Q1.
Introduction:

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission developed a two-part community benefit reporting system that includes an inventory spreadsheet that collects financial and quantitative information and a narrative report to strengthen and supplement the inventory spreadsheet. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. This reporting tool serves as the narrative report. The instructions and process for completing the inventory spreadsheet remain the same as in prior years. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for FY 2018.

	Is this information correct?		If no, please provide the correct information here:
	Yes	No	
The proper name of your hospital is: The Johns Hopkins Hospital	◉	○	
Your hospital's ID is: 210009	◉	○	
Your hospital is part of the hospital system called Johns Hopkins Health System.	◉	○	

Q4. The next two questions ask about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. (Optional) Please describe any other community health statistics that your hospital uses in its community benefit efforts.

In 2015, the Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) merged their respective Community Benefit Service Areas (CBSA) in order to better integrate community health and community outreach across the East and Southeast Baltimore City and County region. The geographic area contained within the nine ZIP codes includes 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, and 21231. This area reflects the population with the largest usage of the emergency departments and the majority of recipients of community contributions and programming. Within the CBSA, JHH and JHBMC have focused on certain target populations such as the elderly, at-risk children and adolescents, uninsured individuals and households, and underinsured and low-income individuals and households. The CBSA covers approximately 27.9 square miles within the City of Baltimore or approximately thirty-four percent of the total 80.94 square miles of land area for the city and 25.6 square miles in Baltimore County. In terms of population, an estimated 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). Within the CBSA, there are three Baltimore County neighborhoods - Dundalk, Sparrows Point, and Edgemere. Baltimore City is truly a city of neighborhoods with over 270 officially recognized neighborhoods. The Baltimore City Department of Health has subdivided the city area into 23 neighborhoods or neighborhood groupings that are completely or partially included within the CBSA. These neighborhoods are Belair-Edison, Canton, Cedonia/Frankford, Claremont/Armistead, Clifton-Berea, Downtown/Seton Hill, Fells Point, Greater Charles Village/Barclay, Greater Govans, Greenmount East (which includes neighborhoods such as Oliver, Broadway East, Johnston Square, and Gay Street), Hamilton, Highlandtown, Jonestown/Oldtown, Lauraville, Madison/East End, Midtown, Midway-Coldstream, Northwood, Orangeville/East Highlandtown, Patterson Park North & East, Perkins/Middle East, Southeastern, and The Waverlies. The Johns Hopkins Hospital is in the neighborhood called Perkins/Middle East, and the neighborhoods that are contiguous to Perkins/Middle East include Greenmount East (including Oliver, Broadway East, Johnston Square, and Gay Street), Clifton-Berea, Madison/East End, Patterson Park North & East, Fells Point, Canton, and Jonestown/Oldtown. Residents of most of these neighborhoods are primarily African American, with the exceptions of Fells Point, which is primarily white, and Patterson Park North & East, which represents a diversity of resident ethnicities. With the exceptions of Fells Point, Canton, and Patterson Park N&E, the median household income of most of these neighborhoods is significantly lower than the Baltimore City median household income. Median income in Fells Point, Canton, and Patterson Park N&E skews higher, and there are higher percentages of white households having higher median incomes residing in these neighborhoods. In southeast Baltimore, the CBSA population demographics have historically trended as white middle-income, working-class communities, Highlandtown, Southeastern, Orangeville/E. Highlandtown; however, in the past few decades, Southeast Baltimore has become much more diverse with a growing Latino population clustered around Patterson Park, Highlandtown, Orangeville/E. Highlandtown. Median incomes in these neighborhoods range from significantly below the City median in Southeastern to well above the median in Highlandtown. In Baltimore County, largely served by JHBMC, Dundalk, Sparrows Point, and Edgemere have been predominantly white with increasing populations of Hispanic and African American residents. Neighborhoods farther north of the Johns Hopkins Hospital include Belair-Edison, Cedonia/Frankford, Claremont/Armistead, CliftonBerea, Greater Charles Village/Barclay, Greater Govans, Hamilton, Lauraville, Midtown, Midway-Coldstream, Northwood, and The Waverlies. Residents of these neighborhoods are racially more diverse than in the neighborhoods closest to JHH and median household incomes range from significantly above the median to close to the median household income for Baltimore City. Since the end of the Second World War, the population of Baltimore City has been leaving the city to the surrounding suburban counties. This demographic trend accelerated in the 1960s and 1970s, greatly affecting the neighborhoods around the Johns Hopkins Hospital and JHBMC. As the population of Baltimore City dropped, there has been a considerable disinvestment in housing stock in these neighborhoods. Economic conditions that resulted in the closing or relocation of manufacturing and industrial jobs in Baltimore City and Baltimore County led to higher unemployment in the neighborhoods around the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, and social trends during the 1970s and 1980s led to increases in substance abuse and violent crime as well. Greater health disparities are found in these neighborhoods closest to the Hospitals compared to Maryland state averages and surrounding county averages. The June 2012 Charts of Selected Black vs. White Chronic Disease SHIP Metrics for Baltimore City prepared by the Maryland Office of Minority Health and Health Disparities highlights some of these health disparities including higher emergency department visit rates for asthma, diabetes, and hypertension in blacks compared to whites, higher heart disease and cancer mortality in blacks than whites, higher rates of adult smoking, and lower percentages of adults at a healthy weight.

Q6. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

JHH CBR Narrative Data FY19.pdf
1.9MB
application/pdf

Q7. Section I - General Info Part 2 - Community Benefit Service Area

Q8. Please select the county or counties located in your hospital's CBSA.

