JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

September 29, 2017

The Honorable Greg Walden
Chairman
Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member
Energy and Commerce Committee
U. S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Tim Murphy
Chairman, Subcommittee on Oversight and Investigations
Energy and Commerce Committee
U. S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Subcommittee on Oversight and Investigations
Energy and Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Walden, Ranking Member Pallone, Chairman Murphy and Ranking Member DeGette:

On behalf of The Johns Hopkins Hospital (JHH), I respectfully submit the following responses to the questions from the September 8, 2017 letter seeking information on JHH's participation in the 340B Drug Discount Program.

In July 2016, I accepted the role and solemn responsibility of being the 11th president of The Johns Hopkins Hospital. Like leaders before me, I recognize the inextricable link between the health and well-being of the hospital and the physical, social and economic well-being of Baltimore City.

JHH is a 1,154-bed acute care facility[1] that is the principal teaching hospital for the Johns Hopkins University School of Medicine. Opened in 1889, JHH, the flagship of The Johns Hopkins Health System Corporation, has been a 340B-eligible covered entity since 2002.

[1] Maryland Health Care Commission, *Licensed Acute Care Hospital Beds Maryland General Hospitals (2018)*, available at https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Licensed_AcuteCare_Update_Hospital_Beds_FY18.pdf

The bequest left by the philanthropist Johns Hopkins, whose gifts established both the university and hospital in the late 19th century, stipulated that both entities be rooted in Baltimore and serve the poor. Located in the heart of East Baltimore, our mission and commitment extend beyond the walls of the hospital. This dual focus on the city and its residents is as important today as it was in 1889.

JHH has long held that one of the strengths of the 340B program is the discretion it affords eligible hospitals in tailoring the use of program savings to address the unique needs of its communities. As a steward of the 340B program, we are cognizant that our efforts take on even greater urgency in uncertain financial times, during public health crises and when rising premiums make health insurance unaffordable.[2]

Today, nearly one in four Baltimore City residents live at or below the poverty level,[3] and the unemployment rate is above the national rate.[4] Jobs that pay a family-sustaining wage are scarce and have steadily declined over the last 50 years. Since 1970, more than 60,000 manufacturing jobs in the Baltimore metropolitan area have been lost due to plant closures by companies such as Bethlehem Steel, Western Electric, Procter & Gamble, General Motors and Solo Cup. These jobs are not projected to return in a post-manufacturing economy.

The health implications of concentrated poverty are well-documented and part of a growing body of evidence into the "social determinants of health," such as income, access to health care, food security, and public school conditions, all of which can affect a person's health. One in four residents of Baltimore City lives in a "food desert"[5] where they must rely on convenience stores and small neighborhood grocery stores that offer few, if any, healthy food choices such as fruits and vegetables. These grim realities frame the context of JHH's work.

JHH is committed to addressing these troubling socioeconomic realities in a variety of ways, including using 340B savings, and is well-positioned to serve our community as a safety net hospital, a not-for-profit organization and an anchor institution in the City of Baltimore. Below are just a few of many examples of the impact JHH has on its community.

As a safety net hospital, JHH counts on 340B savings to respond to emerging crises and to continue its work on the front lines of serving the most vulnerable patients in

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[2] Meredith Cohn, *Obamacare Premium Costs in Maryland Set to Jump as State Approves Rates*, Balt. Sun, Aug. 29, 2017 (Business), *available at* http://www.baltimoresun.com/business/bs-hs-obamacare-rates-20170829-story.html

[3] Census Bureau, U.S. Dep't of Commerce, *American Community Survey* (2015).

[4] Bureau of Labor Statistics, U.S. Dep't of Labor, *Baltimore Area Economic Summary*, Aug. 30, 2017, *available at* https://www.bls.gov/regions/mid-atlantic/summary/blssummary_baltimore.pdf

[5] Amanda Behrens Buczynski, Holly Freishtat & Sara Buzogany, *Mapping Baltimore City's Food Environment*, 2015 Johns Hopkins Center for a Livable Future, *available at* https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-a-livable-future/_pdf/research/clf_reports/Baltimore-Food-Environment-Report-2015-1.pdf

Baltimore. JHH brings ingenuity to its programming, focusing on convenience and access by actively removing hurdles to specialty care and medications. For example:

Since 2009, JHH has offered a charity program designed to improve access to effective, compassionate, evidence-based primary and specialty care to uninsured and underinsured patients from the neighborhoods immediately surrounding the hospital. *The Access Partnership (TAP),* as it is called, has provided medical services to almost 6,000 patients since the inception of the program.[6]

JHH also offers a free bedside delivery service to eliminate barriers that could prevent patients from taking medically necessary prescriptions after a hospital admission, such as financial burden or lack of transportation. Medication adherence, or taking prescribing medications as instructed, is vital for good health outcomes and avoiding hospital readmission. Over 9,000 patients benefitted from this service in 2016.

As a not-for-profit hospital, JHH conducts a community health needs assessment (CHNA)[7] every three years that helps us understand the gaps in care and health status of our closest neighbors. From this work, JHH reinvests 340B savings into evidence-based, community-strengthening programs that have had a proven impact on health. These interventions span the life cycle from early maternal and child health to end of life care. For example:

JHH dispatches pharmacists to patient's homes, through its *Home-Based Medication Management* project. These specially-trained pharmacists work with patients to dispose of expired or discontinued medication, color-code pill containers when labels are too small to read, and review medication administration instructions. Importantly, they also ensure that the patient's medication regimen is not only the right choice therapeutically, but also affordable for the patient in the long term. In this program, which began in 2012, JHH has demonstrated a significant reduction (from 17 to 8 percent) in readmissions among patients who receive a pharmacist home visit.[8]

As an anchor institution, JHH leverages its 340B savings to support purchasing, employment and investment activities that create a safer, healthier and more vibrant community. Studies show that incomes and employment have a profound impact on health outcomes.[9] To help narrow the wealth disparities in our community, The Johns Hopkins University and The Johns Hopkins Health System Corporation launched *HopkinsLocal* in 2015, a comprehensive strategy to promote greater economic growth

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[6] Johns Hopkins Medicine, *The Access Partnership Medical Director Report* (2017).

[7] Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, 79 Fed. Reg. 78,953 (Dec. 29, 2014) (codified at 26 C.F.R. pt. 1, 53, and 602)

[8] Pherson, *Development and implementation of a postdischarge home-based medication management service*, 71 Am J Health Syst Pharm. 1576-83 (2014).

[9] Robert Wood Johnson Foundation, Achieving Equity in Health. Racial and ethnic minorities face worse health and health care disparities – but some interventions have made a difference. Health Affairs (October 6, 2011). http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_53.pdf

and employment opportunities by increasing Johns Hopkins design and construction contracts with local minority- and women-owned businesses and expanding the number of new jobs for city residents. In year one, the program resulted in approximately $5 million more spending with local businesses and 300 new hires from the community.[10]

Countless health and wellness activities would be impossible without the savings afforded by the 340B drug discount program, but it is also a lifeline for hospitals with modest operating margins like JHH.[11] 340B covered entities' focus on preventive medicine, population health and care throughout the lifespan also helps avoid other, more costly, medical interventions, the cost of which would be borne in large part by federal and state government funds if it were not for the 340B program.

Along with the national network of other disproportionate share hospital (DSH) 340B covered entities, we are the bedrock of the national safety net dedicated to saving lives and improving the health of our most vulnerable neighbors. At no cost to taxpayers, the 340B program has been a success for our community, allowing JHH to operate a variety of programs and provide services for vulnerable individuals. JHH's total community benefit totaled nearly $200 million in fiscal year 2016.

Thank you for the opportunity to highlight the significant community reinvestment made possible, in part, by 340B savings. We look forward to meeting in person shortly to discuss JHH's participation in the program in greater detail.

Sincerely,

Redonda G. Miller, M.D., M.B.A.
President, The Johns Hopkins Hospital

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[10] Ronald J. Daniels & Ronald R. Peterson, *Year One Progress Report HopkinsLocal*, Johns Hopkins University & Health System (2017), http://hopkinslocal.jhu.edu/content/uploads/2017/03/HopkinsLocal-Progress-Single-Pages.pdf

[11] The Johns Hopkins Hospital operating margin was 3.6 percent for FY2016 according to audited financial statements

1. **In a chart or similar format, please list each of the following items for 2012, 2013, 2014, 2015, and 2016.**

   a. **The number of 340B drugs your organization, and all associated sites and off-site outpatient facilities registered as child sites, purchased for that year. Please provide a breakdown of the number of these drugs that were purchased by the covered entity's child sites and the number directly purchased by the covered entity.**

	FY2012	FY2013	FY2014	FY2015	FY2016
# of 340B Drugs[12]	317,993	328,797	371,436	406,888	379,026

Source: McKesson[13]

Note: All purchasing is done centrally by the covered entity (JHH) on behalf of child sites.

   b. **The percentage of 340B drugs purchased and dispensed that fall into each of the following categories: Analgesics, antidepressants, oncology treatment drugs, antidiabetic agents, antihyperlipidemic agents.**

	FY2012	FY2013	FY2014	FY2015	FY2016
Analgesics	9.00%	8.84%	11.11%	8.74%	7.99%
Antidepressants	2.14%	1.02%	1.01%	0.60%	0.38%
Oncology (Antineoplastics)	11.83%	13.51%	11.81%	12.66%	14.05%
Antidiabetic agents	3.17%	3.10%	2.88%	1.99%	2.11%
Antihyperlipidemic agents	0.91%	0.72%	0.67%	0.35%	0.31%

Source: McKesson, data categorized by JHH according to American Society of Health-System Pharmacists AHFS Drug Information© classifications.

   c. **The number of 340B drugs your organization purchased that were dispensed to insured patients, including: Medicare beneficiaries, Medicaid beneficiaries, commercially-insured individuals.**

[12] Number of purchased units based on sales history data for JHH during the time period 1/1/2012 – 12/31/2016 provided by JHH's primary wholesaler, McKesson. Purchased units do not correlate to number of prescriptions. These data correspond to sales in active Public Health Service (PHS), which may reflect undiscounted prices for items that are not 340B covered outpatient drugs, individual hospital contracts and Apexus contracts in addition to "340B sales." McKesson data represent approximately 85 percent of JHH's total drug spend.

[13] Per McKesson: "The historical sales information alone may not be fully sufficient to support the scope of analytics and level of detail requested by the committee. As relevant examples, distributor discounts and fees are included in final sales prices and historical reference pricing is not provided, nor available. McKesson is unable to provide reference contract identifiers, historical reference GPO or WAC prices at time of sale, nor to provide GPI, AHFS or other therapeutic class information as this information is not archived."

	FY2012	FY2013	FY2014	FY2015	FY2016
Medicare	73,641	82,634	94,432	103,130	95,591
Medicaid	55,799	49,406	59,844	71,410	67,194
Commercial	175,811	181,482	202,936	219,508	204,572

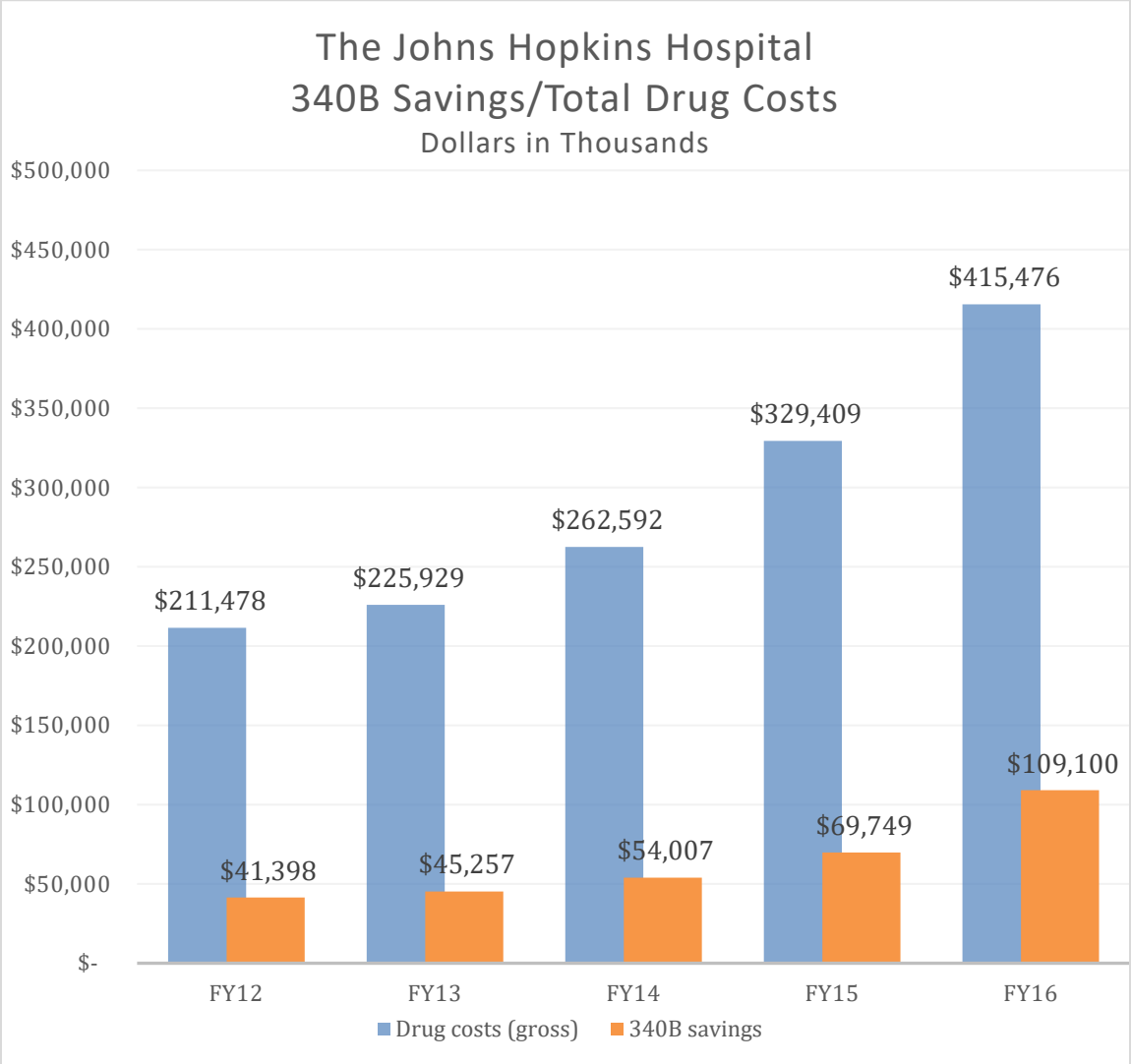
Note: Purchased units distributed according to JHH outpatient payer mix percentages, reflects medical benefit coverage, not prescription benefit coverage.

d. The number of 340B drugs your organization purchased that were dispensed to uninsured patients.

	FY2012	FY2013	FY2014	FY2015	FY2016
Uninsured	12,743	15,275	14,224	12,841	11,669

Note: Purchased units distributed according to JHH outpatient payer mix percentages, reflects medical benefit coverage, not prescription benefit coverage.

e. The amount of savings (in dollars), as compared to the GPO price for the same drug, that your organization generated through participation in the 340B Drug Pricing Program.



The amount of JHH 340B savings in dollars are shown in **ORANGE** above. JHH's savings are the difference between what JHH paid for a drug at the 340B price and what it would have paid at a non-340B price. The 340B program provides covered entities a savings off of high drug costs enabling us to create programs that help our local communities.

The graph above demonstrates that the growth in JHH 340B savings follows the trajectory of JHH's gross drug spend, which has risen significantly in recent years. New medicines introduced in the past three years are a major driver of JHH and national spending growth as clusters of innovative treatments for cancer, autoimmune disease, HIV, and diabetes come into the market.

Prescription drug spending growth in 2015 (9.0 percent) outpaced the overall rate of health care spending growth (5.8 percent) and the rate of spending growth on hospital care (5.6 percent).[14]

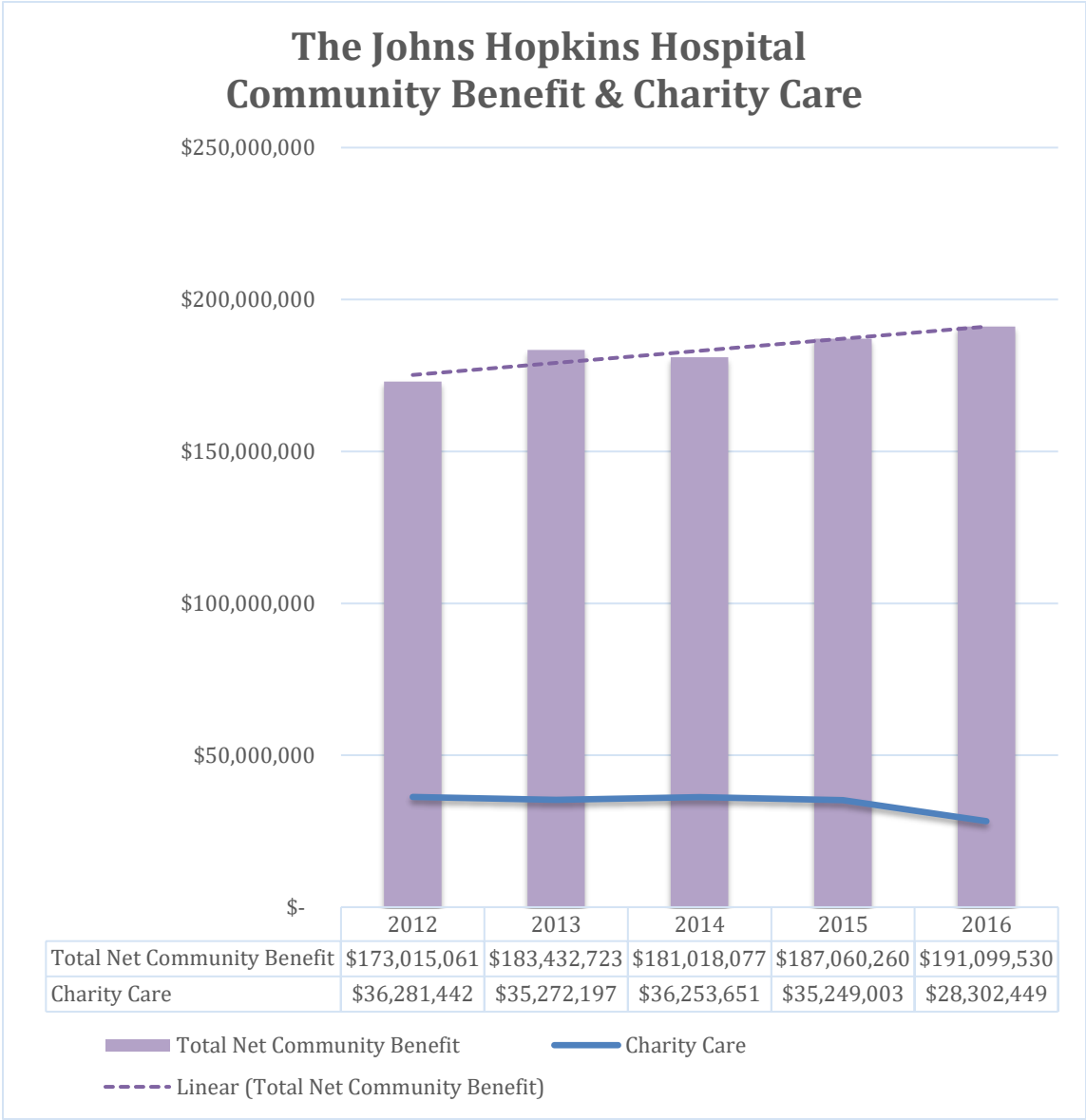
In the generic market, as well, hospitals nationwide struggle to manage unexpected, sustained, and irregular price increases. Often these drugs are essential and life-saving and in many cases, no lower cost alternative exists. For example, from FY2014 to FY2017, the drug spend for just seven long-standing generic drugs used to treat severe allergic reactions, urgent blood pressure control, and cardiac arrhythmias increased by 315 percent, despite purchase volumes for those same drugs increasing by only 12 percent. Such spikes are not limited to a single drug manufacturer but are instead the result of loss of competition and monopolistic business practices that have been the subject of congressional inquiry in recent years.[15]

f. The amount of charity care (in dollars) that your organization provided.

JHH charity care dollars decreased from FY2015 to FY2016 consistent with national trends in states that expanded Medicaid. Community benefit is a more appropriate indicator, than charity care alone, of JHH's overall commitment to its community and free or discounted care to vulnerable patients. As shown below, the total community benefit for JHH increased by $4 million that same year.

In fiscal year 2016, the total amount spent on community benefit activities at JHH approached nearly $200 million. This figure includes charity care or funding for free or discounted medically necessary care for patients, plus community health improvement programs and health screenings, accredited training of doctors, nurses and allied professionals, financial and in-kind contributions to community groups, and other community-building activities. Community benefit provides a fuller picture of JHH's investment in improving public health within its community, consistent with 340B original legislative intent, not just to underwrite the cost of medications.

[14] U.S. Dept. of Health and Human Services, Centers for Medicare and Medicaid Services, *National Health Expenditure Fact Sheet.* Baltimore, MD, 2015.
[15] Susan Collins and Claire McCaskill, Special Senate Committee on Aging, *Sudden Price Spikes in Off-Patent Prescription Drugs: The Monopoly Business Model that Harms Patients, Taxpayers, and the U.S. Health Care System,* December 21, 2016.



Source: IRS 990, Schedule H

g. The number of patients that received charity care from your organization.

	FY2012	FY2013	FY2014	FY2015	FY2016
Patients that received charity care[16]	21,219	19,927	19,443	16,737	16,763

As expected, the total number of charity care patients slowly decreased since the State of Maryland's 2014 expansion of Medicaid (nearly 300,000 new individuals for a total of 1.3 million) and the establishment of the Maryland Health Benefit Exchange (almost 150,000 individuals) as part of the implementation of the Affordable Care Act.[17]

Note: Each patient may have had multiple visits written off to charity care, so the numbers above are significantly lower that the total number of charity care transactions for JHH.

2. How does your organization calculate the amount of savings it generates through participation in the 340B Drug Pricing Program? How does your organization track the amount of money your organization receives when an insured patients' insurance reimbursement exceeds the 340B price paid for the drug?

JHH calculates the amount of 340B savings by comparing the 340B price to the group purchasing organization (GPO) price for the same drug, when available. If GPO price is not available, JHH compares the 340B price to the wholesale acquisition cost (WAC). The difference is then multiplied by the number of units purchased to determine the overall savings. Note: Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs does not require nor specify a particular way to calculate program savings or tracking by insurance status. JHH tracks drug purchases and reimbursement in the aggregate.

Wholesale acquisition cost (WAC) is the price paid by a wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. A *group purchasing organization* (GPO) is an organization created to leverage the purchasing power of entities to obtain discounts from vendors based on the collective buying power of the GPO members.

3. How does your organization use program savings to care for vulnerable populations? Are program savings used for any other purposes?

JHH uses program savings in a variety of ways including, to deliver affordable medications and to provide state-of-the-art, comprehensive clinical services to its neediest patients. The program is integral to reducing the cost of care for patients, beyond their pharmacy needs.

[16] These numbers are an approximation based on unique medical record numbers within the JHH electronic medical record system.

[17] *Assessing the Impact of Health Care Reform in Maryland,* Maryland Department of Legislative Services (January, 2017), http://mgaleg.maryland.gov/Pubs/legislegal/2017rs-Issue-Papers.pdf.

JHH is embedded in, and a product of, its community. JHH serves a medically complex, vulnerable patient population, including patients who are often unable to get the necessary care elsewhere. JHH's priorities in any given year are guided by the health care needs of the community. Some examples of JHH programs and services are included below. This is not an exhaustive list (See *JHH 2016 Community Benefit Report Narrative, Appendix 1*).

- The Johns Hopkins Children's Center is renowned for fulfilling the clinical needs of children that were not being met at other institutions and pediatric clinicians are credited with several major innovations that have transformed care. Most notable are the recent advances in treatments for common pediatric ailments such as asthma and lead poisoning, which are experienced by children in the surrounding community at disproportionately high levels.
- JHH's advances in patient-centered care are replicated globally *and felt locally*. For example, the first and only effective treatment for sickle cell disease was developed at JHH. Sickle cell disease is a rare blood disorder that predominantly affects African-Americans. The Sickle Cell Center for Adults at JHH remains the only facility in the State of Maryland that provides comprehensive services for adults with the disease.
- In 2016, JHH became the first hospital in the United States to perform HIV-positive to HIV-positive kidney and liver transplants. According to the Baltimore City Health Department, Baltimore consistently ranks in the top five cities worldwide for HIV infections. While African-Americans make up 62 percent of the population of Baltimore City, they account for more than 85 percent of those living with HIV.
- JHH is a proud sponsor of *Health Leads*, a program to enable providers to "prescribe" basic resources like food and heat just as they do medication. Health Leads Advocates work side by side with patients to connect them with community resources such as local food pantries and utilities assistance programs. Over 1,100 patients were served in FY2016.[18]
- Since 2009, JHH has offered a charity program designed to improve access to effective, compassionate, evidence-based primary and specialty care to uninsured and underinsured patients from the neighborhoods immediately surrounding the hospital. In that time, *The Access Partnership (TAP),* as it is called, has provided medical services to over 6,000 patients.[19]
- JHH is addressing the transportation needs of local patients with cancer in an effort to make cancer clinical trials more available to minority patients from the surrounding community. In addition to a broader education/awareness campaign and individualized support from a patient navigator, JHH provides free parking or taxi transportation to Baltimore City residents considering clinical trials as a treatment option. The number of minority patients from Maryland treated at the Kimmel Cancer Center increased about 25 percent. *(See Kimmel in the Community report, Appendix 2)*
- Multidisciplinary teams of physicians, nurse practitioners, psychiatric social workers, and substance use professionals conduct proactive screenings to identify patients with substance use and/or psychiatric issues who could benefit from prompt intervention from behavioral health experts during hospitalization or following hospital discharge. So far in FY2017, over 2,370 patients received these services.

[18] The Johns Hopkins Hospital, Johns Hopkins Community Benefits Report Narrative (Fiscal Year 2016).
[19] Johns Hopkins Medicine, *The Access Partnership Medical Director Report* (2017).

- The interdisciplinary "After Care Clinic" (ACC) provides a seamless connection to primary care following hospital or emergency department visit. The ACC also connects patients to “medical homes” and links patients with community resources to address psychosocial barriers to care. So far in FY2017, the after care clinic served over 2,490 patients.
- JHH provides cab rides, bus tokens and/or gas cards as needed for patients who do not have access to transportation.

The needs of the underserved extend past a stay in an inpatient unit or a visit to a hospital clinic. Pharmacy services are critical to care alignment for patients as they transition back into the community. Specifically, with regard to medication access, underinsured/uninsured patients who cannot afford a take-home medication may speak with a social worker who can authorize the use of hospital funds in certain instances *(See Medication Assistance Policy, Appendix 3).* In addition, a team of advanced pharmacy technicians can help patients and prescribers navigate coverage issues and access charitable care funds if the patient cannot afford their medications.

In addition to medication access, comprehensive clinical pharmacy services are critical to care alignment for the underserved. For example, JHH 340B savings support the *Home-Based Medication Management* project, in which pharmacists are dispatched to a patient’s home after discharge to discuss medication adherence, dispose of expired or discontinued medication and review administration instructions. The goal is to ensure that their medication regimen is not only the right choice therapeutically, but also affordable for the patient in the long term. In this program, which began in 2012, JHH has demonstrated a significant reduction (from 17 to 8 percent) in readmissions among patients who receive a pharmacist home visit.[20]

JHH also offers a free bedside delivery service to patients, known as *Meds for Home,* to eliminate barriers, whether due to financial burden, insufficient transportation or inconvenience, for patients who might otherwise not fill their prescription, which can result in their being readmitted or experiencing poor health outcomes. Over 9,000 patients benefitted from this service in 2016 and in certain instances, specially-trained pharmacists and nurses followed up with patients in their homes about their entire medication regimen, sometimes color-coding pill containers when labels were too small to read or organizing chaotic medicine cabinets.

Additional examples of targeted projects to support the community’s health needs may be found in the JHH Community Health Needs Assessment and Implementation Plan. *See Appendix 4.*

a. Does your organization provide any additional charity care to uninsured and underinsured patients with funds derived from sources other than the 340B Drug Pricing Program? If so, please elaborate.

[20] Pherson, *Development and implementation of a postdischarge home-based medication management service*, 71 Am J Health Syst Pharm. 1576-83 (2014).

In addition to the charity care captured in its 990s, JHH connects vulnerable patients with other resources such as endowment funds, outside foundation resources or other forms of financial assistance, when appropriate.

b. What percentage of total health care services provided by your organization is charity care?

	FY2012	FY2013	FY2014	FY2015	FY2016
Charity Care to Total Operating Expenses	2.15%	1.86%	1.88%	1.72%	1.30%

Source: IRS 990, Schedule H

Charity care as a percent of total JHH operating expenses has decreased in tandem with a decline in the State of Maryland's uninsured rate, which dropped from 10.1 percent in 2012 to 6.7 percent in 2015 as a result of the Affordable Care Act.[21]

Community benefit is a more appropriate indicator, than charity care alone, of JHH's programming in its community and free or discounted care to vulnerable patients.

	FY2012	FY2013	FY2014	FY2015	FY2016
Community Benefit to Total Operating Expenses	10.24%	9.67%	9.39%	9.14%	8.77%

Source: IRS 990, Schedule H

4. Does your organization have any policies to help ensure that uninsured and underinsured patients directly benefit from the program by receiving discounts on 340B drugs? If so, please elaborate.

JHH has two policies – financial assistance and medication assistance – that ensure eligible low income patients receive the medications they need, regardless of whether those drugs are bought through 340B or not. *(See Appendix 3)* Assuring that patients have access to the medications they need is inherent in our mission and JHH has numerous programs to directly assist insured, underinsured and uninsured alike. The intent of the 340B program is to assist hospitals that serve large numbers of low-income, vulnerable patients in caring for *all* community residents, even those who are not "low income."

The Financial Assistance Program, which is made available 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 and medications based on their individual financial situation; and Medical Financial Hardship Assistance, which is made available to those patients

[21] *Assessing the Impact of Health Care Reform in Maryland,* Maryland Department of Legislative Services (January, 2017), http://mgaleg.maryland.gov/Pubs/legislegal/2017rs-Issue-Papers.pdf.

who are eligible for reduced cost care under the Financial Assistance criteria and also qualify under the Medical Financial Hardship Assistance Guidelines. It stipulates that JHHS hospitals (including JHH) shall apply the reduction in charges that is most favorable to the patient.

The JHH Medication Assistance Policy describes JHH's charity assistance programs, which consist of grants, donations, and other funds designated for assisting patients in obtaining prescription medication; Patient assistance programs, which allow patients with limited income and resources access to medications via pharmaceutical companies; and Medication access lists, which make available low cost generic alternatives.

5. **How many child sites does your organization have registered to participate in the 340B Drug Pricing Program? Please provide a list of all child sites, including the location of the child site and the date it began participating in the program.**

In accordance with new child site registration requirements (updated in April 2014), JHH has registered all individual outpatient departments and clinics (221). This does not reflect an effort by JHH to expand its 340B program by constructing or acquiring new clinics. These departments and clinics, as demonstrated in the enclosed map, are located within the hospital footprint or "medical campus" and are included as reimbursable on the covered entity's Medicare cost report. These clinics are organizationally, financially and clinically integrated with the main hospital and therefore are subject to the same patient care responsibilities as the parent site. Most have been critical components of patients' care since the start of JHH's participation in the 340B program, well prior to the requirement to enroll each separately.

