and research in its tri-partite mission (Education, Research and Healthcare). Even at this cross entity level (JHU and JHHS) Community Benefit activities and planning go beyond hospital requirements and expectations and are a core objective for all departments, schools and affiliates.

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

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

   a. Senior Leadership - JHHS
      i. _X_ Ronald R. Peterson, President
      ii. _X_ Ronald J. Werthman, CFO/Treasurer and VP, Finance
      iii. _X_John Colmers, VP, Health Care Transformation and Strategic Planning
      iv. _X_Ed Beranek, Senior Director, Regulatory Compliance

      Senior Leadership - JHBMC
      v. _X_Richard C. Bennett, President and CEO
      vi. _X_Carl Francioli, CFO

      Other (please specify)
      vii. _X_Renee Blanding, M.D., Vice President of Medical Affairs
      viii. _X_Craig Brodian, Vice President, Human Resources
      ix. _X_Anita Langford, Vice President, Care Management Services
      x. _X_Dan Hale, Ph.D., Special Advisor to the President

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

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

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

c. Population Health Leadership and Staff
    i. _X__ Patricia M.C. Brown, Senior VP, Managed Care and Population Health
    ii. _X__ Carol Sylvester, VP, Care Management Services

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

d. Community Benefits Department/Team
    i. _X_ Individuals (please specify FTEs)
        a) _X_ Carl Francioli, CFO (0.019 FTE)
        b) _X_ Kim Moeller, Director, Financial Analysis/Special Projects (0.14 FTE)
        c) _X_ Selwyn Ray, Director, Community Relations (0.007 FTE)
        d) _X_ Pat Carroll, Manager, Community Relations (0.098 FTE)
        e) _X_ Sudanah Gray, Budget Analyst (0.074 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 JHBMC clinical leaders to identify promising projects or programs that address CBSA community health needs.

    ii. _X_ Committee (please list members)
    iii. ___ Department (please list staff)

iv. ___ Task Force (please list members)
v. ___ Other (please describe)

JHHS Community Health Improvement Strategy Council

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

- Johns Hopkins Bayview Medical Center
  - Patricia A. Carroll, Manager, Community Relations
  - Kimberly Moeller, Director, Financial Analysis and Special Projects
  - Selwyn Ray, Director, Community Relations JHBMC, Health and Wellness

- Howard County General Hospital
  - Elizabeth Edsall-Kromm, Vice President, Population Health and Advancement
  - Laura Hand, Director, Strategic Planning
  - Fran Moll, Manager, Regulatory Compliance
  - Scott Ryan, Senior Revenue Analyst

- Suburban Hospital
  - Eleni Antzoulatos, Supervisor, Community Health and Wellness Operations, Community Health and Wellness
  - Sara Demetriou, Coordinator, Health Initiative and Community Relations, Community Health and Wellness
  - Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget and Reimbursement, Finance and Treasury
  - Kate McGrail, Program Manager, Health Outcomes and Evaluation, Community Health and Wellness
  - Patricia Rios, Manager, Community Health Improvement, Community Health and Wellness
  - Monique Sanfuentes, Administrative Director, Community Affairs & Population Health, Community Health and Wellness
  - Sunil Vasudevan, Senior Director of Finance and Treasury, Finance and Treasury

- Sibley Memorial Hospital
  - Marti Bailey, Director, Sibley Senior Association and Community Health
  - Courtney Coffey, Community Health Program Manager
  - Angel Fernandez, Financial Analyst
  - Marissa McKeever, Director, Government and Community Affairs
  - Honora Precourt, Community Program Coordinator

- All Children's Hospital
  - Jill Pucillo, Accounting Manager

        - Alizza Punzalan-Randle, Community Engagement Manager

    - Johns Hopkins Health System
        - Christopher Davis, Senior Director, Tax Compliance
        - Bonnie Hatami, Senior Tax Accountant
        - Sandra Johnson, Vice President, Revenue Cycle Management
        - Anne Langley, Senior Director, Health Policy Planning and Community Engagement

The JHHS Community Health Improvement Strategy Council (JCHISC) convenes monthly to bring Community Health/Community Benefit groups together with Tax, Financial Assistance, and Health Policy staff from across the Health System to coordinate process, practice, and policy. JCHISC 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.

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 JHCHISC 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 Health Improvement Strategy Council attends a meeting with all of the JHHS CFOs to review system wide data and final reports to the Health System president. In the final review meeting before submission, the hospital CFOs present to the health system president and discuss strategic alignment, challenges and opportunities discussed during the CBR process.

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

        Prior to its submission to the HSCRC, the Community Benefit Report (CBR) is reviewed in detail by the CFO and the president of the Johns Hopkins Bayview Medical Center, and the president of the Johns Hopkins Health System. Although CBR annual approval by the Board of Trustees is not a legal requirement, the completed report as well as annual progress reports are presented and reviewed by the JHBMC Board of Trustees 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 formally approved by the JHBMC Board on May 23, 2016.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

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

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

List of CHNA Interviewees

Name	Organization
Albury, Pastor Kay	St. Matthew United Methodist Church
Bates Hopkins, Barbara	The Johns Hopkins University, Center for Urban Environmental Health
Benton, Vance	Patterson High School
Bone, Lee	The Johns Hopkins University, Bloomberg School of Public Health
Burke, Camille	Baltimore City Health Department
Cooper, Glenn	G. Cooper Construction & Maintenance Company
Dittman, Pastor Gary	Amazing Grace Lutheran Church
Evans, Janice	The Johns Hopkins Community Advisory Board Community College of Baltimore County; Dundalk Campus
Ferebee, Hathaway	Baltimore's Safe and Sound Campaign
Foster, Katrina	Henderson-Hopkins School

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

Schugam, Larry	Baltimore Curriculum Project
Scott, Pastor Dred	Sowers of the Seed
Stansbury, Carol	The Johns Hopkins Hospital, Department of Medical & Surgical Social Work
Sutton, Shirley	Baltimore Medical System, Inc.
Sweeney, Brian	Highlandtown Community Association
Szanton, Dr. Sarah	The Johns Hopkins University, School of Nursing
Guerrero Vazquez, Monica	Latino Family Advisory Board/Johns Hopkins Centro SOL

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

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

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

63.	Paul Laurence Dunbar High School
64.	Roberta's House
65.	Sacred Heart Church
66.	Sisters Together and Reaching Inc. (STAR)
67.	South East Community Development Corporation
68.	Sowers of the Seed
69.	St. Matthew United Methodist Church
70.	St. Nicholas Greek Orthodox Church
71.	St. Philip's Evangelical Lutheran Church
72.	THREAD
73.	Turner Station Conservation Team
74.	United States Congressman Maryland's 7th District
75.	United States Senator Maryland's District 45
76.	Zion Baptist Church

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

____yes __X___ No

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

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

__X___yes _____ No

JHH and JHBMC have a representative on the Baltimore City LHIC as well as the Baltimore County LHIC.

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 JHBMC CHNAs conducted in 2013 and 2016 identified in Baltimore City a number of health disparities, which refer to differences in occurrence and burden of diseases and other adverse health conditions between specific population groups. For example, there may be differences in health measures between males and females, different racial groups, or individuals with differing education or income levels. Health disparities are preventable occurrences that primarily affect socially disadvantaged populations.

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

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

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

Health Disparities in Baltimore County

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

in this report, the detailed information for the hospitals CBSA in Baltimore City will be described in more detail.

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

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

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

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

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

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

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

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

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

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

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

Health Care

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

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

Community Benefit Initiatives

The 2016 JHBMC Implementation Strategy for the CHNA spells out in considerable detail ways that JHBMC 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 JHBMC gains experience in implementing programs and measuring outcomes.

The Johns Hopkins Bayview Medical Center's 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 100 programs and initiatives were carried out or supported by administrative, clinical, and operational departments at Johns Hopkins Bayview Medical Center. Community health programs and initiatives undertaken during FY 2017 include: Health Leads, The Access Partnership, the Care-A-Van, the Mary Harvin Transformation Center, the Food Re-Education for School Health (FRESH) and HEARTS Program, the Baltimore Population Health Workforce Collaborative, and the Kiwanis Burn Prevention. In the tables below, these initiatives are described in greater detail.

Initiative 1. Health Leads

A. 1. Identified Need: **A. 2. How was the need identified:**	Access to Healthcare Percentages of residents who reported having unmet medical needs in 2009 in the Baltimore City Health Disparities Report Card (2010 edition) reflected a greater number of African Americans (19.8%) than whites (8.3%) reporting unmet needs in the past year. In the 2013 edition of the Report Card, the disparity had declined with African Americans reporting 16.51% had unmet healthcare needs while whites at 14.89% had higher unmet healthcare needs. Strikingly, disparity remained quite high those with less than a high school education (40.36%) and with incomes below $15,000 per year (20.48%). 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.
B: Name of hospital initiative	Health Leads Family Resource Desk JHH Harriet Lane Clinic JHBMC Children's Medical Practice JHBMC Comprehensive Care Practice
C: Total number of people within target population	Estimated individuals and families in the JHBMC CBSA with household income below $50,000 per year is 63,036 (Truven, 2017).
D: Total number of people reached by the initiative	Unique clients served in FY 2017: Harriet Lane Clinic: 1,227 Bayview Children's Medical Practice: 1,119 Bayview Comprehensive Care Practice: 389
E: Primary objective of initiative:	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.
F: Single or multi-year plan:	Multi-year initiative has been ongoing effort at Johns Hopkins Bayview Medical Center and JHH since 2006.

G: Key collaborators in delivery:	Health Leads Baltimore, Johns Hopkins Hospital, Johns Hopkins University
H: Impact of hospital initiative:	**Health Leads Outcomes:**

For FY17, the top presenting needs were as follows:

Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
Health (29%)	Health (22%)	Commodities (24%)
Food (29%)	Food (18%)	Housing (14%)
Financial (13%)	Housing (15%)	Health (12%)
Commodities (9%)	Utilities (10%)	Child-related (12%)
Other (7%)	Employment (9%)	Employment (11%)
Adult Education (6%)	Commodities (8%)	Food (7%)
Child-related (5%)	Transportation (6%)	Utilities (5%)

Clients Served	Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
Unique Clients	1119	389	1227

Total: 2813

Client Race	Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
American Indian or Alaska Native	1%	3%	<1%
Asian	<1%	<1%	1%
Black or African American	3%	38%	82%
Decline to State	1%	<1%	0%
Other	22%	4%	4%
Native Hawaiian or Other Pacific Islander	0%	<1%	0%
White	63%	53%	5%
Grand Total	100%	100%	100%
Client fill-out rate	91%	100%	93%

	% of 10 day followup	% solved at least 1 need	Days to closure
HL National	82%	69%	62
HL Midatlantic	79%	72%	70
BCCP	100%	63%	72
BCMP	76%	77%	66
HLC	79%	70%	74

Client ethnicity	**Children's Medical Practice**	**Bayview Comprehensive Care Clinic**	**Harriet Lane Clinic**
Hispanic	89%	4%	5%
Non-Hispanic	7%	93%	84%
Decline to state	4%	3%	11%
Grand Total	**100%**	**100%**	**100%**
Client fill-out rate	98%	99%	90%

Overall, for the metrics tracked by Health Leads nationally and regionally, the Johns Hopkins Health Leads desks metrics are in line with regional and national metrics. As part of a continual process for improving Health Leads, 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.

Developments from FY17 include: Partnered with JHBMC registration team to improve universal screening results by having the clinic print the Screening Tool as a part of packets given to families when they come for Well Child Care (WCC) appointments; pursued relationships with highest requested community resource organizations which were also the program's least successful to define an improved referral process (ex. Humanim, ShareBaby, and Esperanza Center);

Health Leads now manages the referrals to a variety of child developmental support programs at Kennedy Krieger Institute improving families connection rate to these services; Health Leads supports Priority Partners' seasonal outreach to members who have outstanding HEDIS (Healthcare Effectiveness

	Data and Information Set) measures by calling patients before their appointment, arranging transportation if necessary, and providing outreach incentives at time of visit; and Health Leads advocates supported the innovative MiCORE study investigating the impact of a mobile app and smart watch in helping patients recover from a heart attack. 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, self-help options such as clinic-based kiosks and patient-facing app, 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.
I: Evaluation of 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.
J: Continuation of initiative:	Yes, JHBMC is continuing to support its partnership with Health Leads Baltimore.
K: Expense	a. **Hospital's costs associated with initiative:** $108,058 b. **Costs associated with initiative provided through restricted grant or donation:** $0

Initiative 2. The Access Partnership (TAP)

A. 1. Identified Need: **A. 2. How was the need identified:**	Access to health care The 2010 *Baltimore City Health Disparities Report Card* pointed to African Americans (19.8 percent) experiencing unmet healthcare needs at a rate of nearly 20 percent, compared to 8.3 percent of whites. The 2013 edition of the *Report Card* indicated that the disparity had declined, with African Americans reporting unmet healthcare needs at a rate of 16.51 percent, compared to 14.89 percent of whites. Disparities remained high for residents with less than a high school education (40.36 percent) and with annual incomes below $15,000 (20.48 percent). The primary aims of the Baltimore City *Healthy Baltimore 2015* initiative are to increase the quality of health care for all citizens and specifically, to reduce emergency department utilization rates, decrease hospitalization rates for individuals with chronic conditions and decrease the number of city residents with unmet medical needs. TAP was formed in 2009 to improve access to outpatient primary and specialty care for low-income uninsured and underinsured patients who live in the neighborhoods surrounding Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center.
B: Name of hospital initiative	The Access Partnership (TAP)
C: Total number of people within target population	The estimated uninsured population in TAP's ZIP code catchment area is 25,364 (JHM Market Analysis and Business Planning).
D: Total number of people reached by the initiative	During FY17, 1,587 primary care visits occurred through the TAP program. • Johns Hopkins Bayview Medical Center - General Internal Medicine: 782 • Johns Hopkins Bayview Medical Center - Children's Medical Practice: 173 • Johns Hopkins Hospital - Outpatient Center: 632 During FY17, 2,906 specialty referrals were processed through the TAP program.
E: Primary objective of initiative:	The Access Partnership (TAP) of Johns Hopkins Medicine (JHM) is a mission-driven charity program designed to improve access to effective, compassionate, evidence-based primary and specialty care for uninsured and underinsured patients residing in the community surrounding The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC). TAP's Eligibility Requirements: • Uninsured or underinsured with demonstrated financial need • Enrolled in primary care at a participating primary care clinic at Johns Hopkins or in the Baltimore community

	• Household income of less than 200% of the Federal Poverty Level • Reside in: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231, or 21052 TAP provides access to comprehensive primary care at three hospital-based clinics located in the East Baltimore community: - JHBMC Children's Medical Practice (CMP) - JHBMC General Internal Medicine (GIM) - JHH John Hopkins Outpatient Center (JHOC) There are several community clinic partners that participate in the TAP program through panels of primary care physicians. We do not track primary care access at these sites, which include: - Baltimore Medical Systems (Belair Edison, Highlandtown and Middlesex locations) - East Baltimore Medical Center - Health Care for the Homeless - The Esperanza Center The number of patients served is the program's primary measurable outcome. TAP's zip code catchment area is aligned with the Johns Hopkins Health System Community Benefit Service Area. There are no provisions in TAP that would enable the program to measure improvements in health status. The goal of The Access Partnership is to improve access to outpatient specialty care for patients who do not have access to state or federal health insurance programs.
F: Single or multi-year plan:	TAP has been active since 2009 and is now in its ninth year.
G: Key collaborators in delivery:	Johns Hopkins Medicine, Johns Hopkins Health System, and the Johns Hopkins Clinical Practice Association are critical partners in the implementation of TAP. TAP's community-based primary care partners include Chase Brexton Health Services, The Esperanza Center, Health Care for the Homeless and Baltimore Medical System.
H: Impact of hospital initiative:	Patient demographics, TAP certification dates and specialty referrals are tracked on a monthly basis. The program's metrics are monitored and reviewed on a monthly basis and statistical data and trends are summarized in quarterly and biannual reports.
I: Evaluation of outcome	TAP Outcomes: Since its inception in 2009, the TAP program has provided medical services to more than 5,921 patients and processed 15,221 specialty referrals. During FY17, TAP provided 1,587 primary care visits at 3 rate-regulated clinic sites at Johns Hopkins: JHBMC Children's Medical Practice, JHBMC General Internal Medicine and JHH John Hopkins Outpatient Center.