☐ Allegany County	☐ Charles County	☐ Prince George's County
☐ Anne Arundel County	☐ Dorchester County	☐ Queen Anne's County
☑ Baltimore City	☐ Frederick County	☐ Somerset County
☑ Baltimore County	☐ Garrett County	☐ St. Mary's County
☐ Calvert County	☐ Harford County	☐ Talbot County
☐ Caroline County	☐ Howard County	☐ Washington County
☐ Carroll County	☐ Kent County	☐ Wicomico County
☐ Cecil County	☐ Montgomery County	☐ Worcester County

Q9. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q10. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

☐ 21201	☐ 21212	☐ 21225	☐ 21237
☑ 21202	☑ 21213	☐ 21226	☐ 21239
☐ 21203	☐ 21214	☐ 21227	☐ 21251
☑ 21205	☐ 21215	☐ 21228	☐ 21263
☑ 21206	☐ 21216	☐ 21229	☐ 21270
☐ 21207	☐ 21217	☐ 21230	☐ 21278
☐ 21208	☑ 21218	☑ 21231	☐ 21281
☐ 21209	☐ 21222	☐ 21233	☐ 21287
☐ 21210	☐ 21223	☐ 21234	☐ 21290
☐ 21211	☑ 21224	☐ 21236	

Q12. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

☐ 21013	☐ 21092	☐ 21156	☐ 21225
☐ 21020	☐ 21093	☐ 21161	☐ 21227
☐ 21022	☐ 21094	☐ 21162	☐ 21228
☐ 21023	☐ 21102	☐ 21163	☐ 21229
☐ 21027	☐ 21104	☐ 21204	☐ 21234
☐ 21030	☐ 21105	☐ 21206	☐ 21235
☐ 21031	☐ 21111	☐ 21207	☐ 21236
☐ 21043	☐ 21117	☐ 21208	☐ 21237
☐ 21051	☐ 21120	☐ 21209	☐ 21239
☐ 21052	☐ 21128	☐ 21210	☐ 21241
☐ 21053	☐ 21131	☐ 21212	☐ 21244
☐ 21057	☐ 21133	☐ 21215	☐ 21250
☐ 21065	☐ 21136	☑ 21219	☐ 21252
☐ 21071	☐ 21139	☐ 21220	☐ 21282
☐ 21074	☐ 21152	☐ 21221	☐ 21284
☐ 21082	☐ 21153	☑ 21222	☐ 21285
☐ 21085	☐ 21155	☐ 21224	☐ 21286
☐ 21087			

Q13. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Charles County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q18. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q32. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. How did your hospital identify its CBSA?

☐ Based on ZIP codes in your Financial Assistance Policy. Please describe.

☑ Based on ZIP codes in your global budget revenue agreement. Please describe.

> 21202, 21205, 21213, 21219, 21222, 21224, 21231 are the ZIP codes in our GBR agreement

☐ Based on patterns of utilization. Please describe.

☑ Other. Please describe.

> 21218 and 21206 have also been included in the hospital CBSA in the past based on utilization and community health needs

Q34. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

Q35. Section I - General Info Part 3 - Other Hospital Info

Q36. Provide a link to your hospital's mission statement.

> https://www.hopkinsmedicine.org/the_johns_hopkins_hospital/about/mission.html

Q37. Is your hospital an academic medical center?

◉ Yes
○ No

Q38. (Optional) Is there any other information about your hospital that you would like to provide?

Q39. (Optional) Please upload any supplemental information that you would like to provide.

Q40. Section II - CHNA Part 1 - Timing & Format

Q41.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- ⦿ Yes
- ○ No

Q42. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q43. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/15/2018

Q44. Please provide a link to your hospital's most recently completed CHNA.

https://www.hopkinsmedicine.org/the_johns_hopkins_hospital/about/in_the_community/_docs/2018-community-health-needs-assessment.pdf

Q45. Did you make your CHNA available in other formats, languages, or media?

- ○ Yes
- ⦿ No

Q46. Please describe the other formats in which you made your CHNA available.

This question was not displayed to the respondent.

Q47. Section II - CHNA Part 2 - Participants

Q48. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

	CHNA Activities									
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☐	☑	☑	☐	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Clinical Leadership (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Population Health Staff (facility level)	☐	☐	☑	☑	☐	☑	☑	☑	☑	☐	
Population Health Staff (system level)	☐	☐	☑	☑	☐	☑	☑	☑	☑	☐	
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Community Benefit staff (system level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☐	☐	☐	☑	☑	☑	☑	☐	
Nurse(s)	☐	☐	☐	☐	☐	☑	☑	☑	☑	☐	
Social Workers	☐	☐	☐	☐	☐	☑	☑	☑	☑	☐	
Community Benefit Task Force	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Hospital Advisory Board	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q49. Section II - CHNA Part 2 - Participants (continued)

Q50. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities										Click to write Column 2
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)		Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: University of Maryland Medical Center, UM Midtown, LifeBridge Sinai Hospital, St. Agnes Hospital, Mercy Medical Center, Medstar Harbor, Medstar Good Sam, Medstar Union Memorial	☐	☑	☑	☑	☑	☑	☑	☑	☐		

Organization	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Baltimore City and Baltimore County	☐	☑	☑	☐	☐	☐	☐	☑	☐	
Local Health Improvement Coalition -- Please list the LHICs here: Baltimore City LHIC	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Health	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Area Agency on Aging -- Please list the agencies here: Zeta Healthy Aging Partnership	☐	☐	☐	☐	☑	☑	☐	☐	☐	
Local Govt. Organizations -- Please list the organizations here: Baltimore City Council, Baltimore City Public Schools, Southeast Community Development Corp	☐	☐	☐	☐	☑	☑	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations	☐	☐	☐	☐	☑	☑	☑	☐	☐	
School - K-12 -- Please list the schools here: Highlandtown Elem/Middle, John Ruhrah Elem, Patterson HS	☐	☐	☐	☐	☑	☑	☐	☐	☐	
School - Colleges and/or Universities -- Please list the schools here: Johns Hopkins University	☐	☐	☐	☐	☑	☑	☑	☑	☐	
School of Public Health -- Please list the schools here: Johns Hopkins Bloomberg School of Public Health	☐	☐	☐	☐	☑	☑	☑	☑	☐	
School - Medical School -- Please list the schools here: Johns Hopkins School of Medicine	☐	☐	☐	☐	☑	☑	☑	☑	☐	
School - Nursing School -- Please list the schools here: Johns Hopkins School of Nursing	☐	☐	☐	☐	☑	☑	☑	☑	☐	
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Behavioral Health Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

Organization	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here: Center for Urban Families, Central Baltimore Partnership, CHANA Baltimore, Civic Works, Comprehensive Housing Assistance, Dee's Place, Esperanza Center, Green Healthy Homes Initiative, Health Leads, Helping Up Mission, HEBCAC, Jewish Community Services, League for People with Disabilties, Marian House, Mary Harvin Senior Center, Maryland New Directions, Men and Families Center, Operation PULSE, Our Daily Bread, SAFE, The Door Inc, Waxter Senior Center, Youth Opportunities Baltimore	☐	☐	☐	☐	☑	☑	☐	☐	☐	
Post-Acute Care Facilities -- please list the facilities here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Community/Neighborhood Organizations -- Please list the organizations here: Banner Neighborhoods, Bayview Community Association, Berea East Side Community Association, Colgate Community Association, Eastfield Stanbrook Civic Association, Essex Middle River Civic Council, Harbor View Civic Association, Highlandtown Community Association, North Point Village Civic Association	☐	☐	☐	☐	☑	☑	☐	☐	☐	
Consumer/Public Advocacy Organizations -- Please list the organizations here: American Heart Association, American Diabetes Association	☐	☐	☐	☐	☑	☑	☑	☑	☐	
Other -- If any other people or organizations were involved, please list them here: Baltimore Medical System Inc., Chase Brexton Health Care,	☐	☐	☐	☐	☑	☑	☐	☐	☐	

Q51. Section II - CHNA Part 3 - Follow-up

Q52. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

◉ Yes
○ No

Q53. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

06/15/2018

Q54. Please provide a link to your hospital's CHNA implementation strategy.