Johns Hopkins Hospital Child Site Listing
As of September 2017

Participating start date	Entity	Entity Sub division name	Address	City	State	Zip
1/1/2013	JOHNS HOPKINS HOSPITAL	IV Infusion	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Fetal Assessment	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Cardiac CT Scan	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Neuro IR cvil	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Pathology	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Purchase Service Lab	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Occ Therapy	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Psychiatric OT	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Speech therapy	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Echocardiography	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Perinatal ultrasound	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Heart Failure Clinic	1800 Orleans St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	L&D	1800 Orleans St	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Infectious- Hepatitis C	1800 Orleans St.	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Community Psychiatry	1800 Orleans St.	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	OPD PSYCH	1800 Orleans St.	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Schizophrenia Day Hosp	1800 Orleans St.	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Psych: Geriatric Day Hospital	1800 Orleans St.	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Cardiac Cath Int Rad	1800 Orleans St.	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Institute of Genetic Medicine	1800 Orleans St.	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Medicine/Infectious Disease-Moore-P	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Medicine/General - Nutrition at Moore	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Sickle Cell Infusion	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Cardiology	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Echo	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Peds psych	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Surgery	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Hematology	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Oncology	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Child Psychiatry Day	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Psy Intensive Outpatient	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Phipps Pain program	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Obstetrics	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ophthalmology Same Day	1800 Orleans Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ophthalmological - General	1800 Orleans Street	Baltimore	MD	21287

7/1/2013	JOHNS HOPKINS HOSPITAL	Periop	1800 Orleans Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	GOR Same Day	1800 Orleans Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Adult Emergency Room	1800 Orleans Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Emergency Room	1800 Orleans Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Endoscopy	1800 Orleans Street	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Ped Pulmonary Function	200 N Wolfe St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Peds Specialty clinics 502	200 N Wolfe St	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ped Primary Care 501	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Comprehensive Child Care Ctr	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ped Intensive Primary Care	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Allergy	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Endocrine	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Lipid	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Rheumatology	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Gastroenterology	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Renal	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Cystic Fibrosis	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Diagnostic Referral	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pulmonary	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Immunology	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ped Sub Vascular	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Derm	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Infectious Disease	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ped Infusion	200 N. Wolfe Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Ped Voiding Dysfunction	200 N. Wolfe Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Ped Private Urology	200 N. Wolfe Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Urology	200 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	OPHTH ORX	400 N. Broadway	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Medical Oncology	401 N. Broadway	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	IPOP Ambulatory	401 N. Broadway	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Radiation Oncology	401 N. Broadway	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Weinberg CT/X-ray	401 N. Broadway	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Weinberg ORX	401 N. Broadway	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Children Mental Health	401 N. Caroline St.	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Cardiac Consult (Prevention)	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Infect. Diseases-Program for Alcohol & other Drug Depend	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Medicine/Infectious-Psychiatry	600 N. Wolfe Street	Baltimore	MD	21287

1/1/2013	JOHNS HOPKINS HOSPITAL	Infectious Diseases - Buprenorphine	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Infectious Diseases-Dermatology	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Gynecology At Moore	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Nephrology	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Infectious-Neurology at Moore	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Clinics - AIDS	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Eating Disorders	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Affective Day Hospital	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Prenatal Genetic Counseling	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ophthalmology -Low Vision Center	600 N. Wolfe Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Neuro INT E&M	600 N. Wolfe Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Resident Child Life	600 N. Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Catheter	600 North Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Phipps Outpatient Clinic	600 North Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Cortical Function Lab	600 North Wolfe Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Medical First Step	600 North Wolfe Street	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Oto audiology	601 N Carline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	JHOC OR	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Vascular Lab	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Interventional Radiology	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Physical Therapy	601 N Caroline St	Baltimore	MD	21236
7/1/2014	JOHNS HOPKINS HOSPITAL	Sleep Lab	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Neurosciences OPD Clinic	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Neurosciences OPD	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Photopheresis	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Heart Center Clinic	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Medicine Gastroenterology	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Med Nephrology	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Medicine Pulmonology	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Med Rheumatology	601 N Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Med Rheumatology	601 N Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Med Rheumatology	601 N Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Med Rheumatology	601 N Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Med Rheumatology	601 N Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Med Rheumatology	601 N Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Executive Health Program	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Cortical FN O/P Clinic	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Urology Clinic	601 N Caroline St	Baltimore	MD	21287

7/1/2014	JOHNS HOPKINS HOSPITAL	OHNS ENG clinic	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	PreOP eval	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Radiology IRC	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	radioisotope nuc med	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Nuclear Ned OPD	601 N Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Medicine Diabetes Center	601 N Caroline St.	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Medicine Endocrinology	601 N Caroline St.	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Derm Surgery	601 N. Caroline St	Baltimore	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Medicine Hematology	601 N. Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Medicine Hematology	601 N. Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Medicine Hematology	601 N. Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Medicine Hematology	601 N. Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Medicine Hematology	601 N. Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Medicine Hematology	601 N. Caroline St	BALTIMORE	MD	21287
7/1/2014	JOHNS HOPKINS HOSPITAL	Adult Medicine General Internal Med	601 N. Caroline St	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	NRO-Hydrocephalus	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	NRO-Peripheral Nerve	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	NRO-Stroke Prevention	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Lumbar Puncture	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Neurofibromatosis	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	HATS	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Express Testing-Lab	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Vaccine Administration	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pain Treatment	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pain Treatment - Anesthesia	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Dermatology	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Derm PLC	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Derm Excision	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Cardiac (Congested) Heart Failure	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Hematology (LAB) (7th floor)	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Internal Medicine - Specialty	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Cardiac	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Cardiac - Coumadin Anti-Coag	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Cardiology -Adult	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Cardiac ED Chest Pain	601 N. Caroline Street	Baltimore	MD	21287

1/1/2013	JOHNS HOPKINS HOSPITAL	Cardiology - Heart Station	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Electro Physiology Device Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Infectious Diseases - Treatment Ctr	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Medicine/Endocrinology - Lipodystrophy	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Radiology Diagnostic, Mammography Services	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Genetic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Family Planning	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Gynecology General Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	GYN Colposcopy	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	GYN/OB Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	GYN/OB High-Risk Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	OB Nurse History	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Gynecology Oncology	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	GYN/OB General Gynecology	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	GYN Fertility Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	TYSABRI Infusion Center	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Surgery Vascular CVDL	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Surgery Endocrine	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	General Surgery Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Surgery Advanced Practice	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Surgery General	601 N. Caroline Street	Baltimore	MD	21237
1/1/2013	JOHNS HOPKINS HOSPITAL	Renal/Liver Transplant	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Compr Transplant Center	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Cochlear Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Surgery Suite	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	AVON Breast Center	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Melanoma/Breast	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Breast Center/Plastics	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Vascular Access	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Plastic Surgery	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Surgical Plastic OR	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Surgery Plastic Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Surgery Melanoma Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Orthopedic Fracture	601 N. Caroline street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ortho-Pediatric Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ortho-Pediatric Private	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ortho-Pediatric Scoliosis	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ortho-Adult Private	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	NRO-Muscular Dystrophy	601 N. Caroline Street	Baltimore	MD	21287

1/1/2013	JOHNS HOPKINS HOSPITAL	Adult Ortho Spine	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ortho-Hand	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Ortho	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Orthopaedics Podiatry Clinic	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Urology-Adult-surgical (4th floor)	601 N. Caroline Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Endocrine Surgery	601 N. Caroline Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Plastic Surgery	601 N. Caroline Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Ear, Nose & Throat	601 N. Caroline Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	PEDS Otolaryngology	601 N. Caroline Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Orthopedic Surg	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Epilepsy	601 N. Caroline Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Adult Nutrition	601 N. Caroline Street	Baltimore	MD	21287
7/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Nutrition	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Neurosurgery	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	General Neurosurgery	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Neurology	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric-Tourette's	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Pediatric Neurology	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Adult Neurology	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Cognitive Neurology	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	NRO- Electromyography	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	NRO-Epilepsy	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	NRO- Movement Disorders	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Neurology	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Neuro-Vestibular	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Neurology-IM/ID	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Neuro-Pain Treatment Ctr	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Neuro-Intensive Care	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Neuro-Oncology	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Neuro-Cerebrovascular	601 N. Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Laboratory Services	601 North Caroline Street	Baltimore	MD	21287
10/1/2013	JOHNS HOPKINS HOSPITAL	Pulmonary Function Test Lab	601 North Caroline Street	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Psychiatric Outpatient	911 N. Broadway	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Substance Abuse-Alcoholism	911 N. Broadway	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Broadway Primary Care	911 N. Broadway	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	CWC Extended	911 N. Broadway	Baltimore	MD	21287
1/1/2013	JOHNS HOPKINS HOSPITAL	Substance Abuse- PAODD Extended	912 N. Broadway	Baltimore	MD	21287

Johns Hopkins Medical Campus – Location of JHH Child Sites

Child Site Descriptions

1800 Orleans Street, Baltimore, MD 21287 (JHH)
This address has been the front door to the main hospital since May 2012, when The Johns Hopkins Hospital expanded into the Sheikh Zayed Tower and The Charlotte R. Bloomberg Children's Center. This location houses the only state-designated pediatric trauma service and burn unit for children.

600 North Wolfe Street, Baltimore, MD 21287 (Nelson/Harvey)
This address served as the main entrance to the hospital for more than three decades (since 1977) prior to the hospital's expansion into the Bloomberg/Zayed buildings in 2012. The building remains the primary home of the departments of medicine, pulmonology, gastroenterology and cardiac medicine.

400 North Broadway, Baltimore, MD 21287 (Wilmer Bendann Surgical Pavilion)
This address is home to The Wilmer Eye Institute's surgery center.

401 North Broadway, Baltimore, MD 21287 (Kimmel Cancer Center)
This address offers a convenient, designated entrance for cancer patients (which is helpful for privacy and infection control for individuals with compromised immune systems) to the Sidney Kimmel Comprehensive Cancer Center, Maryland's only comprehensive cancer center designated by the National Cancer Institute. It provides the full range of diagnosis and treatment of cancer, with a special emphasis on Baltimore City residents and at-risk minority populations.

200 North Wolfe Street, Baltimore, MD 21287 (Rubenstein Child Health)
This address is an access point for the Johns Hopkins Children's Center, which houses many of the original pediatric specialty clinics that Hopkins opened nearly a century ago. These include the Harriet Lane Clinic, named for the wife of Baltimore lawyer Henry Johnston, whose bequeathal in the early 20th century led to the creation of the Harriet Lane Home for Invalid Children at Johns Hopkins. It has served the residents of the East Baltimore community for over 100 years; and today, more than 7,500 of Baltimore's children and adolescents receive care there each year.

401 North Caroline Street, Baltimore, MD 21287 (Children's Mental Health Center)
This address is the JHH location for treatment of children and adolescents with behavioral, emotional and psychiatric difficulties.

601 North Caroline Street, Baltimore, MD 21287 (Outpatient Center)
This is the address of the Johns Hopkins Outpatient Center, home to numerous clinical departments, the Diabetes Center, and Heart and Vascular Institute. The space is a convenient hub for patients who do not require hospital admission and are in need of a physician consultation, outpatient procedure and laboratory services.

911 North Broadway, Baltimore, MD 21287
This address is just two blocks north of the main campus and is the location of the Johns Hopkins Broadway Center for Addiction, which offers comprehensive outpatient treatment services for individuals with acute or chronic substance use disorders.

6. How many pharmacies has your organization contracted with to dispense drugs purchased through the 340B Drug Pricing Program on your behalf?

JHH has three external contract pharmacy relationships (specifically, with Walgreens, CVS/Caremark, and Accredo). Both CVS/Caremark and Accredo operate via designated closed-door delivery pharmacies that ship medications directly to the patient's home. The Walgreens pharmacy at N. Washington Street is a unique joint venture between Walgreens and Johns Hopkins Health Care to bring extra services, such as smoking cessation programs, chronic disease education and other programs to the community as part of the broader revitalization of East Baltimore. It is the first Walgreens in Maryland with a clinic staffed by nurse practitioners and community care providers, which has expanded to become the Brancati Center for Community Care, a program focused on improving outcomes for urban patients and community members with a variety of chronic and infectious disease conditions.

JHH also has two contracts with entity-owned pharmacies. Johns Hopkins Bayview Medical Center (JHBMC), a disproportionate share hospital (DSH) located less than five miles from JHH in Baltimore City, is a member of Johns Hopkins Health System and owns pharmacies on its campus. Johns Hopkins Pharmaquip Inc., a subsidiary of the not-for-profit Johns Hopkins Home Care Group, which is 50 percent owned by Johns Hopkins Health System and 50 percent owned by Johns Hopkins University, provides home infusion services for patients transitioning to home.

a. Do your contracts with these pharmacies require that program savings be passed on to the intended beneficiaries, including requiring that uninsured or underinsured patients receive discounts on 340B drugs?

The entity-owned contract pharmacies follow the medication assistance and financial assistance policies to assist patients who have difficulty affording their medications. The external contracts do not stipulate how the covered entity's savings will be used. JHH uses its program savings, some of which originates from contract pharmacy relationships, to benefit our vulnerable patients, consistent with congressional intent. The 340B program allows DSH hospitals to "stretch scarce federal resources," which in turn reduces government expenditures and the burden on taxpayers who would otherwise be responsible for financing the indigent care that 340B hospitals provide.

b. Does your organization share any program savings with these contract pharmacies? If so, please elaborate.

JHH has negotiated dispensing and administrative fees with contract pharmacies to pay for their services. JHH does not consider such payment for services as "sharing program savings" with the pharmacies.

Appendices

Appendix 1 – The Johns Hopkins Hospital Fiscal Year 2016 Community Benefits Report Narrative

Appendix 2 – The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Kimmel in the Community Report

Appendix 3 – The Johns Hopkins Health System Financial Assistance Policy and JHH Medication Assistance Policy

Appendix 4 - Community Health Needs Assessment and Implementation Plan, June 2016

Appendix 1

The Johns Hopkins Hospital Fiscal Year 2016

Community Benefits Report Narrative

The Johns Hopkins Hospital
Fiscal Year 2016
Community Benefits Report
Narrative

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

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I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS

1. Primary Service Area

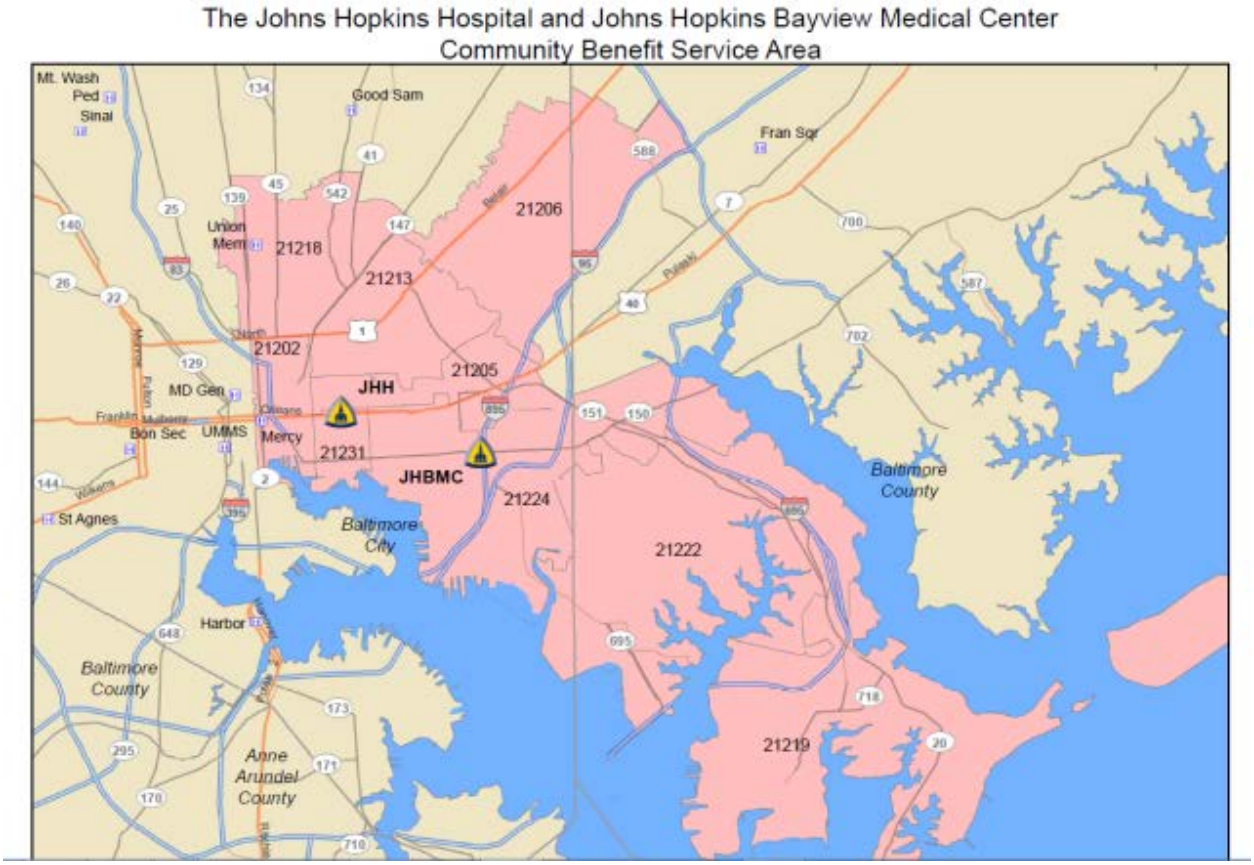
Table I

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

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

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

2. Community Benefits Service Area (CBSA)



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

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

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

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

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

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

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

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

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

B. CBSA Demographics

Table II

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

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

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

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

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

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

_X__Yes
____No

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

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

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

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

_X__Yes
___No

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

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

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

III. COMMUNITY BENEFITS ADMINISTRATION

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

   _X_Yes
   ___No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

JHHS Community Benefit Reporting Work Group

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

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

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

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

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

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

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

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

vi. _X_ Other (please describe)

JHM Community Benefits Advisory Council

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

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

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

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

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

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

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

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

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

List of CHNA Interviewees

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

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

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

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

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

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

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

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

____yes __X___ No

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

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

__X___yes _____ No

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

V. HOSPITAL COMMUNITY BENEFITS PROGRAM AND INITIATIVES

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

Health Disparities in Baltimore City

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

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

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

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

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

Health Disparities in Baltimore County

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

Mortality, Illness and Infant Health

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

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

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

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

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

Health Status

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

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

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

Healthy Homes and Communities

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

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

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

Health Care

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

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

Community Benefit Initiatives

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

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

Initiative 1. Health Leads

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

How were the outcomes evaluated?

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

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

Outcome (Include process and impact measures)

Health Leads Outcomes:

For FY16, the top presenting needs were as follows:

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

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

Total: 2,563

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

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

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

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

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

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

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

Initiative 2. The Access Partnership (TAP)

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

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

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

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

Initiative 3. You Gotta Have Heart Collaboration

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

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

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

Initiative 4. Wilson House

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

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

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

Initiative 5. Broadway Center for Addiction Substance Abuse Program

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

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

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

Initiative 6. Supportive Housing for Male Substance Abuse Patients

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

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

Initiative 7. Camp SuperKids

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

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

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

Initiative 8. Baltimore Population Health Workforce Collaborative

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

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

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

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

Initiative 9. – Mary Harvin Transformation Center

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

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

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

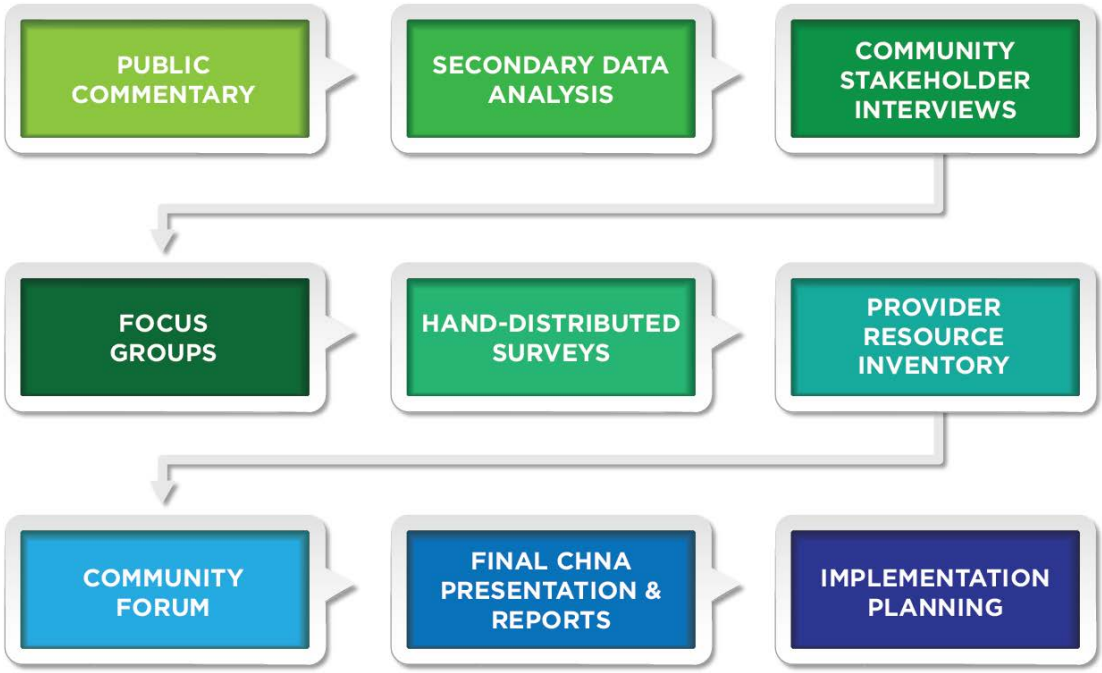
A comprehensive community-wide CHNA process was completed for Johns Hopkins Bayview Medical Center (JHBMC) and The Johns Hopkins Hospital (JHH), connecting public and private organizations, such as health and human service entities, government officials, faith-based organizations and educational institutions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

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

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

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

Flow Chart 2: CHNA Process



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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prioritized Key Community Needs:

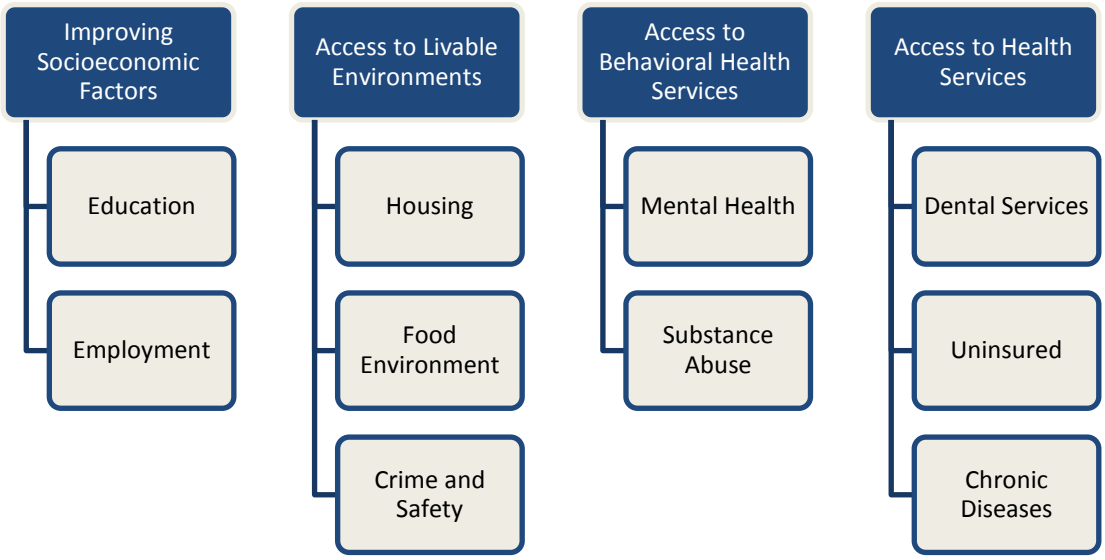
Education (4)
Employment (4)
Housing (3)
Mental health (2)
Food environment (2)
Substance abuse (2)
Crime and safety (1)
Health care/access (1)
Dental health (1)

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

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

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

2016 JHH/JHBMC CHNA Key Needs



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

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

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

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

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

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

VI. PHYSICIANS

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

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

2. Physician subsidies

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

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

APPENDIX I

FINANCIAL ASSISTANCE POLICY DESCRIPTION

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

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

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

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

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

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

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

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

APPENDIX II

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

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

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

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

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

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

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

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

APPENDIX III

FINANCIAL ASSISTANCE POLICY

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

POLICY

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

Purpose

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

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

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

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

Definitions

Medical Debt

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

Liquid Assets

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

qualified deferred compensation plans.

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

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

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

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

(b) Serious impairment of any bodily functions;

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

(d) With respect to a pregnant woman:

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

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

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

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

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

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

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

PROCEDURES

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

   For example:

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

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

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

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

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

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

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

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

d. All insurance benefits must have been exhausted.

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

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

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

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

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

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

f. Proof of disability income (if applicable).

g. Reasonable proof of other declared expenses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REFERENCE[1]

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

Charity Care and Bad Debts, AICPA Health Care Audit Guide

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

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

RESPONSIBILITIES - JHH, JHBMC

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

SPONSOR

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

REVIEW CYCLE

Two (2) years

APPROVAL

_____ _____

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

APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

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

Exception

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

FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 2/1/15

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

*200% of Poverty Guidelines

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

EXAMPLE:

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

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

Appendix A-1

Presumptive Financial Assistance Eligibility

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

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

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

APPENDIX B
MEDICAL FINANCIAL HARDSHIP ASSISTANCE GUIDELINES

Purpose

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

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

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

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

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

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

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

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

General Conditions for Medical Financial Hardship Assistance Application:

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

- Other forms of assistance available through JHM affiliates

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

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

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

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

Factors for Consideration

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

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

Exception

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

Evaluation Method and Process

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

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

MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 2/1/15

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

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

Exhibit A

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

JOHNS HOPKINS
MEDICINE

Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

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

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

Name	Age	Relationship

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

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

Exhibit A

I. Family Income

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

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

II. Liquid Assets

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

III. Other Assets

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

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

IV. Monthly Expenses

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

Do you have any other unpaid medical bills? Yes No

For what service? _____

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

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

_____ _____

Applicant signature Date

_____

Relationship to Patient

Exhibit A

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

JOHNS HOPKINS
MEDICINE

Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

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

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

Name	Age	Relationship

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

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

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? _____

1. Is patient homeless? Yes or No

10. Does patient participate in WIC? Yes or No

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

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

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

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

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

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

Exhibit B

SERVICIOS FINANCIEROS AL PACIENTE
CUESTIONARIO DEL PERFIL DEL PACIENTE

NOMBRE DEL HOSPITAL: _____

NOMBRE DEL PACIENTE: _____

DOMICILIO: _____
(Incluya Código Postal)

No. De Archivo Médico: _____

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

   Tamaño de Familia:

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

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

Exhibit C

MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #: _____

Date: _____

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

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

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

All documentation submitted becomes part of this application.

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

_____ Date: _____
Applicant's signature

_____
Relationship to Patient

For Internal Use: Reviewed By:
_____ Date: _____

Income: _____ 25% of income= _____

Medical Debt: _____ Percentage of Allowance: _____

Reduction: _____

Balance Due: _____

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

Exhibit C

APLICACION PARA DIFICULTADES MEDICAS FINANCIALES

NOMBRE DEL HOSPITAL: _____

NOMBRE DEL PACIENTE: _____

DOMICILIO: _____
(Incluya Código Postal)

No. DE ARCHIVO MEDICO :_____

FECHA: _____

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

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

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

Toda documentacion sometida sera parte de esta aplicación.

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

_____ Fecha: _____
Firma del Aplicante

_____
Relación al Paciente

Para Uso Interno: Revisado Por:
_____Fecha:_____

Ingresos: _____25% de ingresos=_____

Deuda Médica: _____Porcentaje de Subsidio: _____

Reducción: _____

Balance Debido: _____

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

PATIENT BILLING & FINANCIAL ASSISTANCE INFORMATION

YOUR RIGHTS AND RESPONSIBILITIES:

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

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

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

Mail only payments to:

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

Mail correspondence/insurance information directly to Customer Service:

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

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

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

HOSPITAL STATEMENTS DO NOT INCLUDE PHYSICIAN FEES OR CHARGES:

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

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

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

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

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

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

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

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

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

641962M

APPENDIX IV

PATIENT INFORMATION SHEET

JOHNS HOPKINS
MEDICINE

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

PATIENT BILLING and FINANCIAL ASSISTANCE INFORMATION SHEET

Billing Rights and Obligations

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

Financial Assistance

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

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

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

Call: 410-955-5464

with questions concerning:

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

For information about Maryland Medical Assistance

Contact your local department of Social Services

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

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

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

1296 (9/10)

JOHNS HOPKINS
MEDICINE

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

HOJA INFORMATIVA SOBRE LA FACTURACIÓN DE PACIENTES Y LA ASISTENCIA FINANCIERA

Los derechos y obligaciones de la facturación

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

Asistencia financiera

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

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

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

Llame a 410-955-5464

con sus preguntas referentes a:

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

Para más información sobre la Asistencia Médica de Maryland

Por favor llame a su departamento local de Servicios Sociales

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

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

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

1296 (9/10)

APPENDIX V

MISSION

VISION

VALUE STATEMENT

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

Keywords:

Table of Contents		Page Number
I.	POLICY	1
II.	REVIEW CYCLE	2
III.	SPONSOR	2
IV.	APPROVAL	2

I. POLICY

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

The Johns Hopkins Hospital (JHH)

JHH Mission Statement

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

JHH Vision

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

JHH Values

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

Johns Hopkins Medicine (JHM)

JHM Mission Statement

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

JHM Vision

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

JHM Values

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

II. REVIEW CYCLE

Three (3) years

III. SPONSOR

President

IV. APPROVAL

PRESIDENT APPROVAL

_____

_____

Date

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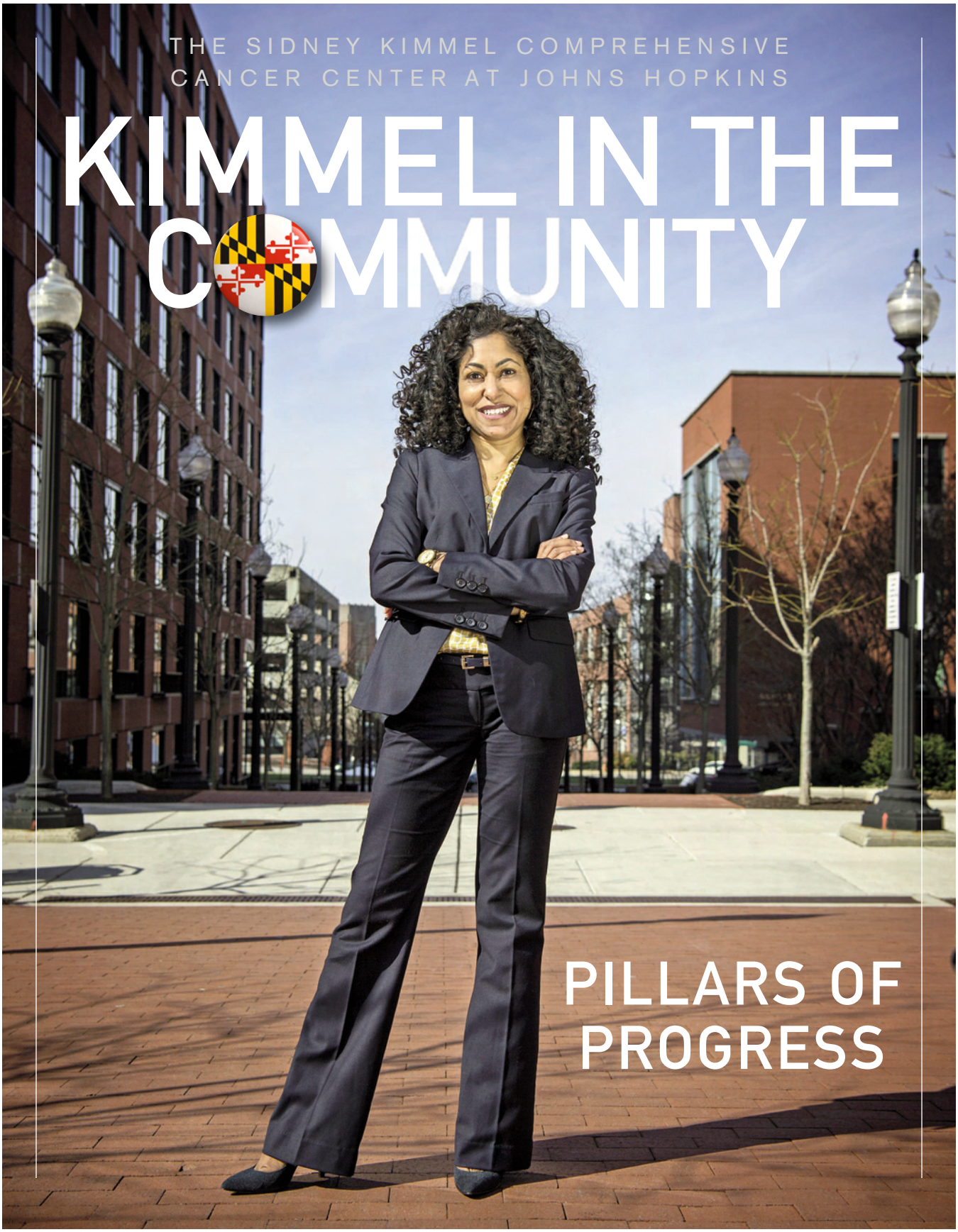
Appendix 2

The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins
Kimmel in the Community Report

THE SIDNEY KIMMEL COMPREHENSIVE CANCER CENTER AT JOHNS HOPKINS

KIMMEL IN THE COMMUNITY



PILLARS OF PROGRESS

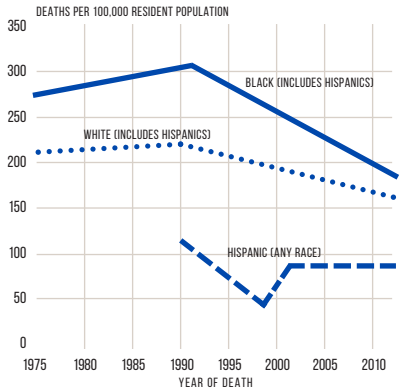
Closing the Gap in Cancer Disparities

MUCH PROGRESS HAS been made in Maryland toward eliminating cancer disparities, and I am very proud of the role the Johns Hopkins Kimmel Cancer Center has played in this progress.

Overcoming cultural and institutional barriers and increasing minority participation in clinical trials is a priority at the Kimmel Cancer Center. Programs like our Center to Reduce Cancer Disparities, Office of Community Cancer Research, the Maryland Cigarette Restitution Fund at Johns Hopkins, and Day at the Market are helping us obtain this goal.

The challenge before Maryland is greater than most states. Thirty percent of Maryland's citizens are African-American, compared to a national average of 13 percent. We view our state's demographics as an opportunity to advance the understanding of factors that cause disparities, unravel the science that may also play a contributory role, and become the model for the rest of the country. Our experts are setting the standards for removing barriers and improving cancer care for African-Americans and other minorities in Maryland and around the world.

Historical Trends (1975-2012)
Mortality, Maryland
All Cancer Sites, Both Sexes, All Ages



Although disparities still exist in Maryland, we continue to close that gap. Overall cancer death rates have declined in our state, and we have narrowed the gap in cancer death disparities between African-American and white Marylanders by more than 60 percent since 2001, far exceeding national progress. We are committed to closing the gap, and it will remain a focus for us in the laboratory and in the clinic until cancer disparities no longer exist.


Sidney Kimmel (left) with Bill Nelson

William G. Nelson, M.D., Ph.D.
Marion I. Knott Professor and Director
The Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins


MARYLAND INSTITUTE COLLEGE OF ART

Improving Minority Participation in Clinical Trials

PILLAR OF PROGRESS

The number of minority patients from Maryland treated at the Kimmel Cancer Center has increased from 985 in 2010 to 1,231 in 2015.

Dina Lansey, Assistant Director for Diversity and Inclusion in Clinical Research

DINA LANSEY heads the Kimmel Cancer Center's initiative to increase minority participation in clinical trials. She directs efforts to increase clinical trials awareness and to improve communication, continuity of care, and support for patients participating in clinical trials. Lansey, a seasoned expert in addressing racial disparities in cancer, is making cancer clinical trials more available to minority patients. She is developing ways to better measure and understand why many African-Americans, women, elderly, people with low income, and Baltimore City residents diagnosed with cancer often choose not to participate in clinical trials. It will help her remove barriers that prevent or discourage minorities from enrolling in clinical trials.

The transportation pilot study is one example. Lansey used patient data to identify cost and convenience of transportation to a doctor or clinic appointment as a barrier to clinical trial participation.

Now, she has started a pilot study to see if addressing transportation needs helps with trial participation. Her study study provides free parking to patients participating in therapeutic clinical trials and the choice of free parking or taxi transportation to Baltimore City residents. Lansey's goal is to eliminate access to transportation or the means to pay for it as a roadblock to receiving innovative new treatments. "This is an example of how we use data and feedback from our patients and research staff to make clinical trials accessible to all of our patients," she says. She is also studying whether support from a patient navigator may increase clinical trial participation.

To help spread the word, Lansey is engaged in a clinical trials awareness campaign that includes an educational brochure and video that provides information to help patients and families understand the value of considering clinical trials as a treatment option. It also details the services provided to support patients participating in clinical trials.