	The top zip codes for patients currently enrolled in TAP are 21224 (70 percent), 21222 (9 percent) and 21205 (9 percent). JHH and JHBMC care for these patients every day in their emergency departments and through hospital admissions, where eligible patients are referred to TAP for follow-up care. TAP takes a proactive approach to managing and navigating primary and specialty care for eligible uninsured patients. Participating primary care clinicians are able to provide comprehensive care to patients, and as a result, TAP patients have the opportunity to develop alliances with their providers that can help facilitate improved health literacy, improved health outcomes, and reduced health disparities. Prior to the implementation of the ACA, the percentage of undocumented patients enrolled in the program ranged from 35-40 percent. Since January 1, 2014, approximately 90 percent of patients enrolling in TAP are undocumented residents who are ineligible for state or federal health insurance programs. These patients are matched with bilingual (English/Spanish) navigators who help with scheduling and attending appointments. TAP's navigators ensure that patients receive timely appointments and work closely with program staff to resolve issues that arise. Program brochures and materials are also available in Spanish. There are uninsured patients served by participating community-based clinics who live outside of TAP's eligible zip codes but need access to specialty care. TAP receives requests to expand the program's zip code catchment area but TAP staff are not aware of other barriers—at this time there are no additional clinics requesting to participate. TAP has grown steadily but carefully since its inception, ensuring access to care for East Baltimore residents. Early on, TAP's leadership met with the University of Maryland Medical System and MedStar Union Memorial; TAP recommended a collaborative approach to addressing access to outpatient specialty care for uninsured residents in each hospital's neighboring geographic area. At that time, there was no interest in expanding the initiative outside of Johns Hopkins. TAP staff are open to continuing this dialogue.	
J: Continuation of initiative:	TAP is a continuing commitment of JHM.	
K: Expense	a. **Hospital's costs associated with initiative:** $50,989	b. **Costs associated with initiative provided through restricted grant or donation:** $0

Initiative 3. Care-A-Van

A. 1. Identified Need: **A. 2. How was the need identified:**	Access to Health Services Focusing on healthcare for Latino and other non-English speaking patients and the uninsured as identified in the 2016 JHBMC CHNA The growth in the Latino population in Baltimore is reflected in the trends among Latino patients receiving care at JHBMC. Data obtained from the Johns Hopkins Health System data analysis unit showed that from 2000 to 2010 there was a six-fold increase in Hispanic admissions at JHBMC. The highest utilization of services by Latino patients occurred in the Department of Pediatrics and Department of Obstetrics where Latino patients accounted for approximately 1/3 of all inpatient admissions for Pediatrics and Ob/Gyn, 35% of outpatient Pediatric visits, and 21% of outpatient Ob/Gyn visits in 2010. About 11% of the residents in the CBSA area are Latino, with greater concentration in the 21224 ZIP code. Forums with families and leaders indicated a number of language-related barriers to care.
B: Name of hospital initiative	Care-A-Van
C: Total number of people within target population	151,309 people in the total population of the following four ZIP codes: 21231, 21224, 21222, 21213 with a focus on the 73,278 underrepresented minorities and/or uninsured residents in this area.
D: Total number of people reached by the initiative	1,346 people reached by Care-A-Van
E: Primary objective of initiative:	A mobile van that brings ambulatory care services and health screenings to the community. The program focuses on children and women of childbearing age and gives access particularly to people who may have transportation and financial limitations. The Care-A- Van, with bilingual providers, is frequently used by Latino patients for primary care or as an entry point to access hospital services.
F: Single or multi-year plan:	Multi-year/ongoing
G: Key collaborators in delivery:	Children's Medical Practice's Latino Family Advisory Board Crianza Y Salud {Parenting and Health}
H: Impact of hospital initiative:	• 1,346 patient encounters • Over 678 patients tested for HIV/Syphilis • 75% Latino patients • 935 new OB patients referred for prenatal care, WIC and Medicaid and provided with access to prenatal vitamins

I: Evaluation of outcome	Process: Patient satisfaction survey, Patients Needs Survey (not done every year) Impact: Number of encounters
J: Continuation of initiative:	Yes, this is a continuing initiative supported by JHBMC.
K: Expense	a. **Hospital's costs associated with initiative:** $277,213 b. **Costs associated with initiative provided through restricted grant or donation:** $50,000

Initiative 4. Mary Harvin Transformation Center

A. 1. Identified Need: **A. 2. How was the need identified:**	Behavioral Health; Employment and Education; Safety and Security; Chronic Disease; Access to Care. Determined through the Johns Hopkins Hospital (JHH)/Johns Hopkins Bayview Medical Center (JHBMC) Community Health Needs Assessment 2016 In FY17, the Mary Harvin Transformation Center (MHTC) began program implementation after the completion of the FY16 startup and planning phase. The MHTC was specifically designed by JHBMC Healthy Community Partnership and JHH Community Health Improvement as a central venue to offer programs addressing the needs identified in the 2016 Community Health Needs Assessment for JHH and JHBMC. The Center is part of a larger Johns Hopkins collaboration with Southern Baptist Church and other members of the faith based community. The Mary Harvin Transformation Center is located in the center of some of the poorest and most distressed neighborhoods in the CBSA (Greenmount East, formerly Broadway East, and Clifton-Berea), with residents facing significant social and economic barriers and experiencing major health disparities. For example, only 10 percent of the residents have a bachelor's degree or greater, while almost 20 percent do not have even a high school diploma; and almost 40 percent of the households have an annual income of $25,000 or less. Given these circumstances, it is not surprising that the life expectancy of residents in these neighborhoods is less than 68 years, well below that of the overall life expectancy for Baltimore City (73.8 years) and 16 years below a neighborhood only four miles away (84 years).
B: Name of hospital initiative	The Mary Harvin Transformation Center (MHTC) partnership

C: Total number of people within target population	Primary – over 4,000 church members and seniors in the immediate area of the center. Secondary – 45,632 - all community members (all ages) living in the two closest zip codes (21205 and 21213) to the MHTC. (2010-2014 American Community Survey)
D: Total number of people reached by the initiative	Programming in FY17 included education sessions for as few as 15 participants to large campaigns involving over 1,000. Total number of unique individuals reached through this initiative was over 2,500.
E: Primary objective of initiative:	Offer diverse programming addressing multiple identified needs in a whole health approach to community health improvement in a target area of East Baltimore. Provide health education and services as part of a growing interfaith community partnership. Become an integral part of the community and build trust with community residents. Individual Objectives: • Improve educational opportunities for residents • Improve employment opportunities for residents • Collaborate with Baltimore City Police Department and other community partners to offer safer opportunities for residents to engage in healthful activities • Collaborate with churches and other community partners to offer mental health and other services • Enhance the capacity of patients to engage in self-care, thus addressing the need to prevent and/or effectively manage chronic conditions • Facilitate access to health services • Strengthens bidirectional communication and build trust through new community partnerships
F: Single or multi-year plan:	Multi-year/on-going
G: Key collaborators in delivery:	External: • Southern Baptist Church • Medicine for the Greater Good • Area church congregations and leaders including: Zion Baptist Church and Israel Baptist Church • Baltimore City Police Department • BACH/Baltimore Alliance for Careers in Healthcare • National Alliance on Mental Illness (NAMI) • Holistic Life Foundation Internal Johns Hopkins: • Wilmer Eye Institute • Healthy Community Partnership • Community Health Improvement Department • Office of Community Health

	• Department of Spiritual Care and Chaplaincy • Office of Healthcare Transformations •
H: Impact of hospital initiative:	FY17 was the first year of program delivery at MHTC, and overall programming was successful in both the depth and breadth of program content and the level of participation from the target populations, i.e. the 4,000 members of the Southern Baptist Church located across the street and the senior center residents in the Mary Harvin building. Over 15 programs were developed and delivered targeting identified needs in the latest Community Health Needs Assessment (CHNA). The goal was to address the whole health of the target group. Program topics included: • Vision testing (diabetic retinopathy) • Hearing tests • Foot care/podiatrist (Ask the Doc session) • Cardiovascular Disease (Heart Health Month) • Health Care Agent campaign (Southern Baptist Church) • Depression/Mental health (NAMI – Coffee House series) • Medicine management (JH HealthCare Transformation) • Flu shot campaign (Medicine for the Greater Good) • Healthy diet (Food and Faith) • Exercise (Exercise Room equipment demonstration and assistance) • Yoga (Holistic Life Foundation and JH Office of Community Health) • Access to healthy foods (JHH Farmers Market and Food and Faith programs) • Spiritual health (Caring for the City) • Workforce development and recruiting (Back to Work Wednesdays)
I: Evaluation of outcome	Partnerships established – Key partnerships were established in many areas including the groups offering services and audiences benefiting from program outreach. Internal Johns Hopkins Program delivery partners include: the Johns Hopkins Wilmer Eye Institute, Holistic Life Foundation, Johns Hopkins Workforce Development, JH Office of HealthCare Transformation. Programs offered >15 some described above Population reached (# and target group) 2,500 Participant feedback – surveys were distributed and collected at many events. The number of new partnerships and/or participants in programs such as Caring for the City was the measure of success towards the objective of building new relationships and trust in the community.

J: Continuation of initiative:	This will be a continuing initiative of JHBMC and JHH.	
K: Expense	a. **Hospital's costs associated with initiative:** $46,648	b. **Costs associated with initiative provided through restricted grant or donation:** $0

Initiative 5. Food Re-Education for School Health (FRESH) and HEARTS Program

A. 1. Identified Need: **A. 2. How was the need identified:**	Chronic Disease Obesity – Childhood Childhood obesity is a significant contributory factor to the onset of early chronic disease. A top priority for Baltimore County and one of 10 priority areas for Healthy Baltimore 2015, childhood obesity is a key need in the JHBMC CBSA related to chronic disease (identified in the 2016 CHNA). Addressing this area is also a priority and objective of the MD SHIP initiative.
B: Name of hospital initiative	FRESH Program & HEARTS Program
C: Total number of people within target population	Total Target population – 12,414 school age children between the ages of 5-14 living in the 21219, 21222, and 21224 ZIP codes (based on 2010-2014 American Community Survey data).
D: Total number of people reached by the initiative	2,402 FRESH 198 HEARTS 249 Summer programs 2,849 total children reached
E: Primary objective of initiative:	Objectives: • Offer elementary school-based programs for teachers, parents and students about heart health behaviors • Prevent obesity, heart disease, lung disease and smoking
F: Single or multi-year plan:	Multi-year/ongoing
G: Key collaborators in delivery:	Public and parochial schools within Baltimore City and Baltimore County Baltimore City Neighborhood Center JH Department of Cardiology Community Health Library at JHBMC Julie Community Center Local Farmers Markets
H: Impact of hospital initiative:	2402 students served seven times during year (included pre/posttest) 18 participating schools 94 classes

	Program evaluation and teacher feedback 198 girl scout troop served 3 times during the year 22 participating troops
I: Evaluation of outcome	Process: Teacher evaluations of the programs were consistently high. Suggestions are reviewed and incorporated in the next year's programming. Impact: • FRESH program was presented to 2402 students in 18 schools. Student pre/post testing showed learning. • FRESH program also reached summer program(s) for a total of 249 children 4 times during the year • HEARTS program reached 198 Girl Scouts in 22 troops
J: Continuation of initiative:	Yes, this is a continuing initiative supported by JHBMC.
K: Expense	a. **Hospital's costs associated with initiative:** $177,281 b. **Costs associated with initiative provided through restricted grant or donation:** $5,013

Initiative 6. Kiwanis Burn Prevention

A. 1. Identified Need: **A. 2. How was the need identified:**	Access to Healthcare Burn injury prevention Johns Hopkins Bayview Medical Center is Baltimore's regional burn center offering special expertise in treating pediatric and adult patients. The children's center cares for all burn victims under the age of 15 in the state of Maryland and surrounding communities and it remains the state-designated burn center for adults. Historically, the identified need addressed by this program is the prevention of burn injuries. JHBMC partnered with Kiwanis over 25 years ago to create this program to educate school children on fire safety and burn prevention. Although burn prevention was not addressed in the 2016 CHNA it continues to be a community need.
B: Name of hospital initiative	Kiwanis School-Based Burn Prevention Program
C: Total number of people within target population	Target population – 97,608 school age children between the ages of 5-14 living in Baltimore County (based on 2010-2014 American Community Survey data). Additionally, the program receives referrals from other central Maryland counties for children referred by Juvenile Justice programs. At present, Baltimore City does not have a referral program for burn prevention/fire safety education.
D: Total number of people	11,300 students reached in FY17

reached by the initiative	
E: Primary objective of initiative:	Objectives: • Provide age-appropriate, school-based lessons about burn prevention, with a retired professional firefighter teaching students.
F: Single or multi-year plan:	Multi-year
G: Key collaborators in delivery:	Primarily public schools in Baltimore City, Baltimore County, Harford County, and Howard County. Six parochial schools in Baltimore City, Baltimore County, and Harford County.
H: Impact of hospital initiative:	Thirty five schools were reached. 393 presentations were given and 11,300 students were educated on burn prevention.
I: Evaluation of outcome	Children are given pre/post tests and teachers evaluate the program
J: Continuation of initiative:	Yes, this is a continuing initiative supported by JHBMC.
K: Expense	a. **Hospital's costs associated with initiative:** $97,848 b. **Costs associated with initiative provided through restricted grant or donation:** $0

Initiative 7. Baltimore Population Health Workforce Collaborative

A. 1. Identified Need: **A. 2. How was the need identified:**	Unemployment, along with the need to earn a living wage, is one of the greatest challenges facing Baltimore City residents. The April 2015 unemployment rate in the city was 7.4%, compared to the statewide rate of 4.9%, with some areas facing unemployment rates as high as 17% (DLLR, 2015). These numbers do not take into account people who have given up hope of finding permanent employment or those who are underemployed. The healthcare industry is one of Baltimore's fastest growing industry sectors. According to the Baltimore Region Talent Development Pipeline study (2013), the healthcare industry will add 20,000 new jobs between 2012 and 2020. Thirty-six percent of these jobs will not require a college education, but will require training beyond high school.
B: Name of hospital initiative	Baltimore Population Health Workforce Collaborative
C: Total number of people within target population	Targeted neighborhoods are those in hospital Community Benefit Service Areas (CBSA) that have higher poverty and unemployment rates than Baltimore City overall. BPHWC will focus on the following 24 zip codes representing CBSA's of the 9 partner hospitals: 21201, 21202, 21205, 21206, 21207, 21211, 21213,