Q55. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q56. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

☑ Access to Health Services: Health Insurance	☐ Environmental Health	☑ Oral Health
☐ Access to Health Services: Practicing PCPs	☐ Family Planning	☐ Physical Activity
☐ Access to Health Services: Regular PCP Visits	☐ Food Safety	☐ Respiratory Diseases
☐ Access to Health Services: ED Wait Times	☐ Global Health	☐ Sexually Transmitted Diseases
☐ Access to Health Services: Outpatient Services	☐ Health Communication and Health Information Technology	☐ Sleep Health
☐ Adolescent Health	☐ Health Literacy	☐ Telehealth
☐ Arthritis, Osteoporosis, and Chronic Back Conditions	☐ Health-Related Quality of Life & Well-Being	☐ Tobacco Use
☑ Behavioral Health, including Mental Health and/or Substance Abuse	☐ Heart Disease and Stroke	☐ Violence Prevention
☐ Cancer	☐ HIV	☐ Vision
☐ Children's Health	☐ Immunization and Infectious Diseases	☐ Wound Care
☐ Chronic Kidney Disease	☐ Injury Prevention	☑ Housing & Homelessness
☐ Community Unity	☐ Lesbian, Gay, Bisexual, and Transgender Health	☐ Transportation
☐ Dementias, Including Alzheimer's Disease	☐ Maternal & Infant Health	☑ Unemployment & Poverty
☐ Diabetes	☐ Nutrition and Weight Status	☑ Other Social Determinants of Health
☐ Disability and Health	☐ Older Adults	☑ Other (specify) [Chronic Disease, Crime & Neighborhood Safety, Education, Food Environmen]
☐ Educational and Community-Based Programs		

Q57. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

> Needs and priorities were nearly identical to those identified in 2016. Neighborhood Safety rose to be a top need in 2018. The uninsured need was expanded to include underinsured individuals, who have high deductibles or low maximum benefit thresholds.

Q58. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q59. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q60. ## Section III - CB Administration Part 1 - Participants

Q61. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

	Activities									Other - If you selected "Other (explain)," please type your explanation below:
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	✔	✔	✔	✔	✔	✔	✔	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	✔	✔	☐	✔	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	✔	✔	☐	✔	☐	☐	☐	☐	
Board of Directors or Board Committee (facility level)	☐	☐	✔	✔	☐	☐	☐	☐	☐	☐	
Board of Directors or Board Committee (system level)	✔	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	✔	✔	☐	✔	✔	☐	☐	☐	
Clinical Leadership (system level)	☐	☐	✔	✔	☐	✔	✔	☐	☐	☐	
Population Health Staff (facility level)	☐	☐	✔	✔	☐	✔	✔	✔	✔	☐	
Population Health Staff (system level)	☐	☐	✔	✔	☐	✔	✔	✔	✔	☐	
Community Benefit staff (facility level)	☐	☐	✔	✔	✔	✔	✔	✔	✔	☐	
Community Benefit staff (system level)	☐	☐	✔	✔	✔	✔	✔	✔	✔	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐	
Nurse(s)	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐	
Social Workers	☐	☐	☑	☑	☐	☑	☑	☑	☐	☐	
Community Benefit Task Force	☐	☐	☐	☐	☑	☐	☐	☐	☑	☐	
Hospital Advisory Board	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other (specify) [_____]	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q62. Section III - CB Administration Part 1 - Participants (continued)

Q63. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities										Click to write Column 2
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)		Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here: [Johns Hopkins Bayview Medical Center, UMMC]	☐	☐	☐	☐	☐	☑	☑	☐	☐		
Local Health Department -- Please list the Local Health Departments here: [____]	☑	☐	☐	☐	☐	☐	☐	☐	☐		
Local Health Improvement Coalition -- Please list the LHICs here: [____]	☑	☐	☐	☐	☐	☐	☐	☐	☐		

Organization	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Area Agency on Aging -- Please list the agencies here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Local Govt. Organizations -- Please list the organizations here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☑	☑	☐	
School - K-12 -- Please list the schools here: City Springs Elementary, Tench Tilghman Elem, Henderson Hopkins Elem/Middle	☐	☐	☐	☐	☐	☐	☑	☐	☐	
School - Colleges and/or Universities -- Please list the schools here: Johns Hopkins University	☐	☐	☐	☐	☐	☐	☑	☐	☐	

Organization	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here: Johns Hopkins Bloomberg School of Public Health							✔			
School - Medical School -- Please list the schools here: Johns Hopkins School of Medicine							✔			
School - Nursing School -- Please list the schools here: Johns Hopkins School of Nursing							✔			
School - Dental School -- Please list the schools here:	✔									
School - Pharmacy School -- Please list the schools here:	✔									
Behavioral Health Organizations -- Please list the organizations here:	✔									
Social Service Organizations -- Please list the organizations here: Health Leads, Helping Up Mission, Wilson House							✔	✔		
Post-Acute Care Facilities -- please list the facilities here:	✔									
Community/Neighborhood Organizations -- Please list the organizations here:	✔									
Consumer/Public Advocacy Organizations -- Please list the organizations here:	✔									
Other -- If any other people or organizations were involved, please list them here:	✔									

N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q64. Section III - CB Administration Part 2 - Process & Governance

Q65. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- ☑ Yes, by the hospital's staff
- ☑ Yes, by the hospital system's staff
- ☐ Yes, by a third-party auditor
- ☐ No

Q66. Does your hospital conduct an internal audit of the community benefit narrative?

- ◉ Yes
- ○ No

Q67. Please describe the community benefit narrative audit process.