These efforts appear to be paying off. The number of minority patients from Maryland treated at the Kimmel Cancer Center increased from 985 in 2010 to 1,231 in 2015. Last year, 22 percent of Kimmel Cancer Center patients were African-American, and just over 20 percent participated in clinical trials.

Stronger Than Colon Cancer

TRINA TAYLOR ISAAC has felt God's guidance throughout her journey with colorectal cancer. She had been out of work for over a year before she was hired at The Johns Hopkins Hospital in 2008, an opportunity that was an answer to her prayers and more.

Isaac remembers feeling sluggish. Already thin, she was losing more weight and didn't know why. She had some mild GI symptoms, and the combination caused her to go to Johns Hopkins Occupational Health Services, which directs employees to experts who can advise them on health-related issues.

Occupational health got the medical tests rolling, including a colonoscopy. Isaac learned she had advanced colon cancer.

"I prayed. I cried, and then I made up my mind that I was going to beat it," says Isaac. "I have cancer, but cancer doesn't have me. I refused to let it control me."

She had surgery to remove a large portion of her colon and began chemotherapy. Her colleagues at Johns Hopkins rallied around her. "I told my staff if I come to work wearing stilettos, that's a sign that it is a good day. If I'm wearing flats, you will know I'm having a tough time," she says. They coined the phrase "strength in stilettos" to honor Isaac's courage and perseverance. "They made me want to come to work," she says.

Isaac's cancer continued to grow, and it persisted even with more chemotherapy and the addition of radiation therapy. In 2013, she had a permanent colostomy to surgically remove more of her cancerous colon.

Isaac remains strong and continues to look to clinical trials—research studies of promising new treatments—to gain an edge on her cancer.

"This journey isn't easy," she says. Isaac has a young son and can't help but worry about not being here for him. She focuses on enjoying each moment with him and bringing hope and information to others battling cancer. She lives her life by her self-proclaimed motto #MMOP—make memories on purpose.

She makes sure her voice is heard. She is a member of a Johns Hopkins patient advisory council, the Hope Project, encouraging other Kimmel Cancer Center patients. She is also an Osti Beauty—one of four African-American women who stepped out of their comfort zone to put a public face to colorectal cancer and offer support to women who have or need colostomies.

"I wanted to go out into the community to talk about my experience," she says. "People don't talk about it."

Isaac has chronicled her journey on Facebook, and the stunning survivor caught the attention of a fashion designer. Now, Isaac can add runway model to her list of accomplishments. More importantly, however, she hopes to be a role model—for her son and for everyone battling cancer.

Ellen Lilly-Foreman (left) with Trina Taylor Isaac

Taking on Prostate Cancer

Mona and Gary Steele

GARY STEELE has faced adversity before. The 69-year-old retired Army colonel is a graduate of the U.S. Military Academy at West Point. As a cadet in 1966, he was the first African-American to play varsity football at West Point.

Five years ago, he took on a new battle—prostate cancer. Since his diagnosis, he has made it a mission to inform other African-American men about their increased risk of prostate cancer and the importance of screening. "I didn't know I was at higher risk, but now I do, and I want to make as many people as possible aware." Steele's two sons and his son-in-law are among those he has told. They have been screened and are now also helping to spread the word.

Despite early diagnosis, robotic surgery to remove his prostate and radiation therapy, Steele's prostate cancer returned, and even worse, it had spread. The doctors who had been treating him had no other options to offer. That's when Steele turned to the Johns Hopkins Kimmel Cancer Center. It was the first time anyone discussed clinical trials—research studies of promising new treatments.

Since coming to the Kimmel Cancer Center, he has participated in two trials. The first therapy didn't help his prostate cancer, so his medical team offered him another option. In June 2015, he began the second clinical trial—one that compares standard hormonal therapy to increased doses of hormonal therapy.

Steele says he feels very emotionally connected to his Kimmel Cancer Center team. "I believe in the people I have met at Johns Hopkins. I trust them and have faith that they care about me and are trying to do the best for me. They are not doing something that is just about research," says Steele.

He is honest about his reason for choosing a clinical trial. "I wanted to slow the growth of my cancer and get the best treatment I could for myself," he says. "If they learn something from this study that could one day help someone else, that would be wonderful, but my main goal was get to get my cancer under control."

Steele's prostate-specific antigen (PSA) level has steadily declined, and it is now undetectable, an indicator that the treatment he received in the second clinical trial is working.

"When I tell people about my prostate cancer, they ask me where I'm going for treatment. I tell them, 'Johns Hopkins,' and they all say the same thing: 'They are the best.'" Steele agrees. "I pray that my sons will never have an issue, but if they do, they are going to Johns Hopkins," he says.

WEB EXCLUSIVE: WATCH "GARY STEELE'S LASTING IMPACT," HIS STORY OF BREAKING THE COLOR BARRIER AT WEST POINT: espn.go.com/video/clip?id=10471226

Prostate Cancer Hits African-American Men Younger and Harder

KIMMEL CANCER Center prostate cancer experts know that African-American men, particularly those with a family history of prostate cancer, are at higher risk for the cancer, tend to get it at an earlier age and often have a more aggressive form of the disease. They are using precision medicine techniques that take genetic characteristics of tumors into consideration to specifically tailor monitoring and treatment recommendations to African-American men.

Recent research by prostate cancer expert and surgeon Ted Schaeffer found that African-American men who have surgery have a higher likelihood of needing additional treatment after surgery. He also revealed that African-American men have lower levels of the screening marker prostate-specific antigen (PSA), and often have more aggressive and advanced prostate cancers than the test indicates.

Detection is also a challenge. Schaeffer says that African-American men tend to develop anterior tumors at the top of the prostate, an area that's harder to sample with a standard biopsy. As a result, all high-risk and African-American patients at Johns Hopkins get an MRI-guided biopsy.

"We have world expertise in treating high-grade, high-risk prostate cancer and also very rare forms of prostate cancer, like prostate sarcomas," says Schaeffer. "The bottom line is if a man has aggressive, high-risk cancer, we can really go after it with multimodal treatment, and we can still get a cure."

Other clinical studies are building upon Kimmel Cancer Center research and should also benefit at-risk minority populations. Work by Elizabeth Platz found that cholesterol-lowering drugs called statins decrease the risk of developing aggressive prostate cancer. Platz and others are now working to identify or develop statinlike drugs that may be used to safely prevent prostate cancer from advancing to a lethal stage.

Cancer prevention and control expert Corrine Joshu is collaborating with Platz on another prevention study. She found that smokers had twice the risk of prostate cancer recurrence following surgery as former smokers and nonsmokers. Joshu also identified a link between weight gain of 5 or more pounds after surgery and a doubled risk of cancer recurrence when compared to men who maintained their weight.

PILLAR OF PROGRESS

Prostate cancer death rates among African-Americans have declined by nearly 20 percent, and race disparities in death rates have also narrowed by 20 percent.

Prostate cancer and chemical therapeutics expert Michael Carducci is studying the benefits of natural products, including pomegranate and muscadine grape extracts, in controlling prostate cancer progression. Pomegranate has the highest level of antioxidants—chemicals known to have cancer-fighting properties. Carducci is collaborating with colleagues at Howard University for a similar study of muscadine grapes. The skin of the grapes contains the same antioxidant found in pomegranates. With further study, the scientists are hopeful that these fruit extracts could be used as a natural treatment for men with rising PSA levels, an indicator of prostate cancer development and recurrence.

"Our studies have shown that the extracts, even at low doses, slow the rise of PSA. We think this is a good thing, but we still have to prove that it makes a difference in patient outcomes," says Carducci.

These studies provide opportunities for community outreach and potentially inexpensive, risk-free remedies to stave off prostate cancer recurrence.

THE SIDNEY KIMMEL COMPREHENSIVE CANCER CENTER AT JOHNS HOPKINS

THE STATE OF CANCER IN MARYLAND

Making Progress Through Research

KIMMEL IN THE COMMUNITY

STATEWIDE

WESTERN MARYLAND

SOUTHERN MARYLAND

CENTRAL MARYLAND
(INCLUDES BALTIMORE CITY)

EASTERN SHORE

THE STATE OF CANCER IN MARYLAND

Making Progress Through Research

KIMMEL IN THE COMMUNITY

- Maryland's cancer death rate—once the second highest in the nation—is now 31st in the nation.
- Cancer death rates in Maryland are below the national cancer death rate and are declining among all citizens.
- Maryland's cancer death rates are falling more rapidly than the national average.
- Cancer death disparities between black and white Marylanders have narrowed by more than 60 percent since 2001.
- Cancer incidence rates in Maryland are in line with the national average.
- Cancer death rates among blacks in Maryland are lower than the national average (21.6/100,000 versus 28.9/100,000), and are significantly lower than adjoining states (37.4/100,000) and the six states with the lowest cancer death rates in the nation (35.5/100,000).
- The rate of decline in incidence and death for colorectal cancer exceeds the national average.
- Lung, prostate, breast, cervical, and oral cancer and melanoma death rates are decreasing.
- Risk factors for cancer—obesity, chronic alcohol use, tobacco use, and low physical activity—have a statewide prevalence below the national average.
- The U.S. Centers for Disease Control and Prevention reports that Maryland excels in cancer screening.
- Maryland smoking rates for adults and youth are below the national average.
- Johns Hopkins clinicians and scientists have been health resources for Maryland's elected officials and have supported anti-smoking and clean air legislation.

WESTERN MARYLAND

- Smoking-related cancers
- Carcinogens in drinking water
- Cancer risk from arsenic exposure
- Youth smoking cessation
- Established tissue repository

STATEWIDE

- Carcinogens in Maryland's air, water, and soil
- Smoking-related cancer detection and prevention
- Breast cancer gene pathways
- New cancer drug discoveries
- Analysis of genetic risk for colon cancer
- GIS survey of environmental risks for colon cancer
- Inflammation and cancer risk
- Core resource for cancer biomarker discovery
- Overcoming breast cancer treatment resistance
- Familial and early markers of pancreatic cancer
- Cholesterol-lowering drugs for prostate cancer prevention
- Reduction of tobacco disparities
- Cancer screening for inpatients
- Electronic cigarette risks
- Personalized cancer screening
- Weight control and cancer risk reduction
- Diabetes and cancer death disparities
- Access to data and cancer research
- Measuring cancer risk
- Triple-negative breast cancer genetic causes
- Smoking and pancreatic cancer
- Epigenetic therapies
- Immune therapies
- Patient navigation
- Connecting care to outcome
- Environment, inflammation and prostate cancer
- Age and cancer

JOHNS HOPKINS SUBURBAN HOSPITAL

JOHNS HOPKINS SIBLEY MEMORIAL HOSPITAL

INOVA FALLS CHURCH, VIRGINIA

MAP KEY

KIMMEL CANCER CENTER LOCATIONS

KIMMEL CANCER CENTER CLINICAL TRIALS PARTNERS, THE JOHNS HOPKINS CENTER TO REDUCE CANCER DISPARITIES

READING HOSPITAL
READING, PENNSYLVANIA

JOHNS HOPKINS
GREEN SPRING STATION

GBMC

THE JOHNS HOPKINS
HOSPITAL

JOHNS HOPKINS
PROHEALTH

JOHNS HOPKINS
BAYVIEW MEDICAL
CENTER

CENTRAL MARYLAND
(INCLUDES BALTIMORE CITY)

- Oral cancer screening
- Faith-based cancer prevention and control
- Youth smoking cessation
- Lung cancer risk factors for women
- Biomarkers for colon cancer
- Racial/ethnic differences in prostate cancer
- Cancer prevention in African-Americans
- Cervical cancer prevention in minorities
- Cadmium exposure and prostate cancer risk
- Genetics of lung cancer
- Urban disparity cancer reduction
- HPV infection and oral cancer
- Cervical cancer vaccine
- Environmental exposures to carcinogens
- Racial disparities and cervical cancer
- Waterway contamination and cancer risk
- Prostate, breast and colon cancer screening
- Prostate cancer biomarkers in African-Americans
- Biospecimen bank for targeting racial disparities
- Cancer education and outreach at Northeast Market
- Traffic-related air pollution exposures
- Cancer prevention in African-American young adults

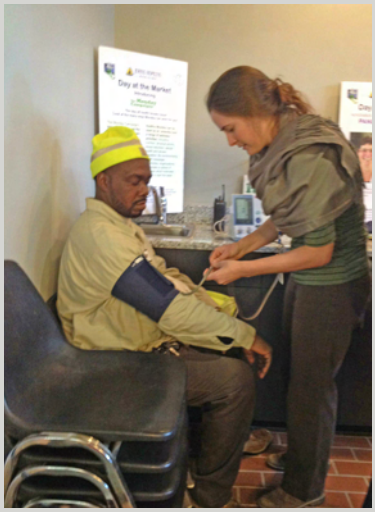
SOUTHERN MARYLAND
(includes suburban D.C. area):

- Racial/ethnic variations in prostate cancer
- Cancer biomarkers and prevention
- Cancer risk from arsenic exposure

PENINSULA REGIONAL
MEDICAL CENTER

EASTERN SHORE

- Carcinogens in drinking water
- Cancer risk from arsenic exposure
- Youth smoking cessation



Kimmel in the Community
Our Partners in Care

Day at the Market: This award-winning program is held twice a month at Northeast Market in East Baltimore. It brings nurses and other clinicians, safety experts, and other caregivers face to face with citizens to offer tips on cancer prevention, detection, and healthy living. One day a month focuses entirely on cancer education, prevention, and screening. Information on clinical trials is provided as well as assistance in obtaining health insurance through the Affordable Care Act. The program received recognition from the Maryland Department of Health and Mental Hygiene and an award from the Maryland Cancer Collaborative, the group that oversees the Maryland Comprehensive Cancer Control Plan.

Community Advisory Group: The Kimmel Cancer Center is working to transform cancer care by making it more patient- and family-centered. Our Community Advisory Group is part the of Johns Hopkins Center to Reduce Cancer Disparities. It forges new bonds with the people of Baltimore and Prince George's County and the community organizations that support its neighborhoods. The advisory group offers critical input and perspective to guide our experts as we provide community-based participatory education and research among minority and underserved populations in Maryland. The advisory group ensures our outreach activities and communication, written materials, and clinical trials information are planned and structured in a way that will inform, engage, and benefit minority citizens, particularly in African-American communities. The COACH (Evaluating Coaches of Older Adults for Cancer Care and Healthy Behaviors) study is an example of a clinical trial organized with the help of the advisory group. COACH evaluates the benefit of using trained, patient-selected health "coaches" versus professional health care navigators to encourage completion of cancer screenings.

Better Delivery of Care: Johns Hopkins voluntarily joined programs like Priority Partners, a managed care organization that provides health care to more than 185,000 uninsured members. The program was established long before the Affordable Care Act, says William Nelson, Kimmel Cancer Center director. "This is not basic health care. This is care that is equal to and, in many cases, exceeds that offered through premier commercial insurance plans," says Nelson.

Community Physicians: Johns Hopkins Community Physicians provides care to nearly a half-million Marylanders in neighborhood locations. It continues to meet the needs of Maryland's underserved by providing screening for prostate, colon, breast, and cervical cancers.

Colon Cancer Screening: Targeted efforts by the Kimmel Cancer Center helped markedly reduce colon cancer death rates and address disparities. For example, faculty members from the Johns Hopkins gastrointestinal program collaborated with the Baltimore City Health Department to provide colonoscopy screening to more than 200 uninsured Baltimore residents. These efforts were effective. Maryland now has the highest rate of decrease of colorectal cancer in the U.S., and racial disparities for colorectal cancer have been eliminated.

Creating Networks: Our National Outreach Network, a collaborative program with the National Cancer Institute, provides outreach and education to underserved Maryland communities.

Helping our D.C. Neighbors: Just 25 years ago, Maryland and Washington, D.C., had the highest cancer death rates in the nation. Through targeted efforts to address causes and disparities, Maryland now ranks 31st in the nation, but Washington, D.C., rates remain largely unchanged. Washington has the highest rates in the nation for prostate cancer and among the highest rates for breast cancer and cervical cancers. Two initiatives in the capital region are aimed at changing that trend. A 15-year partnership with Howard University is focused on developing research-based strategies to eliminate racial disparities in cancer death rates in Maryland and Washington. In another partnership with Howard University, Sibley Memorial Hospital, a member of Johns Hopkins Medicine, and United Medical Center (UMC) are bringing much-needed cancer screening, detection and treatment to the medically underserved and largely African-American neighborhoods of Ward 7 and Ward 8. The program brings Johns Hopkins/Sibley experts to UMC to provide care, but it also provides free transportation to Sibley for services that cannot be provided at UMC.

Getting the Word Out: The Kimmel Cancer Center provides expert speakers and offers free cancer education to community organizations, businesses, churches, and other groups. To schedule a speaker to discuss health disparities in cancer research and care and other timely topics, call 410-955-8800.

CUPID (Cancer in the Underprivileged Indigent or Disadvantaged): CUPID is a unique, laboratory-based summer fellowship program at the Johns Hopkins University School of Medicine. The mission of CUPID is to promote the specialty of oncology to medical students interested in caring for the underserved. The CUPID program is a seven-week summer fellowship, which includes laboratory-based research; lecture series covering topics from basic oncology to specific cancers to health care disparities; clinician shadowing in medical, surgical and radiation oncology clinics; and a visit to the National Cancer Institute to meet researchers addressing health care disparities on a national level. This year, the Kimmel Cancer Center received 231 applications from 115 colleges

Cancer and Racial Disparities

AFRICAN-AMERICANS have lower survival from cancer than their white counterparts. Some of this disparity is attributable to socioeconomics and stage of cancer diagnosis, but diabetes and obesity expert Jessica Yeh is exploring a link between diabetes management and cancer.

Although it is widely understood that African-Americans have a higher prevalence of diabetes, Yeh is among the first to look for possible connections to racial differences in cancer survival rates. Yeh believes that pre-existing diabetes and poor control of it may have a negative impact on cancer survival. She has undertaken a major data search—scouring a large federal database and data collected at the Kimmel Cancer Center—to quantify the long-term risk of pre-existing diabetes and racial disparity in colon, breast and uterine cancer survival, and to decipher any links to increased treatment side effects, such as infection.

PILLAR OF PROGRESS

The SPIRIT study is one of the unique Kimmel Cancer Center trials in the Community. We are going to the Community. They don't have to come to us.

Yeh is conducting a clinical study in partnership with the state of Maryland to see if improved management of diabetes can reduce racial disparity in cancer survival. The SPIRIT (Survivorship Promotion in Reducing IGF-1) study is the first Johns Hopkins clinical study to take place entirely in the community, taking our expertise and trials to the public. Yeh is researching the benefits of the diabetes drug metformin, which lowers a hormone called insulin growth factor, or IGF-1, for its potential to increase cancer survival in African-American cancer patients who also have diabetes. The study compares the benefits of metformin to self-directed weight loss or weight loss with support of a counselor in reducing diabetes-related IGF-1. Yeh is working with colleagues at Johns Hopkins overseeing the POWER (Practice-Based Opportunities for Weight Reduction) trial in the nonmetformin arms of the trial. POWER is a collaborative study with participants from six primary care practices in the Baltimore area.

Cancer prevention and breast cancer expert Kala Visvanathan is studying weight gain in breast cancer survivors. Data from earlier studies suggest that breast cancer survivors who gain weight may have a higher risk of having their cancer return. In a Kimmel Cancer Center study, Visvanathan found that survivors with a family history of the disease, including those who carry cancer-related BRCA1 and BRCA2 gene mutations, gained more weight over the course of four years than cancer-free women—especially if they were treated with chemotherapy. In the four-year span, survivors gained significantly more weight—3.6 pounds on average—than cancer-free women. Among 180 survivors diagnosed with cancer during the last five years of the study period, 37 (21 percent) gained at least 11 pounds over a four-year period compared with 35 of 307 (11 percent) of their cancer-free peers. The weight change findings remained the same after accounting for other factors associated with weight gain, such as increasing age, transition to menopause and level of physical activity, the researchers say.


Visvanathan

WEB EXCLUSIVE: LEARN MORE ABOUT THE SPIRIT STUDY AT: http://bit.ly/SpiritStudy, Spirit@jhmi.edu or 410-281-1600

“I think often about the people who conducted and supported the research that made this treatment possible for my son. They gave us the greatest gift our family could ever receive. It saved Nicholas. When I think about that, it is the most humbling thing.”

—*Caroline Laguerre-Brown*,
Nicholas’ mother and
Chief Diversity Officer for
The Johns Hopkins University

Science Conquers One Disparity

Nicholas was cured through a new kind of bone marrow transplant pioneered at the Kimmel Cancer Center. It is called a haploidentical transplant, and it makes it possible for African-American and minority patients, who often are under-represented in national registries, to receive a bone marrow transplant. Read more at http://bit.ly/ScienceConquersOneDisparity

A Campaign to Prevent Cervical Cancer

THE JOHNS HOPKINS CENTER to Reduce Cancer Disparities has launched a prevention campaign to eliminate cervical cancer incidence and death disparities in Baltimore City and Prince Georges County with HPV vaccination. The study, led by cancer prevention and control expert Norma Kanarek, initially focuses on African-American preteens and teens in these two Maryland locations, but if it is successful, it could then be rolled out throughout the state. HPV is the cause of almost all cervical cancers, and it is also linked to certain oral cancers. By using community outreach and health fairs, face-to-face meetings, and mailings to spread the word to parents and grandparents about the benefit of HPV vaccination for children in their care, the center hopes to increase vaccine participation from its current rate of 25 percent to 80 percent by 2020. Cervical cancer is among the most preventable and curable cancers. "No one ever needs to die from cervical cancer," says Kanarek. "It's our goal to make that a reality in Maryland."

Laboratory research out of the Kimmel Cancer Center may help expand this goal, providing an innovative screening test that can detect three women's cancers not currently eliminated through prevention. The test, called PapGene, is based on the Pap test, which has been routinely performed since the 1950s to detect and prevent cervical cancer. PapGene uses the same cervical fluid collected during a Pap test to capture DNA that is shed from cancer cells; specifically, alterations the researchers have determined lead to endometrial and ovarian cancer development. There are currently no early screening tests for endometrial and ovarian cancers, and the new test could one day make it possible to test for three female cancers at a woman's annual wellness exam.

In early, small-scale studies of PapGene, the test detected 100 percent of endometrial cancers and 40 percent of ovarian cancers. The scientists are working to improve PapGene's sensitivity to ovarian cancer, but even at 40 percent, it could help many women. Large-scale clinical trials are being developed. If the team finds similar results in these larger studies, the $100 test could begin to be introduced in doctors' office in three to five years.

PILLAR OF PROGRESS

The center hopes to increase vaccine participation from its current rate of 25 percent to 80 percent by 2020. Cervical cancer is among the most preventable and curable cancers.

Leslie Edmond is participating in an immune therapy clinical trial for triple-negative breast cancer.

Breast Cancer Turning a Negative into a Positive

MARYLAND IS HOME to twice the number of African-American women than the national average, making breast cancer disparities a critically important issue for our state. Breast cancer is also the second most frequently diagnosed cancer in Maryland. Although white women have a higher incidence of breast cancer, more black women die of the disease. Mammography usage is higher among black women than white women in Maryland, so screening and early detection does not account for the disparities in survival.

One important factor is biology. African-American women in Maryland suffer disproportionally from a treatment-resistant type of breast cancer, known as triple-negative breast cancer. This aggressive type of has the lowest survival rates of all breast cancers, according to breast cancer expert Saraswati Sukumar.

Sukumar and other Kimmel Cancer Center breast cancer scientists are exploring new treatment for a triple-negative breast cancer. Clinical trials of therapeutic advances, such as immune therapy and epigenetic treatments that help prime cancers to respond better to anticancer drugs, are being actively targeted to African-American women with triple-negative breast cancer.

One promising approach now being studied uses new targeted agents known as HDAC inhibitors and aromatase inhibitors. Many of the heralded targeted treatments for breast cancer, such as tamoxifen and trastuzumab therapy, only work in patients whose cancers are sensitive to hormones—ER, PR and HER2 positive. Sukumar found that HDAC or histone deacetylase inhibitors can reactivate estrogen receptors and also make breast cancer cells sensitive to treatment with another class of targeted drugs known as aromatase inhibitors. Our experts are developing a database of patients with triple-negative breast cancer to ensure these women—particularly minority women—get information about clinical studies of promising new treatments.

JOHNS HOPKINS
MEDICINE
THE SIDNEY KIMMEL COMPREHENSIVE CANCER CENTER
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Baltimore, Maryland 21201

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Appendix 3

The Johns Hopkins Health System Financial Assistance Policy
and JHH Medication Assistance Policy

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
Allow ance 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

	The Johns Hopkins Hospital **Pharmacy, Outpatient Retail** **Finance**	*Policy Number*	FIN013
		Effective Date	07/08/2014
		Approval Date	07/08/2014
	Subject **Medication Assistance**	*Page*	1 of 2
		Supercedes	07/01/2011

Keywords: **medication assistance, ch**arity care, vouchers, Social Work,

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V.	DEFINITIONS	2

I. OBJECTIVES

A. **Outpatient pharmacy will** take part in Johns Hopkins Medicine initiatives that assist patients and families in **seeking access to take-ho**me medication.

II. INDICATIONS FOR USE

A. **Outpatient pharmacy lea**dership and staff will not discriminate on the basis of socioeconomic status. This policy **outlines how outpatient p**harmacy collaborates with groups both internal and external to Johns Hopkins Medicine **to assist patients accessin**g take-home medications in the event the patient is unable to afford medication costs.

III. RESPONSIBILITY

Patients	• Patients are accountable for informing health care providers of their need for assistance in accessing take-home medications. • Patients are accountable for providing supporting documentation as required (ex. proof of income).
Department of Social Work	• Responsible for authorizing the use of charity funds for medication access.

IV. PROCEDURE

A. Potential opportunities are available to patients seeking financial aid or assistance with take-home medication costs.
   1. Charity Assistance Programs
      1. All patients presenting to outpatient pharmacy who need assistance with a take home medication will be referred to the Department of Social Work. A member of the Department of Social Work completes a screening process that may include verifying insurance status and discussing patient finances before funds are assigned to a patient. Charity assistance program funds will be authorized by the Department of Social Work.
      2. Prescription quantities covered by Charity Assistance Programs may differ from those ordered by the prescriber.

2. Patient Assistance Programs (PAP)
    1. Pharmaceutical companies are responsible for establishing enrollment criteria for each medication available through a PAP. Eligibility criteria may be based upon the current Federal Poverty Level (FPL), the number of dependents in a household, or the total income per household.
    2. PAP medication may only be dispensed to the patient for whom it was authorized.
    3. PAP medication may never be re-sold.
3. Low Cost Generic Drug Plan
    1. Outpatient pharmacy offers a generic drug discount list that contains commonly prescribed generic medications available to uninsured patients.
    2. The drug discount list is maintained at http://www.insidehopkinsmedicine.org/pharmacy/11_medication_list.pdf.
    3. The low cost generic drug plan may only be used by uninsured patients.

B. Co-payment Assistance for Patients with Medicaid or Medicaid MCO Coverage

i. In the event a patient with Medicaid or Medicaid MCO Coverage does not have access to funds for their co-payment(s), the patient could be eligible for a co-payment(s) waiver. In order to be eligible for a co-payment(s) waiver, the patient must complete a Patient Profile Questionnaire or have a previously completed Patient Profile Questionnnaire on file.

V. DEFINITIONS

Charity Assistance Programs	Charity Assistance programs consist of grants, philanthropic donations, and other funds designated for assisting patients in obtaining prescription medication.
Patient Assistance Programs (PAP's)	Through PAP's, pharmaceutical companies provide select brand-name medications to patients with limited income and resources. Eligibility criteria for PAP may include current Federal Poverty Level (FPL) guidelines, number of dependants in the household, or the total income per household.
Low Cost Generic Drug Plans	Commonly prescribed generic medications (medications no longer under patent and available from multiple manufacturer(s) for various disease states are available in quantities from one to three months at pharmacies.

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Appendix 4

Community Health Needs Assessment and Implementation Plan, June 2016

The Johns Hopkins Hospital
&
Johns Hopkins Bayview Medical Center

Community Health Needs Assessment
&
Implementation Strategy

June 2016

JOHNS HOPKINS
MEDICINE

Table of Contents

Introduction

With the enactment of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, tax-exempt hospitals require community health needs assessments (CHNA) and implementation strategies, which are approaches and plans to actively improve the health of communities served by health systems. These strategies provide hospitals and health systems with the information they need to deliver community benefits that can be targeted to address the specific needs of their communities. Coordination and management strategies based upon the outcomes of a CHNA, and implementing strategies, can improve the impact of hospital community benefits.

To adhere to the requirements imposed by the IRS, tax-exempt hospitals and health systems must:

- Conduct a CHNA every three years.
- Adopt an implementation strategy to meet the community health needs identified through the assessment.
- Report how they are addressing the needs identified in the CHNA and a description of needs that are not being addressed, with the reasons why.

The Department of the Treasury and the IRS require a CHNA to include:

1. A description of the community served by the hospital facility and how the description was determined.
2. A description of the process and methods used to conduct the assessment.
    - A description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs.
    - A description of information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility.
    - Identification of organizations that collaborated with the hospital/health system and an explanation of their qualifications.
3. A description of how the hospital organizations took into account input from persons who represent the broad interests of the community served by the hospital. In addition, the report must identify any individual providing input that has special knowledge of or expertise in public health. The report must also identify any individual providing input who is a "leader" or "representative" of populations.
4. A prioritized description of all of the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs.
5. A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

6. A description of the needs identified that the hospital intends to address, the reasons those needs were selected, and the means by which the hospital will undertake to address the selected needs.[1]

The CHNA process for The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) included the collection and analysis of primary and secondary data. Both public and private organizations, such as faith-based organizations, government agencies, educational systems and health and human services entities were engaged to assess the needs of the community. In total, the extensive primary data collection phase resulted in the contribution of more than 750 community stakeholders/leaders and community residents. The 2013 CHNA served as a baseline to provide a deeper understanding of the health, as well as the socioeconomic needs of the community.

Primary data in the form of an online and a paper survey gathered feedback from community residents and health system staff. Fifty-two stakeholder interviews were conducted with individuals who represented a) broad interests of the community, b) populations of need or c) persons with specialized knowledge in public health. Six focus groups with a total of 83 participants were conducted with vulnerable populations, along with the distribution and collection of a paper hand survey, which gathered a wide range of information from 648 community residents. A community health forum was facilitated with over 30 key community leaders and representatives. The forum prioritized health needs, which helped outline implementation and planning. An interactive resource inventory was created to highlight available programs and services within The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center's (JHBMC) community benefits service area (CBSA)[2]. The inventory identifies organizations and agencies in the community that are serving the various target populations within each of the priority needs.

A secondary data profile was compiled with local, state and federal figures to provide essential information, insight and knowledge on a broad range of health and social issues. Collecting and examining information about different community aspects and behaviors help explain and identify factors that influence the community's health.

Information collected from secondary data provided reliable facts from multiple government and social agencies. The collection of a comprehensive database provides information to understand the health of a community overall. Data collected encompassed socioeconomic information, health statistics, demographics, children's health, mental health issues, etc. This report is a summary of primary and secondary data collected throughout the CHNA.

As part of the secondary data profile, data from Truven Health Analytics[3] was analyzed to gain a deeper understanding of community health care needs. The Community Needs Index (CNI), jointly

[1] The outcomes from the CHNA will be addressed through an implementation planning phase.

[2] The Community Benefits Service Area (CBSA) or the overall study area referenced in the report refers to the nine ZIP codes that defined the communities for JHH and JHBMC in the CHNA. The ZIP codes included are 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224 and 21231.

[3] Truven Health Analytics, formerly known as Thomson Reuters, is a multinational health care company that delivers information, analytic tools, benchmarks, research and services to a variety of organizations and companies. Truven Health Analytics uses: Demographic data, poverty data (from The Nielsen Company) and

developed by Dignity Health and Truven Health, assists in the process of gathering vital socioeconomic factors in the community. The tool is a strong indicator of a community's demand for various health care services.

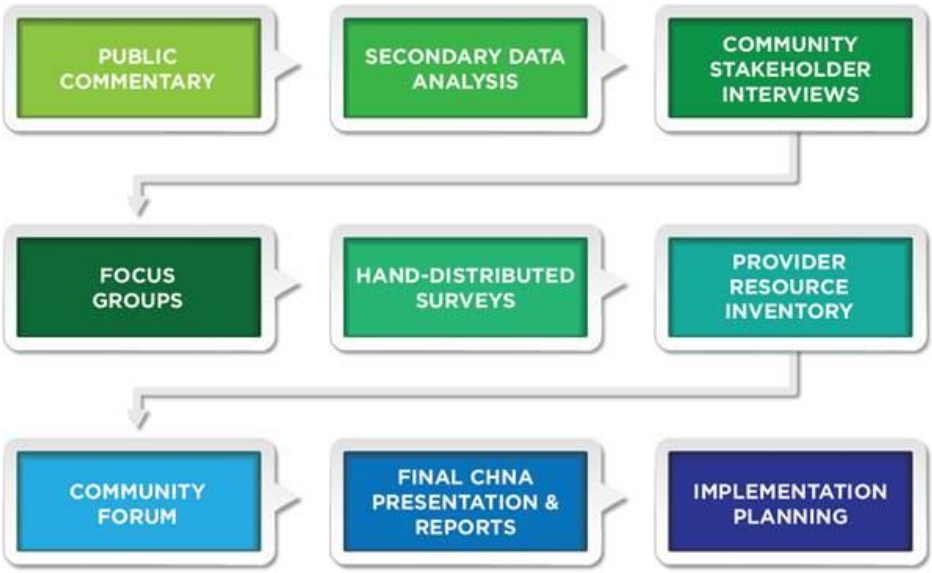
Based on a wide array of demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. A score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need. The CNI should be used as a part of the larger community needs assessment to assist in pinpointing specific areas that have greater needs compared to others. The information collected was used to identify action items for inclusion in the Implementation Strategy.

The development of the CHNA and the Implementation Strategy was led by the Office of Government and Community Affairs (Tom Lewis, Vice President), Dr. Redonda Miller (JHH Vice President for Medical Affairs) and Dr. Richard Bennett (JHBMC President), and involved the contributions of over 750 individuals through direct interviews, surveys, focus groups and a community forum. Key stakeholder groups included but were not limited to, community residents, members of faith based organizations, neighborhood association leaders, health professionals, Johns Hopkins Medicine leadership and other experts both internal and external to Johns Hopkins.

JHH and JHBMC engaged Tripp Umbach to assist in producing a CHNA for their hospitals. This report is the result of the collaborative efforts of Tripp Umbach consultants Ha Pham and Barbara Terry and senior Johns Hopkins leadership.