	21214, 21215, 21216, 21217, 21218, 21221, 21222, 21223, 21224, 21225, 21226, 21227, 21229, 21231, and 21239. The highest poverty communities to be specifically targeted include: a) the west side communities of Penn-North, Harlem Park, Sandtown-Winchester, Greater Rosemont, Upton/Druid Heights, Southern Park Heights, Pimlico/Arlington; b) the east side communities of Clifton-Berea, Madison East End, Oldtown-Middle East and Belair-Edison; c) the southern communities of Cherry Hill, Brooklyn, Curtis Bay; d) the northeast communities of Waverly, Greenmount East, Govans and Northwood; and e) the southeast Baltimore County communities of Essex, Dundalk, and Rosedale.
D: Total number of people reached by the initiative	Total number of people reached through job fairs, partner organizations, church partners, and JHM recruiters is not tracked. Twenty individuals completed the first training component.
E: Primary objective of initiative:	BPHWC is designed to provide the training needed to fill new health care jobs, while also improving the health of high poverty communities BPHWC will target high poverty communities throughout Baltimore City to recruit, train, and hire residents for 198 newly established entry level core jobs over three years. Individual hospitals will establish 35 other new positions related to BPHWC, to include social workers, care coordinators, for a total of 233 new jobs.
F: Single or multi-year plan:	This is a multi-year initiative, running from FY17 to FY19.
G: Key collaborators in delivery:	Internal: Johns Hopkins Hospital External: HSCRC, LifeBridge Sinai, Medstar Franklin Square Medical Center, Medstar Good Samaritan, Medstar Harbor Hospital, Medstar Union Memorial Hospital, UMMC, UM Midtown, Baltimore Alliance for Careers in Healthcare, Baltimore Area Health Education Center, Bon Secours Community Works, BUILD Turnaround Tuesday, Center for Urban Families, Community College of Baltimore County, Mission Peer Recovery Training, Penn North.
H: Impact of hospital initiative:	For FY17, overall JHBMC has hired five trainees into the BPHWC program, of which 2 are community health workers and 3 peer recovery specialists. Over twenty individuals went through the Essential Skills Training course and 12 individuals went through Technical Skills Training.
I: Evaluation of outcome	BPHWC will evaluate its short-term outcomes through BACH's Efforts to Outcomes (ETO) data collection system to track the following demographic and process measures: 1) number of trainees who participate in and complete essential skills training and occupational skills training (CHW, PRS, CNA-GNA); 2) number of trainees who are hired and the communities from which they were

<table>
<tr><td></td><td colspan="2">recruited; 3) percent of trainees and new hires by socio-demographic characteristics; 4) number of trainees hired by job category and hospital employer; 5) number of patients by community and zip code served by these workers; 5) number and percentage of workers retained annually by job category, hospital employer and socio-demographic characteristics; 6) wages and benefit levels for job categories (CHW, PRS, CNA-GNA) by hospital employer; 7) number of promotions of new hires. All community training partners will have access to and be trained in BACH's ETO data management system. All required demographics and process measures will be collected and tracked through this system.</td></tr>
<tr><td>J: Continuation of initiative:</td><td colspan="2">Yes, this is a continuing initiative.</td></tr>
<tr><td>K: Expense</td><td>a. Hospital’s costs associated with initiative: $313,537</td><td>b. Costs associated with initiative provided through restricted grant or donation: $0</td></tr>
</table>

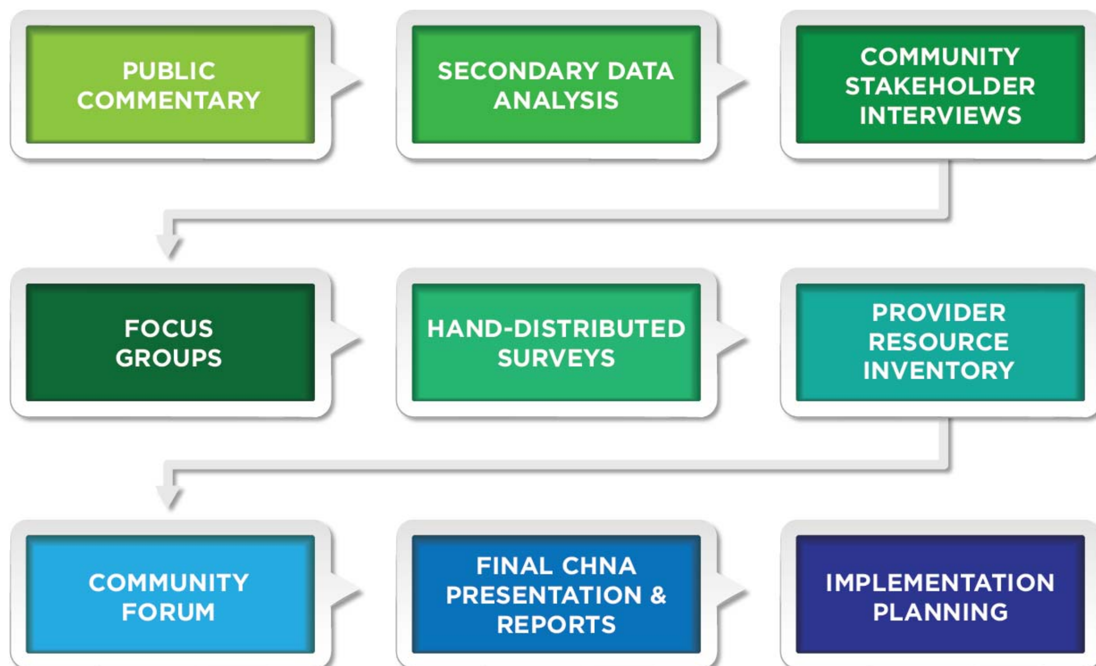
2. Description of the community health needs that were identified through a community needs assessment that were not addressed by the hospital

A comprehensive community-wide CHNA process was completed for Johns Hopkins Bayview Medical Center (JHBMC) and The Johns Hopkins Hospital (JHH), connecting public and private organizations, such as health and human service entities, government officials, faith-based organizations and educational institutions to evaluate the needs of the community. The 2016 assessment included primary and secondary data collection that incorporated public commentary surveys, community stakeholder interviews, a hand-distributed survey, focus groups and a community forum.

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

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

Flow Chart 2: CHNA Process



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

Respondents were asked to review and comment on, via a survey, the 2013 CHNA report and the 2014 Implementation Plan adopted by the Johns Hopkins Institutions. The survey was strategically placed at

JHH's security desk at the Wolfe Street entrance (e.g., Main Hospital Lobby) and at the security desk at the Billings Administration Lobby. At JHBMC, surveys were collected at the main hospital lobby and in the community relations office. The survey questionnaire was also emailed to the Executive Planning Committee, which includes representatives from JHH and JHBMC for review and comment collection.

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

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

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

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

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

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

The consultant also worked with community-based organizations to collect and distribute the surveys to end-users in the underserved populations, and the engagement of local community organizations was vital to the survey process.

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

As part of the CHNA process, a regional community planning forum was held at Breath of God Lutheran Church in Baltimore, MD, on December 7, 2015. Over 30 community leaders attended the event

representing a variety of community organizations, health and human services agencies, health institutions and additional community agencies. Forum participants were invited to a four-hour community event where they reviewed all data collected throughout the comprehensive CHNA process, discussed the results and prioritized the needs. Forum participants were community stakeholders who were interviewed, sponsored and recruited participants for the focus groups, and/or were instrumental in the hand-distributed survey process. Most importantly, forum participants provided critical feedback and prioritized key need areas for the CHNA.

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

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

Prioritized Key Community Needs:

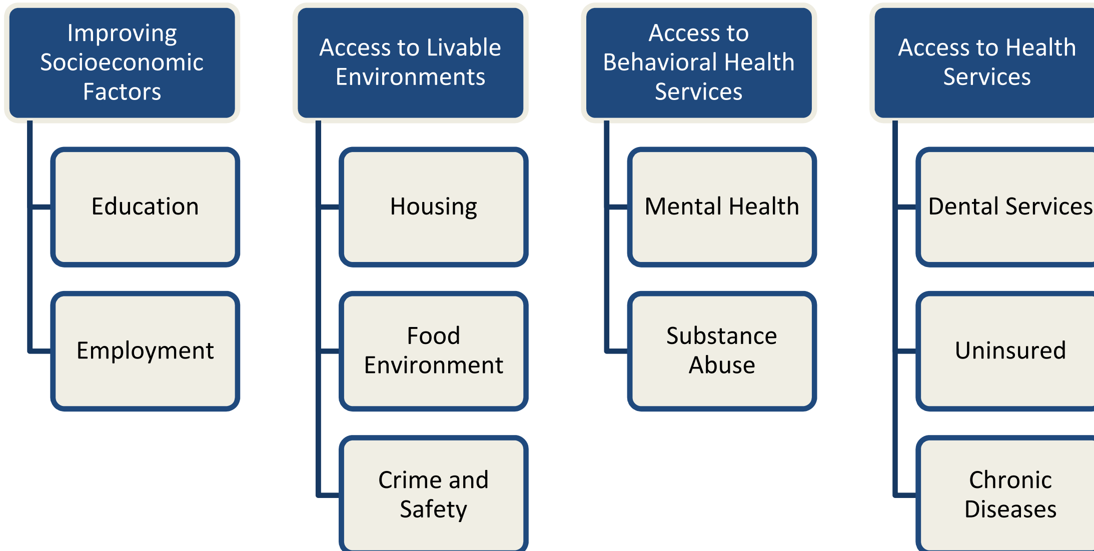
Education (4)
Employment (4)
Housing (3)
Mental health (2)
Food environment (2)
Substance abuse (2)
Crime and safety (1)
Health care/access (1)
Dental health (1)

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

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

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

2016 JHH/JHBMC CHNA Key Needs



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

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

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

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

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

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

VI. PHYSICIANS

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

As stated in its Financial Assistance Policy, Johns Hopkins Bayview Medical Center 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 JHBMC's stated policy. In FY2009, JHBMC implemented a program, The Access Partnership, to address these barriers to outpatient specialty care for uninsured patients living in the ZIP codes that surround JHBMC. 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. JHBMC 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 Bayview Medical Center provides subsidies to physicians for trauma on-call services that they would otherwise not provide to the hospital. In FY 2017, JHBMC paid a total of $3.552 million in subsidies to physicians for the following patient services:

Category of Subsidy	Explanation of Need for Service
Hospital-Based physicians with exclusive contract	As a state-designated Level II trauma center for Maryland, JHBMC provides subsidies to physicians for trauma on-call services that they would otherwise not provide to the Hospital. In FY17, the Hospital contributed $572,465 in Trauma On-call Coverage. For other on-call coverage, the hospital contributed $1,535,737
Non-Resident House Staff and Hospitalists	The Hospital staffs a team of hospitalists and intensivists to provide primary care for patients, working collaboratively alongside specialists and patients' primary care physician.
Coverage of Emergency Department Call	In FY17, for coverage of emergency department call JHBMC contributed $408,057.
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other – (provide detail of any subsidy not listed above – add more rows if needed)	Oncology On-Call ICU On-Call Neonatology On-Call Peds On-Call Interventional Radiology On-Call

VII. Appendices

Appendix I

Financial Assistance Policy Description

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

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

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

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

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

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

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

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

APPENDIX II

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

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

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

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

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

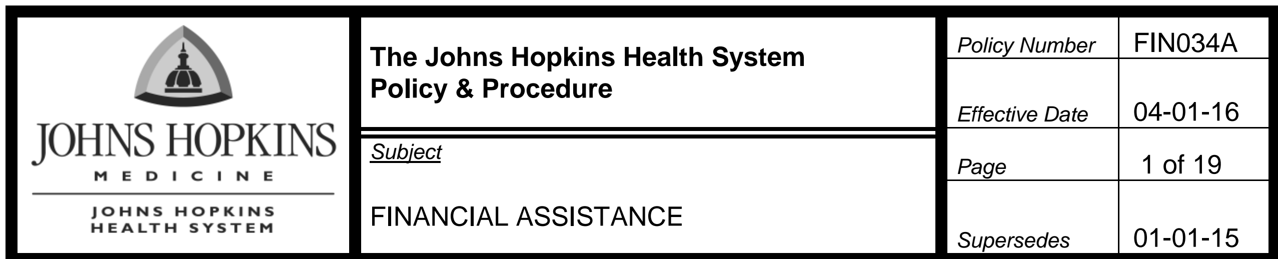
Previously patients had to apply for Medical Assistance as a prerequisite for financial assistance. JHHS added that the patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its designated agent, unless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

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

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

APPENDIX III

FINANCIAL ASSISTANCE POLICY



JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Policy & Procedure	Policy Number	FIN034A
		Effective Date	04-01-16
	Subject	Page	1 of 19
	FINANCIAL ASSISTANCE	Supersedes	01-01-15

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.

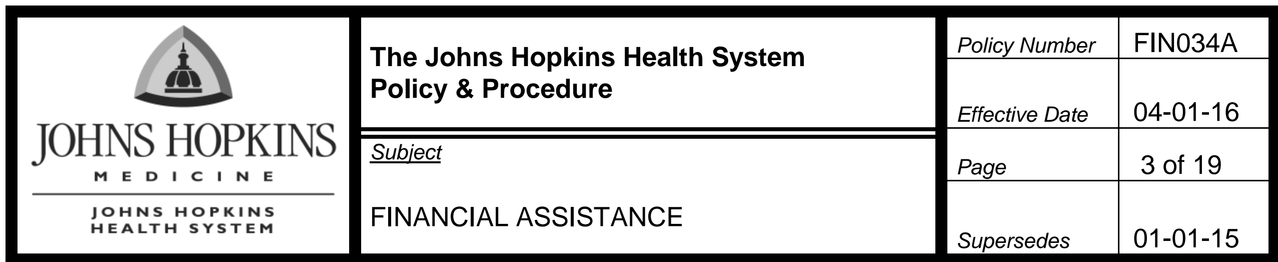
FINANCIAL ASSISTANCE FOR PHYSICIANS PROVIDING CARE NOTICE:
Attached as **EXHIBIT D** is a list of physicians that provide emergency and medically necessary care as defined in this policy at JHH, JHBMC and JHBCC. The lists indicates if the doctor is covered under this policy. If the doctor is not covered under this policy, patients should contact the physician's office to determine if the physician offers financial assistance and if so what the physician's financial assistance policy provides.

Definitions

Medical Debt

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

Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. A safe harbor of $150,000 in equity in patient's primary residence shall not be considered an asset convertible to cash. Equity in any other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non qualified deferred compensation plans.
Elective Admission	A hospital admission that is for the treatment of a medical condition that is not considered an Emergency Medical Condition.
Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, or other acute symptoms such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) Serious jeopardy to the health of a patient; (b) Serious impairment of any bodily functions; (c) Serious dysfunction of any bodily organ or part. (d) With respect to a pregnant woman: 1. That there is inadequate time to effect safe transfer to another hospital prior to delivery. 2. That a transfer may pose a threat to the health and safety of the patient or fetus. 3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.
Emergency Services and Care	Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician which is necessary to relieve or eliminate the emergency medical condition, within the service capability of the hospital.
Medically Necessary Care	Medical treatment that is necessary to treat an Emergency Medical Condition. Medically necessary care for the purposes of this policy does not include Elective or cosmetic procedures.
Medically Necessary Admission	A hospital admission that is for the treatment of an Emergency Medical Condition.