> 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. 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. Population health leadership is involved in the process of planning the 2018 JHH Community Health Needs Assessment and Implementation Strategy by providing input, feedback and advice on the identified health needs and health priorities. The JHH Community Benefit Team interacts with all groups in the hospital performing community benefit activities. They educate, advocate and collaborate with internal audiences to increase understanding, appreciation and participation of the Community Benefit report process and community outreach activities. Team members collect and verify all CB data, compile report, provide initial audit and verification of CBR financials and write CBR narrative. Throughout the year, the CB team attends local and regional community health conferences and meetings, represents the Hospital to external audiences, and works with community and JHH clinical leaders to identify promising projects or programs that address CBSA community health needs. 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.

Q68. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- ◉ Yes
- ○ No

Q69. Please explain:

This question was not displayed to the respondent.

Q70. Does the hospital's board review and approve the annual community benefit narrative report?

- ◉ Yes
- ○ No

Q71. Please explain:

This question was not displayed to the respondent.

Q72. Does your hospital include community benefit planning and investments in its internal strategic plan?

- ◉ Yes
- ○ No

Q73. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

Community Benefit planning is an integral part of the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center's strategic plan. The Johns Hopkins Medicine's Innovation 2023 strategic plan implemented in 2019, highlights community health as one of six main priorities. Annual evaluation of the community goals is part of the leadership hospital performance review. The commitment of Johns Hopkins' leadership to improving the lives of its nearest neighbors is illustrated by the incorporation of Community Engagement at the highest level in the Innovation 2023 plan.

Q74. (Optional) If available, please provide a link to your hospital's strategic plan.

Q75. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

Q76. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Q77. Based on the implementation strategy developed through the CHNA process, please describe *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q78. Section IV - CB Initiatives Part 1 - Initiative 1

Q79. Name of initiative.

Baltimore Population Health Workforce Collaborative

Q80. Does this initiative address a community health need that was identified in your most recently completed CHNA?

- ◉ Yes
- ○ No

Q81. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Behavioral Health, including Mental Health and/or Substance Abuse, Oral Health, Housing & Homelessness, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Chronic Disease, Crime & Neighborhood Safety, Education, Food Environmen

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

☐ Access to Health Services: Health Insurance	☑ Heart Disease and Stroke
☐ Access to Health Services: Practicing PCPs	☐ HIV
☐ Access to Health Services: Regular PCP Visits	☑ Immunization and Infectious Diseases
☐ Access to Health Services: ED Wait Times	☐ Injury Prevention
☐ Access to Health Services: Outpatient Services	☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Adolescent Health	☑ Maternal and Infant Health
☑ Arthritis, Osteoporosis, and Chronic Back Conditions	☑ Nutrition and Weight Status
☑ Behavioral Health, including Mental Health and/or Substance Abuse	☑ Older Adults
☑ Cancer	☐ Oral Health
☐ Children's Health	☐ Physical Activity
☑ Chronic Kidney Disease	☐ Respiratory Diseases
☐ Community Unity	☐ Sexually Transmitted Diseases
☑ Dementias, including Alzheimer's Disease	☐ Sleep Health

☑ Diabetes   ☐ Telehealth

☐ Disability and Health   ☐ Tobacco Use

☐ Educational and Community-Based Programs   ☐ Violence Prevention

☐ Environmental Health   ☐ Vision

☐ Family Planning   ☐ Wound Care

☐ Food Safety   ☑ Housing & Homelessness

☐ Global Health   ☐ Transportation

☐ Health Communication and Health Information Technology   ☑ Unemployment & Poverty

☑ Health Literacy   ☑ Other Social Determinants of Health

☑ Health-Related Quality of Life & Well-Being   ☐ Other (specify) [_____]

Q82. When did this initiative begin?

> 01/09/2017

Q83. Does this initiative have an anticipated end date?

○ No, the initiative has no anticipated end date.

○ The initiative will end on a specific end date. Please specify the date. [_____]

○ The initiative will end when a community or population health measure reaches a target value. Please describe.

○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

● The initiative will end when external grant money to support the initiative runs out. Please explain.

> Initial end date of June 30, 2019, was extended by the HSCRC to June 30, 2022.

○ The initiative will end when a contract or agreement with a partner expires. Please explain.

○ Other. Please explain.

Q84. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

> 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, SandtownWinchester, 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 BelairEdison; 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.

Q85. Enter the estimated number of people this initiative targets.

> 63,747

Q86. How many people did this initiative reach during the fiscal year?

72

Q87. What category(ies) of intervention best fits this initiative? Select all that apply.

- ☐ Chronic condition-based intervention: treatment intervention
- ☑ Chronic condition-based intervention: prevention intervention
- ☐ Acute condition-based intervention: treatment intervention
- ☐ Acute condition-based intervention: prevention intervention
- ☐ Condition-agnostic treatment intervention
- ☑ Social determinants of health intervention
- ☐ Community engagement intervention
- ☐ Other. Please specify.

Q88. Did you work with other individuals, groups, or organizations to deliver this initiative?

- ⦿ Yes. Please describe who was involved in this initiative.

  Internal: Johns Hopkins Bayview
  Medical Center

  External: HSCRC, LifeBridge Sinai,
  Medstar Franklin Square Medical
  Center, Medstar Good Samaritan,
  Medstar Harbor Hospital, Medstar Union
  Memorial Hospital, UMMC, UM Midtown,
  Baltimore Alliance for Careers in
  Healthcare, Baltimore Area Health
  Education Center, Bon Secours
  Community Works, BUILD Turnaround
  Tuesday, Center for Urban Families,
  Community College of Baltimore County,
  Mission Peer Recovery Training, Penn
  North.

- ○ No.

Q89. Please describe the primary objective of the 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.

Q90. Please describe how the initiative is delivered.

A consortium of four major health systems that includes nine hospitals trains and hires individuals from high poverty communities in the Baltimore Metropolitan area to be community healthcare workers (CHWs), peer outreach specialists (PRSs), and certified nursing /geriatric nursing assistants (CNAs/GNAs). The hospitals partner with the Baltimore Alliance for Careers in Healthcare (BACH), which coordinates the recruitment and training of individuals from the community. BACH works with several community organizations to select, screen, and provide essential skills training to the potential recipients of the PWSDA program. They also recruit hospital employees from "high poverty communities" to train and promote them to positions with a "career ladder." The hospital collaborative works with BACH to screen, select, and train individuals in essential skills over three years. For the CHA and PRS positions, individuals will complete 160 and 50 hours, respectively, of occupational skills training before being recruited. For the CNA position, training and certification takes place at the Baltimore County Community College.