The overall CHNA involved multiple steps that are depicted in the flow chart below. Additional information regarding each component of the project, and the results, can be located in the Appendices section of this report.

Flow Chart 1: CHNA Process



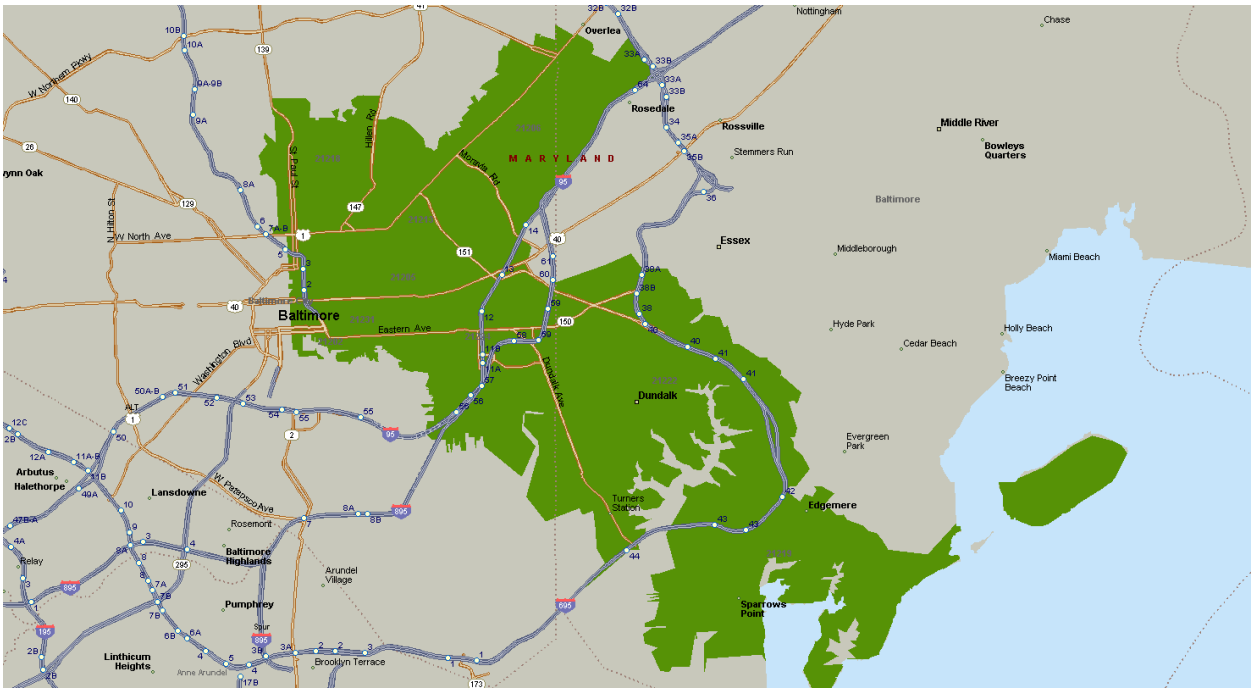
insurance coverage estimates (from Truven Health Analytics) to provide Community Needs Index (CNI) scores at the ZIP code level. Additional information on Truven Health Analytics can be found in the Appendices.

Community Benefits Service Area (CBSA)

In 2015, a total of nine ZIP codes were analyzed for the Johns Hopkins Institutions. These ZIP codes represent the community benefit service area (CBSA) for The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. The Johns Hopkins Institutions provide services to communities throughout Maryland, adjoining states and internationally. The community health needs assessment focused on nine specific ZIP codes: 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 benefit 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 following map geographically depicts the community benefits service area by showing the communities that are shaded. Again, the CBSA encompasses nine ZIP codes across East Baltimore City and southeast Baltimore County (See Map 1).

Map 1: Overall Community Benefits Service Area – 2015 Study Area Map



Source: Truven Health Analytics 2015

The overall study area for JHH and JHBMC shows that all of the ZIP codes in the CBSA, with the exception of ZIP code 21213, are expected to have population growth from 2015 to 2020. ZIP code 21213 is anticipated to have a decrease in population of -0.2 percent. ZIP code 21202 and Baltimore County are expected to have the greatest population increase from 2015 to 2020, each reporting a 3.5 percent rise. (See Table 1).

Table 1: Area Population Snapshot

	21202	21205	21206	21213	21218	21219	21222	21224	21231	Baltimore City	Baltimore County
2015 Total Population	23,812	16,300	50,347	32,146	48,890	9,743	56,953	50,053	16,032	637,630	834,555
2020 Total Population	24,648	16,509	50,903	32,091	49,310	10,012	58,438	51,513	16,575	646,775	864,079
% Change 2015-2020	3.5%	1.3%	1.1%	-0.2%	0.9%	2.8%	2.6%	2.9%	3.4%	1.4%	3.5%

Source: Truven Health Analytics 2015

There is a close representation of males and females in the overall study area and the state. ZIP code 21202 has a higher percentage of males than the rest of the study area ZIP codes in 2015, a trend that is expected to continue into 2020 (See Table 2).

Table 2: Gender Snapshot

	21202	21205	21206	21213	21218	21219	21222	21224	21231	Overall Study Area	Maryland
2015 Male Population	59.7%	45.9%	46.5%	45.7%	48.1%	49.4%	48.4%	50.0%	49.3%	48.8%	48.5%
2020 Male Population	59.4%	46.3%	46.7%	46.0%	48.3%	49.4%	48.5%	50.0%	49.3%	49.0%	48.5%
2015 Female Population	40.3%	54.1%	53.5%	54.3%	51.9%	50.6%	51.6%	50.0%	50.7%	51.2%	51.5%
2020 Female Population	40.6%	53.7%	53.3%	54.0%	51.7%	50.6%	51.5%	50.0%	50.7%	51.0%	51.5%

Source: Truven Health Analytics 2015

The data reveal a higher representation in the overall study area of Black, Non-Hispanic when compared to the state and the nation. ZIP codes 21219 (92.4 percent), 21222 (76.4 percent), 21224 (57.2 percent) and 21231 (52.9 percent) are predominately White, Non-Hispanic. ZIP codes 21202 (60.6 percent), 21205 (69.3 percent), 21206 (70.2 percent), 21213 (90.5 percent) and 21218 (61.0 percent) are predominately Black, Non-Hispanic (See Table 3).

- ZIP code 21224 has the highest rate of Hispanic (21.7 percent) population.
- ZIP code 21218 has the highest rate of Asian/Pacific Islander, Non-Hispanic (6.1 percent) population.

Table 3: Race/Ethnicity Snapshot

	21202	21205	21206	21213	21218	21219	21222	21224	21231	Overall Study Area	MD	USA
White Non-Hispanic	29.6%	16.5%	22.6%	6.1%	27.1%	92.4%	76.4%	57.2%	52.9%	41.4%	52.6%	61.8%
Black Non-Hispanic	60.6%	69.3%	70.2%	90.5%	61.0%	3.5%	11.9%	15.8%	28.5%	45.9%	29.0%	12.3%
Hispanic	3.3%	11.0%	2.4%	1.4%	3.2%	1.5%	5.6%	21.7%	11.2%	7.2%	9.4%	17.6%
Asian/Pacific Islander Non-Hispanic	4.3%	1.1%	1.9%	0.4%	6.1%	0.8%	2.0%	2.7%	5.2%	2.9%	6.2%	5.3%
All Others	2.2%	2.2%	2.8%	1.7%	2.5%	1.8%	4.2%	2.5%	2.2%	2.7%	2.8%	3.1%

Source: Truven Health Analytics 2015

It is important to review the CNI scores obtained by Truven Health Analytics. The CNI ZIP code summary provides valuable background information to begin addressing and planning for the community's current and future needs. The CNI provides greater ability to diagnose community needs as it explores ZIP code areas with significant barriers to health care access.

In assessing the CNI scores for the overall study area or CBSA, the CNI score in 2014 was 4.2*; while the CNI for 2015 was 4.3*. This is an increase of +0.1 from 2014 to 2015, indicating that the overall study area now faces increased barriers to accessing care. Again, a CNI score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with significant need. It is important to note that ZIP codes with a low score (e.g., 1.0) do not imply that no attention should be given to that neighborhood; rather, hospital leadership should decipher what specifically is strategically working well to ensure a low neighborhood score (See Table 4).

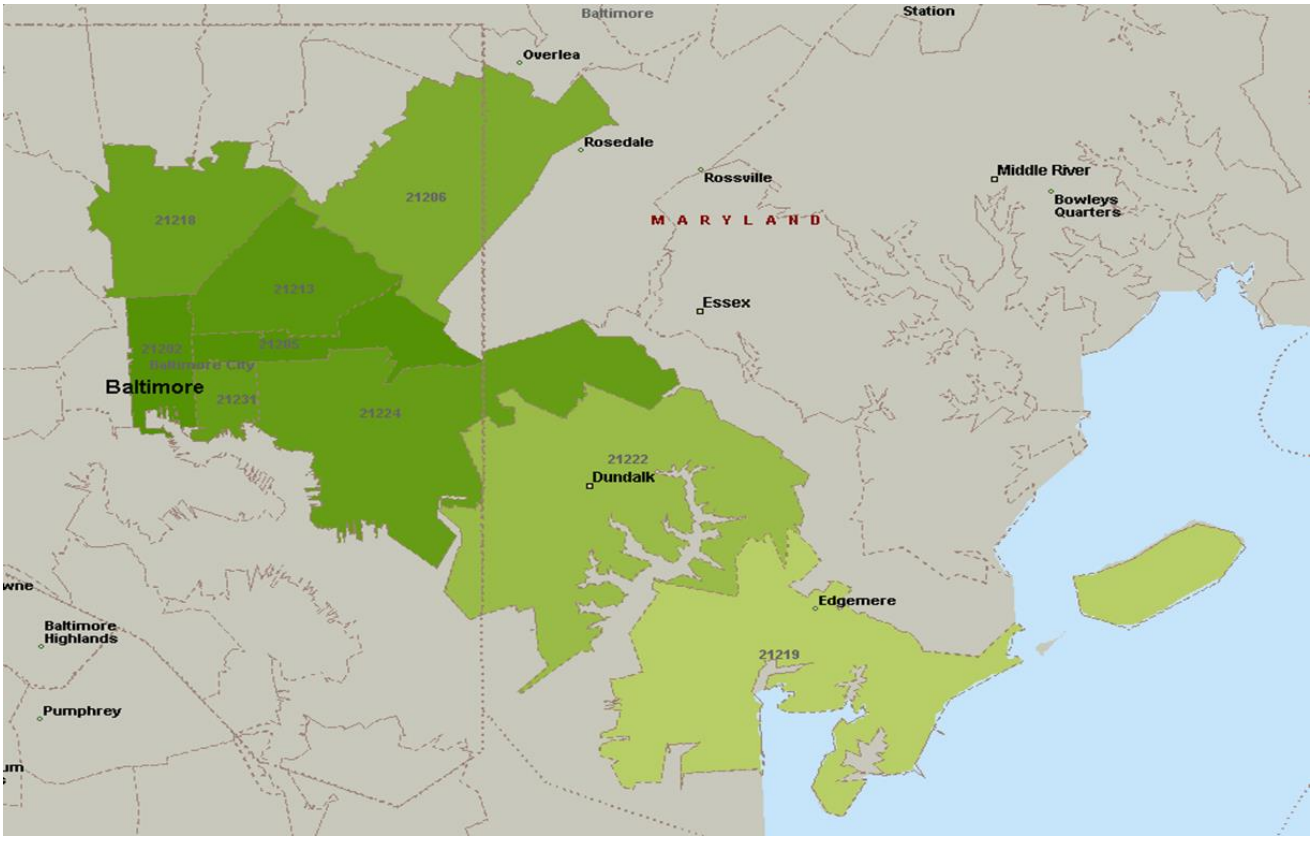
Table 4: Overall Study Area Summary

	2015 Population	Poverty 65 years +	Poverty Child	Single w/ Children Poverty	Limited English	Minority	No High School Diploma	Unemployment	Uninsured	Rent	Income Rank	Cultural Rank	Education Rank	Insurance Rank	House Rank	2014 CNI Score*	2015 CNI Score *	CNI Score Change
Overall Study Area	304,276	18.55%	28.32%	40.82%	2.98%	58.62%	20.72%	14.52%	11.19%	46.57%	3	5	4	4	5	4.2	4.3	+0.1

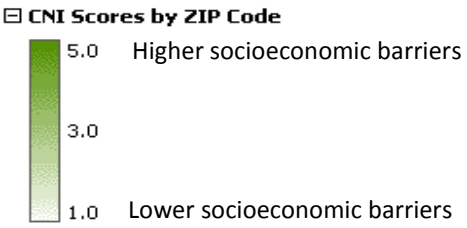
Source: Truven Health Analytics 2015 ** Weighted average of total market*

Continuing to review CNI information, the map below provides a geographic representation of the CNI scores depicted from Table 4. ZIP codes that have higher socioeconomic barriers (5.0) are represented in dark green. As the socioeconomic scores decrease, the coding color lightens. There are concentrated areas within Baltimore City that signify high socioeconomic barriers to care (See Map 2).

Map 2: CNI Study Area Map



Source: Truven Health Analytics 2015



Key Community Health Needs

The health status of a community depends on many factors, including quality of health care, social and economic determinants, individual behaviors, heredity, education and the physical environment.

Healthy People 2020 creates targets for the nation for improving health status, promoting community health, and challenging individuals, communities and professionals to take specific steps to ensure that good health, as well as long life, are enjoyed by all. Because "health" is more than just the absence of disease, a focus on socioeconomic factors is required.

Socioeconomic status is often defined as the social and economic experiences that shape and frame a person's lifestyle. The environment—in particular, where we work and live—as well as education, income and age play a significant role in an individual's socioeconomic status. It is well documented that residents who are uneducated and have limited financial resources often experience challenges such as poor housing, limited employment advancement and a low quality of life. All of these challenges ultimately affect their health outcomes.

Children attending school in poor conditions may have low educational achievements and lack a rich educational infrastructure. Parents who struggle with employment opportunities will be less likely to afford educational resources for their children such as computers, tutors and books—materials which often assist students becoming successful.

Similarly, community residents living in neighborhoods that are underserved may face higher levels of stress if their community is plagued with crime, drugs and poverty. The increased tension due to the city's social injustices and inequalities have produced higher levels of stress leading to civil unrest, mental and behavioral health problems, and the potential for increased use and abuse of drugs and alcohol products.

Residents in East Baltimore City and southeast Baltimore County are aware of the health and social inequalities and disparities that exist. Addressing these disparities and working to reduce the socioeconomic gaps can bridge and provide sustainable support for those who have limited options. Residents who have a low socioeconomic status have significant challenges when accessing resources and services.

The Johns Hopkins Institutions have significant strategies that are geared towards addressing the health and well-being of the community's marginalized youths and residents. As a large economic driver in the region, JHH and JHBMC's leaders have encouraged the health and well-being of the marginalized populations through their programs, community initiatives and economic development projects. Providing programs that offer employment opportunities, platforms which address the social and health needs of the disparate population, and continued regional support working in close collaboration with regional and local community organizations, the Johns Hopkins Institutions have placed a substantial footprint in the region.

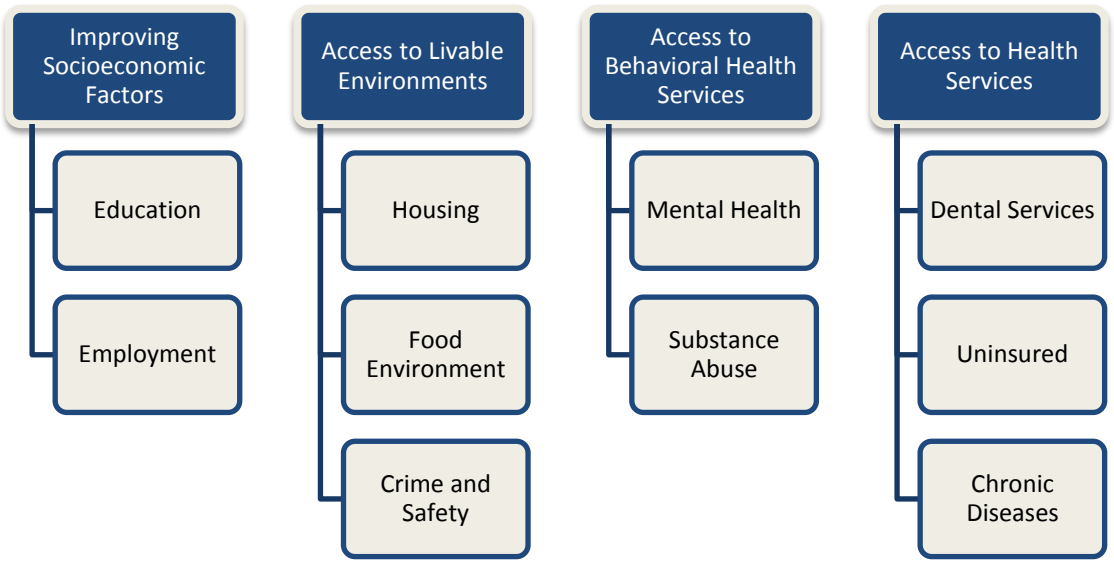
The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center will continue to address the socioeconomics of their community residents with innovative and effective programs, community outreach efforts, and collaboration and partnerships with nonprofits and local organizations to reach vulnerable residents and those most affected by the health and social disparities across the city.

In the summer of 2015, JHH and JHBMC continued their commitment to the community through a comprehensive CHNA process and engaged a variety of community organizations, community leaders and agencies in order to identify the needs of their community residents. The CHNA focused on nine ZIP codes within the study area known as the community benefits service area (CBSA). With support from key community representatives, health officials, hospital leadership and community stakeholders with in-depth knowledge regarding East Baltimore City and southeast Baltimore County, the CHNA helped identify and prioritize the community's needs.

One of the objectives of the Patient Protection and Affordable Care Act (PPACA) is to identify ways to better coordinate health services to allow greater accessibility, while reducing health care costs for patients and caregivers. As a result, health care organizations are streamlining services and collaborating with community agencies and organizations to capitalize on the ability to share resources. By providing affordable health care insurance, a large portion of the previously uninsured population now has a pathway to affordable and accessible preventive services.

Four key need areas were identified during the CHNA process through the gathering of primary and secondary data from local, state and national resources, community stakeholder interviews, hand-distributed surveys, focus groups with vulnerable populations, a community forum and a health provider inventory (highlighting organizations and agencies that serve the community). The identified community needs are depicted in order of priority in the graph below (See Graph 1).

Graph 1: Key Community Health Needs



Improving Socioeconomic Factors

While biological makeup or genetics determine some health issues an individual will experience, socioeconomic factors, like income, education and employment opportunities, can shape how people make decisions related to their health and the access they have to health care services. There is a direct and indirect correlation between community residents' overall health and low levels of educational attainment and the inability to secure employment. It is not uncommon that residents living in poverty face multiple challenges related to high crime rates, poor home conditions and low educational attainment. Often, individuals in these situations are focused on obtaining basic living needs (e.g. food, affording utilities and housing) for themselves and their families. Without access to higher education and associated employment opportunities, community residents will continue to struggle with these challenges.

The table below provides a snapshot from County Health Rankings and Roadmaps of where Baltimore City compares to Baltimore County in years 2012 and 2015. The ranking scale enables communities, organizations and agencies to assess where their communities lie in comparison to the remaining 23 counties in Maryland. Baltimore City ranks 24 out of 24 on Socioeconomic Factors in years 2012 and 2015; while Baltimore County ranks 12 in years 2012 and 2015 (See Table 5).

Factors that are used to derive the overall socioeconomic rankings are high school graduation, some college, unemployment, children in poverty, income inequality, children in single-parent households, social associations, violent crime and injury deaths.

Table 5: County Health Rankings and Roadmaps Social and Economic Factors

County Health Rankings and Roadmaps[4]	Social and Economic Factors Rankings
Baltimore City	
2012	24
2015	24
Baltimore County	
2012	12
2015	12

Source: County Health Rankings & Roadmaps 2015 and 2012

[4] Maryland has 24 counties; the rating scale for Maryland is 1 to 24 (1 being the healthiest county and 24 being the least healthy). Counties are ranked relative to the health of other counties in the same state on specific measures.

Education

An individual's level of education affects their health status, as it can dictate employment opportunities and comprehension capabilities. The role of education is essential due to the connection between income and employment. Educated individuals are more likely to have job security, are often better equipped to navigate to and access the services they need, and understand the importance of services like preventive health measures and making healthy choices for themselves and their families. Educated residents are more aware of their own health status and the health status of their family. Being educated can mitigate some of the environmental factors that negatively affect the health status of disadvantaged populations by providing them with the tools they need to better understand their environment and to take advantage of opportunities to improve their situation.

Higher education attainment statistics of the overall study area compared poorly with the state and the nation. Slightly more than one-third (34.0 percent) of community residents have a high school diploma, higher than the state (26.0 percent) and the nation (28.1 percent), just 21.6 percent or one in five community residents have a bachelor's degree or greater; much lower than the overall rates for both the state (36.8 percent) and the nation (28.9 percent) (See Table 6).

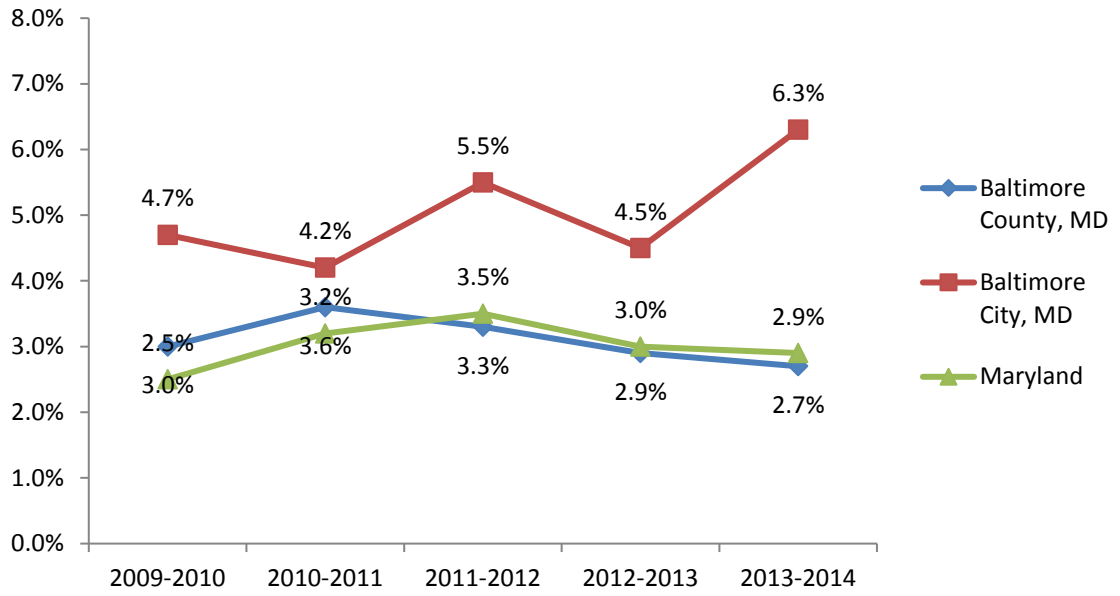
Table 6: Education Level

	21202	21205	21206	21213	21218	21219	21222	21224	21231	Overall Study Area	MD	USA
Less than High School	5.6%	12.9%	4.8%	5.3%	4.9%	5.2%	6.5%	12.5%	8.1%	7.2%	4.4%	5.9%
Some High School	17.4%	23.6%	10.4%	18.2%	12.6%	12.0%	12.7%	12.6%	8.6%	13.5%	6.7%	8.0%
High School Diploma	28.3%	37.0%	37.0%	42.1%	27.5%	41.1%	43.9%	28.1%	16.5%	34.0%	26.0%	28.1%
Some College / Assoc. Degree	18.4%	19.1%	31.5%	24.0%	24.2%	30.6%	27.3%	18.4%	13.9%	23.8%	26.1%	29.1%
Bachelor's Degree or Greater	30.3%	7.4%	16.2%	10.4%	30.9%	11.1%	9.6%	28.4%	52.9%	21.6%	36.8%	28.9%

Source: Truven Health Analytics 2015

Data from The Annie E. Casey Foundation highlights the dropout rate. Baltimore City had the highest dropout rate (6.3 percent) of students in grades 9-12 in 2013-2014. This rate is more than double that of Baltimore County (2.7 percent) and the state (2.9 percent). Baltimore City saw a marked increase in the dropout rate from 2012-2013 to 2013-2014, going from 4.5 percent to 6.3 percent (See Chart 1), while both Baltimore County and the overall state rate saw a slight decline.

Chart 1: Dropout Rate (Students in Grades 9-12)



Source: Kids Count 2015, The Annie E. Casey Foundation

Community stakeholders reported that education begins at the elementary stage, addressing and reinforcing information beyond basic subjects (e.g., nutrition, health topics/disease, mental health, etc.). It was cited that most often community residents do not foresee nor comprehend how education is linked to a pathway towards a healthier, more productive life.

A greater emphasis needs to be placed on the correlation between education and income, noting there are greater employment opportunities, options and availability to those who have a higher level of educational attainment. Higher education enables community residents to understand concepts and theories, expanding their overall knowledge base; which in turn, leads to residents having a stronger understanding of their community, environment and health.

In February 2014, a new Baltimore City School Superintendent was appointed. With this appointment, there is hope that education in the City will improve and community residents and their children will be able to obtain and secure the education needed to prosper in their communities.

Employment

Employment and income provide a lifestyle that offers choices and options that influence health status and environmental factors such as housing, food, skill building for better employment opportunities, transportation, health care and more. Data reveal that there are significant income disparities in the CBSA as compared to the state.

Table 7 provides a detailed breakout of household income within the CBSA and how the CBSA compares to state and national statistics. In the CBSA, or the overall study area, there is a high percentage of households who earned an income in 2015 of $25,000-$50,000 a year (24.5%). The overall study area analysis also showed income disparities when compared to the state. There are more low-income households within the CBSA compared to state percentages. For example, within the overall study area or CBSA, there are more households who earn under $15,000 and more households who earn $15,000-$25,000.

Studying data at the neighborhood level, ZIP codes 21202 and 21205 have a high percentage of households who earn less than $15,000 a year (33.5% and 30.6% respectively). These percentages are more than three times higher when compared to the state (8.5%) and more than doubled compared to national (12.7%) income percentages.

Neighborhoods 21205 (19.2%) and 21213 (15.5%) have higher percentages of households who earn $15,000-$25,000 yearly, when compared to the remaining ZIP codes in the study area.

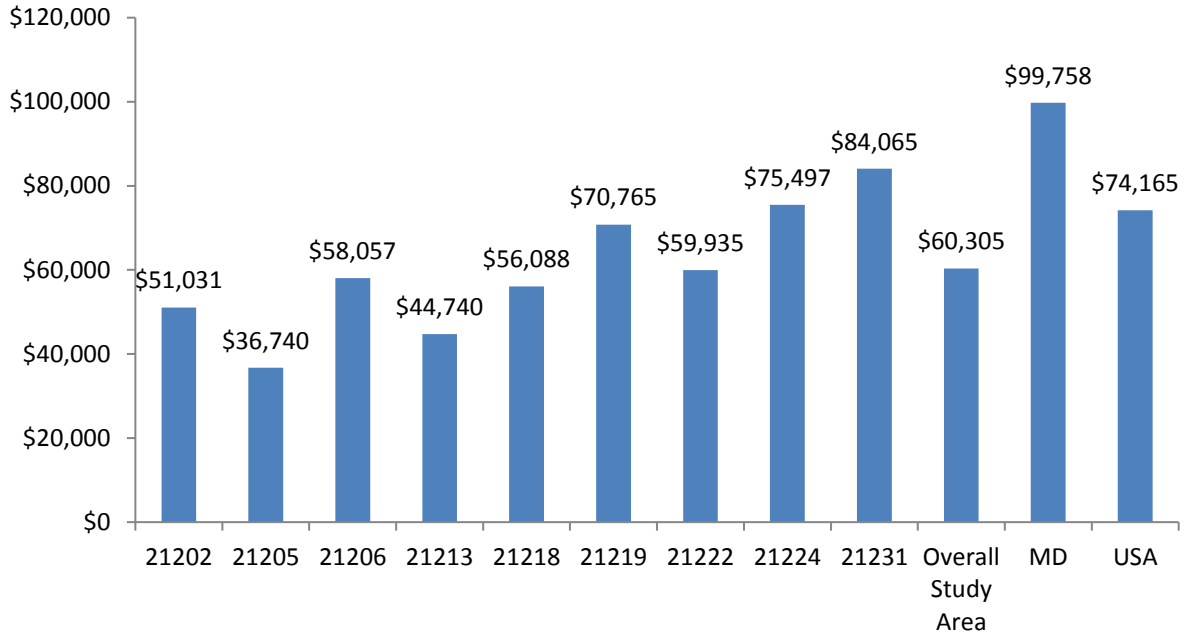
Table 7: Household Income Detail

	21202	21205	21206	21213	21218	21219	21222	21224	21231	Overall Study Area	MD	USA
<$15K	33.50%	30.60%	14.10%	23.40%	23.20%	11.00%	12.30%	13.60%	21.30%	18.7%	8.50%	12.70%
$15-25K	12.60%	19.20%	10.70%	15.50%	14.30%	9.20%	11.30%	11.00%	9.00%	12.3%	7.00%	10.80%
$25-50K	21.60%	24.90%	27.30%	27.20%	24.40%	22.30%	27.40%	22.40%	14.40%	24.5%	17.90%	23.90%
$50-75K	14.00%	13.80%	20.10%	18.00%	15.80%	21.80%	20.80%	16.20%	14.30%	17.6%	17.00%	17.80%
$75-100K	6.00%	5.80%	12.70%	7.70%	8.10%	14.00%	12.60%	11.60%	11.30%	10.4%	13.10%	12.00%
Over $100K	12.30%	5.60%	15.20%	8.20%	14.30%	21.70%	15.50%	25.10%	29.60%	16.6%	36.60%	22.80%

Source: Truven Health Analytics 2015

Providing an average household income snapshot across all ZIP codes, we can note that ZIP codes 21205 ($36,740) and 21213 ($44,740), on average, have the lowest yearly household income compared to their counterparts in the CBSA. The average household income in the overall study area ($60,305) is significantly lower than the state ($99,758) and the nation ($74,165) (See Chart 2).

Chart 2: Average Household Income



Source: Truven Health Analytics 2015

Community residents with a low household income can struggle to afford basic necessities such as food, shelter and clothing; these community residents fare worse than those with a higher income bracket on many levels. Residents who are economically disadvantaged will continue to face significant life challenges affecting the ability to obtain resources and improve their living environment. Without employment prospects and access to a sustainable living wage, these residents are more likely to engage in unhealthy behaviors, ignore mental health issues, not engage in preventive health practices and perpetuate the generational cycle of living in poverty.

Community leaders are aware that employment opportunities for low income residents can improve their quality of life on multiple levels. It is often necessary to provide training, education, work force development and resources to those in need.

The lack of employment opportunities for many community residents has not changed over the years, and the employment prospects for those with limited skills and those who have been incarcerated are bleak; thus, re-entry opportunities from businesses continue to provide hope. Community residents in the focus group cited extreme employment challenges due to multiple factors. Prior criminal history,

lack of skills and not being properly educated are some barriers that prohibit many from securing and obtaining employment. While obtaining steady employment can be difficult, it is a goal many want to achieve.

Focus group participants stated that employment training or workforce development programs can assist those struggling to gain the skills and resources they need. It comes as no surprise that community residents who actively seek employment cite the lack of transportation options as hindering their job prospects.

Community leaders' concerns about employment opportunities were often communicated in conjunction with residents' need for affordable transportation. Improved transportation can increase employment opportunities for low income residents. It was voiced that strong employment opportunities exist outside of the city; however, many residents struggle to secure reliable transportation due to limited and insufficient bus routes. Light rails and buses do not extend far enough to access employment opportunities in outlying areas.

Having a strong, economically healthy community contributes to a healthier environment for residents and for neighborhoods overall. Community organizations and area agencies work diligently trying to connect residents to services and programs. Community leaders and community participants reported that area residents are loyal and faithful; many have great pride in their neighborhoods, and many hope to obtain the education and employment opportunities in order to be better citizens.

Access to Livable Environments

Within the context of the CHNA's key identified needs, a healthy or livable environment refers to the surroundings in which one resides, lives and interacts. A livable environment refers to the availability of safe, affordable, clean housing, a community with healthy food options and low crime rates. A poor or unlivable environment can lead to a shorter lifespan, poor health outcomes and health disparities. Often, the environment and the lifestyle choices of community residents affect the overall health and mental well-being of the individual. Without a proper and healthy surrounding, especially for people who already have a compromised health status, individuals will struggle and perform poorly on tasks.

Families are often deterred from engaging in outdoor activities in neighborhoods where high crime rates and safety issues are prevalent. The inability to be outside will hinder residents from walking and playing, thus contributing to higher rates of physical inactivity and obesity. This is detrimental, in particular, for community residents whose primary form of exercise is walking.

In the CBSA, safe and affordable housing is a critical environmental need. Outdated and unsafe infrastructures in many Baltimore City homes can also present hazardous elements that can trigger and elevate chronic conditions. The lack of affordable, clean housing, the inaccessibility of healthy foods and the area's high crime rates are common issues for families and individuals who struggle to secure employment in order to improve their environmental conditions.

Housing

Baltimore City, in 2015, ranked 16th out of 24 counties in relationship to physical environment according to County Health Rankings and Roadmaps; improving from a 2012 ranking of 24. The calculations used to produce the ranking number under physical environment include air pollution, drinking water violations, severe housing problems, driving alone to work and long commutes (drive time) as factors in how the rank score was achieved. The physical environment in Baltimore County has gotten worse, going from a ranking of 22 in 2012 to a ranking of 24 in 2015. It is important to note that there is a high percentage of commuters in Baltimore County, which could influence the poor ranking score.

Under the physical environment ranking, County Health Rankings and Roadmaps defined severe housing as the percentage of households with at least one out of four housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities. County Health Rankings do not take into consideration lead paint violations, energy cut-off rates, etc. (See Table 8).