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

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

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

PROCEDURES

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

   For example:

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

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

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

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

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

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

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

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

d. All insurance benefits must have been exhausted.

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

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

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

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

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

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

f. Proof of disability income (if applicable).

g. Reasonable proof of other declared expenses.

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

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

a. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments to the Financial

Assistance Evaluation Committee for final evaluation and decision.

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

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

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

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

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

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

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

13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance

Eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Financial Assistance Evaluation Committee. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

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

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

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

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

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

REFERENCE[1]

JHHS Finance Policies and Procedures Manual

Policy No. FIN017 - Signature Authority: Patient Financial Services
Policy No. FIN033 - Installment Payments

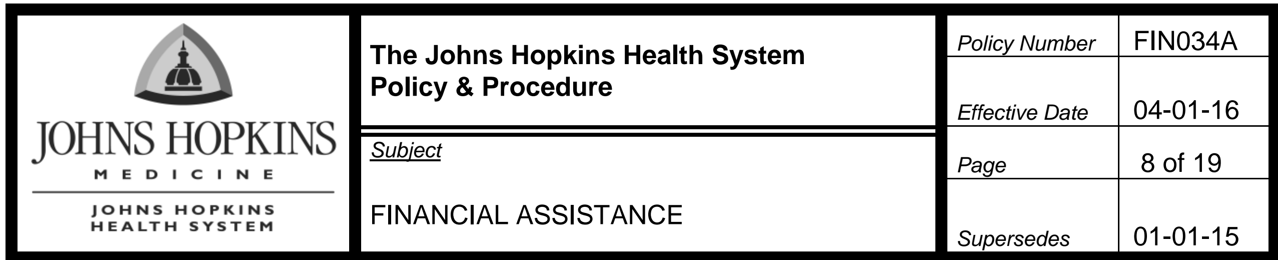
Charity Care and Bad Debts, AICPA Health Care Audit Guide

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

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

RESPONSIBILITIES - JHH, JHBMC

Financial Counselor (Pre-Admission/Admission/In-House/ Outpatient) Customer Service Collector Admissions Coordinator Any Finance representative designated to accept applications for Financial Assistance	Understand current criteria for Assistance qualifications. Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form. On the day preliminary application is received, fax to Patient Financial Services Department's dedicated fax line for determination of probable eligibility. Review preliminary application, Patient Profile Questionnaire and Medical Financial Hardship Application (if submitted) to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments. If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review. Review and ensure completion of final application. Deliver completed final application to appropriate management. Document all transactions in all applicable patient accounts comments. Identify retroactive candidates; initiate final application process.



Management Personnel (Supervisor/Manager/Director)	Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies. Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.] Notices will not be sent to Presumptive Eligibility recipients.
Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent) CP Director and Management Staff	Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

SPONSOR

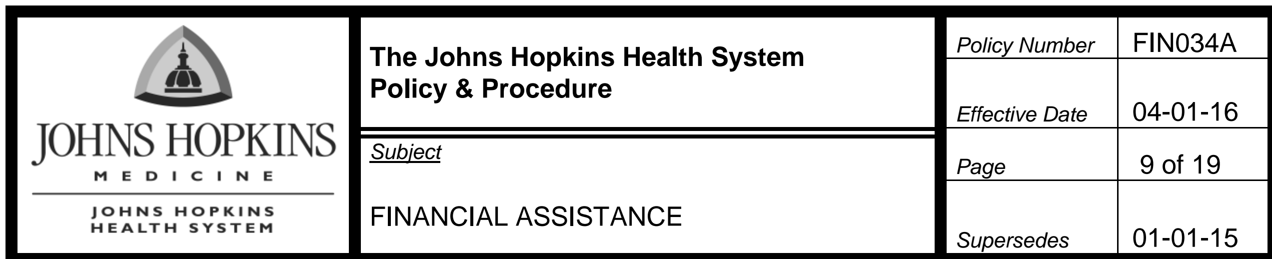
Senior Director, Patient Finance (JHHS)
Director, PFS Operations (JHHS)

REVIEW CYCLE

Two (2) years

APPROVAL

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



APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

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

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

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

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

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

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

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

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

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

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

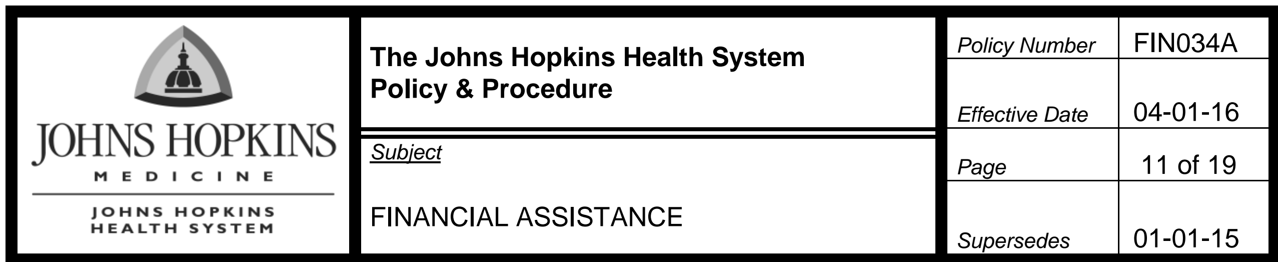
11. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.

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

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

Exception

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



FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 3/1/16

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	**$ 23,760**	$ 26,136	$ 28,512	$ 30,888	$ 33,264	$ 35,640
2	**$ 32,040**	$ 35,244	$ 38,448	$ 41,652	$ 44,856	$ 48,060
3	**$ 40,320**	$ 44,352	$ 48,384	$ 52,416	$ 56,448	$ 60,480
4	**$ 48,600**	$ 53,460	$ 58,320	$ 63,180	$ 68,040	$ 72,900
5	**$ 56,880**	$ 62,568	$ 68,256	$ 73,944	$ 79,632	$ 85,320
6	**$ 65,160**	$ 71,676	$ 78,192	$ 84,708	$ 91,224	$ 97,740
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
Allow ance 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	48,600
Upper Limits of Income for Allowance Range	$58,320 (60% range)

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

Appendix A-1

Presumptive Financial Assistance Eligibility

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

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

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

APPENDIX B
MEDICAL FINANCIAL HARDSHIP ASSISTANCE GUIDELINES

Purpose

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

Medical Financial Hardship Assistance is available for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom:
1.) Medical Debt incurred over a twelve (12) month period exceeds 25% of the Family Income creating Medical Financial Hardship; and
2.) who meet the income standards for this level of Assistance.

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

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

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

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

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

General Conditions for Medical Financial Hardship Assistance Application:

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

- Other forms of assistance available through JHM affiliates

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

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

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

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

Factors for Consideration

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

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

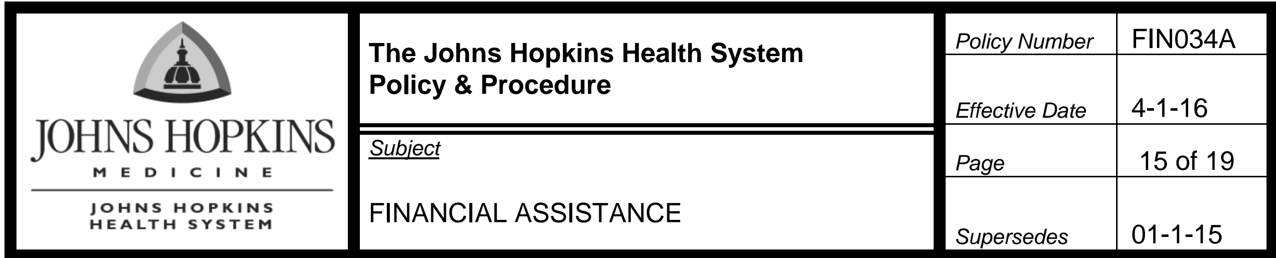
Exception

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

Evaluation Method and Process

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

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



MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 3/1/16

# of Persons in Family	Income Level**		
# of Persons in Family	300% of FPL	400% of FPL	500% of FPL
1	**$ 35,640**	$ 47,520	$ 59,400
2	**$ 48,060**	$ 64,080	$ 80,100
3	**$ 60,480**	$ 80,640	$ 100,800
4	**$ 72,900**	$ 97,200	$ 121,500
5	**$ 85,320**	$ 113,760	$ 142,200
6	**$ 97,740**	$ 130,320	$ 162,900
7	**$ 110,190**	$ 146,920	$ 183,650
8*	**$ 122,670**	$ 163,560	$ 204,450
Allowance to Give:	50%	35%	20%

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

Exhibit A

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

JOHNS HOPKINS
MEDICINE

Maryland State Uniform Financial Assistance Application

Information About You

Name ____
First Middle Last

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

Home Address ____ Phone _______________

____

____ _______________
City State Zip code Country

Employer Name ____ Phone _______________

Work Address ____

____
City State Zip code

Household members:

Name	Age	Relationship
______________________	____	______________________
______________________	____	______________________
______________________	____	______________________
______________________	____	______________________
______________________	____	______________________
______________________	____	______________________
______________________	____	______________________
______________________	____	______________________

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

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

Exhibit A

I. Family Income

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

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

II. Liquid Assets

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

III. Other Assets

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

Home	Loan Balance ________________		Approximate value ______________
Automobile	Make _________	Year ______	Approximate value ______________
Additional vehicle	Make _________	Year ______	Approximate value ______________
Additional vehicle	Make _________	Year ______	Approximate value ______________
Other property			Approximate value ______________
		Total	______________

IV. Monthly Expenses

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

Do you have any other unpaid medical bills? Yes No

For what service? ____

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

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

____ ________________________

Applicant signature Date

____

Relationship to Patient

EXHIBIT 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? ________
9. 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
16. Is patient employed? Yes or No
    If no, date became unemployed. ________
    Eligible for COBRA health insurance coverage? Yes or No

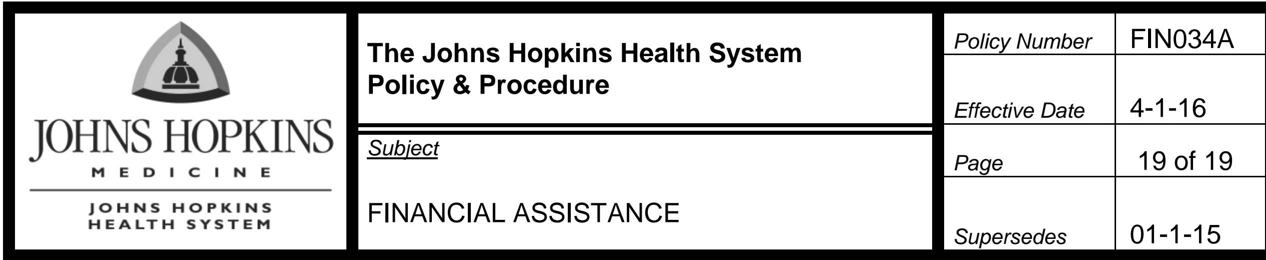


EXHIBIT C MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: ____

PATIENT NAME: ____

PATIENT ADDRESS: ____
(Include Zip Code)

MEDICAL RECORD #:____

Date: ____

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

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

Date of service	Amount owed
_________________	________________________
_________________	________________________
_________________	________________________
_________________	________________________

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

_____________________________________ Date: _____________________
Applicant's signature

____
Relationship to Patient

For Internal Use:

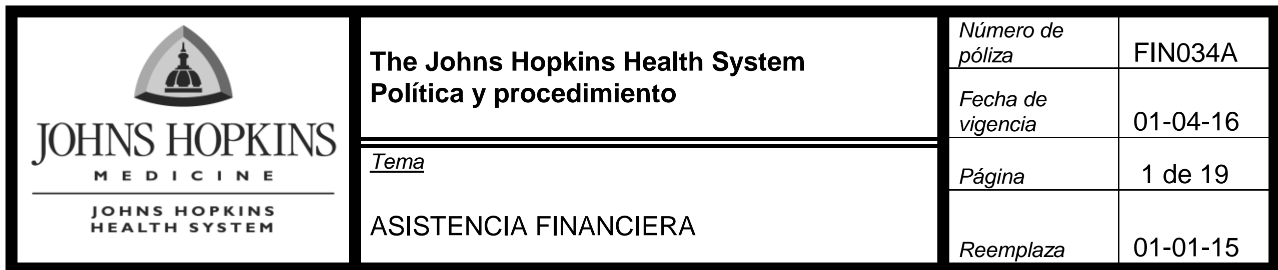
Reviewed By: ___________________________________Date:______________

Income: __________________________ 25% of income=_____________________

Medical Debt: ______________________ Percentage of Allowance: ____________________

Reduction: _________________________ Balance Due: _______________

Monthly Payment Amount: _____________ Length of Payment Plan: ________months



JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Política y procedimiento	*Número de póliza*	FIN034A
		Fecha de vigencia	01-04-16
	Tema	*Página*	1 de 19
	ASISTENCIA FINANCIERA	*Reemplaza*	01-01-15

POLÍTICA

Esta política se aplica a las siguientes entidades de The Johns Hopkins Health System Corporation (JHHS): The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc. Acute Care Hospital and Special Programs (JHBMC) y The Chronic Specialty Hospital del Johns Hopkins Bayview Care Center (JHBCC).

Propósito

JHHS tiene el compromiso de proporcionar asistencia financiera a los pacientes que tienen necesidades de atención de la salud y no tienen seguro médico, tienen un seguro insuficiente, no son elegibles para un programa gubernamental o quienes, de otro modo, no pueden pagar su atención médica necesaria por causa de su situación financiera particular.

Es política de las instituciones médicas Johns Hopkins proporcionar Asistencia financiera apoyándose en motivos de indigencia o deudas médicas excesivas y a aquellos pacientes que satisfagan los criterios financieros especificados y soliciten tal asistencia. El propósito de la siguiente declaración de política consiste en describir la manera de presentar las solicitudes de Asistencia financiera y dar a conocer los criterios de elegibilidad y pasos para procesar cada solicitud.

Los hospitales JHHS publicarán la disponibilidad de Asistencia financiera anualmente en sus periódicos locales y colocarán avisos de disponibilidad en los centros de registro, en la Oficina de admisiones/comercial de la Oficina de facturación del paciente y en el servicio de emergencias de cada centro de atención. El Aviso de disponibilidad será colocado en el sitio web de cada hospital, se mencionará durante las comunicaciones orales y también será enviado a los pacientes en las facturas de los pacientes. Se entregará a los pacientes una Hoja de información de facturación y asistencia financiera del paciente antes de darlo de alta, la cual estará disponible a todos los pacientes, según la soliciten.