Q91. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- ☑ Count of participants/encounters | #s trained, successfully credentialed, and hired/retained
- ☐ Other process/implementation measures (e.g. number of items distributed) |
- ☐ Surveys of participants |
- ☐ Biophysical health indicators |
- ☐ Assessment of environmental change |
- ☐ Impact on policy change |
- ☐ Effects on healthcare utilization or cost |
- ☑ Assessment of workforce development | BACH tracks workforce training effectiveness
- ☐ Other |

Q92. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

> 8 individuals were trained and hired as CHW, CNA, and CNA/GNA positions. 29 individuals were retained and full time employed as CHW, PRS, CNA and CNA/GNA positions.

Q93. Please describe how the outcome(s) of the initiative addresses community health needs.

> CHWs provide an opportunity to combat health disparities by promoting and supporting healthy behaviors; they can assist with care management activities to directly prevent or manage chronic disease. With the focus of health care shifting from the hospital setting to the community, CHWs can improve healthcare outcomes in the US (1) including 30-day readmission (2) as well as preventing and managing chronic diseases. CHWs help promote healthy behaviors and are connectors with the health care system to increase access to care to reduce health disparities and identify/navigate patients with unmet social needs to appropriate health care. CHWs are most effective when they serve the communities from which they come and thus provide continuity between healthcare systems and the community (3). PRSs have experienced substance use disorder (SUD) or mental illness and recovery and can help persons with behavioral health issues by serving as a link between the clinical setting and the community to enhance access to and participation in treatment services to prevent relapse. PRS services are an important wrap-around to clinical services. CNA/GNAs expand the current homes support reach in the community. They will also serve hospital discharged patients who need personal care at home, but cannot afford it to avoid readmission. The goal of BPHWC is to concomitantly improve the socio-economic status of disadvantaged communities and promote population health in the Baltimore region. We will do this by improving the continuity and healthcare of the communities where CHWs and PRSs work, thus providing income through jobs that impact the health and well-being of the workers.

Q94. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

> $3,225,901

Q95. (Optional) Supplemental information for this initiative.

Q96. Section IV - CB Initiatives Part 2 - Initiative 2

Q97. Name of initiative.

> Broadway Center for Addiction and Supportive Housing

Q98. Does this initiative address a need identified in your most recently completed CHNA?

- ⦿ Yes
- ○ No

Q99. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Behavioral Health, including Mental Health and/or Substance Abuse, Oral Health, Housing & Homelessness, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Chronic Disease, Crime & Neighborhood Safety, Education, Food Environmen

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

☐ Access to Health Services: Health Insurance	☐ Heart Disease and Stroke
☐ Access to Health Services: Practicing PCPs	☐ HIV
☐ Access to Health Services: Regular PCP Visits	☐ Immunization and Infectious Diseases
☐ Access to Health Services: ED Wait Times	☐ Injury Prevention
☐ Access to Health Services: Outpatient Services	☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Adolescent Health	☐ Maternal and Infant Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions	☐ Nutrition and Weight Status
☑ Behavioral Health, including Mental Health and/or Substance Abuse	☐ Older Adults
☐ Cancer	☐ Oral Health
☐ Children's Health	☐ Physical Activity
☐ Chronic Kidney Disease	☐ Respiratory Diseases
☐ Community Unity	☐ Sexually Transmitted Diseases
☐ Dementias, including Alzheimer's Disease	☐ Sleep Health

☐ Diabetes	☐ Telehealth
☐ Disability and Health	☐ Tobacco Use
☐ Educational and Community-Based Programs	☐ Violence Prevention
☐ Environmental Health	☐ Vision
☐ Family Planning	☐ Wound Care
☐ Food Safety	☐ Housing & Homelessness
☐ Global Health	☐ Transportation
☐ Health Communication and Health Information Technology	☐ Unemployment & Poverty
☐ Health Literacy	☑ Other Social Determinants of Health
☐ Health-Related Quality of Life & Well-Being	☐ Other (specify) [＿＿＿＿＿]

Q100. When did this initiative begin?

01/01/2000

Q101. Does this initiative have an anticipated end date?

◉ No, the initiative does not have an anticipated end date.

◯ The initiative will end on a specific end date. Please specify the date. [＿＿＿＿＿]

◯ The initiative will end when a community or population health measure reaches a target value. Please describe.

◯ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

◯ The initiative will end when external grant money to support the initiative runs out. Please explain.

◯ The initiative will end when a contract or agreement with a partner expires. Please explain.

◯ Other. Please explain.

Q102. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

As identified in the City Health Department's Healthy Baltimore 2015 report, substance abuse represents a health challenge for Baltimore because it is related to so many other issues the city faces such as family/community disruption, crime, homelessness, and health care utilization. Additionally, Baltimore 2015 data shows racial/ethnic disparity in the rate of unmet mental health care needs exists in Baltimore City with an incidence rate of 33.4% in blacks and 8.5% in whites (per 100,000 population).

Q103. Enter the estimated number of people this initiative targets.

45,133

Q104. How many people did this initiative reach during the fiscal year?

2,672 patient visits at the Broadway Center; 266 men accommodated at Helping Up Mission and 25 women accommodated at Wilson House

Q105. What category(ies) of intervention best fits this initiative? Select all that apply.

- ☑ Chronic condition-based intervention: treatment intervention
- ☐ Chronic condition-based intervention: prevention intervention
- ☐ Acute condition-based intervention: treatment intervention
- ☐ Acute condition-based intervention: prevention intervention
- ☐ Condition-agnostic treatment intervention
- ☑ Social determinants of health intervention
- ☐ Community engagement intervention
- ☐ Other. Please specify.

Q106. Did you work with other individuals, groups, or organizations to deliver this initiative?

- ◉ Yes. Please describe who was involved in this initiative.

  Alcohol and Drug Abuse Administration, Behavioral Health Systems Baltimore, Baltimore City Substance Abuse Directorate, Helping Up Mission, Wilson House

- ○ No.

Q107. Please describe the primary objective of the initiative.