Table 8: County Health Rankings & Roadmaps Physical Environment

County Health Rankings and Roadmaps	Physical Environment Ranking
Baltimore City	
2012	24
2015	16
Baltimore County	
2012	22
2015	24

Source: County Health Rankings and Roadmaps 2015 and 2012

When examining lead paint violations and data related to lead poisoning among children, the highest number of lead paint violations is found in the neighborhoods of Madison/East End (90.3), Greenmount East (64.6), Clifton-Berea (63.6), Midway-Coldstream (47.1) and Patterson Park North & East (34.0). Children in these specific neighborhoods are also found to have elevated levels of lead in their blood (See Table 9). Children under the age of 6 are vulnerable to lead poisoning, which affects mental and physical development. Lead poisoning at very high levels can be fatal.

Older homes and buildings in the city are common sources of lead poisoning. Other sources include contaminated air, water and soil. Adults who complete home renovations, who are employed in auto repair shops, and who work with batteries may also be exposed to unhealthy levels of lead.

Table 9: Lead Paint Violations & Children with Lead Poisoning[5]

	ZIP Code	Lead Paint Violation*	Children with Elevated Blood Lead Levels (>10 µg/dL)^
1. Downtown/Seton Hill	21202	0.9	0.0
2. Greenmount East	21202	64.6	11.5
3. Jonestown/Oldtown	21202	1.1	2.2
4. Midtown	21202	1.5	3.6
5. Claremont/Armistead	21205	1.3	0.6
6. Madison/East End	21205	90.3	10.7
7. Perkins/Middle East	21205	24.9	5.7
8. Cedonia/Frankford	21206	2.5	1.2
9. Hamilton	21206	2.2	2.5
10. Lauraville	21206	5.2	2.9
11. Belair Edison	21213	9.3	2.9
12. Clifton-Berea	21213	63.6	8.2
13. Greater Charles Village/Barclay	21218	7.7	4.2
14. Greater Govans	21218	12.6	5.9
15. Midway-Coldstream	21218	47.1	5.9
16. Northwood	21218	1.8	3.5
17. The Waverlies	21218	9.1	1.8
18. Highlandtown	21224	4.5	3.8
19. Orangeville/East Highlandtown	21224	9.3	1.9
20. Patterson Park North & East	21224	34.0	5.5
21. Southeastern	21224	0.5	0.0
22. Canton	21231	1.3	1.2
23. Fells Point	21231	3.3	2.8
24. Baltimore City	N/A	11.8	4.1

Source: Neighborhood Health Profiles 2011

*Per 10,000 households in each specific neighborhood

Primary data collected from the hand survey identified affordable housing/homelessness (9.2 percent) as the second top health concern among a list of 24 available options,. Findings from primary data collected during the CHNA align with secondary data findings regarding housing problems in the City. Overall, the top five health concerns in the community, according to survey responses, were drug and alcohol abuse (11.5 percent), affordable housing/homelessness (9.2 percent), crime/assault (8.4 percent), access to affordable healthy foods (7.3 percent) and high blood pressure (6.5 percent).

[5] Information related to ZIP codes 21219 and 21222 was not available.

Affordable, clean and safe housing was a common theme discussed by community stakeholders. Public housing and rental properties are often in poor condition and can contain harmful elements that can lead to respiratory conditions. Landlords often do not maintain their rental properties nor adhere to building codes, and families are often unsure where to seek housing assistance. There are limited services and programs for residents who struggle with homelessness.

Community stakeholders also reported that residents in transitional housing situations are there, in part, due to the lack of affordable homes. Additional factors such as unemployment and lack of education prohibit residents from finding better housing options. Older row homes, common to the Baltimore region, present challenges because many are not conducive to current building regulations needed for individuals with disabilities and mobility issues, in particular seniors who require the use of assistive walking devices (e.g., walkers, canes or wheelchairs).

Focus group participants indicated that access to safe, clean and affordable housing is not easy to obtain and is especially difficult for minorities and those with a limited or fixed income. Contractors and large construction companies are purchasing and renovating properties, then increasing rent and limiting access to residents who need affordable homes. The lack of affordable housing is leading to homelessness in the community. Group participants agreed that low-cost housing in their communities is in poor condition and that there are limited resources and housing services for people seeking clean and safe housing.

It is important to evaluate and strategize on ways to assist community residents in addressing the growing housing crisis that plagues the region. There are multiple factors that prohibit community residents from affordable, clean and safe housing, and understanding the societal elements can help resolve some disparities that Baltimore residents face.

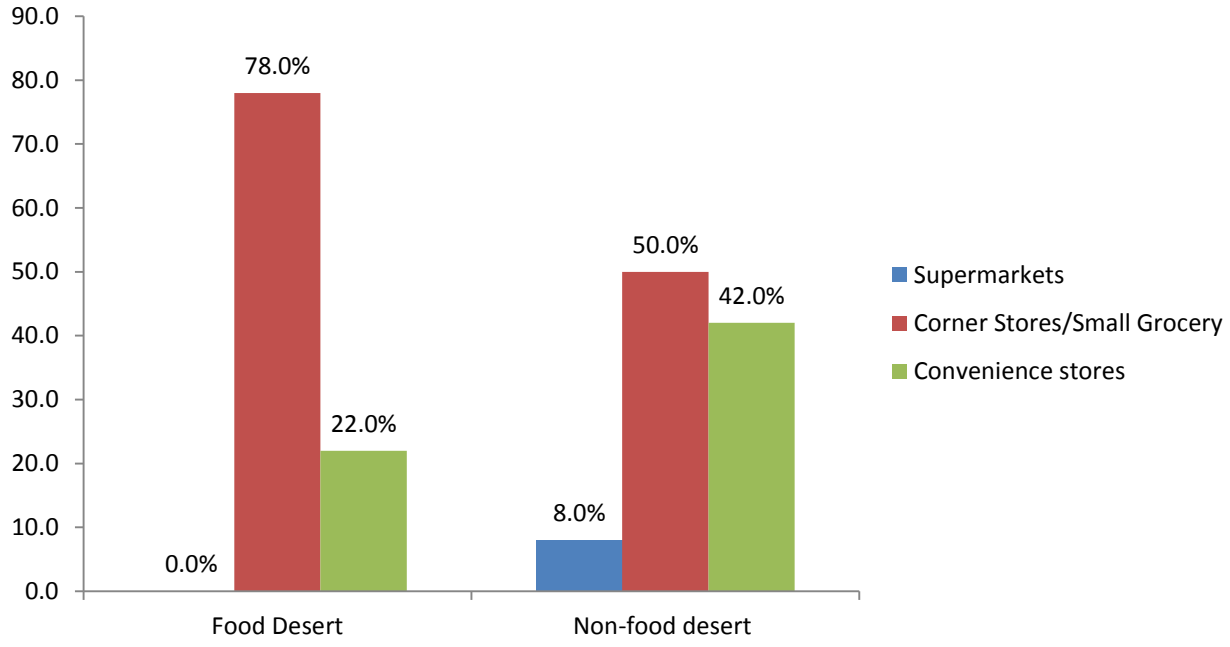
Food Environment

A healthy food environment ensures that residents have the ability to purchase nutritious foods and that those foods are affordable and conveniently located. The term “food desert” describes geographic regions where affordable, nutritious healthy foods are typically difficult to obtain, especially for residents with limited transportation options. Healthy food choices, such as fruits and vegetables, are often unavailable or expensive in the small convenience-type stores characteristic of underserved and low-income areas. Food options found in such convenience stores are usually processed, high caloric and high in unhealthy fats. The unavailability of large grocery stores, supermarkets and farmers’ markets and the vast convenience of junk foods have contributed to the obesity epidemic. It is important to address the food environment to reduce the health disparities and improve diet-related health conditions such as obesity, high blood pressure, high cholesterol and diabetes, etc.

In Chart 3, additional data highlight the breakdown in Baltimore City, where supermarkets are not available in designated food desert locations (0 percent). There were more convenience stores/small grocery stores (78.0 percent) in food desert locations when compared to non-food desert locations (50.0 percent).

This information emphasizes the need for more grocery stores and supermarkets in Baltimore City in order to provide fresh produce and healthy food options to residents. Creating a pathway and providing access to healthy foods would impact the long-term health outcomes of residents who typically rely on sugary and cheap processed food options.

Chart 3: Percent of Food Stores in Food Deserts and Non-Food Deserts



Source: Mapping Baltimore City's Food Environment: 2015 Executive Summary

In Baltimore City, the food retail environment for small grocery/corner stores (435) and convenience stores (300) were dramatically higher when compared to supermarkets (45), farmers' markets (17), public markets (6), and virtual supermarkets (4) in the region. The information validates what community leaders and focus group participants reported regarding the lack of supermarkets and grocery stores in their immediate neighborhoods (See Table 10).

Table 10: Food Retail Environment

Types	Numbers
Supermarkets	45
Small grocery and corner stores	435
Convenience stores	300
Farmers' markets	17
Public markets	6
Virtual supermarkets	4

Source: Mapping Baltimore City's Food Environment: 2015 Executive Summary

There are expansive initiatives underway in Baltimore City to combat the food environment problem. One initiative from B'more Fresh, Baltimore's Food Desert Retail Strategy, is to reduce the number of people living in food deserts and to grow the economy using five key approaches: Expand and Retain Supermarkets, Improve Non-Traditional Grocery Retail Options (e.g., small grocery stores, corner stores, pharmacies, and virtual supermarkets), Improve Healthy Food Availability in the Public Market Setting, Expand Homegrown Baltimore to Serve Food Desert Neighborhoods, and Transportation Strategy).

The affordability of healthy foods is problematic in these neighborhoods. Healthy foods in the form of fresh fruits and vegetables are costlier than canned varieties that often contain unhealthy additions of sugar, salt and fat. Processed foods tend to be vastly cheaper and more widely available, and many families, already on a fixed-income or on a limited budget, are unable to afford fresh produce.

It was reported by the U.S. Census Bureau American Community Survey that more than one-third of Baltimore City residents (44.8 percent) live below 200 percent of the Federal Poverty Level (FPL); this is twice the level of the state (22.8 percent) and higher than the U.S. (34.2 percent). The 2015 Annual Guidelines state that a family of four below 200 percent FPL has an average household income below $48,500.

Fortunately, the Supplemental Nutrition Assistance Program (SNAP) offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. This program is essential to many as it assists community residents with food options that allow them to

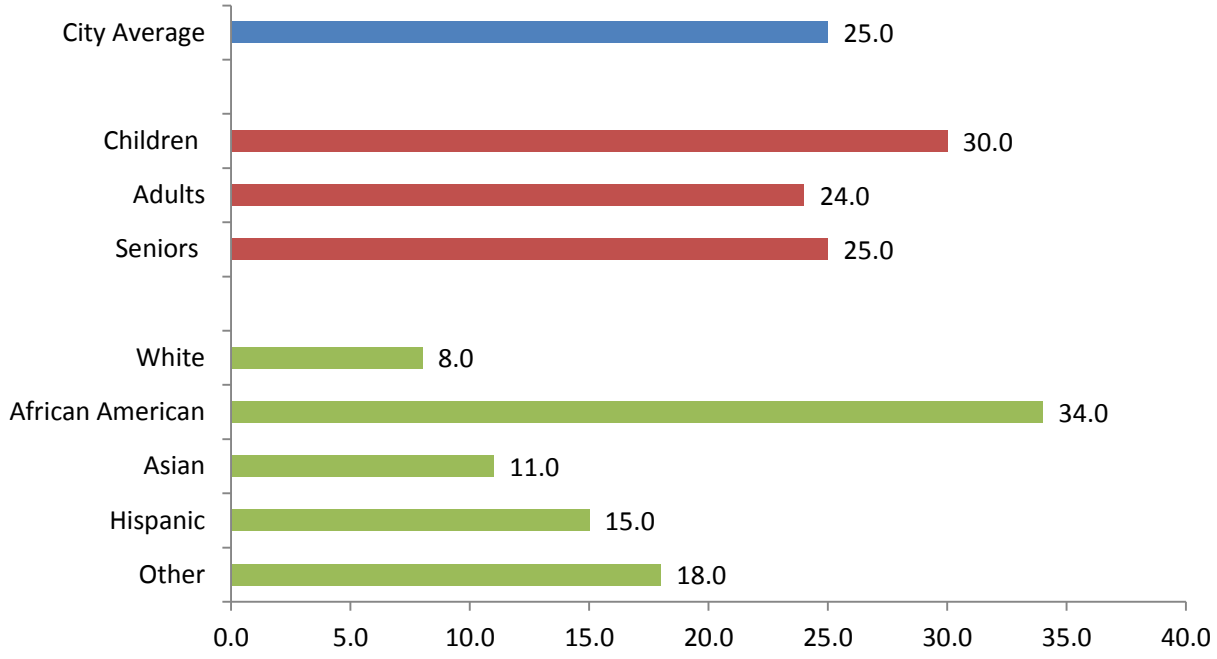
be healthy and maintain their well-being. The U.S. Census Bureau reported 22.3 percent of Baltimore City community residents receive SNAP benefits; this is higher than Baltimore County (8.61 percent), the state (9.4 percent) and the U.S. (12.4 percent).

Of the 621,000 people living in Baltimore City, the 2015 Food Environment reported that 25 percent (158,271 people) live in food deserts. 48 percent of neighborhoods (as defined by the Department of Planning) contain food deserts. In some cases, this could be the whole neighborhood, while in others it may be only a few blocks. Baltimore City residents have limited access to healthy foods and certain groups are affected disproportionately.

In Baltimore City, there were more African Americans (34 percent) living in a food desert when compared to Whites (8 percent), Asians (11 percent), Hispanics (15 percent) and Other races (18 percent). The overall City average of community residents living in a food desert is 25 percent. Looking at groups of citizens by age, more than one-fourth of children (30 percent) live in Baltimore City's food desert (See Chart 4).

A variety of factors have shaped the landscape regarding food deserts. Socioeconomic factors play a significant role in how the low income residents are more likely to face environmental challenges.

Chart 4: Percentage of Each Population Group Living in Food Deserts



Source: Mapping Baltimore City's Food Environment: 2015 Executive Summary

Community leaders are aware, from the residents they serve, that access to fresh, healthy foods is limited. Typically, residents have little access to grocery stores, yet a clear path to fast foods and highly processed meals.

Leaders also cited that the region has a large population of people with diabetes, including a growing number of youth, individuals with high blood pressure and obese people. Community leaders are aware that African Americans are more likely to have diabetes, and state data reinforce that notion. The Maryland Vital Statistics Annual Report (2013) stated that Black males were more likely to die from diabetes than were White Males (39.3 vs 18.6 per 100,000 population); this holds true for Black females as well. Black females were twice as likely to die from diabetes when compared to White females (27.3 vs. 12.8 per 100,000 population). The rate of all citizens who have diabetes in Maryland in 2013 was 19 per 100,000 population.

The inaccessibility of healthy food options paired with the absence of health education and the inability to participate in outdoor activities or in a structured physical exercise regimen creates an environment that perpetuates chronic health problems. Access to proper nutrition is vital to maintaining good health, according to focus group participants. There is general awareness regarding the connection between nutrition and making healthy food choices, and the role both play in overall health.

Focus group participants reported cultural eating habits, the lack of quality grocery stores (living in a food desert) and the unaffordability of healthy foods are underlying factors causing high rates of diabetes, in particular, among African Americans. There was a perception that food establishments and restaurants were more inclined to serve unhealthy foods (e.g., fried foods, salty foods, etc.) and limit healthy food options to their customers due to the popularity of fried or salty foods in neighborhoods they serve. Fast food restaurants and convenience stores are widely available in their communities; unfortunately, large, full-scale grocery stores are not available.

Another barrier for many low-income residents is education. Community residents may not have the proper health education and understanding of how to prepare a healthy meal. Proper educational information and dietary guidelines can assist those who want to eat healthy; however, the availability of healthy food choices must be present.

Crime and Safety

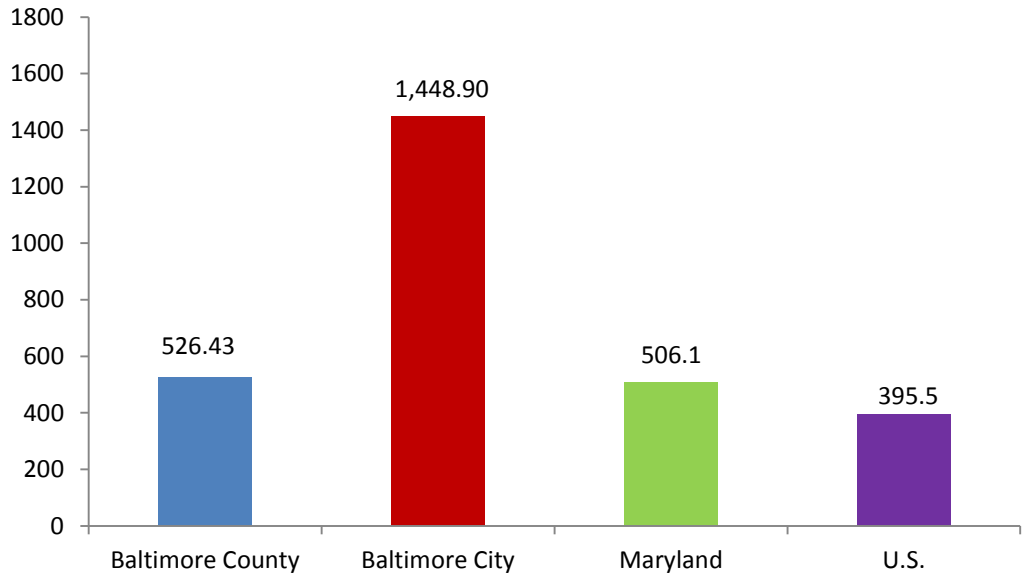
While many families and individuals live in a comfortable and safe environment, there are a number of Baltimoreans who do not. Crime and safety factors significantly impact the ability of an individual to enjoy a livable environment. Neighborhoods with high crime rates increase the likelihood of individuals engaging in unhealthy behaviors (e.g., substance abuse, assault, prostitution, etc.). Lack of a livable environment affects the ability of individuals to access adequate preventive health care services, engage in outdoor activities and obtain other basic needs. Unfortunately, City residents face the threat of crime each day. Access to a livable environment is an imperative part of each individual's overall well-being, as it promotes healthy lifestyles and enhances quality of life.

In 2013, the overall rates of crime decreased in the state. There was a 2.3 percent reduction in total crime with 4,394 fewer crimes reported in 2013 compared to 2012. This marks the lowest number of

total index crimes and total crime per 100,000 residents since 1975, with 185,422 and 3,127.5 respectively. The violent crime rate (467.5) and property crime rate (2,659.9) were also the lowest ever reported in Maryland.

Violent crime is a major problem across the United States. Maryland and Baltimore City are no exception. Data obtained from the FBI indicate that Baltimore City's violent crime rate surpasses Baltimore County, the state and the U.S. combined at 1,448.90 per 100,000 population. Compared to other locations, Baltimore City's crime rate is nearly triple that of its counterparts (See Chart 5).

Chart 5: Violent Crime (per 100,000 Population)

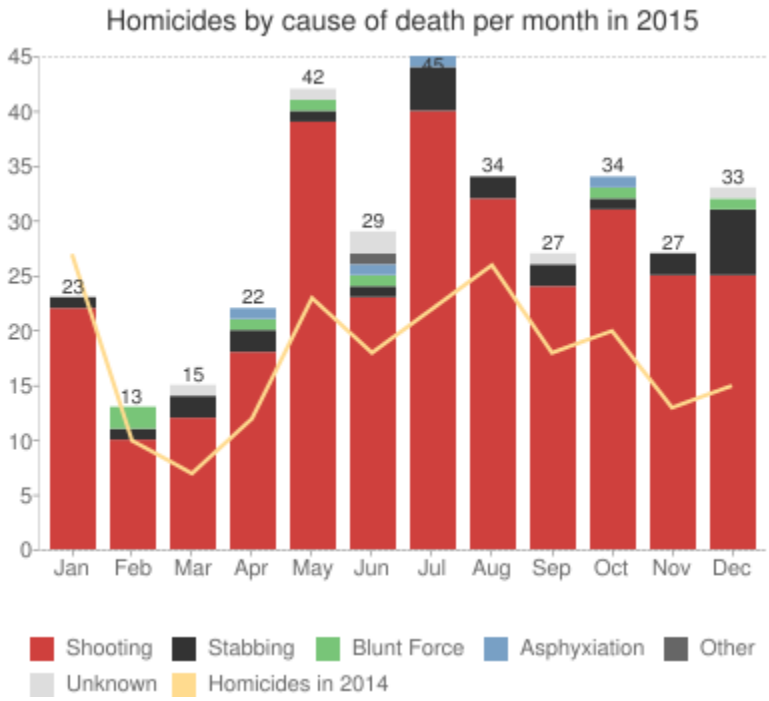


Source: Federal Bureau of Investigation, FBI Uniform Crime Reports 2010-2012

Data from the hand survey revealed more than one-half of survey respondents (62 percent) feel 'somewhat safe' from crime in their neighborhood/community; while 11.3 percent do not feel safe at all. Crime, violence and drugs were the top reasons why respondents do not feel safe in their neighborhood/community.

Within the community, many stakeholders reported that serious crime is prevalent in Baltimore City. Trauma experienced at a young age, drug addiction and incarcerated family members can create an emotional toll. Many families are one-parent households struggling to support and provide a safe and positive environment for their families.

Chart 6: Baltimore Homicides



Source: The Baltimore Sun 2016

Progress made in 2013 has recently been negated as Baltimore reached its highest ever per capita homicide rate in 2015. As shown in Chart 6, homicides in Baltimore City for the year 2015 increased by 63% over the previous year. The increase for a five year period is 49.1% as total homicides reached 344, compared to 224 in 2010.

Community leaders are aware that safety is a significant concern for many parents, and children are often forced to stay inside as a result of their unsafe environment. Regions within the city are also plagued with urban decay, further creating an atmosphere to attract unwanted illegal activities. Having an unsafe community creates an environment conducive to drug use and limits the ability to attract employment opportunities to the region.

Focus group participants stated that residents are exposed to drugs, alcohol abuse and violence in their neighborhoods on a regular basis. Domestic violence and other types of assaults were also mentioned as issues that the community deals with regularly. For residents of the City, crime is a significant part of their communities.

Reducing the crime rate and providing a safe environment requires participation from all City entities. Some would argue that improvements in law enforcement and more aggressive consequences could deter offenders. However, if the ultimate outcome is to have community residents contribute fruitfully as part of society, income disparities must be reviewed. Closing the gap and providing economic opportunities for residents could prove to be a long-term solution and a pathway to assist those who have limited future opportunities.

Access to Behavioral Health Services

Across the nation and during the CHNA process, access to behavioral health services, which includes mental health and substance abuse services, arose as a key priority in the study area. Secondary data, results from the hand-distributed survey, discussions with community leaders and focus groups with vulnerable populations also highlighted the growing national and local need to increase access to behavioral health services.

With the growing aging population, the need and the demand for mental and behavioral health services will continue to grow. The shortage of mental and behavioral health providers played a key role in seeking care for community residents who struggle with their mental and behavioral health issues. Residents who experience the loss of being independent, loss of a loved one and the overall decline of health are also some contributable factors that make mental health a critical concern. Mental health is shaped in part by the socioeconomic factors and physical environment where people live. Primary and secondary data collected from the CHNA reinforced these statements.

Mental Health

There are many factors linked to mental health, such as genetics, age, income, education, employment, and environmental conditions. As identified by primary and secondary data, mental health provider shortages, overall access issues, high rates of co-occurring mental disorders , and substance abuse issues all create significant growing concerns about the state of behavioral health issues and the need to bring additional focus on providing behavioral health services.

Community residents also struggle with environmental stress such as loss of or limited employment opportunities, poor living environments and an overall sense of hopelessness creating feelings of depression and anxiety, all of which impact the mental and spiritual well-being of the individual. The use and abuse of drugs and alcohol are attractive avenues for community residents who struggle to face their mental health problem. In many cases, residents who have a mental health issue also are substance abusers.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), behavioral health is essential to overall health, with prevention and effective treatment measures allowing individuals to recover from mental health crises. Direct access to health professionals and health services for behavioral health problems enables community residents to obtain proper care and treatment, leading to healthier lives.

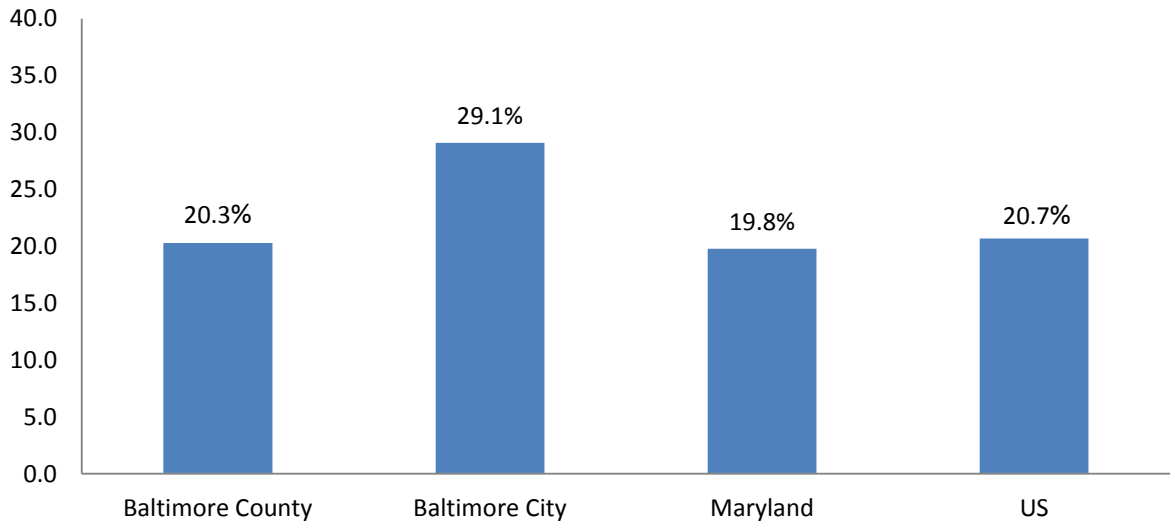
Across the nation, mental illness continues to be a major issue for individuals and families. The Centers for Disease Control and Prevention define mental illness as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning.” Affecting more than 26 percent of the U.S. adult population, depression is the most common type of mental illness.

Data show that roughly 60 percent of adults with mental illness received no mental health treatment within the last year, indicating a nationwide issue with individuals being able to receive proper mental health services and treatment. This is due, in part, to the lack of mental health providers across the U.S.

According to the U.S. Department of Health and Human Services, almost 91 million adults live in areas where shortages of mental health professionals make obtaining treatment difficult.

Looking at a regional perspective, the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System reported that 17.4 percent of Maryland residents aged 18 and older reported mental illness in the past year, compared to 17.6 percent in Baltimore County and 17.7 percent in Baltimore City. More than one-fourth (29.1 percent) of Baltimore City residents lacked social or emotional support they needed compared to 20.3 percent in Baltimore County, 19.8 percent in Maryland and 20.7 percent in the U.S. (See Chart 7).

Chart 7: Lack of Social or Emotional Support

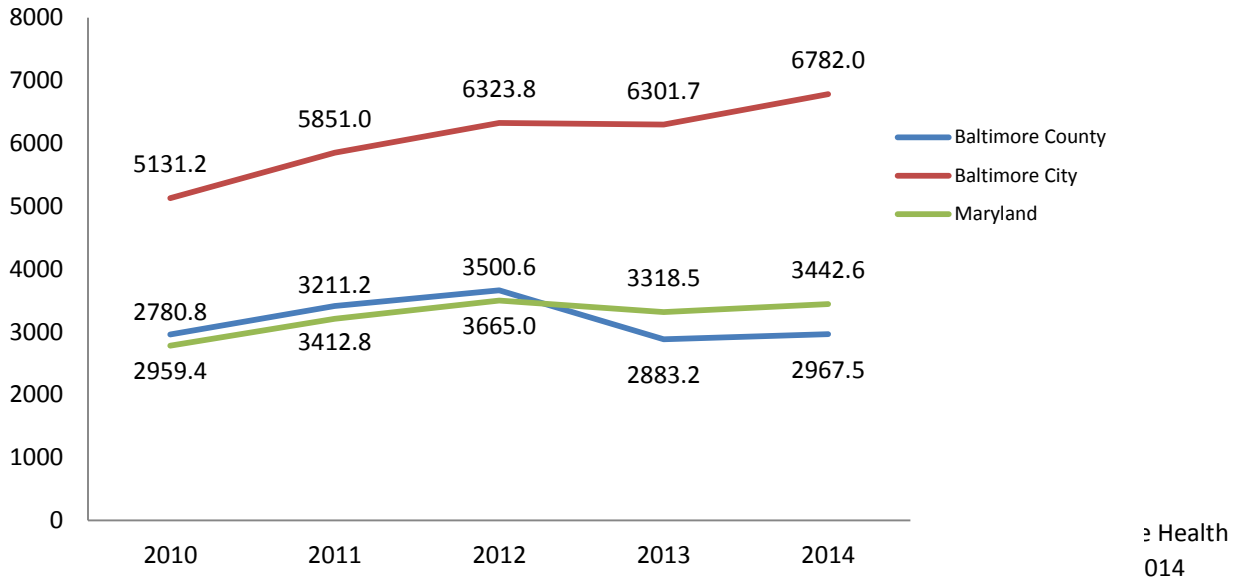


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. 2006-2012

The Maryland State Health Improvement Process data revealed that Baltimore City residents saw a steady increase in emergency room visits from 2010-2014 related to mental health conditions, compared to Baltimore County and the state. In 2014, there were 6782 per 100,000 population of Baltimore City residents who visited the emergency room related to a mental health condition, compared to 3442.6 in the state and 2967.5 in Baltimore County (See Chart 8).

It was also revealed that Baltimore City emergency department visits related to mental health conditions beginning in 2010, with 5131.2 visits per 100,000 population, steadily rose throughout the years with a minor decrease in the number of visits in 2013 with 6301.7 (per 100,000 population). However, an additional 480 visits occurred from 2013-2014 (See Chart 8).

Chart 8: Emergency Department Visits Related to Mental Health Conditions (Per 100,000 population)



Residents who attempt suicide are typically depressed and/or face another significant mental health challenge. Residents who attempt suicide are typically depressed and/or face a mental health problem in which they believe there are limited solutions to their problems. The Maryland State Health Improvement Partnership from 2011-2013 reported 9 suicides per 100,000 population among Maryland residents. Suicide is a serious public health problem and is a preventable cause of death. There is a correlation between mental health disorders and substance abuse among those who have committed suicide. Approximately 500 lives are lost each year in the state of Maryland due to suicide.

Information from the hand-distributed survey showed that community residents in the CBSA are faced with mental health challenges. More than one-fourth of survey respondents reported having depression (29.7 percent); while 25.1 percent reported having problems remembering things or concentrating, and 23.2 percent reported having anxiety, nervousness and/or panic attacks.

Among survey respondents, more than one-third received mental health services in the past 12 months (36 percent). Of those survey respondents who received mental health services, 41.5 percent obtained services from a mental health counselor or provider; 18.6 percent obtained services from their community or neighborhood organization or hospital/emergency room.

Reviewing additional hand survey results, 16 percent of respondents needed but did not receive mental health services in the past 12 months. 18.4 percent of those survey respondents (who needed mental health services but did not receive care) reported that their insurance did not cover the care. Other responses to the question included that they did not know where to go (13.2 percent) and or preferred alternative forms of treatment (13.2 percent). It was reported that 20.3 percent had a mental/emotional problem that affected their daily activities. Information collected from the hand survey highlights the

growing local problem and the opportunity to increase the availability of mental health providers to this population.

Community stakeholders reported the need to continue to invest in improving access to health care, focusing primarily on mental health and addiction recovery services. Shortages in mental health providers and facilities, lack of access and challenges with the inability to obtain employment can interfere with individuals seeking the mental health services they need.

According to community stakeholders, residents with a mental and or a behavioral health issue also tend to have a substance abuse problem. Poor socioeconomic factors contribute to the use and the abuse of drugs. Some underlying chronic diseases such as diabetes, high blood pressure, heart disease, high cholesterol and asthma are the physical results due to the inability to control and seek treatment for a mental health issue. Daily trauma (e.g., not having enough food for the family, being homeless, etc.), adapting to new cultural surroundings and domestic violence are additional perceived concerns that affect whole communities within the region. Community leaders reported that community residents who also have mental health issues also tend to have dual behavioral diagnoses, making access to care and treatment essential.

Additional primary data collected from focus group participants reported mental health is a significant issue that affects all members of the community, regardless of age or race. Barriers such as the lack of insurance coverage, negative social stigmas and lack of health education prevent individuals from seeking needed care. Educating community members on the signs and symptoms of depression and other mental health issues can enable those to be more aware of the disease in order to seek and obtain needed services.

Focus group participants also cited stress and anxiety many families face because they are unable to meet the basic needs of their children. The prevalence of violence and crime in neighborhoods are contributing factors to increased mental health issues. Focus group participants reported that youth in middle school are overwhelmed trying to address issues related to violence, peer pressure, depression, abuse, sexually transmitted diseases and early pregnancy. One solution cited was that if funding were available, students could take advantage of school sponsored therapy sessions, providing long-term benefits to those students who struggle with a mental health problem. Overall, both community leaders and focus group participants were aware of their communities' mental health problems, yet access and the availability of treatment options hinder residents from obtaining needed care.

Substance Abuse

Another major growing concern along with mental illnesses is substance abuse, which refers to the abuse of alcohol, the use of illegal drugs, prescription medicine and marijuana.

According to the Substance Abuse and Mental Health Services Administration (SAMSHA) 2013 National Survey of Drug Use and Health, 24.6 million individuals 12 years or older were current illicit drug users during the time of survey admission. The most commonly used drug is the U.S. is marijuana with 19.8 million users in 2013 compared to 14.5 in 2007. Additionally, more than one-half of Americans aged 12

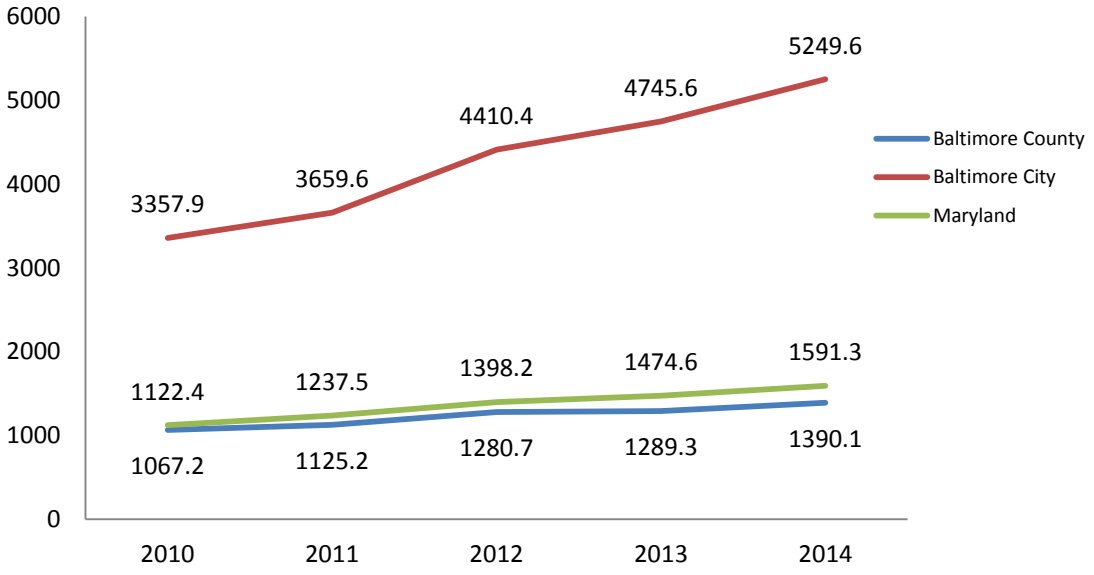
or older were current alcohol users in 2013. In 2013, 22.7 million individuals aged 12 or older needed treatment for an illicit drug or alcohol problem; however, only 2.5 million received treatment in a specialty facility.