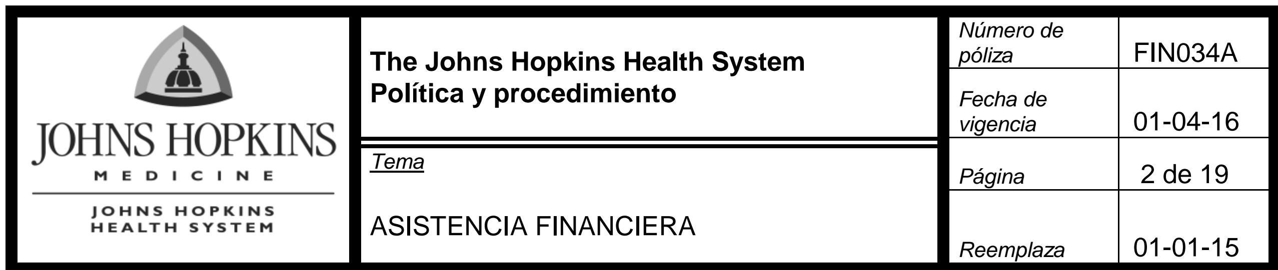
Se podrá ofrecer Asistencia financiera cuando se haya realizado y documentado una revisión de la situación económica particular de un paciente. La Revisión de la Asistencia por dificultades médicas y financieras incluirá una revisión de los gastos médicos y las obligaciones actuales del paciente (incluyendo cualquier cuenta colocada en la lista de deudas incobrables) y cualquier gasto médico proyectado. Las solicitudes de Asistencia financiera y de Asistencia por dificultades médicas y financieras pueden ser ofrecidas a los pacientes cuyas cuentas estén en una agencia de cobro y se aplicarán sólo a aquellas cuentas para las que no se haya concedido un dictamen, siempre que se cumplan otros requisitos.

AVISO DE ASISTENCIA FINANCIERA DE MÉDICOS QUE PROPORCIONAN ATENCIÓN:
Adjunta en el **ANEXO D** se presenta una lista de los médicos que proporcionan atención de emergencia y servicios médicamente necesarios, según se definen en esta política, en las instituciones JHH, JHBMC y JHBCC. Estas listas indican si el médico está incluido en esta política. Si el médico no está incluido en esta política, los pacientes deben comunicarse con la oficina de consulta del médico para determinar si el médico ofrece asistencia financiera y, si es así, cuál es la política de asistencia financiera que ofrece el médico.

Definiciones

Deuda médica

La deuda médica se define como los gastos de bolsillo para cubrir los gastos médicos derivados de la atención médica necesaria facturada por el hospital



Hopkins en el que se presente la solicitud. Los gastos de bolsillo no incluyen copagos, coseguros ni deducibles, a menos que el paciente haya adquirido un seguro a través de un Plan de Salud Calificado y cumpla con los requisitos de elegibilidad. La deuda médica no incluye aquellas facturas de hospital para las que el paciente haya elegido ser registrado como paciente de Pago voluntario por cuenta propia (exclusión voluntaria de la cobertura de seguro, o de facturación de seguro).

Activos líquidos — Efectivo, valores, pagarés, acciones, bonos, bonos de ahorro de Estados Unidos, cuentas corrientes, cuentas de ahorro, fondos mutuales, certificados de depósito, pólizas de seguros de vida con valores de rescate en efectivo, cuentas por cobrar, beneficios de pensión u otra propiedad inmediatamente convertible en efectivo. Una garantía de protección legal de $150.000 en el patrimonio de la residencia principal del paciente no se considerará como activo convertible en efectivo. El patrimonio en cualesquiera otros bienes inmuebles podrá ser objeto de liquidación. Los activos líquidos no incluyen los activos de jubilación para los que el Servicio de Impuestos Internos (IRS) haya concedido trato fiscal preferencial, tales como una cuenta de jubilación incluyendo, sin sentido limitativo, los planes de compensación diferidos que hayan calificado en el marco del Código de Impuestos Internos o los planes de compensación diferidos no calificados.

Admisión electiva — Admisión en el hospital que sea para el tratamiento de una condición médica que no se considere una Condición médica de emergencia.

Familia inmediata — Si el paciente es menor de edad, el miembro de la familia inmediata se define como la madre, el padre, los hermanos solteros menores de edad, naturales o adoptados, que residan en el mismo hogar.
Si el paciente es un adulto, un miembro de la familia inmediata se define como el cónyuge o los hijos menores solteros naturales o adoptivos que residan en el mismo hogar.

Emergencias médicas Condición — Condición médica que se manifieste con síntomas agudos de gravedad suficiente, que puedan incluir dolor severo u otros síntomas agudos de modo tal, que pueda esperarse razonablemente que la ausencia de atención médica inmediata ocasione cualquiera de los eventos siguientes:

(a) Un grave peligro para la salud de un paciente;

(b) Deterioro grave de las funciones corporales;

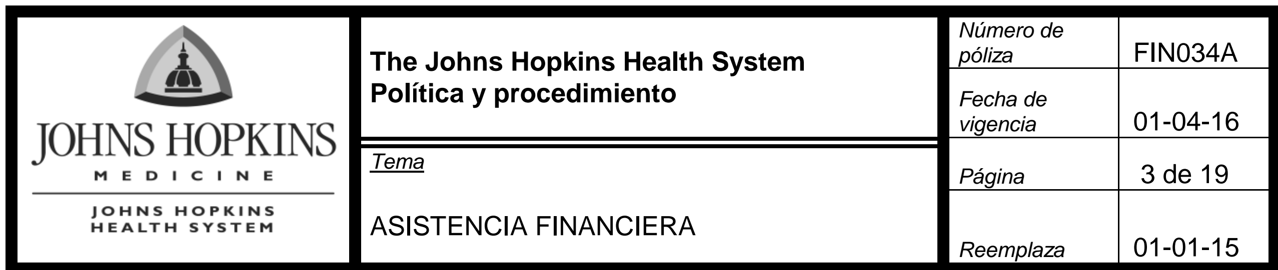
(c) Disfunción grave de cualquier órgano o parte del cuerpo.

(d) Con respecto a una mujer embarazada:

1. Que no haya tiempo suficiente para efectuar un traslado seguro a otro hospital antes del parto.

2. Que un traslado pueda representar una amenaza para la salud y seguridad del paciente o feto.

3. Que haya evidencia de la aparición y persistencia de contracciones uterinas o de ruptura de las membranas.



Servicios y atención de emergencia — Exploración selectiva, exámenes médicos y evaluación por parte de un médico o, en la medida permitida por la ley aplicable, por otros miembros apropiados del personal bajo la supervisión de un médico, para determinar si existe una condición médica de emergencia y, si existe, la atención, tratamiento o cirugía por parte de un médico que sea necesaria para aliviar o contrarrestar la condición médica de emergencia, dentro de la capacidad de servicio del hospital.

Atención médica necesaria — Tratamiento médico que sea necesario para tratar una condición médica de emergencia. La atención médica necesaria, para los efectos de esta política, no incluye los procedimientos electivos o cosméticos.

Admisión médicamente necesaria — Admisión en el hospital que sea para el tratamiento de una condición médica de emergencia.

Ingresos familiares — Sueldos, salarios, ganancias, propinas, intereses, dividendos, distribuciones de réditos en empresas, ingresos por alquiler, jubilación/ingresos de pensión, prestaciones de la Seguridad Social y otros ingresos del paciente y/o la parte responsable, tal como los define el Servicio de Impuestos Internos (IRS), para todos los miembros de su familia inmediata que residan en el hogar.

Documentación de soporte — Talones de pago; W-2; 1099; compensaciones de trabajador, cartas de notificación de beneficios de seguridad social o por discapacidad; estados de cuenta bancarios o de corretaje; declaraciones de impuestos; pólizas de seguro de vida; tasaciones de bienes raíces e informes de oficinas de crédito, explicación de beneficios para respaldar la deuda médica.

Plan de salud calificado — En virtud de la Ley de Asistencia asequible, a partir de 2014, un plan de seguro de salud calificado que cuente con la certificación del Health Insurance Marketplace (mercado de seguros de salud), proporciona beneficios de salud esenciales se rige por los límites establecidos en los costos compartidos (como deducibles, copagos, cantidades máximas de pagos del bolsillo del paciente) y cumple con otros requisitos. Un plan de salud calificado tendrá una certificación para cada mercado en el que se venda.

PROCEDIMIENTOS

1. Una evaluación de asistencia financiera puede comenzar de diversas maneras:

   Por ejemplo:

   - Un paciente con un saldo de pago por cuenta propia vencido notifica al cobrador de pagos por cuenta propia o a una agencia de cobro en sentido de que no está en capacidad de pagar la factura y solicita ayuda.
   - Un paciente se presenta en un área clínica sin seguro y afirma que no está en capacidad de pagar los gastos médicos asociados con sus servicios médicos actuales o anteriores.
   - Un paciente con una cuenta de hospital remitida a una agencia de cobro notifica a la agencia de cobro que no está en capacidad de pagar la factura y solicita ayuda.

- Un médico u otro profesional clínico remite a un paciente para una Evaluación de asistencia financiera, ya sea para servicios de pacientes internos o externos.

2. Cada Clínica o Unidad de negocios designará a una persona o personas que será responsable de tomar las solicitudes de Asistencia financiera. Estos miembros del personal pueden ser Asesores financieros, especialistas en pagos por cuenta propia, personal administrativo, de servicio al cliente, etc.

3. El personal designado se reunirá con los pacientes que soliciten asistencia financiera para determinar si cumplen con los criterios preliminares para la asistencia.

   a. Todas las solicitudes hospitalarias serán procesadas en un lapso de dos días hábiles y se realizará una decisión para determinar la elegibilidad probable. Para facilitar este proceso, cada solicitante debe proporcionar información sobre el tamaño e ingresos de la familia, (como se definen en las normativas de Medicaid). Para ayudar a los solicitantes a completar el proceso, proporcionaremos una declaración de aprobación condicional que les permitirá saber qué documentos se requieren para una determinación final de elegibilidad.
   b. Las solicitudes recibidas serán enviadas a la línea de solicitud de asistencia financiera dedicada del Departamento de servicios financieros del paciente de JHHS para su revisión; al paciente se le emitirá una determinación probable de elegibilidad por escrito.

4. Para determinar la elegibilidad final, se deben cumplir los siguientes criterios:

   a. El paciente debe solicitar Asistencia médica o cobertura de seguro a través de un plan de salud calificado y cooperar plenamente con el equipo de Asistencia médica o con su agente designado, a menos que el representante financiero pueda determinar con rapidez que el paciente no cumple con los requisitos de elegibilidad. El Cuestionario de perfil del paciente (Anexo B) se utiliza para determinar si el paciente debe solicitar Asistencia médica. En los casos en que el paciente tenga cobertura de farmacia con asistencia médica activa o cobertura QMB, no sería necesario volver a solicitar Asistencia médica, a menos que el representante financiero tenga razones para creer que el paciente puede ser beneficiario de Asistencia médica completa.

   b. Considerar su elegibilidad para otros recursos, tales como fondos de dotación, recursos de fundaciones externas, etc.

   c. El paciente debe ser un ciudadano de, o residente legal permanente en, los EE.UU. (debe haber residido en los EE.UU. durante un mínimo de un año).

   d. Todas las posibilidades para obtener beneficios de seguro deben haber sido agotadas.

5. En la medida de lo posible, habrá un solo proceso de solicitud para todos los hospitales JHHS de Maryland. Se requiere que el paciente proporcione lo siguiente:

   a. Una Solicitud de Asistencia financiera completada (Anexo A) y el Cuestionario de perfil del paciente (Anexo B).

   b. Una copia de su más reciente Declaración Federal de Impuestos (si es casado(a), y presenta una solicitud por separado, también debe entregar una copia de la declaración de impuestos del cónyuge y una copia de la declaración de impuestos de cualquier otra persona cuyo ingreso se considere parte de los ingresos de la familia, como se define en las normativas de Medicaid).

c. Una copia de los tres (3) últimos talones de pago (si tiene empleo) o prueba de ingresos de cualquier otra persona cuyo ingreso se considere parte de los ingresos de la familia, tal como se define en normativas de Medicaid.

d. Un Aviso de determinación de asistencia médica (si corresponde).

e. Prueba de ciudadanía de, o estatus legal de residencia permanente en, los EE.UU. (tarjeta verde) según corresponda.

f. Prueba de ingresos por incapacidad (según corresponda).

g. Prueba razonable de otros gastos declarados.

h. Si no está trabajando, prueba razonable de desempleo, como una Declaración de la oficina del seguro de desempleo, una declaración de la fuente actual de apoyo financiero, etc...

6. Un paciente puede solicitar Asistencia financiera, o bien por falta de seguro suficiente, o por deudas médicas excesivas. La Deuda médica se define como los gastos de bolsillo, sin contar copagos, coseguros y deducibles, a menos que el paciente adquiera un seguro a través de un Plan de salud calificado y cumpla con los requisitos de admisión para costos médicos facturados por un hospital Hopkins. Una vez que un paciente haya presentado toda la información exigida, el Asesor financiero revisará y analizará la solicitud y la remitirá al Departamento de servicios financieros del Paciente para la determinación final de elegibilidad, de conformidad con las directrices de JHMI.

   a. Si la solicitud es rechazada, el paciente tiene el derecho de solicitar que la solicitud sea examinada nuevamente. El Asesor financiero enviará la solicitud y los anexos al Comité de Evaluación de Asistencia Financiera para su evaluación y tomar la decisión final.

   b. Si la solicitud del paciente para recibir Asistencia financiera se apoya en deuda médica excesiva, o si hay circunstancias atenuantes identificadas por el Asesor financiero o la persona designada, el Asesor financiero enviará la solicitud y los anexos al Comité de evaluación de asistencia financiera. Este comité tendrá autoridad para tomar la decisión sobre si aprobar o rechazar la solicitud(es). Se espera que para una solicitud de asistencia financiera revisada por el Comité se dicte una resolución definitiva en un lapso de los 30 días contados a partir de la fecha en que la solicitud se considere completa. El Comité de Evaluación de Asistencia Financiera basará su determinación de necesidad financiera apoyándose en las directrices de JHHS.

7. Cada departamento clínico tiene la opción de designar ciertos procedimientos electivos para los que no se dará ninguna opción de asistencia financiera.

8. Los servicios proporcionados a los pacientes registrados como pacientes de Pago voluntario por cuenta propia no califican para asistencia financiera.

9. Un departamento que ponga en práctica programas en el marco de una subvención u otra autoridad gubernamental externa (por ejemplo, Psiquiatría) podrá seguir utilizando un proceso de solicitud patrocinado por el gobierno junto con la escala de ingresos asociada.

10. Una vez que a un paciente se le haya sido aprobada la asistencia financiera, la cobertura de asistencia financiera se hará efectiva para el mes de la determinación y para los siguientes seis (6) meses calendario. Si al paciente se le aprueba una asignación porcentual debido a dificultades financieras, se recomienda que el paciente realice un pago de buena fe al comienzo del período de asistencia financiera. A petición de un paciente que no tiene seguro y cuyo nivel de ingresos se ubique dentro de la Cuadrícula de ingresos de dificultades médicas y financieras incluida en el

Anexo B, JHHS deberá poner un plan de pago a disposición del paciente. Cualquier cronograma de pagos desarrollado a través de esta política normalmente no durará más de dos años. En circunstancias extraordinarias y con la aprobación del gerente designado podrá prorrogarse un cronograma de pagos.