The Johns Hopkins Hospital Broadway Center offers comprehensive treatment services for persons experiencing acute or chronic substance use problems. The program has a holistic approach to care delivery, addressing medical, psychiatric, social service and social network needs through comprehensive, on-site, integrated program services. The major categories of services provided are screening/assessment, intensive outpatient (IOP), and standard outpatient (SOP). Service enhancements are abundant, highly utilized, and include ambulatory detoxification, psychiatric assessment and treatment, basic medical assessment and treatment, case management, and opioid maintenance. Treatment services focus on establishing alcohol and drug abstinence and stabilizing health and living situations. Patients are educated about the nature and consequences of addiction. A cognitive/behavioral treatment curriculum teaches patients the necessary skills to stop substance use. Specific services include: individual therapy, group education and therapy, urinalysis testing for drug monitoring, Breathalyzer testing for alcohol monitoring, and peer recovery support. The Broadway Center for Addiction focuses on establishing alcohol and drug abstinence and stabilizing health and living situations. Patients are educated about the nature and consequences of addiction. IOP service delivery operates in close collaboration with the JHH halfway housing for women (Wilson House) and with near-by men's recovery housing in East Baltimore (Helping Up Mission). Meals are provided on-site at the treatment program. NA meetings are hosted daily after treatment hours to support recovery.

Q108. Please describe how the initiative is delivered.

Patients receive treatment 2.5-3 hours/day for 4-5 days/week, with a minimum of 9 hours of clinical services scheduled each week. Patients at this treatment level also begin to work on longterm goal setting, including such areas as job training, GED completion, and family reunification – goals continued after eventual stabilization and transfer to a standard outpatient level of care. Individual treatment sessions are scheduled at least once weekly, and treatment plans are reviewed every four weeks. Transfer to a less restrictive level of care typically occurs only after approximately 4 weeks of drug-free status and good treatment adherence. The number of weeks until achievement of this goal varies from patient to patient, but is typically 4 to 12 weeks. Wilson House prepares women for re-entry into independent living situations. Housing staff began to work with residents to secure preventative medical appointments, obtain employment or other meaningful activities. Helping Up Mission (HUM) is contracted to provide up to 48 male recovery beds for male patients enrolled in the Broadway Center. All patients are required to maintain excellent attendance and progression in treatment goals at the Broadway Center. Transportation is provided between the HUM and the Broadway Center multiple times per day. The maximum length of stay is 6 months. When not engaged in services at the Broadway Center, patients have access to a wide array of HUM services and programming, such as GED courses, computer literacy classes, faith services, peer support groups, art therapy, physical fitness equipment, and a patient library.

Q109. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- ☐ Count of participants/encounters
- ☑ Other process/implementation measures (e.g. number of items distributed) Tox screenings, treatment compliance scores
- ☑ Surveys of participants Patient satisfaction surveys
- ☑ Biophysical health indicators
- ☐ Assessment of environmental change
- ☐ Impact on policy change
- ☐ Effects on healthcare utilization or cost
- ☐ Assessment of workforce development
- ☐ Other

Q110. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

Successful recovery from substance use and eventual transition into independent living.

Q111. Please describe how the outcome(s) of the initiative addresses community health needs.

Broadway Center and the supportive housing programs for men and women directly address the need for substance use treatment in Baltimore City as well as the accompanying homelessness that often results from substance use.

Q112. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$1,035,422

Q113. (Optional) Supplemental information for this initiative.

Q114. Section IV - CB Initiatives Part 3 - Initiative 3

Q115. Name of initiative.

Hopkins Health Connection (formerly Health Leads)

Q116. Does this initiative address a need identified in your most recently completed CHNA?

● Yes
○ No

Q117. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Behavioral Health, including Mental Health and/or Substance Abuse, Oral Health, Housing & Homelessness, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Chronic Disease, Crime & Neighborhood Safety, Education, Food Environmen

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

☐ Access to Health Services: Health Insurance
☐ Access to Health Services: Practicing PCPs
☐ Access to Health Services: Regular PCP Visits
☐ Access to Health Services: ED Wait Times
☐ Access to Health Services: Outpatient Services
☐ Adolescent Health
☐ Arthritis, Osteoporosis, and Chronic Back Conditions
☐ Behavioral Health, including Mental Health and/or Substance Abuse
☐ Cancer
☐ Children's Health
☐ Chronic Kidney Disease
☐ Community Unity
☐ Dementias, including Alzheimer's Disease
☐ Diabetes
☐ Disability and Health
☐ Educational and Community-Based Programs
☐ Environmental Health
☐ Family Planning

☐ Heart Disease and Stroke
☐ HIV
☐ Immunization and Infectious Diseases
☐ Injury Prevention
☐ Lesbian, Gay, Bisexual, and Transgender Health
☐ Maternal and Infant Health
☐ Nutrition and Weight Status
☐ Older Adults
☐ Oral Health
☐ Physical Activity
☐ Respiratory Diseases
☐ Sexually Transmitted Diseases
☐ Sleep Health
☐ Telehealth
☐ Tobacco Use
☐ Violence Prevention
☐ Vision
☐ Wound Care

☐ Food Safety   ☐ Housing & Homelessness

☐ Global Health   ☐ Transportation

☐ Health Communication and Health Information Technology ☐ Unemployment & Poverty

☐ Health Literacy   ☑ Other Social Determinants of Health

☐ Health-Related Quality of Life & Well-Being   ☐ Other (specify) [   ]

Q118. When did this initiative begin?

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01/01/2006
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Q119. Does this initiative have an anticipated end date?

○ No, the initiative does not have an anticipated end date.

○ The initiative will end on a specific end date. Please specify the date. [   ]

○ The initiative will end when a community or population health measure reaches a target value. Please describe.

○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

○ The initiative will end when external grant money to support the initiative runs out. Please explain.

○ The initiative will end when a contract or agreement with a partner expires. Please explain.

◉ Other. Please explain.

```
Johns Hopkins is taking on full
management of the program, which has
been renamed the Hopkins Health
Connection. There is no anticipated
end date to the restructured program.
```

Q120. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

```
Persons with below median household incomes, undocumented residents, homeless individuals and families. 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.
```

Q121. Enter the estimated number of people this initiative targets.

```
63,036
```

Q122. How many people did this initiative reach during the fiscal year?

```
2,743 unique families
```

Q123. What category(ies) of intervention best fits this initiative? Select all that apply.

- ☐ Chronic condition-based intervention: treatment intervention
- ☐ Chronic condition-based intervention: prevention intervention
- ☐ Acute condition-based intervention: treatment intervention
- ☐ Acute condition-based intervention: prevention intervention
- ☐ Condition-agnostic treatment intervention
- ☑ Social determinants of health intervention
- ☐ Community engagement intervention
- ☐ Other. Please specify.