Data at the national level from the Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System revealed more Baltimore County residents (56.1 percent) and Marylanders (56.1 percent) aged 12 and older used alcohol in the past month compared to Baltimore City (48.9 percent) residents. The percentages of drinkers in Baltimore City (48.9 percent) aged 12 or older was lower than the state (56.1 percent). However, close to one-fourth of Baltimore City residents (24.5 percent) had five or more drinks on the same occasion compared to residents in Baltimore County (21 percent) and the state (21.8 percent).

SAMSHA also reported that the use of illicit drugs among Baltimore City residents (10.5 percent) aged 12 and older was higher compared to residents in Baltimore County (7.5 percent) and the state (7.6 percent). There were lower percentages of Baltimore County residents (7.5 percent) aged 12 and older that used illicit drugs in the past month compared to the state (7.6 percent).

Additional data revealed that Baltimore City residents saw a steady increase of emergency room visits for addiction-related conditions from 2010-2014. In 2014, Baltimore City had 5249.6 (per 100,000 population) emergency room visits for addiction-related conditions compared to 1390.1 in Baltimore County and 1591.3 in the state. Baltimore County residents fell below the state and Baltimore City on visits to the emergency room for addiction-related conditions starting in 2011-2014 (See Chart 9).

Chart 9: ED Visits for Addiction-Related Conditions (Per 100,000 population)



Source: Maryland State Health Improvement Process 2014

Community residents recognize the dangers associated with drug and alcohol abuse. Results from the hand-distributed survey, community leaders input and focus groups emphasize their awareness of the problem. Hand-distributed survey results showed 21.7 percent of respondents always smoke cigarettes. 11.5 percent of survey respondents were most concerned about drug and alcohol use/addiction in their community. Discussions with community leaders echoed the concerns of survey respondents. Community leaders understood the severity of substance abuse in the community and the negative impact it has on the community at large. Poor socioeconomic factors tend to create environments where community residents are more susceptible to the use and abuse of drugs, especially among those with preexisting mental health issues.

Community stakeholders reported that substance abuse is rampant in the city. . Many community residents, especially young African American males, struggle with the disease, and this contributes to a higher incidence of crime and violence. Without counseling and treatment options, community residents are less likely to obtain employment due to their erratic behavior, typical of individuals with substance abuse issues. Programs and services are lacking in the community and counseling and treatment options are scarce. Focus group participants expressed a strong need for more community resources and funding to combat the substance abuse problem, as well as a need for more mental and behavioral health programs.

Behavioral health disorders, which include mental illness and substance abuse, left undiagnosed and untreated can lead to physical, emotional and spiritual issues manifesting into larger health problems. Community residents dealing with behavioral health issues need access to adequate services and resources, as well as the knowledge of where to obtain care. Communities will suffer and face damaging effects if behavioral services and treatment options are not addressed.

Access to Health Services

Access to health care services is a recurring problem in the community. As a point of reference, this typically refers to the ability and ease with which people can obtain health care or use health care coverage.

In the community, health services should be effective and relevant for community residents to be able to obtain them. Health insurance coverage can only go so far for those living in the community. There are a multitude of factors and barriers that prohibit residents from obtaining care and services, such as affordability, health literacy, navigation through the health care system, the availability of providers, transportation, etc.

The CHNA identified specific areas of focus regarding access to health services. They include obtaining dental care, providing access to the uninsured population and access to services related to chronic diseases. Addressing the needs of the uninsured and creating an accessible pathway provides community residents with the ability to obtain needed health care services.

Dental Care

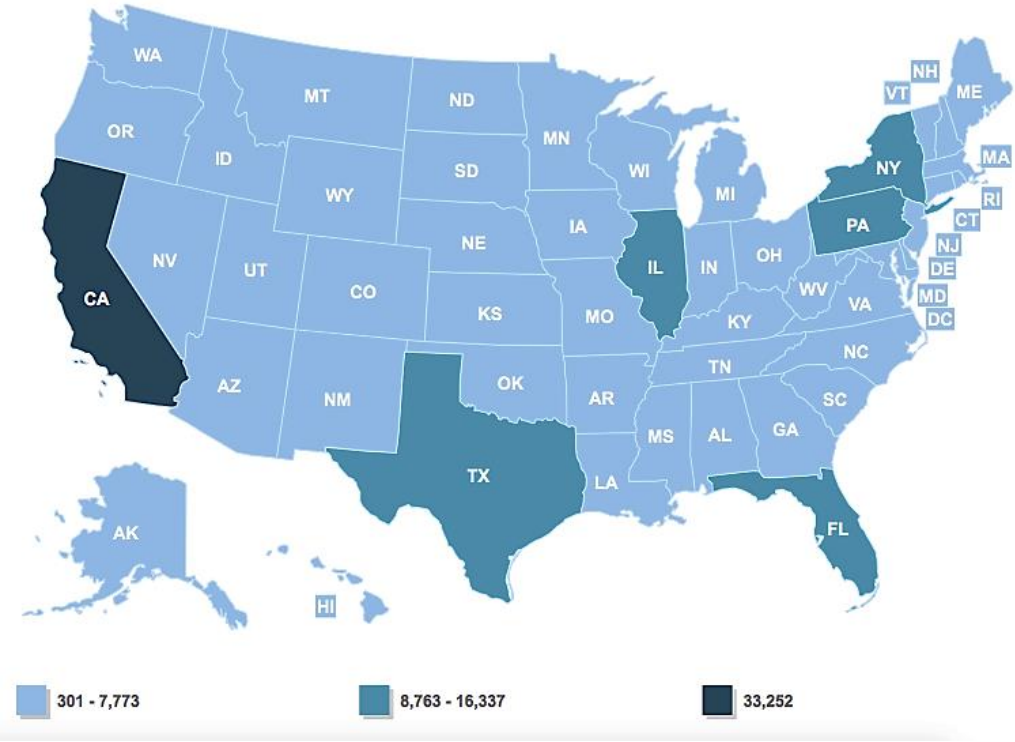
Dental care is an important part of basic health care; however, for many Americans, there is a great need to make it more available. There are many factors that cause access to dental care to be an issue within communities, such as, but not limited to: age, cultural and racial background, economics and access to transportation.

Today, countless individuals will prioritize basic living necessities such as food, housing and standard health care over other types of care. In most cases, awareness and understanding of primary, preventive oral health services will take a back seat to other health care needs. The importance of good oral hygiene and its relationship to physical well-being are not commonly understood among a majority of people. Oral hygiene is a must to ensure proper health; otherwise, the risk of severe mouth diseases is present. The American Dental Association (ADA) recommends regular dental visits. However, individuals who are more prone to or are considered high-risk for dental diseases (e.g., smokers, people with diabetes, people with gum disease, etc.) may need frequent visits to a dental care provider.

Certain diseases such as diabetes and HIV/AIDS can lower the body's resistance to infection, making oral health problems more severe. Oral health might affect, be affected by, or contribute to various diseases and conditions, such as endocarditis, cardiovascular disease, premature birth, low birth weight, diabetes, HIV/AIDS, osteoporosis, Alzheimer's disease and other conditions.

The Patient Protection and Affordable Care Act has provided Americans with improved access to dental health care since its inception; however, there are still significant gaps that need to be addressed. In 2015, the number of residents living in a defined Health Professional Shortage Area (HPSA) within Baltimore City is 68 percent when compared to Baltimore County (20.2 percent), the state (26.3 percent) and the U.S. (34.1 percent). While Maryland is home to one dental school, accessibility to providers and care remains a challenge for many in the community. In 2016, Maryland reported having 4,769 professionally practicing dentists, according to the Henry J. Kaiser Family Foundation (See Table 11 and Map 3).

Map 3: Professional Active Dentists



Source: The Henry J. Kaiser Family Foundation 2016

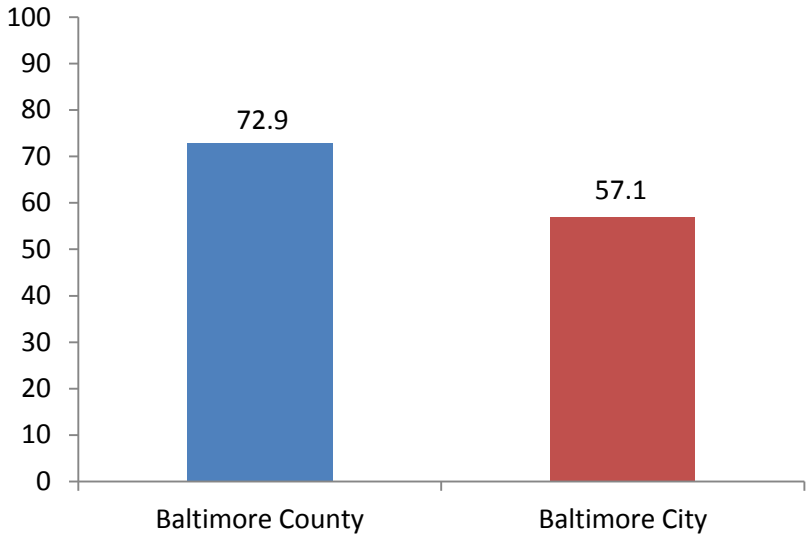
Table 11: Professional Active Dentists

Location	Dentists, 2016
USA	210,036
Maryland	4,769

Source: The Henry J. Kaiser Family Foundation 2016

Baltimore City residents will face additional access barriers to dental providers based upon availability. City residents have less access to dental care providers at 57.1 per 100,000 than in Baltimore County (72.9 per 100,000 population) (See Chart 10). The inaccessibility of dentists has placed a significant toll on the oral health of residents.

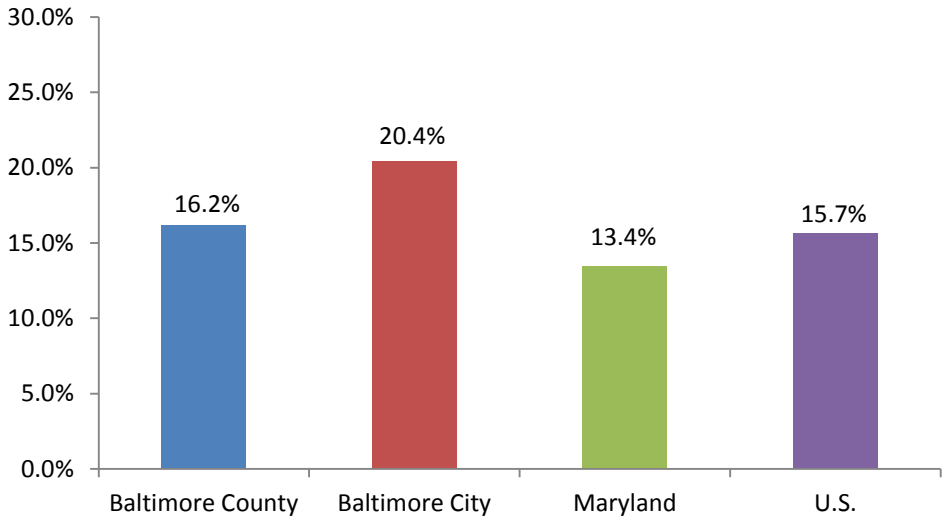
Chart 10: Access to Dental Providers (Per 100,000 Population)



Source: US Department of Health Human Services, Health Resources and Services Administration 2013

National data indicate that 20.4 percent of Baltimore City residents aged 18 and older had six or more teeth removed due to poor dental health; as compared to residents in Baltimore County (16.2 percent), the state (13.4 percent) and the nation (15.7 percent) (See Chart 11). Preventive dental measures and good oral practices could decrease the amount of teeth community residents have extracted. Education and the dissemination of information play a vital role to those who are unaware of the correlation between good oral hygiene and preventive actions.

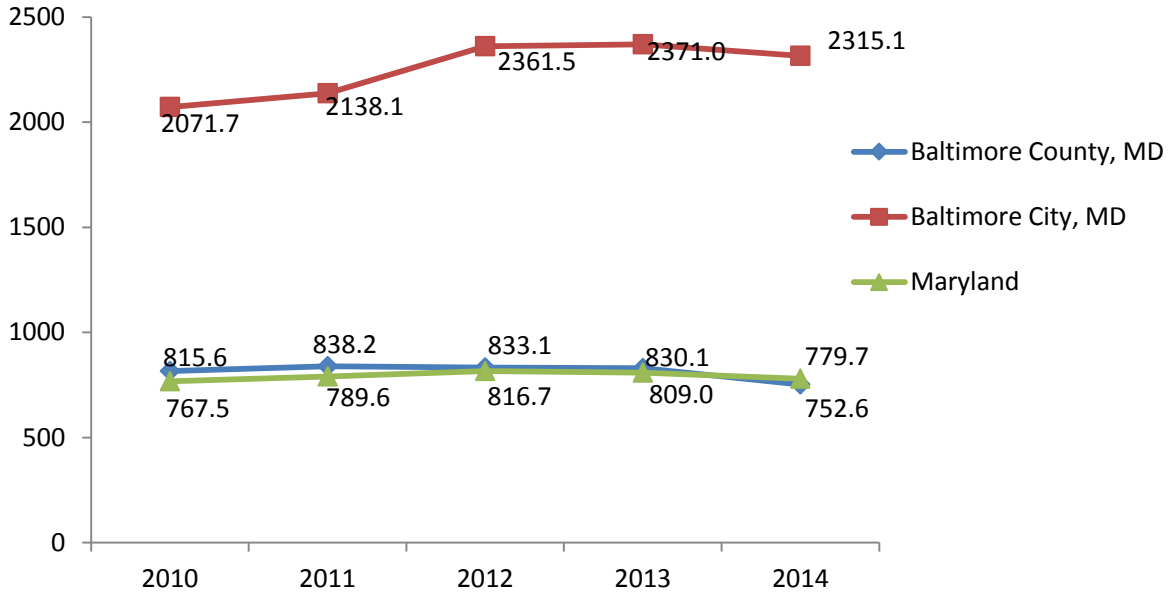
Chart 11: Poor Dental Health; Adults who had six or more teeth removed due to poor dental health



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System 2006-2010

The rate of residents in Baltimore City from 2010-2014 who visited the emergency room for dental care was much higher than Baltimore County residents and the state. Starting in 2013, Baltimore County (830.1) and the state (809) started to see decreased rates of residents who visited the emergency room for dental care (See Chart 12).

Chart 12: Emergency Department Visit Rate for Dental Care (ED rates related to dental problems per 100,000 population)



Source: Maryland State Health Improvement Process 2014

The need for dental care in the U.S. is growing and the need for dental care in Baltimore City is no different. Community residents identified oral health care as a top priority and identified lack of dental coverage, access and out-of-pocket costs as limiting their ability to obtain proper and consistent dental care. Community leaders reported oral health as an area of concern and specified that provider shortages, high costs and limited preventive information often keep residents from obtaining oral health care.

When examining data from hand-distributed surveys, more than one-half of survey respondents (58.2 percent) seek dental care at a dentist's office, while 16.1 percent do not go to the dentist. Additionally, fewer than one-half of survey respondents (48.6 percent) had an appointment with a dentist or dental clinic within the past year, and 11.6 percent indicated that they have not seen a dentist in five or more years.

Financial barriers are another issue that decreases the accessibility of oral health care for individuals in the community. In a majority of cases, health insurance does not often cover dental care, causing residents to forgo routine dental maintenance or wait until an emergency occurs. Close to one-quarter of survey respondents (23.1 percent) reported having to pay out-of-pocket costs for their dental services, while 11.9 percent reported that they did not pay for their dental services.

Closing the gap for residents to obtain needed dental care is essential. Information on the importance of oral health and the adoption of good oral hygiene coupled with effective preventive measures can reduce disparities in accessing dental treatment services.

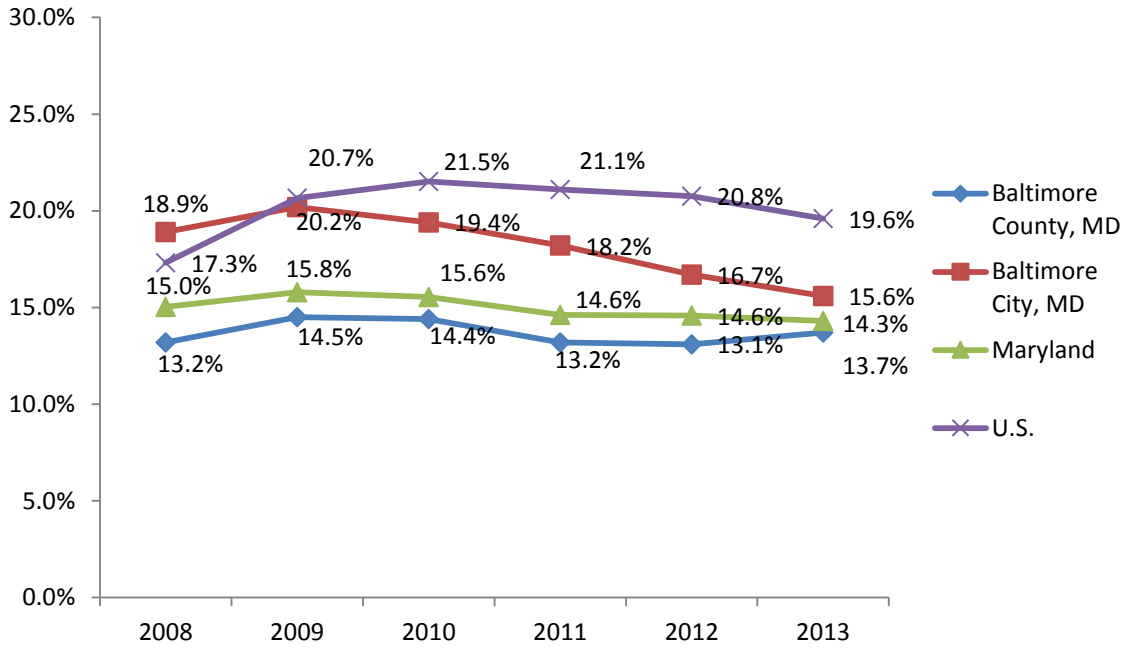
Uninsured

Availability of health care insurance is one of the most important pieces in obtaining primary health care access; however, for many Americans, there is a great need to make it more available. The limitations in health care coverage readily affect the vulnerable, underserved and low-income populations. Many factors contribute to the availability of health insurance, such as economic factors, language, knowledge, citizenship and ease of accessibility.

Since the enactment of the PPACA, access to health insurance has become a basic right and necessity for all. This Act provides Americans with better health security by putting in place comprehensive health insurance reforms that expand coverage, holds insurance companies accountable, lowers health care costs, guarantees more choice and enhances the quality of care for all Americans. Although this legislation introduced historical reform, millions of Americans still find themselves unable to afford health insurance. Often choosing to meet basic needs versus paying health insurance premiums, Americans will go without health insurance coverage, increasing the risk of injury and illnesses, as well as deterring a healthy lifestyle.

The availability and ease of use for insurance have increased with the passage of the PPACA. In 2014, the U.S. Census Bureau cited that 7.9 percent of Marylanders, compared to 10.4 percent of the U.S. population, lives without any type of health care insurance. These numbers are a good indication of progress made, as 2013 levels were significantly higher with 10.2 percent of Marylanders and 13.3 percent of the U.S. population living without insurance coverage. In 2013, the U.S. Census Bureau reported Baltimore City and Baltimore County fell below the nation's rate of 19.6 percent for the uninsured population for those aged 18 to 64 years–with 15.6 percent and 13.7 percent, respectively (See Chart 13). While the coverage of community residents in Baltimore City is above the national rate, the uninsured population still remains vulnerable to the inability of obtaining health care services. Data also revealed that more than one-third of Baltimore City residents (34.2 percent) compared to 14.2 percent in Baltimore County reported Medicaid as their health care insurance provider.

Chart 13: Uninsured Population Aged 18-64 years



Source: U.S. Census Bureau, Small Area Health Insurance Estimates 2010

The County Health Rankings database provided a snapshot and benchmark data on how each county ranks in comparison to one another on multiple measures. Maryland has 24 counties; thus, each county is ranked one through 24.

Exploring clinical care rankings, Baltimore County had increased their clinical care score in 2012 from a five to a ranking of eight in 2015; this represents a negative change in the clinical care ranking score. Baltimore City increased ranking scores from a 15 to a 19 between 2012 and 2015, which indicated that a specific measurement affected the ranking negatively. The increased ranking scores indicated that specific health care issues such as the uninsured, primary care physicians, dentists, mental health providers, preventable hospital stays, diabetic monitoring and mammography screening rates have been impacted; thus, altering the overall ranking outcome (See Table 12). It is recommended to examine and explore what specifically affected the higher ranking scores as a community group.

Table 12: County Health Rankings; Clinical Care

	Clinical Care Rankings
Baltimore City	
2012	15
2015	19
Baltimore County	
2012	5
2015	8

Source: County Health Rankings and Roadmaps 2015 and 2012

The CNI insurance rankings for the CBSA shows ZIP codes 21202, 21205, 21213 and 21218 had a score of 5, which indicates that community residents in these specific neighborhoods have additional insurance access issues when compared to the remaining neighborhoods.

In reviewing information from Table 13, CNI data revealed neighborhoods 21205 (26.34 percent), 21213 (21.26 percent), 21202 (15.72 percent) and 21218 (14.69 percent) had higher percentages of unemployment when compared to the remaining ZIP codes in the CBSA. CNI calculates the percentage of the unemployed population in the labor force, aged 16 and older, and the percentage of the population without health insurance when calculating the insurance barriers.

Additionally, the CNI measures income barriers based on:

a. Percentage of households below poverty line, with head of household age 65 or more
b. Percentage of families with children under 18 below poverty line
c. Percentage of single female-headed families with children under 18 below poverty line

Therefore, even though zip code 21231 had the highest average income within the CBSA (as shown previously in Chart 2), Table 13 shows a calculated CNI income score of 5, indicating significant barriers. This is due to the high percentages for seniors in poverty at 29%, children in poverty at 47%, and single households who have children in poverty at 69%.

There are several socioeconomic issues community residents face when the inability to obtain employment is a factor. Higher unemployment rates add greater accessibility issues to health, social and daily living factors.

Table 13: CBSA CNI ZIP Codes and Scores: Specific Data and Measures

Zip	2015 Population	Poverty 65+	Poverty Children	Poverty Single w/kids	Limited English	Minority	No H/S Diploma	Unemployed	Uninsured	Rent	House	Income	Culture	Education	Insurance Rank	Housing	2015 CNI Score
21202	23,812	33.00%	47.07%	57.42%	1.13%	70.41%	23.04%	15.72%	18.18%	78.29%	5	5	5	5	5	5	5.0
21205	16,300	30.63%	46.69%	55.48%	3.88%	83.52%	36.55%	26.34%	17.85%	60.52%	5	5	5	5	5	5	5.0
21206	50,347	12.66%	20.19%	28.69%	1.60%	77.37%	15.23%	12.98%	9.26%	39.80%	5	2	5	4	4	5	4.0
21213	32,146	23.72%	30.38%	42.37%	1.08%	93.94%	23.55%	21.26%	14.10%	43.05%	5	4	5	5	5	5	4.8
21218	48,890	22.22%	23.90%	36.41%	0.72%	72.89%	17.43%	14.69%	13.40%	55.22%	5	3	5	4	5	5	4.4
21219	9,743	8.67%	13.01%	24.48%	0.54%	7.64%	17.19%	10.62%	6.46%	18.64%	2	2	2	4	3	2	2.6
21222	56,953	11.38%	20.30%	30.65%	1.69%	23.65%	19.13%	12.99%	6.93%	33.58%	4	2	4	4	3	4	3.4
21224	50,053	13.67%	30.85%	49.26%	9.79%	42.81%	25.12%	10.76%	9.23%	42.36%	5	4	5	5	4	5	4.6
21231	16,032	28.51%	46.54%	69.38%	4.66%	47.11%	16.73%	11.08%	11.73%	63.48%	5	5	5	4	4	5	4.6

Source: Truven Health Analytics 2015

While hand survey results reported that a majority of community residents had insurance, for the percentage of residents who did not have health insurance the most common reasons were: cost (29.6 percent) and the belief that that they did not qualify (25.4 percent).

Community leaders believe there are a number of factors that affect insurance status within the community. Fear and a lack of trust were two consistent points that surfaced during community leader discussions.

Input from focus group sessions found that many residents do not have health insurance because they do not know how to obtain it and do not have access to affordable health services. There was belief that the process is difficult and that 'Obamacare' does not provide adequate coverage. Some stated that they avoid seeking health services because they are not eligible, nor can they afford health insurance

premiums or the costs associated with uninsured medical care. For those aware of existing health resources, there was a claim for needed information to come from trusted organizations. Overall, the cost of care, insurance and lack of community awareness are barriers to receiving health care. Many feel that payment for health care services is expensive, which includes out-of-pocket costs, prescription medications and high deductibles.

Disparities and gaps in services plague communities and neighborhoods. Primary and secondary data figures collected provide in-depth information to address and pinpoint areas of concern for improvement.

Chronic Diseases

Heart disease, cancer, diabetes and stroke, which are chronic diseases, are a few leading causes of death and disability among citizens. Chronic diseases are responsible for seven of 10 deaths each year, and treating people with chronic diseases accounts for 86 percent of our nation's health care costs according to the CDC.

Obesity, a nationally growing concern, has affected many communities and neighborhoods and shows no signs of waning. Communities are seeing children as young as two years old diagnosed as being overweight and/or obese. According to The State of Obesity, Maryland has the 26th highest adult obesity rate in the nation. Maryland's adult obesity rate is currently 29.6 percent, up from 19.6 percent in 2000 and from 10.8 percent in 1990. Specifically examining the BMI of adults, the CDC reported that there were more Baltimore City (34.1 percent) residents aged 18 and older with a BMI greater than 30 (which indicates that they are obese) when compared to residents in Baltimore County (27.9 percent) and the state (28 percent) in 2012.

The toll and the overall health care costs associated with chronic diseases are staggering. The CDC reports, 86 percent of all health care spending in 2010 was for people with one or more chronic medical condition. Costs of heart disease and stroke in 2010 were estimated to be $315.4 billion. Of this amount, $193.4 billion was for direct medical costs, not including costs of nursing home care. Medical costs linked to obesity were estimated to be $147 billion in 2008.

Although common, many of the chronic diseases diagnosed in community members are preventable. Living a healthy lifestyle by incorporating exercise, eating healthy and avoiding tobacco and alcohol can assist community residents from developing certain diseases.

Maryland State Health Improvement Process reported that Marylanders and Baltimore County residents have roughly the same life expectancy (79.6 years of age and 79.4 years of age respectively); while dramatically lower, Baltimore City residents have a life expectancy of 73.9 years of age.

Data obtained from Neighborhood Health Profile identify the top leading causes of death in Baltimore City as heart disease, cancer and stroke. These top three leading causes of death mimic those of the overall state of Maryland (See Table 14).

Additional causes of death such as HIV/AIDS, homicide, drug-induced deaths of undetermined manner and injury were not reported in Maryland's overall top leading causes of death. Identifying causes of death can assist health systems, organizations, community groups and community resources in

allocating and assisting in the direction where funding can be properly assigned for maximum impact. For example, education and health literacy regarding HIV/AIDS can assist community residents who are unaware of how the disease is transmitted, how to avoid contracting the disease and how to seek treatment options, potentially avoiding death.

HIV/AIDS, homicide, drug-induced deaths of an undetermined manner and injury are leadings causes of death found in Baltimore City. Primary data collected from the CHNA echo the secondary data findings.

Table 14: Top 10 Causes of Death in Baltimore City

	Rate (per 100,000)	Percent of Total Deaths	Percent of YPLL[6]
1. Heart Disease	28.4	25.8	15.4
2. Cancer	23.1	20.8	14.8
3. Stroke	5.2	4.7	2.6
4. HIV/AIDS	3.9	3.5	7.6
5. Chronic lower respiratory disease	3.9	3.5	1.6
6. Homicide	3.5	3.4	12.5
7. Diabetes	3.5	3.2	2.0
8. Septicemia	3.5	3.1	2.1
9. Drug-induced deaths of undetermined manner	3.2	2.8	6.9
10. Injury	2.8	2.5	4.8

Source: Neighborhood Health Profiles 2011

In 2013, the ten leading causes of death in Maryland were diseases of the heart (25 percent), malignant neoplasms (23 percent), cerebrovascular diseases (5 percent), chronic lower respiratory diseases (4 percent), accidents (4 percent), diabetes mellitus (3 percent), septicemia (2 percent), nephritis (2 percent), influenza and pneumonia (2 percent) and Alzheimer's disease (2 percent) (See Table 15).

[6] Years of Potential Life Lost

Table 15: Leading Causes of Death in Maryland

2013	Percent
1. Diseases of heart	25.0
2. Malignant Neoplasms	23.0
3. Cerebrovascular disease	5.0
4. Chronic lower respiratory diseases	4.0
5. Accidents	4.0
6. Diabetes Mellitus	3.0
7. Septicemia	2.0
8. Nephritis	2.0
9. Influenza and Pneumonia	2.0
10. Alzheimer's disease	2.0

Source: Maryland Department of Health and Mental Hygiene Vital Statistics 2013

The mortality breakdown reveals that 72.5 deaths per 10,000 population occur between the ages of 15 and 44 (See Table 16). Within this age group, it is likely or plausible that a percentage of these deaths may be preventable. Further analysis to determine the causes of death among this population could provide additional insight regarding how to best disseminate, distribute and promote health education/information, prevention efforts and awareness on diseases, which could assist those who are vulnerable.

Table 16: Mortality by Age

Age Group	Baltimore City (per 10,000)
Less than 1 year old	12.1
1-14 years old	1.8
15-24 years old	28.9
25-44 years old	43.6
45-64 years old	115.0
65-84 years old	489.9
85 years and up	1,333.3

Source: Neighborhood Health Profiles 2011

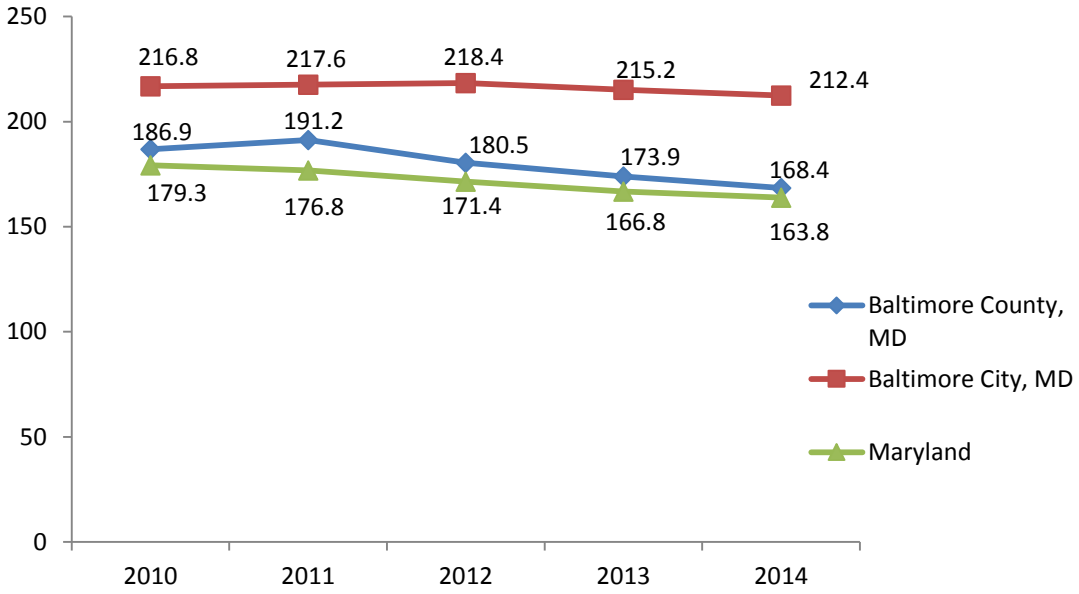
The Centers for Medicare and Medicaid Services reported that there were more residents aged 18 years and older with coronary heart disease or angina who are on Medicare in Baltimore County (30.4 percent) than residents who have the same condition in Baltimore City (28.6 percent), the state (28.5 percent) and the nation (28.6 percent). There were more Baltimore County (62.3 percent) and Baltimore

City residents (62.7 percent) aged 18 and older with high blood pressure on Medicare than the state (59.5 percent) and the nation (55.5 percent) that also had the same condition. Close to one-third of Baltimore City diabetic residents aged 20 and older are on Medicare (31.4 percent).

The rate of residents in Baltimore City from 2010-2014 who visited the emergency room due to their diabetes was much higher than Baltimore County and the state (See Chart 14).

Information gathered related to causes of death, high blood pressure and diabetes, etc. all point towards the need for community action. Education, information and improving access for those in the area can have a significant impact in reducing the chronic conditions of residents.

Chart 14: Emergency Department Visit Rate Due to Diabetes (per 100,000 population)



Source: Maryland State Health Improvement Process 2014

Sexually transmitted diseases (STDs) are significant health issues that are largely preventable. Socioeconomic factors have a direct relationship with how STDs are spread. Racial and ethnic disparities, poverty, drug abusers and access to care are some factors that contribute to the spread of the disease. The Maryland State Health Improvement Process reported from 2011-2013 a 73.8 HIV incidence rate per 100,000 population among Baltimore City residents. This rate is more than double the rate of Marylanders (28.1) and four times the rate of Baltimore County residents (17.8).