11. Presunción de elegibilidad para asistencia financiera. Hay casos en que un paciente pueda aparecer como elegible para asistencia financiera, pero no existe un formulario de asistencia financiera consignado. Es frecuente que haya información adecuada proporcionada por el paciente u otras fuentes, lo que podría aportar evidencia suficiente para proporcionar Asistencia financiera al paciente. En caso de que no haya evidencia para respaldar la elegibilidad de un paciente para recibir asistencia financiera, JHHS se reserva el derecho de recurrir a agencias externas para determinar las cantidades de ingresos estimados, a efectos de determinar la elegibilidad para asistencia financiera y las posibles tarifas de atención con reducción de costos. Una vez determinada, debido a la naturaleza inherente de las circunstancias presuntas, la única asistencia financiera que se puede conceder es una anulación del 100% del saldo de la cuenta. La Elegibilidad para asistencia financiera presunta sólo será válida para la fecha específica del servicio del paciente y no será efectiva por un período de seis (6) meses. La elegibilidad presunta puede determinarse basándose en las circunstancias de vida individuales. A menos que sea elegible para Medicaid o CHIP, los pacientes que son beneficiarios/ destinatarios de programas de servicio social con comprobación de recursos que aparecen en la lista de la Comisión de revisión de costos de servicios de salud en COMAR 10.37.10.26 A-2 se consideran presuntamente elegibles para la atención gratuita, siempre que el paciente presente una prueba de inscripción en un lapso de 30 días posteriores a la fecha del servicio. Este lapso de 30 días podrá ampliarse a 60 días si el paciente o el representante del paciente solicita 30 días adicionales. El Anexo A-1 proporciona una lista de las circunstancias de vida, además de las especificadas por las normas mencionadas anteriormente que califican a un paciente para Elegibilidad presunta.

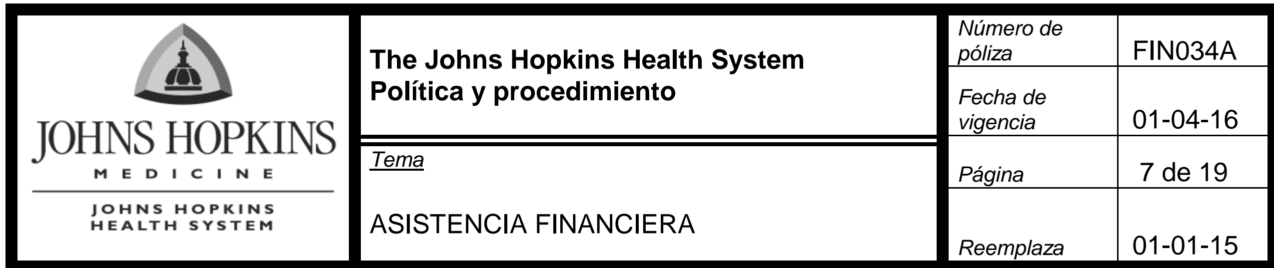
12. Las solicitudes de asistencia financiera sólo podrán ser presentadas para/por pacientes con cuentas de hospital abiertas y cuentas pendientes de pago.

13. Los pacientes que indiquen que están desempleados y no tengan cobertura de seguro estarán obligados a presentar una Solicitud de asistencia financiera, a menos que cumplan los criterios de elegibilidad presunta para asistencia financiera. Si el paciente califica para la cobertura COBRA, la capacidad financiera del paciente para pagar las primas del seguro COBRA serán revisadas por el Asesor financiero y se harán las recomendaciones respectivas al Comité de evaluación de Asistencia financiera. Se exhortará a las personas con capacidad financiera para adquirir un seguro de salud a que adquieran su correspondiente póliza, como un medio para asegurarse de contar con acceso a servicios de salud y para efectos de su salud personal en general.

14. Los pacientes que cuenten con cobertura en un Plan de salud calificado y soliciten asistencia para cubrir los gastos de bolsillo (copagos y deducibles) para gastos médicos derivados de la atención médica necesaria, estarán obligados a presentar una Solicitud de Asistencia financiera si el paciente se ubica en un porcentaje igual o inferior al 200% de las directrices del nivel federal de pobreza.

15. Si la cuenta de un paciente ha sido asignada a una agencia de cobro y el paciente o el fiador solicita Asistencia financiera o parece calificar para Asistencia financiera, la agencia de cobro deberá notificar a PFS y deberá entregar al paciente/fiador una solicitud de asistencia financiera con instrucciones de devolver la solicitud completada a PFS para su revisión y determinación y deberá colocar la cuenta en suspenso durante 45 días en espera de más instrucciones de PFS.

16. A partir del 1 de octubre de 2010, si en un lapso de dos (2) años posteriores a la fecha de servicio, se determina que un paciente es elegible para atención gratuita en la fecha de servicio (según las



normas de elegibilidad aplicables en la fecha de servicio), se deberá reembolsar al paciente las cantidades que el paciente/fiador haya pagado, siempre que sean mayores que $25. Si la documentación del hospital demuestra falta de cooperación del paciente o fiador para suministrar la información necesaria para determinar la elegibilidad para atención gratuita, el período de dos (2) años estipulado en el presente documento podrá reducirse a 30 días contados desde la fecha de la primera solicitud de información. Si el paciente está inscrito en un plan de atención de salud del gobierno con comprobación de recursos que requiera que el paciente pague de su bolsillo los servicios hospitalarios, no serán reembolsados al paciente o fiador los montos que tenga que pagar por causa de que el paciente pierda su elegibilidad financiera para cobertura de salud.

17. Esta Política de asistencia financiera no se aplica a pacientes fallecidos o para quienes se haya abierto, o deba abrirse, una herencia en virtud de los activos pertenecientes a un paciente fallecido. Johns Hopkins presentará una reclamación en el acervo hereditario del difunto y dicha reclamación estará sujeta a la administración del estado y sus leyes sucesorales y fiduciarias aplicables.

18. Los hospitales JHHS pueden prorrogar la asistencia financiera a los residentes con necesidad económica demostrada, independientemente de su nacionalidad, en los vecindarios que circundan a sus respectivos hospitales, según lo determinado por la Evaluación de necesidades de salud de la comunidad cercana al hospital. Los códigos postales de JHH y JHBMC son: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231 y 21052. Una vez que a un paciente se le haya aprobado asistencia financiera, la cobertura de asistencia financiera se hará efectiva durante el mes de la determinación y los siguientes seis (6) meses calendario. Los Asesores financieros remitirán a estos pacientes al programa The Access Partnership en Hopkins (consulte FIN057 para informarse sobre los procedimientos específicos).

REFERENCIA[1]

Manual de Políticas y Procedimientos Financieros de JHHS

Política Nº FIN017 - Firma Autoridad: Servicios Financieros del Paciente
Política No. FIN033 - Pagos a plazos

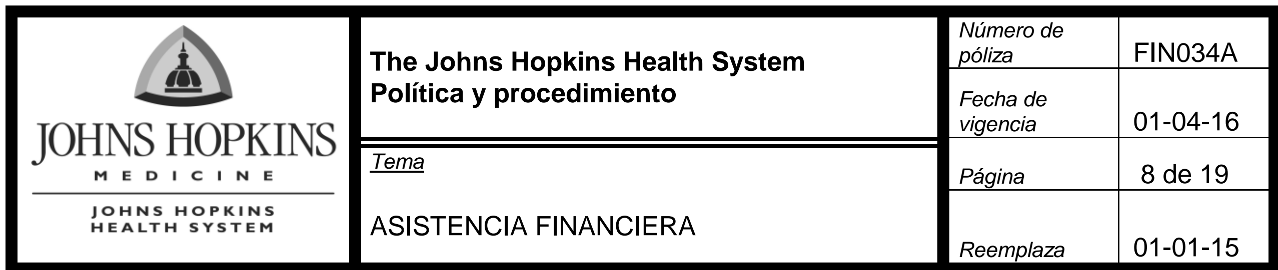
Atención caritativa y deudas incobrables, Guía AICPA de auditoría de atención a la salud

Código de Normativas de Maryland COMAR 10.37.10.26 y siguientes
Código General de Salud de Maryland 19 a 214 y siguientes
Directrices del nivel federal de pobreza (actualizado anualmente) en el Registro Federal

RESPONSABILIDADES - JHH, JHBMC

Asesor financiero (Pre-Admisión/Admisión/Paciente admitido/Ambulatorio) Coordinador d	Entender los criterios actuales de la calificación para asistencia. Identificar a los posibles pacientes; iniciar el proceso de solicitud

1[1] NOTA: Se han desarrollado solicitudes estandarizadas para la Asistencia financiera, Cuestionario de perfil de paciente y Dificultades médicas y financieras. Para obtener información sobre cómo realizar un pedido de las mismas, comuníquese con el Departamento de servicios financieros del Paciente. Se adjuntan copias a esta política como Anexos A, B y C.



servicio al cliente Coordinador de admisiones Cualquier representante de finanzas designado para aceptar solicitudes de Asistencia financiera	cuando sea necesario. Si es necesario, ayudar a los pacientes a completar la solicitud o el formulario específico para el programa. En la fecha en que se reciba la solicitud preliminar, enviar por fax a la línea de fax dedicada del Departamento de servicios financieros al paciente para la determinación de la elegibilidad probable. Revisar la solicitud preliminar, el Cuestionario de perfil del paciente y la Solicitud de dificultades médicas y financieras (si son presentadas) para hacer la determinación de elegibilidad probable. En un lapso de dos días hábiles posteriores a la recepción de la solicitud preliminar, enviar la determinación por correo convencional a la última dirección conocida del paciente o entregar al paciente si el paciente es actualmente un paciente hospitalizado. Tome en cuenta los comentarios del paciente. Si no es necesaria una Solicitud de asistencia financiera, debido a que el paciente cumple con los criterios específicos, tome en cuenta los comentarios del paciente sobre la cuenta y reenvíe al personal de administración para su revisión. Revisar y asegurarse que la solicitud final haya sido completada. Entregar la solicitud final completada a la gerencia correspondiente. Documentar todas las transacciones en todos los comentarios de cuenta de paciente que correspondan. Identificar candidatos retroactivos; iniciar el proceso de solicitud final.
Personal de administración (Supervisor/Gerente/Director)	Revisar la solicitud final completada; supervisar aquellas cuentas para las cuales no se requiera solicitud; determinar la elegibilidad del paciente; comunicar la determinación final por escrito al paciente en un lapso de 30 días laborales posteriores a la recepción de solicitud completada. Si el paciente es elegible para atención con reducción de costos, aplicar la reducción más favorable en los cargos para los que califique el paciente. Asesorar a los pacientes no elegibles sobre otras alternativas disponibles para ellos, incluidos los pagos a plazos, préstamos bancarios o la consideración en el marco del programa de Dificultades médicas y financieras, si no han presentado la solicitud suplementaria, Anexo C. [Consultar el Anexo B -. Directrices de asistencia por dificultades médicas y financieras] No se enviarán notificaciones a los destinatarios de elegibilidad presunta.
Personal de administración financiera (Director Senior/Tesorero adjunto o afiliado equivalente)	Revisar y aprobar las solicitudes de asistencia financiera y las cuentas para las que no se requiere solicitud y que no se anulan automáticamente de acuerdo con la autoridad de firma establecida

Director de CP y personal de administración	en la Política de finanzas de JHHS Nº FIN017 - Autoridad de firma: Servicios financieros del paciente.

PATROCINADOR

Director Senior de Finanzas del Paciente (JHHS)
Director de Operaciones de PFS (JHHS)

CICLO DE REVISIÓN

Dos (2) años

APROBACIÓN

_______________________________________ ____________________
VP Senior de Finanzas/Tesorero y CFO de JHH y JHHS Fecha

ANEXO A
DIRECTRICES DE ELEGIBILIDAD DEL PROGRAMA DE ASISTENCIA FINANCIERA

1. Cada paciente que solicite asistencia financiera debe llenar una solicitud Asistencia financiera de JHM (también conocida como Solicitud de asistencia financiera uniforme del estado de Maryland), Anexo A, y el Cuestionario de perfil del paciente, Anexo B. Si el paciente desea ser considerado para Dificultades médicas y financieras, el paciente debe presentar la Solicitud de asistencia por dificultades médicas y financieras, Anexo C.

2. Se aceptará una solicitud preliminar que indique el tamaño de la familia y los ingresos familiares (tal como se definen en las normativas de Medicaid) y se hará una determinación de elegibilidad probable en un lapso de dos días hábiles siguientes a la recepción de la solicitud.

3. El paciente debe solicitar Asistencia médica o cobertura de seguro a través de un Plan de salud calificado y cooperar plenamente con el equipo de Asistencia médica o su agente designado, a menos que el representante financiero pueda determinar con rapidez que el paciente no cumple con los requisitos de elegibilidad. Se ha desarrollado un cuestionario del perfil del paciente (consulte el Anexo B) para determinar si el paciente debe solicitar Asistencia médica. En los casos en que el paciente tenga cobertura de farmacia con asistencia médica activa o cobertura QMB, no sería necesario volver a solicitar Asistencia médica, a menos que el representante financiero tenga razones para creer que el paciente puede ser beneficiario de Asistencia médica completa.

4. El paciente debe ser un ciudadano de, o residente legal permanente en, los EE.UU. (debe haber residido en los EE.UU. durante un mínimo de un año)

5. La prueba de ingresos debe estar provista de la solicitud final. Entre las pruebas aceptables figuran las siguientes:
   (a) Declaración de impuestos del año anterior;
   (b) Talones de pago actuales;
   (c) Carta del empleador o, si presenta documentación de desempleo, verificación del estado de desempleo; y
   (d) Un informe de agencia de crédito obtenido por los afiliados de JHM y/o por el Departamento de servicios financieros del paciente.

6. Los pacientes serán elegibles para recibir Asistencia financiera si el nivel de ingresos máximo (marido y mujer, parejas casadas del mismo sexo) de su familia (como se define en las normativas de Medicaid) no es superior al estándar de cada afiliado (en relación con las directrices federales de pobreza) y que no poseen activos líquidos *que excedan $10,000, los cuales estarían disponibles para honrar sus facturas de afiliado a JHHS.

7. Se deben utilizar todos los recursos financieros para poder solicitar la Asistencia financiera. Esto incluye seguros, Asistencia médica y todos los demás programas de asistencia social para los cuales el paciente pueda calificar.

8. Los pacientes que opten por pasar a ser pacientes de Pago voluntario por cuenta propia no califican para Asistencia financiera para la cantidad adeudada en ninguna cuenta registrada como Pago voluntario por cuenta propia.

9. La Asistencia financiera sólo es aplicable a la Atención médica necesaria, tal como se define en esta política. La Asistencia financiera no es aplicable a artículos de comodidad, alojamiento en una habitación privada ni cirugía estética que no sea esencial. Los cargos no hospitalarios serán

responsabilidad del paciente. En caso de que surja una pregunta sobre si una admisión es una "Admisión electiva" o es una "Admisión médicamente necesaria", se deberá consultar al médico que haya admitido al paciente y el asunto también será remitido al asesor médico designado por el hospital.

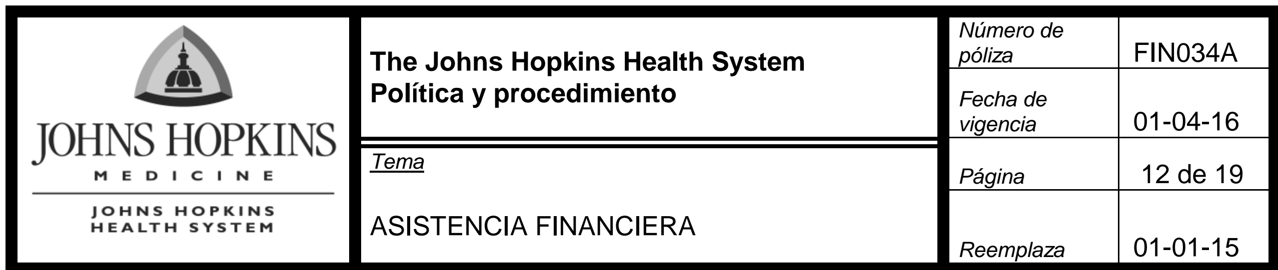
10. Cada afiliado determinará la elegibilidad final para Asistencia financiera en un lapso de treinta (30) días hábiles contados desde el día en que la solicitud haya sido satisfactoriamente completada y presentada.
11. La documentación de la determinación final de elegibilidad se realizará en todas las cuentas del paciente (saldos abiertos). Se enviará al paciente un aviso de determinación.