Q124. Did you work with other individuals, groups, or organizations to deliver this initiative?

- ◉ Yes. Please describe who was involved in this initiative.

  Johns Hopkins Bayview Medical Center, Johns Hopkins University

- ○ No.

Q125. Please describe the primary objective of the initiative.

Hopkins Health Connection 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.

Q126. Please describe how the initiative is delivered.

Hopkins Health Connection has program staff and student volunteers at Harriet Lane Clinic, Bayview Children's Medical Practice, and Bayview Comprehensive Care Practice working with each clinic's care teams. They screen patients for social needs and work to connect patients to resources. The navigation requires regular follow-up with patients, maintaining an up-to-date resource directory, connecting with the clinic care teams, and relationships with community organizations.

Q127. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- ☑ Count of participants/encounters | Monthly measures include clients served, total lives reached, number of resource connections.
- ☑ Other process/implementation measures (e.g. number of items distributed) | 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.
- ☑ Surveys of participants | After a case is closed, we send text surveys to patients that have agreed to be reached by text. The surveys rate the services they received from Health Leads and ask for additional feedback
- ☐ Biophysical health indicators
- ☐ Assessment of environmental change
- ☐ Impact on policy change
- ☐ Effects on healthcare utilization or cost
- ☐ Assessment of workforce development
- ☐ Other

Q128. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

Johns Hopkins has made changes to the Epic EHR system to track social determinants of health, it will be possible to conduct analyses to determine if connecting patients with essential needs affects their probability of achieving a certain outcome.

Q129. Please describe how the outcome(s) of the initiative addresses community health needs.

Hopkins Health Connection directs patients of need to resources that can address social determinants of health. For FY19, the top five presenting needs for each clinic were as follows: Bayview Children's Medical Practice Food (29%) Health (25%) Financial (12%) Commodities (12%) Case Management (9%) Bayview Comprehensive Care Practice Health (20%) Food (18%) Transportation (17%) Housing (15%) Financial (9%) Harriet Lane Clinic Commodities (24%) Health (20%) Employment (11%) Housing (10%) Food (9%) Outcomes Bayview Children's Medical Practice Unique Clients 1381 Successful Connections 1108 Patients successfully accessed a resource 56% Patients equipped to access a resource 28% Patients who did not access a resource 1% Patients disconnected from resources 14% Bayview Comprehensive Care Practice Unique Clients 205 Successful Connections 96 Patients successfully accessed a resource 28% Patients equipped to access a resource 19% Patients who did not access a resource 4% Patients disconnected from resources 47% Harriet Lane Clinic Unique Clients 1142 Successful Connections 1007 Patients successfully accessed a resource 49% Patients equipped to access a resource 15% Patients who did not access a resource 2% Patients disconnected from resources 32%

Q130. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

$221,015

Q131. (Optional) Supplemental information for this initiative.

Q132. ## Section IV - CB Initiatives Part 4 - Other Initiative Info

Q133. Additional information about initiatives.

Q134. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

Additional CB Initiatives FY 2019 JHH.pdf
47.3KB
application/pdf

Q135. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

◉ Yes
○ No

Q136.
In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Health Insurance, Behavioral Health, including Mental Health and/or Substance Abuse, Oral Health, Housing & Homelessness, Unemployment & Poverty, Other Social Determinants of Health, Other (specify)
Other: Chronic Disease, Crime & Neighborhood Safety, Education, Food Environmen

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q137. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q138. Do any of the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? Specifically, do any activities or initiatives correspond to a SHIP measure within the following categories?

See the SHIP website for more information and a list of the measures:
https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx

	Select Yes or No	
	Yes	No
Healthy Beginnings - includes measures such as babies with low birth weight, early prenatal care, and teen birth rate	◉	○
Healthy Living - includes measures such as adolescents who use tobacco products and life expectancy	◉	○

Healthy Communities - includes measures such as domestic violence and suicide rate	⦿	◯
Access to Health Care - includes measures such as adolescents who received a wellness checkup in the last year and persons with a usual primary care provider	⦿	◯
Quality Preventive Care - includes measures such as annual season influenza vaccinations and emergency department visit rate due to asthma	⦿	◯

Q139. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q140. Section V - Physician Gaps & Subsidies

Q141. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

- ☐ No gaps
- ☐ Primary care
- ☐ Mental health
- ☐ Substance abuse/detoxification
- ☐ Internal medicine
- ☐ Dermatology
- ☐ Dental
- ☐ Neurosurgery/neurology
- ☐ General surgery
- ☐ Orthopedic specialties
- ☐ Obstetrics
- ☐ Otolaryngology
- ☑ Other. Please specify. | Outpatient specialty care |

Q142. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand.

Hospital-Based Physicians	As a state-designated Level I trauma center for Maryland, The Johns Hopkins Hospital provides subsidies to physicians for trauma on-call services that they would otherwise not provide to the Hospital
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	
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other (provide detail of any subsidy not listed above)	On call/standby anesthesia
Other (provide detail of any subsidy not listed above)	On call/standby radiology
Other (provide detail of any subsidy not listed above)	On call/standby GYN/OB

Q143. (Optional) Is there any other information about physician gaps that you would like to provide?

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

Q144. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Q145. Section VI - Financial Assistance Policy (FAP)

Q146. Upload a copy of your hospital's financial assistance policy.

policy_35770.pdf
162.2KB
application/pdf

Q147. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

jhh-patient-billing-and-financial-assistance-information-sheet-english.pdf
220.9KB
application/pdf

Q148. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL). Please select the percentage of FPL below which your hospital's FAP offers free care.

	100	150	200	250	300	350	400	450	500	
Percentage of Federal Poverty Level										200
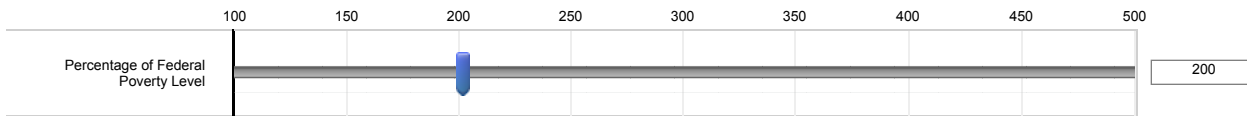
Q149. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.