Maryland Department of Health and Mental Hygiene Vital Statistics reported in 2013, the HIV death rate per 100,000 in population for black males (13) was ten times higher when compared to white males (1.3).

Baltimore City residents had higher rates of chlamydia, gonorrhea and syphilis when compared to Baltimore County. Baltimore City residents had more than double the cases of chlamydia, more than three times the gonorrhea cases, and more than six times the syphilis cases when compared to Baltimore County (See Table 17).

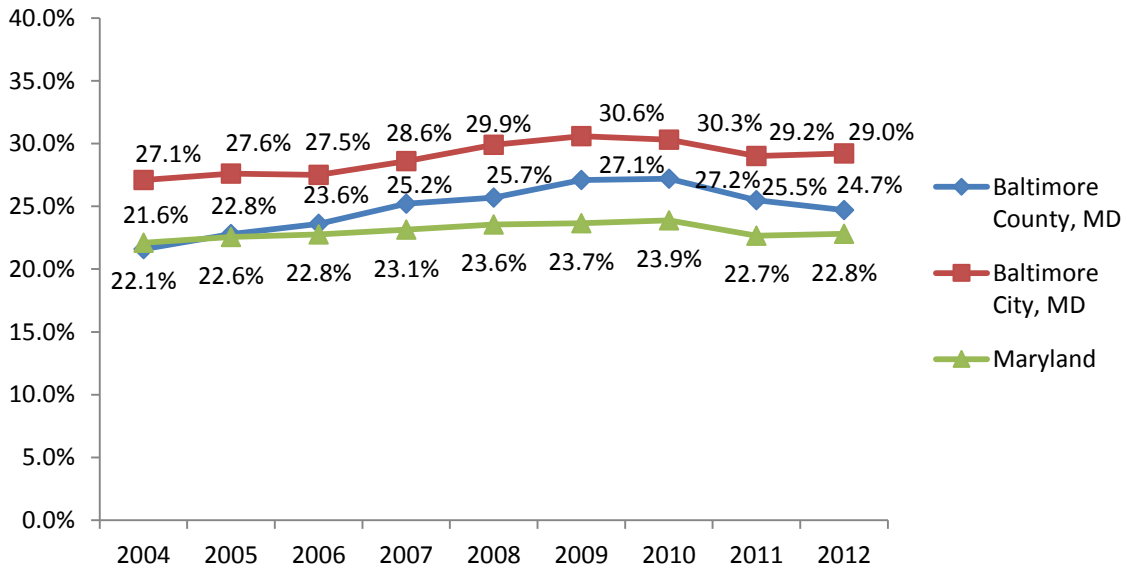
Table 17: Sexually Transmitted Diseases

	Population in 2013	2013 Chlamydia Cases	2013 Gonorrhea Cases	2013 Syphilis (Primary and Secondary) Cases
Baltimore County	823,015	1 in 277	1 in 1,404	1 in 23,515
Baltimore City	622,104	1 in 80	1 in 288	1 in 2,948
Maryland	5,939,000	1 in 222	1 in 922	1 in 13,024

Source: Maryland Dept. of Health and Mental Hygiene; Center for STI Prevention (CSTIP) 2008-2013

The Maryland State Health Improvement Process reported more physically inactive adults aged 20 and older living in Baltimore City when compared to Baltimore County and the state. Both Baltimore City and Baltimore have more adults, aged 20 and older, who are physically inactive compared to the state and the nation beginning in 2005-2012 (See Chart 15).

Chart 15: Physical Inactivity (Percent of Adults Aged 20 and Older Who Are Physically Inactive)



Source: Maryland State Health Improvement Process, 2014

Hand survey results identified more than one-third of survey respondents (40.2 percent) have been told by a health professional that they are overweight or obese. More than one-half of survey respondents (51.5 percent) reported that they have high blood pressure, 22.5 percent have diabetes and 20.6 percent have heart problems. Top health concerns reported by survey respondents include drug and alcohol abuse, affordable housing/homelessness, crime/assault, access to affordable healthy foods, high blood pressure, diabetes, mental health/illness, cancer, obesity/overweight and domestic violence.

Community stakeholders reported lifestyle choices to be a major factor that contributes to the development of chronic diseases. Many cited smoking, obesity, substance abuse, high blood pressure and poor food choices to be underlying causes of chronic diseases in residents. It was noted that more education and information are needed for community residents and patients who have these conditions in order to reduce complications and improve the health of the residents. Some stakeholders reported the lack of available community resources to assist diabetic patients in complying with treatment plans (e.g., diet, weight loss, exercise and medications). Lack of access to affordable healthy food, safe venues for physical exercise, and adequate education and support are major road blocks to many who want to improve their health. Many feel a need for a more concerted effort to make a significant change in the community. Community leaders believed that African Americans and Latinos have the highest rates of cardiovascular disease, and that environmental influences are the main contributors of the disease.

Obesity, according to community stakeholders, has become a community epidemic. While obesity can be considered an intergenerational issue, there are additional contributing factors, for example, the limited availability of fresh healthy foods in the community. Low-income areas are stricken with poverty and regions in the city only have access to fast food. It is understood from community stakeholders that accessibility is an issue, and socioeconomic factors play a significant role in the obesity epidemic.

Information cited from focus group participants also revealed their growing concerns over obesity in the community. The group discussed the role obesity plays in an individual's overall physical health, as well as mental health issues. The lack of accessibility to affordable healthy foods along with limited opportunities for physical fitness contribute to the rise in obesity. The inability to engage in outdoor activities due to factors such as crime and safety pose limited options for residents to engage in exercise. Focus group participants are aware that obesity can lead to diabetes and that exercising and eating healthy can alter and manage the condition. However, not having access to primary care services makes chronic diseases difficult to diagnose, treat and manage.

Focus group attendees are aware of the high rates of African Americans who have diabetes and many cite cultural eating habits, the lack of quality grocery stores (living in a food desert) and the affordability of healthy foods as being underlying factors, which contribute to the high rates of diabetes in their community.

Chronic diseases can be managed and many are preventable; however, generational attitudes along with the ability to obtain necessary health care services need to be addressed in order to allow community residents the opportunity to live a healthier life.

Conclusions and Recommendations

With the completion of the 2015 CHNA, JHH and JHBMC will develop goals and strategies for the CHNA implementation phase. In this phase, the health institutions will leverage their strengths, resources and outreach to help community partners best identify ways to address their communities' health needs; thus improving overall health and addressing the critical health issues and well-being of residents in their communities. The community health needs assessment and implementation planning builds on the previous 2013 CHNA assessment and planning reports. The comprehensive CHNA addressed who was involved, what, where and why; while the implementation planning phase will address the how and when JHH and JHBMC will address the identified community health needs.

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center, partnering with community organizations and regional partners, understand that the CHNA document is not the last step in the assessment phase, but rather the first step in an ongoing evaluation process. Communication and continuous planning efforts are vital throughout the next phase of the CHNA. Information regarding the CHNA findings will be important to residents, community groups, leaders and other organizations that seek to better understand the health needs of the communities surrounding JHH and JHBMC and how to best serve their needs.

In the assessment process, common themes and issues rose to the top as each project component was completed. The data collected from the overall assessment included feedback and input from community leaders, and hard-to-reach, underserved and vulnerable populations. The information collected provides JHH and JHBMC with a framework to begin evaluating, identifying and addressing gaps in services and care, which will ultimately alleviate challenges for individuals living in the community.

Solidifying and reinforcing existing relationships and creating new relationships must be paramount in order to address the needs of community residents. Expanding and creating new partnerships with multiple regional entities is vital to developing community-based strategies to tackle the region's key community health needs.

The key community health needs identified by JHH and JHBMC include Improving Socioeconomic Factors (Education and Employment), Access to Livable Environments (Housing, Food Environment, Crime and Safety), Access to Behavioral Health Services (Mental Health and Substance Abuse), and Access to Health Services (Dental Services, Uninsured and Chronic Diseases).

The collection and analysis of primary and secondary data provided the working group with an abundance of information, which enabled the group to identify key health services gaps. Collaborating with local, regional, statewide and national partners, JHH and JHBMC understand the CHNA is one component to creating strategies to improve the health and well-being of community residents.

Implementation strategies took into consideration the higher need areas that exist in regions that have greater difficulties in obtaining and accessing services.

Action Steps:

- Communicate the results of the CHNA process to staff, providers, leadership, boards, community stakeholders and the community as a whole.
- Use the inventory of available resources in the community in order to explore further partnerships and collaborations.
- Implement a comprehensive grassroots community engagement strategy to build upon the resources that already exist in the community, including committed community leaders that have been engaged in the CHNA process.
- Develop working groups to focus on specific strategies to address the top identified needs of the communities in which the health system serves and develop a comprehensive implementation plan.
- Involve key community stakeholders to participate or be involved with working groups who will strategically address and provide expert knowledge on ways to address key community health needs.

Implementation Strategy Introduction

The CHNA is a report based on epidemiological, qualitative and comparative methods that assesses the health issues in a hospital organization's community and that community's access to services related to those issues. The Implementation Strategy is a list of specific actions and goals that demonstrate how The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center plan to meet the CHNA-identified health needs of the residents in the communities surrounding the hospital, i.e. the Community Benefit Service Area (CBSA). This Implementation Strategy was approved by the hospitals' Boards of Trustees.

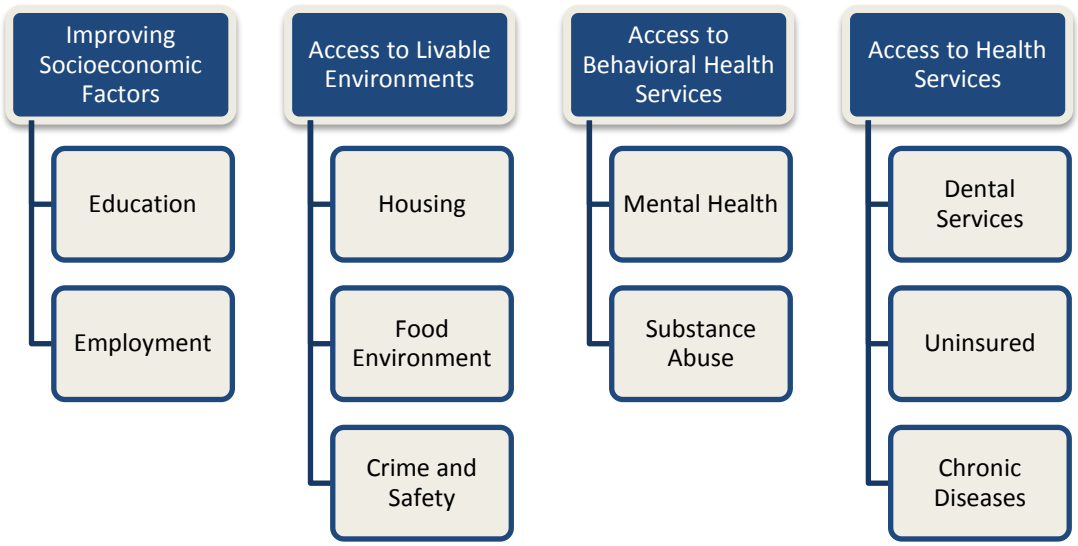
IRS Requirements – Implementation Strategy

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

Health Priorities

As noted in the CHNA, four key need areas were identified through the gathering of primary and secondary data from local, state and national resources, community stakeholder interviews, hand-distributed surveys, focus groups with vulnerable populations, a community forum and a health provider inventory (highlighting organizations and agencies that serve the community). The identified community needs are depicted in order of priority in the graph below (See Graph 1). The Implementation Strategy items which follow, provide action plan strategies that address the identified needs.

Graph 1: Key Community Health Needs



HEALTH NEED #1 Improving Socioeconomic Factors

HEALTH NEED 1A: EDUCATION			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/External Organizations**
GOAL: Improve the health and well-being of our youth.	**Strategy 1**: Support youth mentoring	• Increase number of participants enrolled in mentoring programs • Establish evaluation of program success and participant satisfaction via survey methodology	• Baltimore City Community College (BCCC) • State of MD • Dunbar HS / Baltimore City Public Schools (BCPS) • Project REACH • Institute of Notre Dame (JH Sponsored internships) • Henderson-Hopkins School • Other Mentoring program partnerships: ➢ Creative Alliance ➢ MERIT (SOM) ➢ THREAD
	Strategy 2: Increase child participation in Early Childhood Education and integrate health services into schools	• Increase number of children enrolled in early childhood programs	• Weinberg Early Childhood Center • Rales Health Center at the KIPP School with comprehensive school health • Southeast Community Development Corp (SECDC) – Community School Coordinator Program • Headstart

HEALTH NEED 1B: EMPLOYMENT			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/External Organizations**
GOAL: Increase employment opportunities to local and minority communities.	**Strategy 1**: Improve career development among youth	• Increase number of youth participating in career development programs and/or number of programs available	• CBSA schools • Historic East Baltimore Community Action Coalition (HEBCAC) • Civic Works
	Strategy 2: Create new employment opportunities for local communities and minorities; increase youth and adult workforce training programs	• Increase number of new employees hired living within CBSA • Increase job opportunities for residents in the CBSA • Increase number of participants in workforce coaching and training programs	• EB Jobs HUB • Historic East Baltimore Community Action Coalition (HEBCAC) • Hospital Employment Program • BUILD • Center for Urban Families • Men & Families Center • Biotechnical Institute - Lab Associates Program • Supply Chain Academy
	Strategy 3: Support/Contract with local and minority vendors to improve the local economy	• Increase number of contracts with local vendors • Increase amount spent with local and minority contractors	• Minority Contractors Associations • East Baltimore Jobs Hub

HEALTH NEED #2. Access to Livable Environments

HEALTH NEED 2A: HOUSING			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/External Organizations**
GOAL: Increase access to housing and healthy homes in the CBSA	**Strategy 1:** Expand capacity to identify housing issues among low-income, uninsured, and homeless residents including challenges related to asthma triggers and lead among children	• Number of Neighborhood Navigator encounters addressing housing issues • Number of Health Leads connections to housing resources • Increase screening rates for lead poisoning	• Health Leads • Green & Healthy Homes Initiative • Helping Up Mission • BCHD Asthma Program
	Strategy 2: Provide social support services to low-income, uninsured and homeless residents including improving homelessness initiatives	• Increase number of low- income, underinsured, and homeless screened for social determinants and connected to services • Number of transition housing slots	• Men & Families Center • Helping Up Mission • Center for Urban Families • Southeast Community Development Corp (SECDC) • United Way 211 • Health Leads • Healthcare for the Homeless • Homeless Connect

HEALTH NEED 2B: FOOD ENVIRONMENT ACCESS/NUTRITION/PHYSICAL ACTIVITY			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/External Organizations**
GOAL: Improve access to healthy food and healthy behaviors among youth and adults.	**Strategy 1**: Expand program education on healthy eating and health practices	• Increase number of participants in workshops on healthy meal planning and preparation • Aggregate improvement in knowledge via pre and post assessments and teacher evaluations	• American Heart Assoc./ Community Kitchen • American Diabetes Assoc • East Baltimore Health Fairs • MD Food Bank Culinary Kitchen • Amazing Grace Lutheran Church • American Institute of Food and Wine (Days of Taste) • Rales Health Center at KIPP school
	Strategy 2: Support programs that improve access to healthy foods for low income families	• Increase number of participating food pantries in churches and community organizations • Number of healthy food and nutrition programs/participants	• MD Food Bank • Meals on Wheels • Community Food pantries • JHM Community Farmers' Market • Faith communities • Amazing Grace Lutheran Church
	Strategy 3: Increase physical activity among adults and youth	• Number of youth and adults who are physically active • Increase number of community and school-based partners	• Youth organizations, schools, and churches • Playworks (Baltimore City Youth Program) • Rales Health Center at KIPP school

HEALTH NEED 2C: CRIME AND SAFETY			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/External Organizations**
GOAL: Enhance neighbor-hood safety.	**Strategy 1**: Establish safe haven facilities for after school programs, summer camps and neighborhood youth recreation programs	• Increase number of programs/participants involved • Increase number of community organizations involved	• Henderson-Hopkins School • Baltimore City Dept. of Parks & Recreation • Baltimore City/County Public Schools • Dundalk Youth Services Center • Youth orgs and churches • Mary Harvin Transformation Center • Living Classrooms • Port Street Center • Rales Health Center at KIPP schools
	Strategy 2: Establish safety education sessions and intervention programs	• Number of people counseled	• Baltimore City and County Police Departments • Operation PULSE (People United to Live in a Safe Environment) • CURE (Clergy United for Renewal in East Baltimore) • Men and Families Center • Baltimore City and County Fire Departments • Saftety Center in Harriet Lane Clinic and the JH Children's Center

HEALTH NEED #3. Access to Behavioral Health Services

HEALTH NEED 3A: MENTAL HEALTH			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/ External Organizations**
Goal: Improve access to mental health and behavioral health services.	**Strategy 1**: Provide individual, group, family therapy, medication treatment, and other mental health services, as well as prevention interventions	• Number of schools participating in program • Number of children who receive services • Number of adults who receive services	• Baltimore City and County School Districts • Head Start Programs • Judy Center at Commodore John Rogers school • Stulman Foundation/Baltimore Community Foundation • After Care Clinic • Mary Harvin Transformation Center • Rales Health Center at KIPP school
	Strategy 2: Develop program(s) to support ED patients waiting for outpatient mental health and/or substance use disorder treatment	• Number of patients served by the Bridge Program • Number of patients serviced by ED-based Community Health Workers	• HSCRC Regional Partnership

HEALTH NEED 3B: SUBSTANCE ABUSE (SA)			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/External Organizations**
Goal: Improve access to available substance abuse (SA) services.	**Strategy 1:** Expand outpatient treatment for homeless men needing SA services	• Number of outpatient treatment slots	• Helping Up Mission
	Strategy 2: Provide substance abuse and mental health services to pregnant women with active substance use disorders	• Number of pregnant women served for substance abuse and or mental health services • Number of pregnant ED patients connected to substance abuse services	
	Strategy 3: Provide addiction treatment services to address opioid addiction in local community	• Number of patient visits per year	• East Baltimore Medical Center • Broadway Center for Addictions

HEALTH NEED #4 Access to Health Services

HEALTH NEED 4A: DENTAL SERVICES			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/External Organizations**
Goal: Increase access to dental care services for uninsured patients.	**Strategy 1:** Increase network of dental providers serving uninsured/underinsured patients accepting referrals from JH facilities	• Increase number of dentists/providers involved • Increased referrals for dental health screenings and preventive maintenance	• Baltimore Medical System - BMSI • Chase Brexton • Univ of MD dental school • BCCC dental hygiene program • United Way 211 • Esperanza Center • Healthcare for the Homeless • Baltimore City Health Dept (BCHD) • Baltimore VA Medical Center • Rales Center at KIPP School
	Strategy 2: Provide dental health education outreach	• Increased availability and distribution of dental care education materials	• Community orgs • Center for Urban Environmental Health • UMD dental school

HEALTH NEED 4B: UNINSURED CARE			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/External Organizations**
Goal: Improve access to healthcare services for uninsured and underinsured residents across JHH/ JHBMC CBSA.	**Strategy 1:** Connect uninsured residents into private insurance, Medicaid, or other available coverage	• Number of residents enrolled • Number of resources available to assist with identifying coverage and enrollment	• Esperanza Center • HealthCare for the Homeless • Centro Sol • Charm City Clinic • Care-A-Van
	Strategy 2: Reduce transportation barriers and enhance awareness of available services	• Number of transportation vouchers • Resource information distribution	• Baltimore Transit Service • Esperanza Center • Elder Plus • Care-A-Van
	Strategy 3: Provide annual training for all JHH/JHBMC medical staff on accessing and utilizing interpretive services	• Number of medical staff completing interpretive service training • Number of house staff participating in interpreter testing	

HEALTH NEED 4C: CHRONIC DISEASE			
Goal	**Strategies**	**Metrics/What we are measuring**	**Potential Partnering/External Organizations**
Goal: Share clinical expertise with community organizations to prevent, detect, and manage chronic diseases.	**Strategy 1:** Work with community organizations, congregational health networks and individuals to improve care, awareness, management and promote prevention of chronic diseases	• Increase number of health education/outreach encounters provided to community- based organizations and churches • Number of participants in health events and number of screenings performed • Number of vision screenings- (retinopathy, glaucoma, vision testing in schools etc.) • Expand programing at the JHOC Diabetes Center	• Area schools • Faith based organizations • Community meetings • BCHD • Comiendo Juntos • Isaiah Wellness Center • Mary Harvin Transformation Center • Vision to Learn Program • Centro Sol • After Care Clinic • Rales Health Center at KIPP school
	Strategy 2: Support patients with chronic conditions during transitions and in accessing resources to reduce barriers to patient engagement (i.e. social determinants)	• Number of patients seen in the After Care Clinic at JHH • Number of patients connected to services addressing social determinants • Increase transition support home care services available to patients with chronic conditions	• Health Leads • Men and Families Center • Sisters Together And Reaching • Visiting Nurses • After Care Clinic

Note: For more information on community benefit programs and support please see the annual Community Benefit Report for each hospital available at http://web.jhu.edu/administration/gca/CHNA

Appendix A: Primary Data

Primary Data

Process Overview

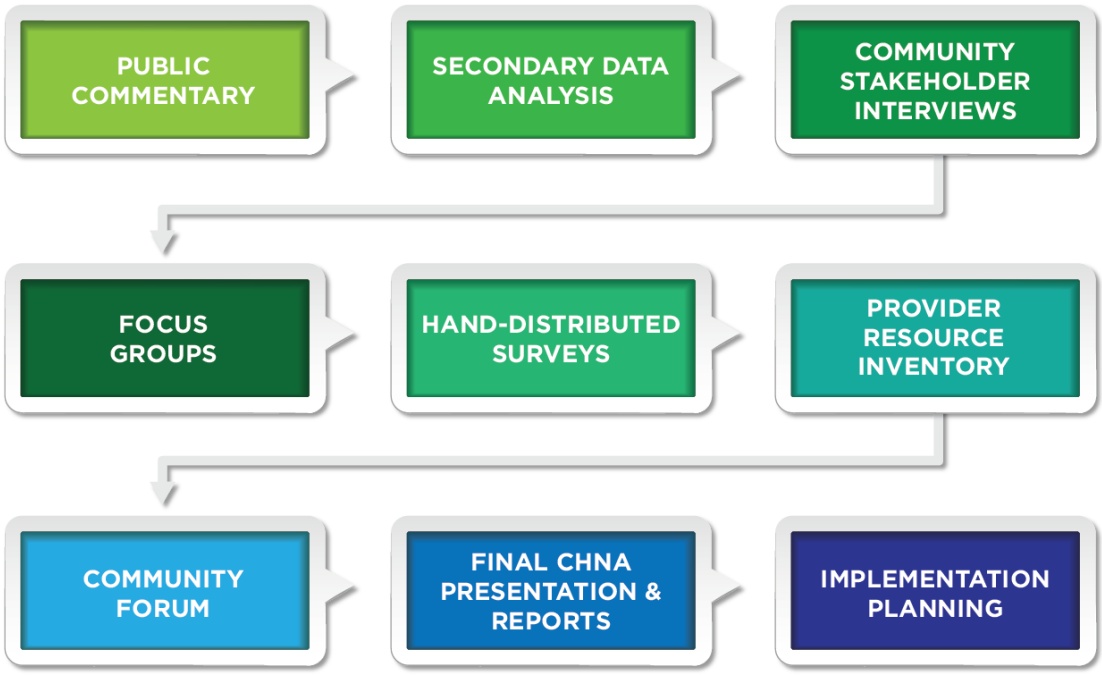
A comprehensive community-wide CHNA process was completed for The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC), connecting public and private organizations, such as health and human service entities, government officials, faith-based organizations and educational institutions to evaluate the needs of the community. The 2015 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. The Johns Hopkins leadership will develop an Implementation Strategy that will highlight, discuss and identify ways the health system will meet the needs of the communities they serve.

Tripp Umbach worked closely with JHH and JHBMC to collect, analyze, review and discuss the results of the CHNA, culminating in the identification and prioritization of the community's needs at the local level.

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

Flow Chart 2: CHNA Process



PUBLIC COMMENTARY

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.

Public Comments:

- Close to three-fourths of survey respondents (71.4 percent) reviewed the CHNA and Implementation Plan for JHBMC; while the remaining 28.6 percent reviewed the CHNA and Implementation Plan for JHH.
- When asked if the assessment "included input from community members or organizations" 90.5 percent of survey commenters reported that it did. 4.8 percent reported that it did not and the remaining 4.8 percent did not know.
- More than one-half of survey respondents (66.7 percent) reported that the assessment that was reviewed did not exclude any community members or organizations that should have been involved in the assessment; while 28.6 percent did not know and 4.8 percent reported that a community member/organization was excluded. The community organizations that the survey respondent identified as being excluded from the assessment included Helping Up Mission and Powell Recovery.
- In response to the question "Are there needs in the community related to health (e.g., physical health, mental health, medical services, dental services, etc.) that were not represented in the CHNA"; 47.6 percent of commenters indicated community needs related to health were represented and 28.6 percent did not know. However, five respondents (23.8 percent) reported that cardiac, childcare for working parents, diabetes, addiction treatment services and senior needs/barriers were not covered in the previous CHNA.
- The specific populations who experienced needs/barriers related to health were residents with addictions (especially dual diagnosis) (4.8 percent), seniors (9.5 percent), the working population (4.8 percent) and African Americans (4.8 percent).

- A majority of survey respondents (85 percent) indicated that the Implementation Plan was directly related to the needs identified in the CHNA.

According to respondents, the CHNA and the Implementation Plan benefited them and their community in the following manner (in no specific order):

- Meeting the IRS's criteria.
- Unsure if new initiatives in substance abuse were introduced.
- The CHNA provided various ongoing needs of the community and solutions to address them.
- Brought blood pressure awareness.
- Kept me in tune with body needs and health plans.
- The CHNA compiles a lot of excellent information focused on the local community. It is a tool that helps the hospital develop a structured way to track and measure impact.

Additional feedback on the CHNA/Implementation Plan (in no specific order):

- The need for more community awareness of free programs and volunteer awareness.
- JHBMC should look at community-based substance abuse programs off campus.
- Our center provides many health programs.

COMMUNITY STAKEHOLDER INTERVIEWS

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.

Tripp Umbach worked closely with the Johns Hopkins Institutions to identify community stakeholders. A letter was mailed, along with a follow-up email to community stakeholders, to introduce Tripp Umbach and define the stakeholders' roles in the CHNA process. The letter also introduced the project and conveyed the importance of the CHNA to the community. Each interview was conducted by a Tripp Umbach consultant and was approximately 30 to 60 minutes in duration. The interviews provided a platform for stakeholders to identify health issues and concerns affecting residents in their service area, as well as ways to address those concerns.

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.

The common themes from the stakeholder interviews were (in no particular order):

1) Environment (the economy, housing, educational, employment availability, crime/safety issues and parks/recreation)
2) Health Services (access)
3) Health Issues (mental health, chronic diseases)
4) Barriers to Health (employment, environment, transportation, physical inactivity and lack of grocery stores)
5) Populations/Residents (children, seniors, African-Americans, Latinos/Hispanics)

FOCUS GROUPS

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

The number of focus group participants ranged from nine to 15 attendees, with each focus group lasting roughly 1.5 hours. The total number of participants for all six focus groups was 83. Demographic information on focus group attendees is available in the Focus Group Report.

The common themes from the focus group audiences were (in no particular order):

1) Asthma
2) Children's health
3) Chronic diseases
4) Crime and safety
5) Dental health
6) Food environment
7) Health disparities
8) Mental health
9) Physical inactivity
10) Substance abuse
11) Sexually transmitted infections

The table below lists the focus group audiences and the locations where each group was conducted (See Table 18).

Table 18: Focus Group Audiences

FOCUS GROUP AUDIENCE:	LOCATION OF THE EVENT:
Providers who have access to "at risk-kids"[7] Number of Attendees: 9	Henderson-Hopkins
Ex-offenders Number of Attendees: 15	Men & Families Center
Latinos/Spanish-Speaking Number of Attendees: 15	Sacred Heart Church
Seniors in Baltimore County Number of Attendees: 15	Edgemere Senior Center
Seniors in East Baltimore City Number of Attendees: 14	Parkview Ashland Terrace
Substance Abusers/Recovering Addicts Number of Attendees: 15	Center for Urban Families

HAND-DISTRIBUTED SURVEYS

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

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

In total, 648 were used for analysis; 619 surveys were collected in English and 29 surveys were collected in Spanish. The information below represented key survey findings collected from the hand-distributed survey.

Methodology:

- A hand-distributed survey methodology was employed to collect input from populations in East Baltimore City and parts of southeast Baltimore County in order to identify health risk factors and health needs in the community. Hand surveys were collected in the ZIP codes that represent the Johns Hopkins Institutions' CBSA.

[7] An "at-risk child" was defined as a child under the age of 18 years old, who lives in a family whose income is below the poverty line, are/were exposed to an abusive environment/violence, have environmental health problems, have an unplanned pregnancy, or a sexually transmitted infection.

- Working through community-based organizations, community associations, faith-based organizations and FQHCs/clinics, hundreds of hand surveys were collected from residents within the CBSA.
- Community-based organizations encouraged participants to fill out the survey upon entry to their facility, while waiting in the lobby, cafeteria, meetings and or attending classes at their organizations. Engagement of local community organizations was vital in the distribution process. The information collected from the hand surveys is representative of residents who use and obtain services from community-based organizations.
    - Tripp Umbach provided assistance to community organizations in the distribution of the hand survey, as requested.
- Hard copies of the hand survey were mailed to community-based organizations and returned to Tripp Umbach for input and analysis.

Key Findings:

- More than one-half of survey respondents (67.5 percent total) reported that their health was either excellent or good.
- More than three-fourths of survey respondents have a primary care physician (87.9 percent).
- Survey respondents are likely to receive medical care at a doctor's office (48.5 percent), a clinic (37.2 percent) or emergency room (6.8 percent).
- More than three-fourths of survey respondents (86.7 percent) had an appointment with their physician within the past year.
- More than three-fourths of survey respondents have health insurance (89.5 percent).
- More than one-half of survey respondents seek dental care at a dentist's office (58.2 percent).
- Slightly less than one-half of survey respondents had an appointment with a dentist or dental clinic within the past year (48.6 percent).
- More than one-third of survey respondents have been told by a health professional that they are overweight or obese (40.2 percent) and about one-half of survey respondents have high blood pressure (51.5 percent).
- Slightly less than one-fourth of survey respondents have been told that they have diabetes (22.5 percent) or heart problems (20.6 percent).
- Slightly more than one-fourth of survey respondents have a physical ailment that affects their daily activities (26.2 percent); while 20.3 percent have a mental/emotional ailment that affects their daily activities.
- 52.2 percent of survey respondents 'always get a flu shot once a year', 49.6 percent of respondents 'always feel satisfied with life' and 33.3 percent 'always get 6-8 hours of sleep a night'.

- ‘Word-of-mouth’ (20.6 percent) and TV (19.3 percent) were the most reported avenue in how survey respondents obtained information in their community.
- ‘Public transportation’ (37.1 percent) and survey respondents’ ‘own car’ (35.4 percent) were the main forms of transportation.
- More than one-half of survey respondents feel ‘somewhat safe’ from crime in their neighborhood/community (62 percent). Crime (25.3 percent), violence (24.2 percent) and drugs (23.7 percent) were the top three reasons why survey respondents did not feel safe in their neighborhood/community.
- Drug and alcohol use/addiction (11.5 percent), affordable housing/homelessness (9.2 percent) and crime/assault (8.4 percent) were the top health concerns reported by survey respondents.
- More than one-fourth of survey respondents were depressed (29.9 percent) or had problems remembering things or concentrating (25.1 percent); and 23.2 percent had anxiety, nervousness, or panic attacks.
- More than one-third of survey respondents received mental health services in the past 12 months (36 percent).
- 16 percent of survey respondents needed but did not receive mental health services in the past 12 months (16 percent).

PROVIDER RESOURCE INVENTORY

An inventory of programs and services available in the region was developed by Tripp Umbach. The provider inventory highlights available programs and services within JHH and JHBMC’s CBSA. The inventory identifies the range of organizations and agencies in the community that are serving the various target populations within each of the priority needs. The inventory provides program descriptions and collects information about the potential for coordinating community activities and creating linkages among agencies.

An interactive link of the provider resource inventory will be made available on JHH’s and JHBMC’s website.

COMMUNITY FORUMS

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 were privy to all data collected throughout the comprehensive CHNA process. Forum participants were community stakeholders who were interviewed, sponsored and recruited participants for the focus groups, and/or were instrumental in the hand-distributed survey process. Most importantly, forum participants provided critical feedback and prioritized key need areas for the CHNA.

At the community forum, Tripp Umbach presented results from secondary data analysis, community leader interviews, hand surveys and focus group results and used these findings to engage community participants in a group discussion. Upon review of primary and secondary data, participants broke into four groups to determine and identify issues that were most important to address in their community. Finally, the breakout groups were charged with 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).

The following list identifies prioritized community health needs based upon input collected from forum participants. They are listed in order of mention.[8]

Prioritized Key Community Needs:

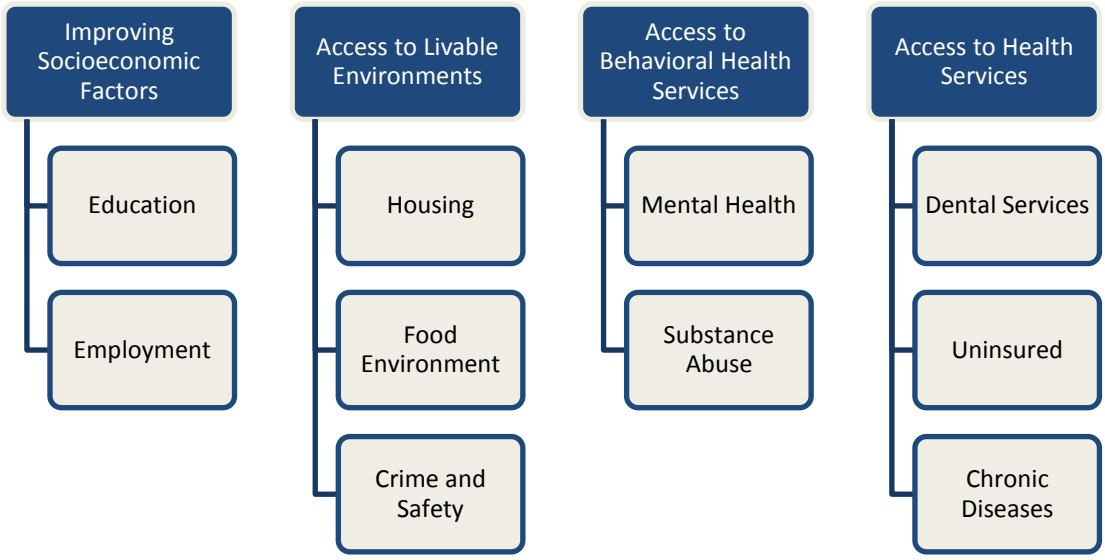
Education (4)
Employment (4)
Housing (3)
Mental health (2)
Food environment (2)
Substance abuse (2)
Crime and safety (1)
Health care/access (1)
Dental health (1)

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 Executive Planning Committee, community leaders, community residents, project leadership and extensive primary and secondary data research, four CBSA priorities were identified. Tripp Umbach categorized and grouped the key community needs into broader areas taking 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 2015 CHNA are aligned and merged with the previous CHNA needs and are depicted in the chart below (See Graph 2). All identified key community needs were addressed either directly through designation as a prioritized key community need or incorporated as a component of a prioritized key community need.