12. Una determinación de elegibilidad para Asistencia financiera basada en la presentación de una Solicitud de asistencia financiera seguirá siendo válida durante un período de seis (6) meses para todos los servicios de afiliado a JHM necesarios prestados, basándose en la fecha de la carta de determinación. Los pacientes que actualmente estén recibiendo Asistencia financiera de uno de los afiliados a JHM no tendrán que volver a solicitar la Asistencia financiera de otro afiliado.

13. Todas las determinaciones de elegibilidad para Asistencia financiera se realizarán únicamente a discreción del afiliado a JHHS.

Excepción

El Director de Servicios financieros del paciente (o su equivalente en un afiliado) puede hacer excepciones de acuerdo a las circunstancias individuales.



CUADRÍCULA DE INGRESOS DE DIFICULTADES MÉDICAS Y FINANCIERAS PARA ATENCIÓN GRATUITA O CON REDUCCIÓN DE COSTOS

TABLA PARA DETERMINAR LAS ASIGNACIONES DE ASISTENCIA FINANCIERA

Con entrada en vigencia el 28 de febrero de 2016

Número de personas en la familia	Nivel de ingresos*	Límites superiores de los insegresos para la gama de signaciones				
1	**$ 23,760**	$ 26,136	$ 28,512	$ 30,888	$ 33,264	$ 35,640
2	**$ 32,040**	$ 35,244	$ 38,448	$ 41,652	$ 44,856	$ 48,060
3	**$ 40,320**	$ 44,352	$ 48,384	$ 52,416	$ 56,448	$ 60,480
4	**$ 48,600**	$ 53,460	$ 58,320	$ 63,180	$ 68,040	$ 72,900
5	**$ 56,880**	$ 62,568	$ 68,256	$ 73,944	$ 79,632	$ 85,320
6	**$ 65,160**	$ 71,676	$ 78,192	$ 84,708	$ 91,224	$ 97,740
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
**Monto por miembro	$8,320	$9,152	$9,984	$10,816	$11,648	$12,480 cada
Asignación que se proporcionará:	100%	80%	60%	40%	30%	20%

* 200% de las Directrices de pobreza
** Para familias con más de ocho (8) miembros.

EJEMPLO:

EJEMPLO:	Ingreso familiar anual	$55.000
	Número de personas en la familia	4
	Nivel de ingresos de pobreza aplicable	48.600
	Límites superiores de los rangos de asignación	$58.320 (rango de 60%)

($55.000 es menos que el límite superior de ingresos, por lo que el paciente es elegible para recibir Asistencia financiera.)

Anexo A-1

Elegibilidad para asistencia financiera presunta

Hay casos en que un paciente pueda aparecer como elegible para asistencia financiera, pero no existe un formulario de asistencia financiera consignado. A menudo, hay información adecuada proporcionada por el paciente o por medio de otras fuentes, lo que podría bastar como evidencia para proporcionar Asistencia financiera al paciente. En caso de que no haya evidencia para respaldar la elegibilidad de un paciente para recibir asistencia financiera, JHHS se reserva el derecho de recurrir a agencias externas para determinar las cantidades de ingresos que le sirva como base a fin de estimar la elegibilidad para asistencia financiera y las posibles tarifas de atención con reducción de costos. Una vez determinada, debido a la naturaleza inherente de las circunstancias presuntas, la única asistencia financiera que puede concederse es una anulación del 100% del saldo de la cuenta. La Elegibilidad para asistencia financiera presunta sólo será válida para la fecha específica del servicio del paciente y no será efectiva por un período de seis (6) meses. La presunta elegibilidad puede determinarse basándose en las circunstancias de vida individuales, entre las que podrían figurar:

- Cobertura de farmacia con asistencia médica activa
- Cobertura QMB / cobertura SLMB
- Carencia de vivienda
- Pacientes con Asistencia médica y Medicaid Managed Care por servicios prestados en la sala de emergencias que superen la cobertura de estos programas
- Pacientes de emergencia por petición del Sistema de Salud Pública de Maryland
- Participación Programas para mujeres, infantes y niños (WIC)*
- Programa de asistencia nutricional complementaria (SNAP) o elegibilidad para Cupones de alimentos *
- Hogares con niños en el programa de Almuerzo gratis o con costo reducido *
- Participación en programas de asistencia energética para hogares con bajos ingresos*
- Elegibilidad para otros programas de asistencia estatales o locales que tengan elegibilidad financiera de, o por debajo de, 200% del FPL
- El paciente ha fallecido sin sucesión patrimonial conocida
- Programa Access Partnership (consulte FIN057 para informarse sobre los procedimientos específicos)
- Los pacientes a quienes se determine que satisfacen los criterios de elegibilidad establecidos en virtud del antiguo Programa de Asistencia médica proveniente sólo del estado
- El Programa de atención de salud para el embarazo de JHBMC (consulte FIN053 para informarse sobre los procedimientos específicos)

*Estas circunstancias de vida se exponen en COMAR 10.37.10.26 A-2. El paciente debe presentar un comprobante de inscripción en estos programas en un lapso de 30 días posteriores al tratamiento, a menos que el paciente solicite un período adicional de 30 días.

ANEXO B
DIRECTRICES DE ASISTENCIA POR DIFICULTADES MÉDICOS Y FINANCIERAS

Propósito

Estas directrices están destinadas a proporcionar una determinación separada, complementaria, de la Asistencia financiera. Esta determinación se ofrecerá a todos los pacientes que soliciten Asistencia financiera.

La Asistencia por dificultades médicas y financieras está disponible para los pacientes que no son elegibles para la Asistencia financiera en el marco de la sección principal de esta política, sino para quienes:
1.) Hayan generado una deuda médica durante un período de doce (12) meses que supere el 25% de los ingresos familiares, lo cual les haya creado dificultades médicas y financieras; y
2.) cumplan con los estándares de ingresos para este nivel de asistencia.

Para aquellos pacientes que sean elegibles para la atención con reducción de costos según los criterios de Asistencia financiera y también califiquen según las directrices de Asistencia por dificultades médicas y financieras, JHHS aplicará la cantidad de reducción en los cargos que sea más favorable para el paciente.

Las Dificultades médicas y financieras se definen como la deuda médica por tratamiento médicamente necesario incurrido por una familia durante un período de doce (12) meses, la cual supere el 25% de los ingresos de esa familia.

La deuda médica se define como gastos de bolsillo para los gastos médicos de la Atención médica necesaria facturados por el hospital Hopkins en el que se presente la solicitud; los gastos de bolsillo mencionados anteriormente no incluyen los copagos, coseguros, ni deducibles, salvo que el paciente se encuentre por debajo del 200% del nivel federal de pobreza.

El paciente/fiador puede solicitar que se haga tal determinación presentando una Solicitud de Asistencia por dificultades médicas y financieras (Anexo C), al presentar la Solicitud de Asistencia de JHM/financiera, también conocida como Solicitud de asistencia financiera uniforme del Estado de Maryland (Anexo A) y el Cuestionario de perfil del paciente (Anexo B). El fiador del paciente también debe presentar la documentación financiera de los ingresos familiares para los doce meses (12) calendario anteriores a la fecha de la solicitud y la documentación que acredite una deuda médica de al menos 25% de los ingresos familiares.

Una vez que a un paciente se le haya aprobado la Asistencia financiera por dificultades médicas, la cobertura de Asistencia financiera por dificultades médicas se hará efectiva a partir del mes del primer servicio calificado y los siguientes doce (12) meses calendario. Se cubrirá a los miembros de la familia inmediata del paciente que residan en el mismo hogar. El paciente y los miembros de la familia inmediata seguirán siendo elegibles para la atención médica necesaria con reducción de costos cuando posteriormente busquen atención en el mismo hospital durante doce (12) meses calendario a partir de la fecha en que inicialmente se haya recibido la atención médica necesaria con reducción de costos. La cobertura no se aplicará a las Admisiones electivas, ni a procedimientos electivos o cosméticos. Sin embargo, el paciente o el miembro de la familia inmediata del paciente que resida en el mismo hogar debe notificar al hospital acerca de su elegibilidad para la atención médica necesaria con reducción de costos al momento de registrarse o al ser admitido(a).

Condiciones generales para la Solicitud de asistencia por dificultades médicas y financieras:

1. El ingreso del paciente es inferior a 500% del nivel federal de pobreza.

2. El paciente ha agotado toda la cobertura de seguro.
3. Los saldos de las cuentas del paciente para los pacientes que optaron por inscribirse como pacientes de pago voluntario por cuenta propia no se cuentan para deuda médica para Asistencia por dificultades médicas y financieras.
4. El paciente/fiador no posee activos líquidos *que excedan $10.000, los cuales estarían disponibles para satisfacer sus facturas de afiliados a JHHS.
5. El paciente no es elegible para ninguna de las asistencias siguientes:
   - Asistencia médica
   - Otras formas de asistencia disponibles a través de afiliados a JHM
6. El paciente no es elegible para el Programa de Asistencia financiera de JHM, o es elegible, pero el Programa de dificultades médicas y financieras pudiera ser más favorable para el paciente.
7. El afiliado tiene derecho a solicitar que el paciente presente la documentación de respaldo actualizada.
8. El período de tiempo máximo permitido para pagar la cantidad no cubierta por la Asistencia financiera es de tres (3) años.
9. Si un paciente de Medicaid calificado a nivel federal requiriese un tratamiento que no haya sido aprobado por Medicaid, pero puede ser elegible para cobertura en el marco del programa de Asistencia por dificultades médicas y financieras, el paciente, de cualquier modo, deberá presentar una Solicitud de Asistencia por dificultades médicas y financieras de JHHS, pero no tiene que presentar la documentación de apoyo por duplicado.

Factores a considerar

Los siguientes factores se tendrán en cuenta en la evaluación de una solicitud de Asistencia por dificultades médicas y financieras:

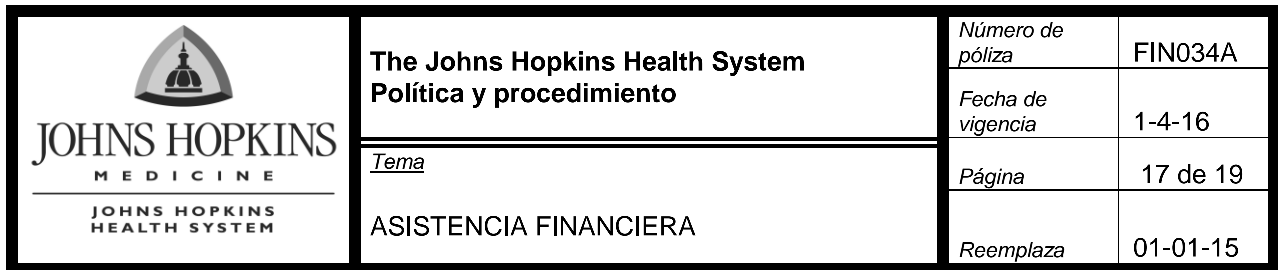
- Deuda médica incurrida durante los doce (12) meses anteriores a la fecha de la Solicitud de Asistencia por dificultades financieras en el centro de tratamiento Hopkins donde se presentó la solicitud.
- Activos Líquidos (dejando un residuo de $10.000)
- Ingresos familiares de los meses de doce (12) anteriores a la fecha de la solicitud de Asistencia por dificultades financieras
- Documentación de respaldo

Excepción

El Director o su designado de Servicios financieros al paciente (o su equivalente en un afiliado) pueden hacer excepciones según las circunstancias individuales.

Método y proceso de evaluación

1. El Asesor financiero revisará la Solicitud de Asistencia por dificultades médicas y financieras y la documentación de las garantías aportadas por el paciente/parte responsable.
2. El Asesor financiero luego completará una Hoja de cálculo de Asistencia por dificultades médicas y financieras (que se encuentra en la parte inferior de la solicitud) para determinar la elegibilidad para una consideración especial en virtud de este programa. En el proceso de notificación y aprobación



se utilizarán los mismos procedimientos descritos en la sección del Programa de asistencia financiera de esta política.

CUADRÍCULA DE DIFICULTADES MÉDICAS Y FINANCIERAS

Límites superiores del ingreso de la familia para el rango de asignación

TABLA PARA DETERMINAR LAS ASIGNACIONES DE ASISTENCIA FINANCIERA

Con entrada en vigencia el 28 de febrero de 2016

Número de personas en la familia	Nivel de ingresos**		
Número de personas en la familia	*300% of FPL	400% of FPL	500% of FPL
1	**$ 35,640**	$ 47,520	$ 59,400
2	**$ 48,060**	$ 64,080	$ 80,100
3	**$ 60,480**	$ 80,640	$ 100,800
4	**$ 72,900**	$ 97,200	$ 121,500
5	**$ 85,320**	$ 113,760	$ 142,200
6	**$ 97,740**	$ 130,320	$ 162,900
7	**$ 110,190**	$ 146,920	$ 183,650
8*	**$ 122,670**	$ 163,560	$ 204,450
Asignación que se proporcionará:	50%	35%	20%

*Para familias con más de 8 miembros, sume $12.480 por cada persona adicional a 300% del FPL, $16.640 a 400% de FPL; y $20.800 a 500% del FPL.

Anexo A

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

Solicitud de Asistencia financiera uniforme del Estado de Maryland

Información sobre usted

Nombre ____
Primer nombre Segundo nombre Apellido

Número de seguridad social ______-____-______ Estado civil: Soltero(a) Casado(a) Separado(a)
Ciudadano estadounidense: Si No Residente permanente: Si No

Dirección de su residencia___________________________________ Teléfono _______________

____

____ _______________
Ciudad Estado Código Zip País

Nombre del empleador _____________________________________ Teléfono _______________

Dirección en el trabajo______________________________________

____
Ciudad Estado Código Zip

Miembros del hogar:

_________________________________ _____ ______________________________
Nombre Edad Relación
_________________________________ _____ ______________________________
Nombre Edad Relación
_________________________________ _____ ______________________________
Nombre Edad Relación
_________________________________ _____ ______________________________
Nombre Edad Relación
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Nombre Edad Relación
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Nombre Edad Relación
_________________________________ _____ ______________________________
Nombre Edad Relación

¿Ha solicitado Asistencia médica Sí No
En caso afirmativo, ¿en qué fecha hizo su solicitud? _______________
En caso afirmativo, ¿qué se determinó? ____
¿Recibe usted algún tipo de ayuda estatal o de condado? Sí No

Anexo A

I. Ingresos de la familia

Indique la cantidad de todas sus fuentes de ingresos mensuales. Posiblemente se le exija suministrar una prueba de ingresos, activos y gastos. Si usted no tiene ingresos, por favor, proporcione una carta de apoyo de la persona que le proporciona alojamiento y comidas.