	200	250	300	350	400	450	500	
Lowest FPL								
Highest FPL								500
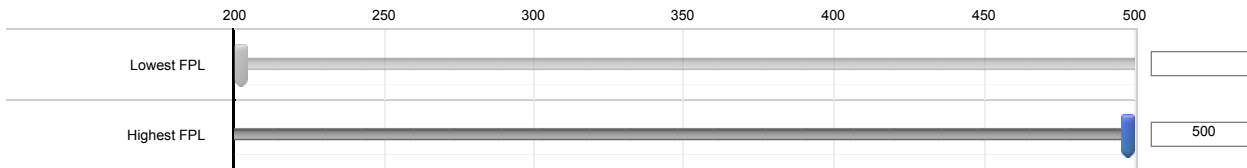
Q150. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.

	100	200	300	400	500	600	700	
Lowest FPL								201
Highest FPL								500

Q151. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.

	0	10	20	30	40	50	60	70	80	90	100	
Debt as Percentage of Income												25
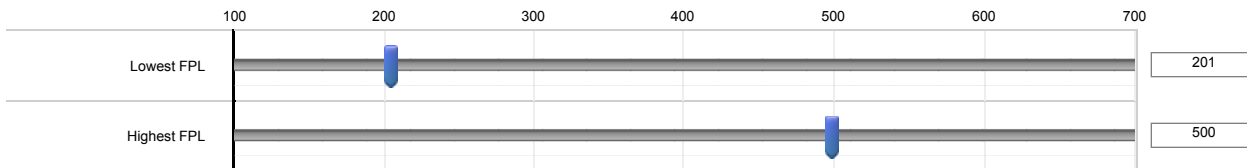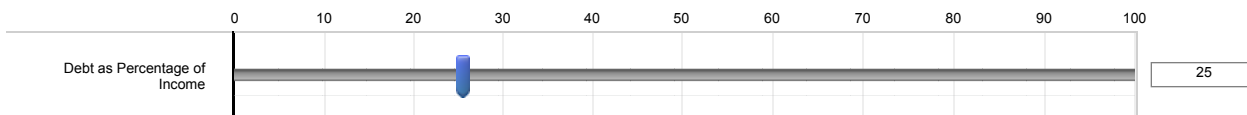
Q152. Has your FAP changed within the last year? If so, please describe the change.

⦿ No, the FAP has not changed.
◯ Yes, the FAP has changed. Please describe: _____

Q153. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

Financial Assistance Policy is available in English, Spanish, French and Chinese.

Q154. (Optional) Please attach any files containing further information about your hospital's FAP.

Q155. Summary & Report Submission

Q156.

<p style="text-align:center;color:red;">Attention Hospital Staff! IMPORTANT!</p>

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (39.324798583984, -76.606201171875)

Source: GeoIP Estimation

Report This Email

I've insert into the text below the answers and clarifications requested for the Johns Hopkins Hospital's FY19 Community Benefit Report. It took me a longer than I expected to check in with our highlighted clinic to get the needed detail but I think I've collected everything now. Please let me know if you have any more questions, thoughts, feedback etc.

Thank you,

Sharon

Sharon Tiebert-Maddox, MM, MBA
Director, Strategic Initiatives
JHH Community Benefit/Health Improvement
Government and Community Affairs
Johns Hopkins University and Medicine
443-997-2070 (work)
443-845-9626 (cell)

From: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Sent: Friday, February 28, 2020 3:54 PM
To: Sharon Tiebert-Maddox <tiebert@jhu.edu>
Cc: Hilltop HCB Help Account <hcbhelp@hilltop.umbc.edu>
Subject: Clarification Required - The Johns Hopkins Hospital FY 19 CB Narrative

Thank you for submitting The Johns Hopkins Hospital's FY 2019 Community Benefit Narrative Report. Upon reviewing your report, we require clarification of certain issues:

- In response to Question 50, beginning on page 7 of the attached, responses for the lines on "Local Health Improvement Coalition" and "Maryland Department of Health" are blank. Please provide a response. MD Department of Health should have a check under "provided secondary data"; Local Health Improvement Coalition should have all boxes checked except N/A, Other and provided secondary data. A coalition of all Baltimore City Hospitals and the city health department formed the LHIC.

- In response to Question 81, beginning on page 17, you report CHNA needs addressed by the initiative as including: "Arthritis, Osteoporosis, and Chronic Back Conditions," "Cancer," "Chronic Kidney Disease," "Dementias," "Diabetes," "Health Literacy," "Health-Related Quality of Life & Well-Being," "Heart Disease and Stroke," "Immunization and Infectious Disease," "Maternal and Infant Health," "Nutrition and Weight Status," and "Older Adults." However, your response to Question 56 on page 11 does not include any of these as identified CHNA needs. Please indicate whether these needs should have been selected in Question 56, or should not have been selected in Question 81. . They should be selected in Q56. In our CHNA many conditions are grouped together in broader categories (e.g. chronic disease) but they should be listed individually in both Q81 and Q65. Sorry we didn't notice the lack of consistency before submitting.

- In response to Question 109 on page 22, you select "Biophysical health indicators" as a type of evidence used to determine effectiveness but no not provide further explanation. Please provide an example of a biophysical health indicator used for evaluation. By way of

biophysical health indicators, 100% of patients receive a history and physical upon entering the program. Care is also coordinated with the patient's primary care provider. If a patient does not have a PCP they are provided with assistance to help link them to one. All patients receive a tobacco use assessment upon admission. Identified smokers are assisted with smoking cessation programs.

- In response to Question 110 on pages 22-23, your response lacks detailed outcomes. If possible, please provide concrete outcomes of the initiative. There are multiple outreach services at the Broadway Center as described in the response to Q107. Across multiple areas, a patient satisfaction survey is used as a measurement of overall well-being. Based on the FY'19 survey, 73% of patients surveyed agreed or strongly agreed to being better able to manage their symptoms and everyday life issues. The Broadway program housing partnership with Helping up Mission served 33 people in FY19. Of that number 43% completed the program and transitioned to independent living or remain active in treatment currently; 19% transferred to another facility due to declining health, full time employment or other reasons; and 38% left against medical advice. (Note: There is another short term overnight housing program at Helping Up Mission serving more individuals for overnight stays but the 33 referenced participants in treatment at the Broadway Center receive housing at HUM for up to six months while in the program.)

- Your response to Question 149 on page 28 is unclear. Did you intend to select "200?" Yes, we did mean to select 200.

Please provide your clarifying answers as a response to this message. Thank you for your attention to this matter.