	Cantidad mensual
Empleo	________________
Beneficios de jubilación/pensión	________________
Beneficios de Seguro Social	________________
Beneficios de asistencia pública	________________
Beneficios por discapacidad	________________
Beneficios de desempleado	________________
Beneficios para veteranos	________________
Pensión alimenticia	________________
Ingresos por propiedades en alquiler	________________
Beneficios de huelga	________________
Adjudicación militar	________________
Empleo en granja o autoempleo	________________
Otras fuentes de ingresos	________________
Total	__________________

II. Activos líquidos	Saldo actual
Cuenta corriente	________________
Cuenta de ahorros	________________
Acciones, bonos, certificados de depósito o en el mercado monetario	________________
Otras cuentas	________________
Total	__________________

III. Otras activos

Si es propietario de cualquiera de los siguientes elementos, indique el tipo y valor aproximado.

Vivienda	Saldo del préstamo _________________		Valor aproximado ___________
Automóvil	Marca ___________	Año ___________	Valor aproximado ___________
Vehículo adicional	Marca ___________	Año ___________	Valor aproximado ___________
Vehículo adicional	Marca ___________	Año ___________	Valor aproximado ___________
Otros bienes			Valor aproximado ___________
		Total	___________

IV. Gastos mensuales	Cantidad
Alquiler o hipoteca	___________
Servicios públicos	___________
Pago(s) de automóvil	___________
Tarjeta(s) de crédito	___________
Seguro de automóvil	___________
Seguro de salud	___________
Otros gastos médicos	___________
Otros gastos	___________
Total	___________

¿Tiene otras facturas médicas sin pagar? Sí No

¿Por cuál servicio? ____

Si ha acordado un plan de pago, ¿cuál es el pago mensual? _____________________________

Si solicita que el hospital le extienda asistencia financiera adicional, el hospital podría solicitarle información adicional con el fin de tomar una determinación complementaria. Al firmar este formulario, usted certifica que la información proporcionada es verdadera y se compromete a notificar al hospital acerca de cualquier cambio en la información proporcionada en un lapso de diez días posteriores al cambio.

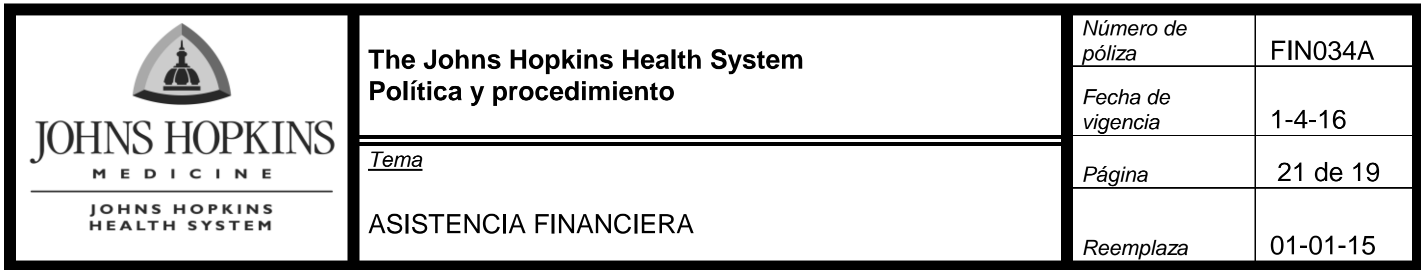
Anexo A

______________________________________ ______________________

Firma del solicitante Fecha

____

Relación con el paciente



ANEXO B CUESTIONARIO DEL PERFIL DE SERVICIOS FINANCIEROS DEL PACIENTE

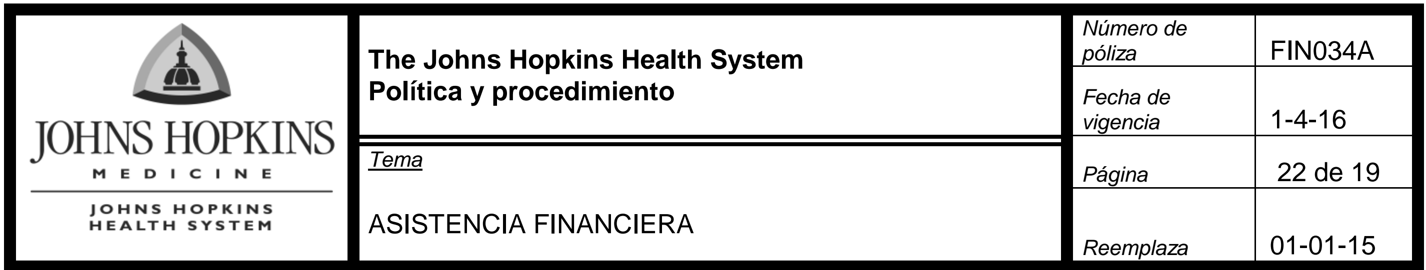
NOMBRE DEL HOSPITAL: ____

NOMBRE DEL PACIENTE: ____

DIRECCION DEL PACIENTE: ____
(Incluya el código Zip)

REGISTRO MÉDICO #:______________________________________

1. ¿Cuál es la edad del paciente? ________
2. ¿Es el paciente un ciudadano de EE.UU. o un residente permanente? Sí o No
3. ¿Está la paciente embarazada? Sí o No
4. ¿El paciente tiene hijos menores de 21 años de edad que viven en casa? Sí o No
5. ¿El paciente es ciego o ha estado potencialmente inhabilitado durante 12 meses, o más, para un empleo remunerado? Sí o No
6. ¿El paciente está recibiendo actualmente beneficios de SSI o SSDI? Sí o No
7. ¿El paciente (y, si es casado, su cónyuge) tiene cuentas bancarias o activos totales convertibles en efectivo que no superen las siguientes cantidades? Sí o No
   Tamaño de la familia:
   Individual: $2.500.00
   Dos personas: $3.000,00
   Por cada miembro adicional de la familia, sume $100,00
   (Ejemplo: Para una familia de cuatro, si usted tiene activos líquidos totales menores a $3.200,00, le conviene contestar SÍ).
8. ¿Es el paciente un residente del estado de Maryland? Sí o No
   Si no es residente de Maryland, ¿en qué estado reside el paciente? ________
9. ¿El paciente carece de vivienda? Sí o No
10. ¿El paciente participa en WIC? Sí o No
11. ¿El hogar tiene niños en el programa de almuerzo gratuito o de costo reducido? Sí o No
12. ¿El hogar participa en el programa de asistencia energética por bajos ingresos? Sí o No
13. ¿El paciente recibe SNAP/cupones para alimentos? Sí o No
14. ¿Está el paciente inscrito en Healthy Howard y fue remitido a JHH? Sí o No
15. ¿Tiene el paciente actualmente...?
    Asistencia médica sólo farmacia Sí o No
    Cobertura QMB/cobertura SLMB Sí o No
16. ¿Está empleado el paciente? Sí o No
    Si no, determine la fecha en que quedó desempleado. ________
    ¿Es elegible para cobertura de seguro de salud COBRA? Sí o No



ANEXO C SOLICITUD POR DIFICULTADES MÉDICAS FINANCIERAS

NOMBRE DEL HOSPITAL: ____

NOMBRE DEL PACIENTE: ____

DIRECCION DEL PACIENTE: ____
(Incluya el código Zip)

REGISTRO MÉDICO #:____

Fecha: ____

Ingresos de la familia de doce (12) meses calendario precedentes a la fecha de esta solicitud: ___________________

Deuda médica incurrida en el Hospital Johns Hopkins (sin incluir coaseguros, copagos o deducibles) para los doce (12) meses anteriores a la fecha de esta solicitud:

Fecha del servicio	Cantidad adeudada
_________________	________________________
_________________	________________________
_________________	________________________
_________________	________________________

Toda la documentación presentada pasa a ser parte de esta solicitud.
Toda la información presentada en la solicitud es verdadera y exacta a mi mejor saber y entender.

_____________________________________ Fecha: _____________________
Firma del solicitante:

____
Relación con el paciente

Para uso interno:

Revisada por: ____________________________________ Fecha: ______________

Ingresos: __________________________ 25% de los ingresos = _____________________

Deuda médica: ______________________ Porcentaje de la asignación: ____________________

Reducción: _________________________ Saldo adeudado: _______________

Monto mensual del pago: _____________ Duración del plan de pagos: ________ meses

APPENDIX IV

PATIENT INFORMATION SHEET

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

PATIENT BILLING and FINANCIAL ASSISTANCE INFORMATION SHEET

Billing Rights and Obligations

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

Financial Assistance

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

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

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

Call: 410-955-5464

with questions concerning:

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

For information about Maryland Medical Assistance

Contact your local department of Social Services

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

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

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

1296 (9/10)

JOHNS HOPKINS
MEDICINE

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

HOJA INFORMATIVA SOBRE LA FACTURACIÓN DE PACIENTES Y LA ASISTENCIA FINANCIERA

Los derechos y obligaciones de la facturación

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

Asistencia financiera

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

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

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

Llame a 410-955-5464

con sus preguntas referentes a:

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

Para más información sobre la Asistencia Médica de Maryland
Por favor llame a su departamento local de Servicios Sociales
1-800-332-6347 TTY 1-800-925-4434
O visite al: www.dhr.state.md.us

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

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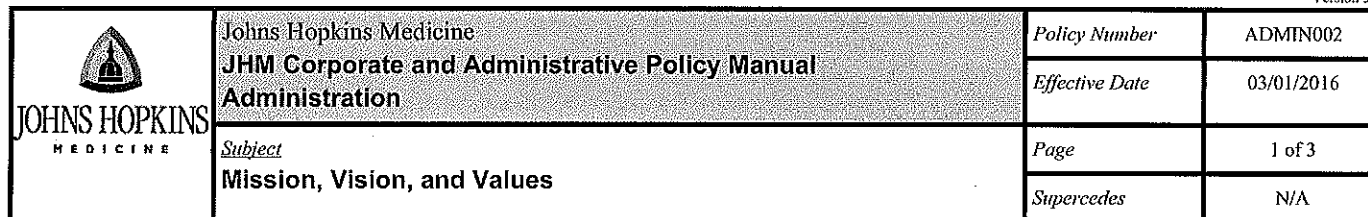
APPENDIX V

MISSION

VISION

VALUE STATEMENT



Johns Hopkins Medicine **JHM Corporate and Administrative Policy Manual** **Administration**	*Policy Number*	ADMIN002
	Effective Date	03/01/2016
Subject **Mission, Vision, and Values**	*Page*	1 of 3
	Supercedes	N/A

This document applies to the following Participating Organizations:

All Children's Health System, Inc.
All Children's Hospital
Howard County General Hospital
Johns Hopkins Bayview Medical Center
Johns Hopkins Community Physicians
Johns Hopkins HealthCare LLC
Johns Hopkins Home Care Group
Johns Hopkins Medicine International
Johns Hopkins School of Medicine
Sibley Memorial Hospital
Suburban Hospital
The Johns Hopkins Health System Corporation
The Johns Hopkins Hospital

Keywords: Mission, Values, Vision

I. PURPOSE

A. This policy describes the mission, vision, and values for Johns Hopkins Medicine (JHM) which are adopted by the Board of Johns Hopkins Medicine and the Participating Organizations which have evidenced their adoption by signing this policy.

II. POLICY

A. **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.

B. **JHM Vision**
Johns Hopkins Medicine pushes the boundaries of discovery, transforms health care, advances medical education and creates hope for humanity. Together, we will deliver the promise of medicine.

C. **JHM Values**
- Excellence & Discovery
- Leadership & Integrity
- Diversity & Inclusion
- Respect & Collegiality

III. RELATIONSHIP TO PARTICIPATING ORGANIZATIONS' MISSION, VISION AND VALUES

A. Each Participating Organization may adopt its own unique mission and vision so long as such mission and vision are not inconsistent with the JHM Mission and Vision.
B. Each Participating Organization shall adopt the JHM Values as the values of the Participating Organization.

IV. DISSEMINATION

This policy will be communicated to the appropriate JHM personnel via the following channels:

A. The President of each Participating Organization will be accountable for dissemination and implementation of this document.
B. Substantive updates and revisions shall be communicated at the JHM monthly Corporate and Administrative Policy Committee meetings.

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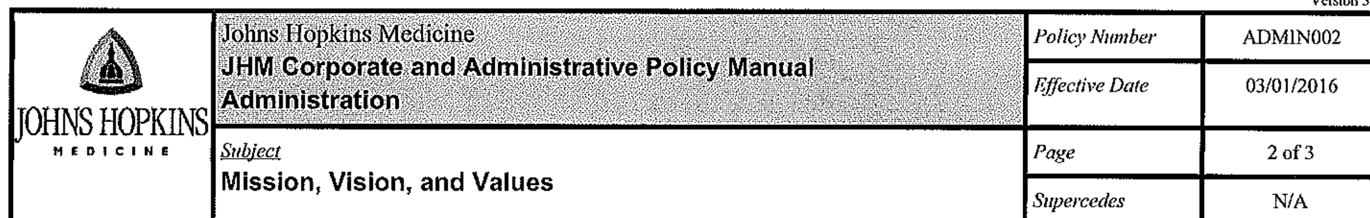

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		Supercedes	N/A

C. Approved policies shall be placed on the enterprise location of the Hopkins Policy and Document Library policy management website.

V. SUPPORTIVE INFORMATION

Sponsor:

- Office of Johns Hopkins Medicine (JHM)

Developer

- JHM Corporate and Administrative Policy Committee

Review Cycle: 3 years	**Office of JHM-** Approval Date: 1/14/2016	Effective Date: 3/1/16

VI. SIGNATURES

Electronic Signature(s)	Date
Ronald Peterson The Johns Hopkins Hospital and Johns Hopkins Health System Corporation, President	02/15/2016
Richard Bennett Johns Hopkins Bayview Medical Center, President	02/22/2016
Steven Snelgrove Howard County General Hospital, Inc., President	02/15/2016
Jacqueline Schultz Suburban Hospital, Inc., Acting President	02/15/2016
Richard Davis The Lucy Webb Hayes National Training School for Deaconnesses and Missionaries d/b/a Sibley Memorial Hospital, President	02/12/2016
Steven Kravet Johns Hopkins Community Physicians, Inc., President	02/25/2016
Jonathan Ellen All Children's Hospital, Inc., All Children's Health System, Inc, President	02/18/2016
Pamela Paulk Johns Hopkins International, LLC, President	02/14/2016
Patricia Brown Johns Hopkins HealthCare LLC, President	02/15/2016

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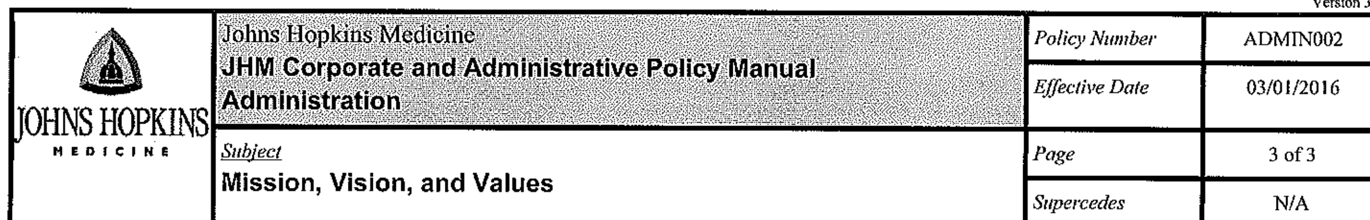

Mary Myers Johns Hopkins Home Care Group, Chief Operating Officer	02/26/2016
Paul Rothman (KL) Dean of the Medical Faculty, CEO Johns Hopkins Medicine	03/14/2016

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