[8] 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).

Graph 2: Key Community Health Needs



IMPLEMENTATION PLANNING

With the completion of the community health needs assessment, an implementation phase began with the onset of work sessions facilitated by Tripp Umbach. The work sessions maximized system cohesion and synergies. The planning process ultimately resulted in the development of an implementation plan that meets system and IRS standards.

BOARD OF TRUSTEE APPROVALS

The CHNA and Implementation Strategy were presented to and approved by the Board of Trustees of the Johns Hopkins Hospital on June 10, 2016 and The Board of Trustees of Johns Hopkins Bayview Medical Center on May 23, 2016.

Appendix B: Truven Health Analytics

Truven Health Analytics: Community Needs Index (CNI) Overview

Not-for-profit and community-based health systems have long considered a community's needs to be a core component of their mission of service to local communities. While specific initiatives designed to address health disparities vary across local communities (e.g., outreach to migrant farm workers, asthma programs for inner city children, etc.), the need to prioritize and effectively distribute hospital resources is a common thread among all providers.

Given the increased transparency of hospital operations (quality report cards, financial disclosures, etc.), community benefit efforts need to become increasingly strategic and targeted in order to illustrate to a variety of audiences how specific programs have been designed and developed. While local community needs assessments will always play a central role in this process, they are often voluminous, difficult to communicate, and may lack necessary qualitative and statistical justification for choosing specific communities as having the "greatest need."

Because of such challenges, Dignity Health and Truven Health jointly developed a Community Need Index (CNI) in 2004 to assist in the process of gathering vital socioeconomic factors in the community. The CNI is strongly linked to variations in community health care needs and is a strong indicator of a community's demand for various health care services.

Based on a wide array of demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. The CNI should be shared with community partners and used to justify grants or resource allocations for community initiatives.

Methodology

The CNI score is an average of five different barrier scores that measure various socioeconomic indicators of each community using the source data. The five barriers are listed below, along with the individual statistics that are analyzed for each barrier. The following barriers, and the statistics that comprise them, were carefully chosen and tested individually by both Dignity Health and Truven Health:

1. Income Barrier

- Percentage of households below poverty line, with head of household aged 65 or older
- Percentage of families, with children under age 18, below poverty line
- Percentage of single female-headed families, with children under age 18, below poverty line

2. Cultural Barrier

- Percentage of population that is a minority (including Hispanic ethnicity)
- Percentage of population, over age 5, that speaks English poorly or not at all

3. Education Barrier

- Percentage of population, over age 25, without a high school diploma

4. Insurance Barrier

- Percentage of population in the labor force, age 16 or older, without employment
- Percentage of population without health insurance

5. Housing Barrier

- Percentage of households renting their home

Every populated ZIP code in the United States is assigned a barrier score of 1,2,3,4, or 5 depending upon the ZIP national rank (quintile). A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally. For example, ZIP codes that score a 1 for the Education Barrier contain highly educated populations; ZIP codes with a score of 5 have a very small percentage of high school graduates.

For the two barriers with only one statistic each (education and housing), Truven Health used only the single statistic listed to calculate the barrier score. For the three barriers with more than one component statistic (income, cultural and insurance), Truven Health analyzed the variation and contribution of each statistic for its barrier; Truven Health then weighted each component statistic appropriately when calculating the barrier score.

Once each ZIP code is assigned its barrier scores from 1 to 5, all five barrier scores for each ZIP code are averaged together to yield the CNI score. Each of the five barrier scores receives equal weight (20 percent each) in the CNI score. An overall score of 1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need.

Data Sources

- 2014 Demographic Data, The Nielsen Company
- 2014 Poverty Data, The Nielsen Company
- 2014 Insurance Coverage Estimates, Truven Health Analytics

Applications and Caveats

- CNI scores are not calculated for non-populated ZIP codes. These include such areas as national parks, public spaces, post office boxes and large unoccupied buildings.
- CNI scores for ZIP codes with small populations (especially less than 100 people) may be less accurate. This is due to the fact that the sample of respondents to the 2010 census is too small to provide accurate statistics for such ZIP codes.

Appendix C: Secondary Data Profile

Secondary Data Profile

Tripp Umbach collected and analyzed secondary data from multiple sources, including Community Commons, County Health Rankings, Maryland Department of Health and Mental Hygiene Vital Statistics, Maryland Health Services Cost Review Commission (HSCRC), Neighborhood Health Profiles, Substance Abuse and Mental Health Services Administration, The Annie E. Casey Foundation, The Centers for Disease Prevention and Control (CDC) and Truven Health Analytics, etc.

The secondary data profile includes information from multiple health, social and demographics sources. Tripp Umbach used secondary data sources to compile information related to disease prevalence, socioeconomic factors and behavioral habits. Where applicable, data were benchmarked against state and national trends. ZIP code analysis was also completed to illustrate community health needs at the local level.

The information provided in the secondary data profile does not replace existing local, regional and national sites but rather provides a comprehensive (but not all-inclusive) overview that complements and highlights existing and changing health and social behaviors of community residents for the health system, social and community health organizations involved in the CHNA. A robust secondary data report was compiled for JHH and JHBMC; select information collected from the report has been presented throughout the CHNA. Data specifically related to the identified needs were used to support the key health needs.

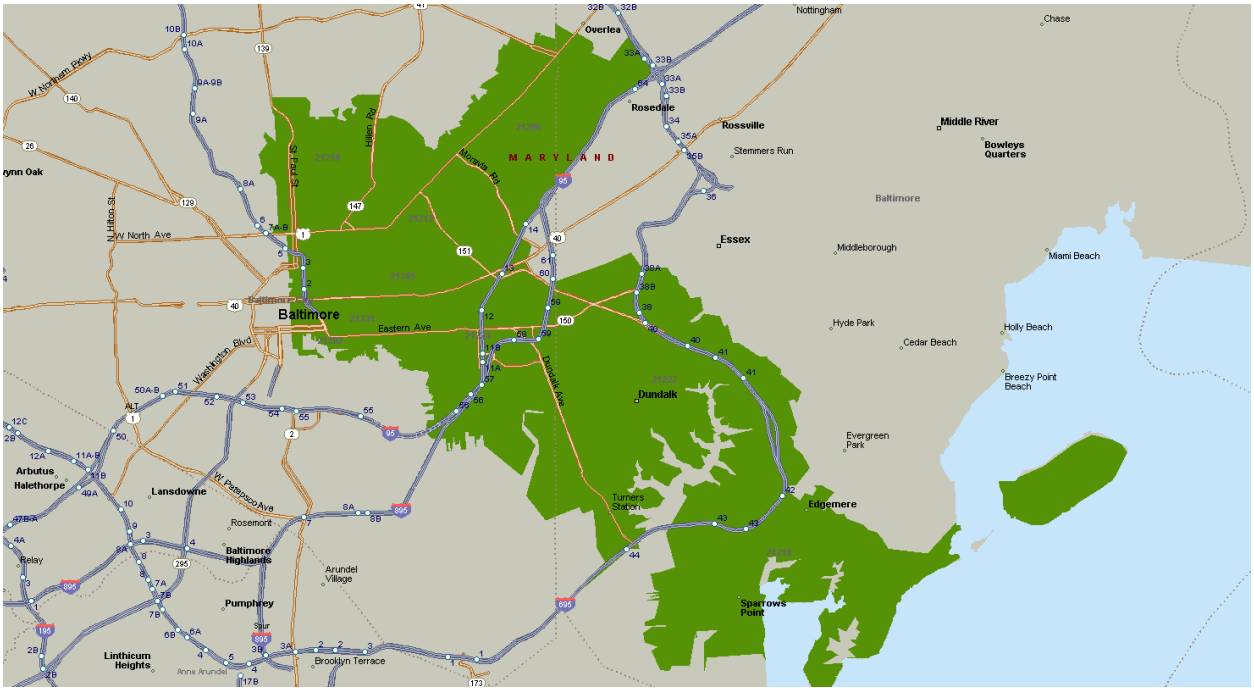
Tripp Umbach obtained data through Truven Health Analytics (formerly known as Thomson Reuters) to quantify the severity of health disparities for ZIP codes in The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center's community-benefit service area. Truven Health Analytics provides data and analytics to hospitals, health systems and health-supported agencies.

The Community Need Index (CNI) data source was also used in the health assessment. CNI considers multiple factors that are known to limit health care access; the tool is useful in identifying and addressing the disproportionate and unmet health-related needs of neighborhoods. The five prominent socioeconomic barriers to community health quantified in the CNI are Income Barriers, Cultural/Language Barriers, Educational Barriers, Insurance Barriers and Housing Barriers. Additional information related to CNI can be found in Appendix B.

In 2015, a total of nine ZIP codes were analyzed for the Johns Hopkins Institutions. These ZIP codes represent the community served by The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center as portions of the health institutions' community-benefits service areas. The Johns Hopkins Institutions provides services to communities throughout Maryland, adjoining states and internationally. The community health assessment focused on these nine specific ZIP codes which fell into Baltimore City and parts of Baltimore County. They included 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224 and 21231.

The following map geographically depicts the community benefits service area by showing the communities that are shaded. The CBSA encompasses nine ZIP codes across east and southeast Baltimore City and county (See Map 3).

Map 3: Overall Community Benefits Service Area – 2015 Study Area Map



Source: Truven Health Analytics 2015

Table 19: Community Needs Index Overall Study Area Summary

	2015 Population	Poverty 65 years +	Poverty Child	Single w/ Children Poverty	Limited English	Minority	No High School Diploma	Unemployment	Uninsured	Rent	Income Rank	Cultural Rank	Education Rank	Insurance Rank	House Rank	2014 CNI Score*	2015 CNI Score *	CNI Score Change
Overall Study Area	304,276	18.55%	28.32%	40.82%	2.98%	58.62%	20.72%	14.52%	11.19%	46.57%	3	5	4	4	5	4.2	4.3	+0.1

Source: Truven Health Analytics 2015 **Weighted average of total market*

Community Needs Index Overall Study Area Summary (See Table 19)

- CNI analysis for the CBSA encompassed nine ZIP codes in the 2015 CHNA study. They include 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224 and 21231.
- The median score for the CBSA is 3.0.

- The CNI score for the CBSA in 2014 was 4.2.*
- The CNI score for the CBSA in 2015 was 4.3.*
    - ➢ This is an increase of +0.1 from 2014 to 2015; indicating that the overall CBSA faces increased barriers to accessing care.

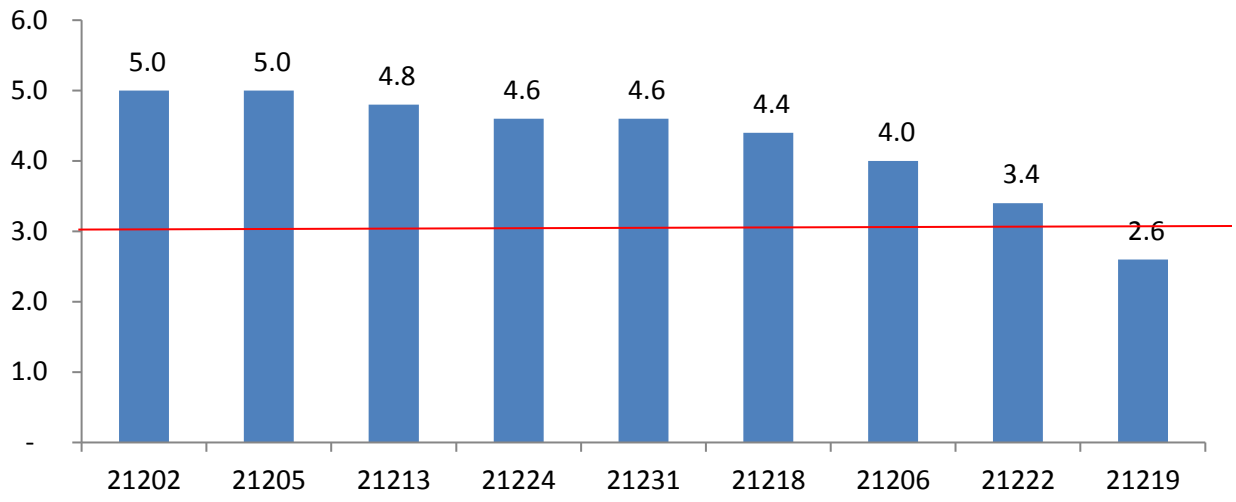
Table 20: CBSA Community Needs Index ZIP Codes and Scores: Specific Data and Measures

Zip	2015 Population	Poverty 65+	Poverty Children	Poverty Single w/kids	Limited English	Minority	No H/S Diploma	Unemployed	Uninsured	Rent	House	Income	Culture	Education	Insurance Rank	Housing	2015 CNI Score
21202	23,812	33.00%	47.07%	57.42%	1.13%	70.41%	23.04%	15.72%	18.18%	78.29%	5	5	5	5	5	5	5.0
21205	16,300	30.63%	46.69%	55.48%	3.88%	83.52%	36.55%	26.34%	17.85%	60.52%	5	5	5	5	5	5	5.0
21206	50,347	12.66%	20.19%	28.69%	1.60%	77.37%	15.23%	12.98%	9.26%	39.80%	5	2	5	4	4	5	4.0
21213	32,146	23.72%	30.38%	42.37%	1.08%	93.94%	23.55%	21.26%	14.10%	43.05%	5	4	5	5	5	5	4.8
21218	48,890	22.22%	23.90%	36.41%	0.72%	72.89%	17.43%	14.69%	13.40%	55.22%	5	3	5	4	5	5	4.4
21219	9,743	8.67%	13.01%	24.48%	0.54%	7.64%	17.19%	10.62%	6.46%	18.64%	2	2	2	4	3	2	2.6
21222	56,953	11.38%	20.30%	30.65%	1.69%	23.65%	19.13%	12.99%	6.93%	33.58%	4	2	4	4	3	4	3.4
21224	50,053	13.67%	30.85%	49.26%	9.79%	42.81%	25.12%	10.76%	9.23%	42.36%	5	4	5	5	4	5	4.6
21231	16,032	28.51%	46.54%	69.38%	4.66%	47.11%	16.73%	11.08%	11.73%	63.48%	5	5	5	4	4	5	4.6

Source: Truven Health Analytics 2015

- ZIP codes 21202 and 21205 had a 2015 CNI score of 5.0, which indicates individuals in these ZIP codes have greater barriers to accessing health care.
- ZIP code 21219 had a 2015 CNI score of 2.6, which indicates that residents in this ZIP code have fewer barriers to accessing care. This ZIP code is located in Baltimore County.

Chart 16: Community Needs Index Overall Study Area Summary



Source: Truven Health Analytics 2015

- Only ZIP code 21219 falls below the median score of 3.0 for the CBSA or overall study area. All other ZIP codes for the study area are above the median score of 3.0, indicating significant barriers to health care.
- The red line depicts the median score of CBSA or study area.

Table 21: Community Needs Index Results (Top 5 Highest CNI Scores)

ZIP Codes	City	Income Rank	Insurance Rank	Education Rank	Culture Rank	Housing Rank	2015 CNI Score
21202	Baltimore	5	5	5	5	5	5.0
21205	Baltimore	5	5	5	5	5	5.0
21213	Baltimore	4	5	5	5	5	4.8
21224	Baltimore	4	5	5	4	5	4.6
21231	Baltimore	5	5	4	4	5	4.6
21218	Baltimore	3	5	4	5	5	4.4
21206	Baltimore	2	5	4	4	5	4.0
21222	Dundalk	2	4	4	3	4	3.4
21219	Sparrows Point	2	2	4	3	2	2.6
Overall Study Area		**3**	**5**	**4**	**4**	**5**	**4.3***

Source: Truven Health Analytics 2015 **Weighted average of total market*

CBSA Community Needs Index Results (See Table 21)

The 2015 CNI score for the service area is 4.3. This is score is above the median CNI score of 3.0 for all nine ZIP codes within the study area.

At the ZIP code level, the highest CNI score in the study area is 5.0 in the ZIP codes of 21202 and 21205. This indicates that these ZIP codes have the most barriers to accessing health care when compared to other ZIP codes in the study area.

The lowest CNI score in the study area has a score of 2.6 in ZIP code 21219 (Sparrows Point). This ZIP code has the least barriers to health care access in the study area, but this does not imply that this area requires no attention.

Table 22: Community Needs Index Yearly Comparison Scores

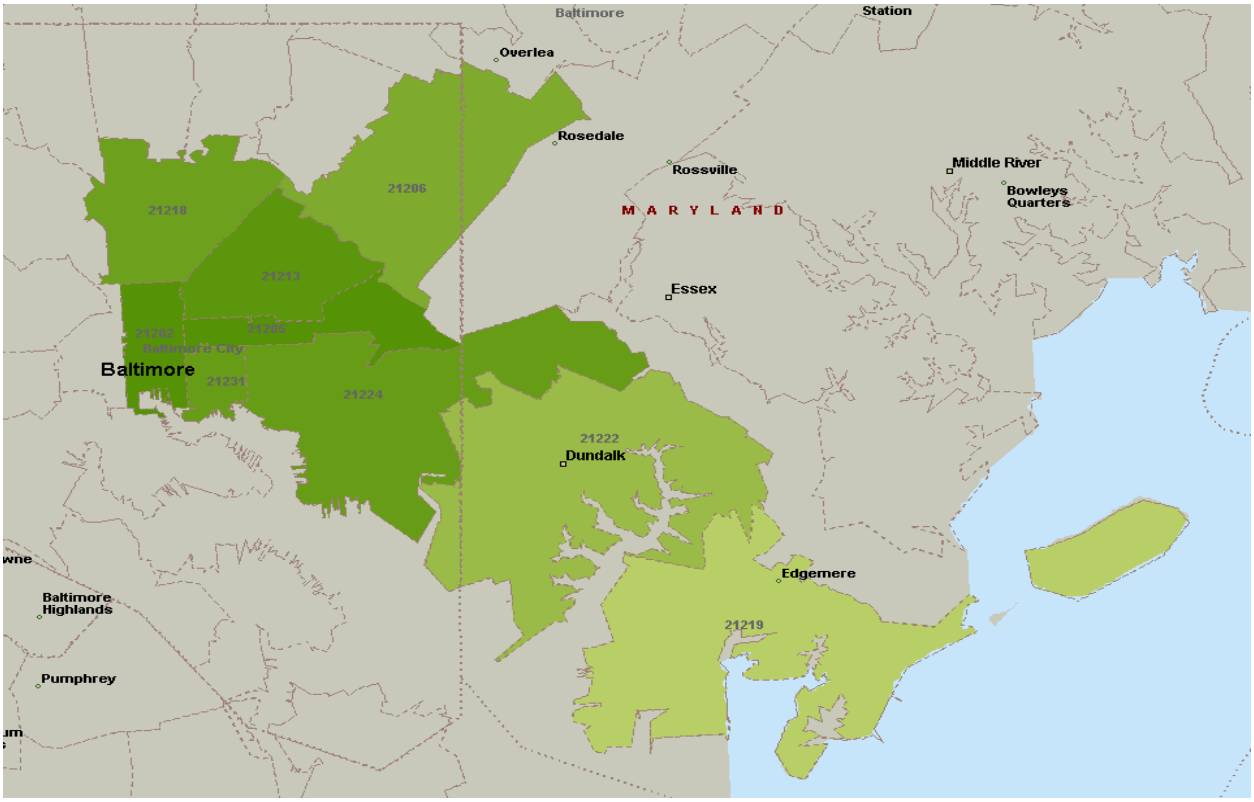
ZIP	City	2015 Population	2014 CNI Score	2015 CNI Score
21202	Baltimore	23,812	5.0	5.0
21205	Baltimore	16,300	5.0	5.0
21213	Baltimore	32,146	4.6	**4.8**
21224	Baltimore	50,053	4.6	4.6
21231	Baltimore	16,032	4.8	**4.6**
21218	Baltimore	48,890	4.4	4.4
21206	Baltimore	50,347	3.8	**4.0**
21222	Dundalk	56,953	3.6	**3.4**
21219	Sparrows Point	9,743	2.6	2.6

Source: Truven Health Analytics 2015

CBSA Community Needs Index Yearly Comparison Scores (See Table 22)

- Of the nine ZIP codes in The JHH and JHBMC study area:
  - Two saw declines in CNI score (reduced barriers to health care)
  - Five ZIP codes remained the same
  - Two experienced rises in CNI score (increased barriers to health care)
  - CNI scores in green indicate a positive change in scores, showing a decrease in score from 2014 to 2015.
  - CNI scores in red indicate a negative change in scores, showing an increase in score from 2014 to 2015.

Map 5: Community Need Index–Trending Map



Source: Truven Health Analytics 2015

In reviewing scores from 2014 and 2015 scores, the above map provides a geographic trending snapshot of the CBSA between the years. The dark green colors represent ZIP codes that have higher socioeconomic barriers, as the color lightens, as in southeast Baltimore, lower socioeconomic barriers to health care are present (Map 5).

Appendix D: General Description of the Johns Hopkins Institutions

General Description of the Johns Hopkins Hospital (JHH)

Johns Hopkins Medicine is a renowned and leading health care system throughout the United States. It is a global enterprise which operates ix academic and community hospitals, four suburban health care and surgery centers and more than 39 primary and specialty care outpatient sites. Opened in 1889, JHH has been ranked number one by U.S. News & World Report for 22 years, most recently in 2013. JHH is a premier medical facility serving the health care needs of those in Maryland, nationally and internationally. Training and educating researchers, scientists, health care professionals and students are part of JHH's mission and tradition. The advancement of medicine, detection and treatment of diseases sets the standard in medical education and research.

The mission of The Johns Hopkins Hospital is to improve the health of our community and the world by setting the standard of excellence in patient care. Specifically, JHH aims:

- To be the world's preeminent health care institution
- To provide the highest quality care and service for all people in the prevention, diagnosis and treatment of human illness
- To operate cooperatively and interdependently with the faculty of The Johns Hopkins University to support education in the health professions and research development into the causes and treatment of human illness
- To be the leading health care institution in the application of discovery
- To attract and support physicians and other health care professionals of the highest character and greatest skill
- To provide facilities and amenities that promote the highest quality care, afford solace and enhance the surrounding community

General Description of the Johns Hopkins Bayview Medical Center (JHBMC)

The history of JHBMC began in 1773 by committing to superior and innovative health care, compassionate care, education and research. With the union of JHH, the medical campus of JHBMC has been transformed to connect clinical care and medical education focusing on distinctive models of care in Johns Hopkins Centers of Excellence, including the Burn Center, Women's Center for Pelvic Health, Asthma & Allergy Center, and Memory and Alzheimer's Treatment Center, etc. U.S. News & World Report highly ranked JHBMC's Geriatric Medicine and Rheumatology programs.

Appendix E: Communities Served by JHH and JHBMC

Community Benefits Service Area of JHH and JHBMC[9]

In 2015, The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) merged their respective Community Benefits 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 34 percent of the total 80.94 square miles of land area for the city and 25.6 square miles in Baltimore County. In terms of population, an estimated 304,276 people live within the CBSA, of which the population in City ZIP codes accounts for 38 percent of the City's population and the population in County ZIP codes accounts for 8 percent of the County's population (2014 Census estimate of Baltimore City population, 622,793, and Baltimore County population, 826,925).

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

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

Johns Hopkins Bayview Medical Center is located in east Baltimore City and southeast Baltimore County, 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

[9] Information in this section (Communities Served by JHH and JHBMC) was obtained from the Johns Hopkins Health System Community Benefits Report.

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.

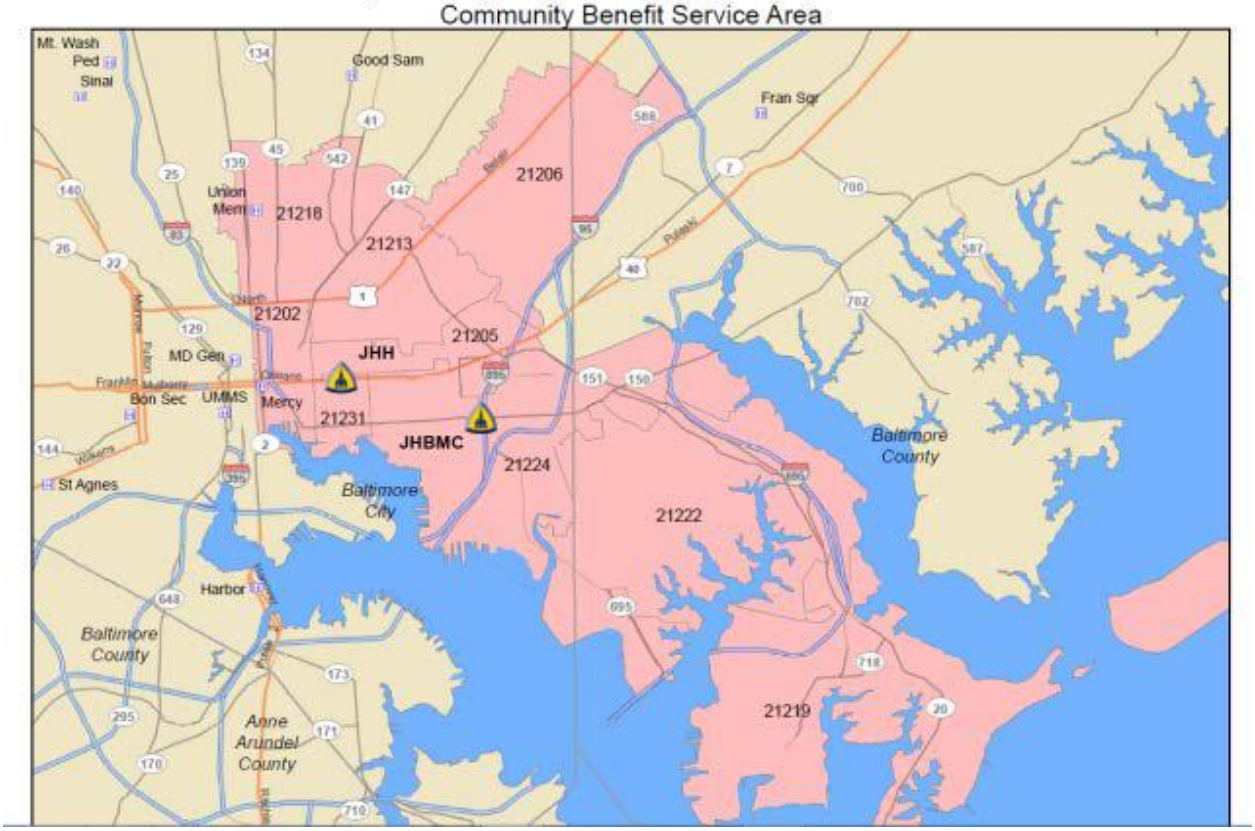
Neighborhoods farther north of The Johns Hopkins Hospital include Belair-Edison, Cedonia/Frankford, Claremont/Armistead, Clifton-Berea, Greater Charles Village/Barclay, Greater Govans, Hamilton, Lauraville, Midtown, Midway-Coldstream, Northwood and The Waverlies. Residents of these neighborhoods are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

Since the end of the Second World War, the population of Baltimore City has been leaving the city to the surrounding suburban counties. This demographic trend accelerated in the 1960s and 1970s, greatly affecting the neighborhoods around JHH 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.

-

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



Appendix F: JHH and JHBMC CBSA Demographic Snapshot

Table 23: JHH and JHBMC CBSA Demographic Snapshot

		Data Source
Community Benefits Service Area (CBSA)	21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231	JHM Market Analysis & Business Planning
CBSA demographics, by sex, race, ethnicity and average age	Total population: 304,276 Sex Male: 148,582/48.8% Female: 155,694/51.2% Race White non-Hispanic: 122,915/41.4% Black non-Hispanic: 139,602/45.9% Hispanic: 21,801/7.2% Asian and Pacific Islander Non-Hispanic: 8,701/2.9% All others: 8,257/2.7% Age 0-14: 54,696/18.0% 15-17: 10,357/3.4% 18-24: 31,725/10.4% 25-34: 54,784/18.0% 35-54: 79,559/26.1% 55-64: 36,478/12.0% 65+: 36,677/12.1%	2015 Truven
Median household income within CBSA	Average household income: $60,305	2015 Truven
Percentage of households (families and people) with incomes below the federal poverty guidelines within CBSA (past 12 months)	All families: 19.1% Married couple family: 6.3% Female householder, no husband present, family: 32.3% Female householder with related children under 5 years only: 39.2% All people: 23.8% Under 18 years: 34.1% Related Children under 5 years: 36.0% (Baltimore City, 2013) All families: 6.0% Married couple family: 3.0% Female householder, no husband present, family: 15.0% Female householder with related children under 5 years only: 21.9%	U.S. Census Bureau, 2013 American Community Survey http://factfinder2.census.gov

	All people: 8.9% Under 18 years: 11.3% Related Children under 5 years: 12.6% (Baltimore County, 2013)	
Please estimate the percentage of uninsured people within CBSA	11.2%	2015 Truven
Percentage of Medicaid recipients within CBSA	37.2%	2015 Truven
Life expectancy and crude deaths within CBSA	73.9 years at birth (Baltimore City, 2013) 79.4 years at birth (Baltimore County, 2013) 79.6 years at birth (Maryland, 2012) Baltimore City by Race: White: 76.5 years at birth Black: 72.2 years at birth Baltimore County by Race: White: 79.6 years at birth Black: 78.1 years at birth	Maryland Vital Statistics Annual Report 2013 http://dhmh.maryland.gov/vsa
Infant mortality rates within CBSA	All: 10.4 per 1,000 live births White: 7.1 per 1,000 live births Black: 12.8 per 1,000 live births (Baltimore City, 2014) All: 6.9 per 1,000 live births White: 3.1 per 1,000 live births Black: 14.6 per 1,000 live births (Baltimore County, 2014) All: 6.5 per 1,000 live births (Maryland, 2014)	Maryland Vital Statistics Infant Mortality in Maryland, 2014 http://dhmh.maryland.gov/vsa
Language other than English spoken at home	8.8% (Baltimore City, 2013) 13.1% (Baltimore County, 2013)	U.S. Census Bureau, Quickfacts, 2013
Access to healthy food	Baltimore City food deserts map	Johns Hopkins Bloomberg School of Public Health, Center for a Livable Future http://www.jhsph.edu/bin/k/o/BaltimoreCityFoodEnvironment.pdf Baltimore City Food Policy Initiative http://archive.baltimorecity.gov/portals/0/agencies/planning/public%

		20downloads/Baltimore%20Food%20Environment%20info-map%20handout.pdf

Table 24: Primary Service Areas for JHH and JHBMC

		Data Source
Bed Designation	1529 (JHH 1,082 JHBMC 447)	MHCC
Inpatient Admissions	69,866 (JHH 50,217; JHBMC 19,649)	JHM Market Analysis and Business Planning
JHH/JHBMC Primary Service Area ZIP codes	21213, 21205, 21224, 21218, 21202, 21206, 21231, 21217, 21215, 21222, 21234, 21216, 21212, 21229, 21223, 21207, 21043, 21239, 21208, 21221, 21220, 21228, 21044, 21225, 21045, 21201, 21230, 21244, 21122, 21042, 21061, 21214, 21236, 21237, 21093, 21209, 21075, 21133, 21136, 21227, 21157, 21287, 21784, 21740, 21401, 21211, 21040, 21060, 21144, 21113, 21014, 20723, 21804, 21030, 21015, 21210, 21146, 21204, 21009, 21701, 21403, 21742, 21502, 20707, 21771, 21702, 20854, 21801, 21046, 21219	HSCRC
All other Maryland hospitals sharing JHH/JHBMC primary service area	Laurel Regional Hospital, Upper Chesapeake Medical Center, Howard County General Hospital, Baltimore Washington Medical Center, Northwest Hospital Center, Carroll Hospital Center, University of Maryland Medical Center Midtown, University of Maryland Medical Center, Mercy Medical Center, Greater Baltimore Medical Center, UM Saint Joseph Medical Center, James Lawrence Kernan Hospital, Mount Washington Pediatric Hospital, Sinai Hospital, Medstar Union Memorial Hospital, Bon Secours Hospital, , Medstar Harbor Hospital, Saint Agnes Hospital, Franklin Square Hospital Center, Medstar Good Samaritan Hospital, Anne Arundel Medical Center, Western Maryland Regional Medical Center, Frederick Memorial Hospital, Meritus Medical Center, Peninsula Regional Medical Center, Chesapeake Rehabilitation Hospital	JHM Market Analysis and Business Planning

Percentage of uninsured patients by county	JHH: Anne Arundel: 0.2% Baltimore: 0.5% Carroll: 0.1% Frederick: 0.1% Harford: 0.1% Howard: 0.3% Montgomery: 0.3% Prince George's: 0.6% Washington: 0.8% Wicomico: 0.3% Baltimore City: 0.9% JHBMC: Baltimore City: 3.9% Baltimore: 2.7%	JHM Market Analysis and Business Planning
Percentage of patients who are Medicaid recipients by county	JHH: Anne Arundel: 20.6% Baltimore: 30.9% Carroll: 18.9% Frederick: 16.7% Harford: 18.7% Howard: 18.4% Montgomery: 11.6% Prince George's: 19.7% Washington: 24.5% Wicomico: 42.5% Baltimore City: 52.7% JHBMC: Baltimore City: 48.2% Baltimore: 30.7%	JHM Market Analysis and Business Planning

Appendix G: Community Stakeholder Interviewees

Tripp Umbach completed 52 interviews with community stakeholders throughout the region to gain a deeper understanding of community health needs from organizations, agencies and government officials that have a deep understanding from their day-to-day interactions with populations in greatest needs.

Interviews provide information about the community's health status, risk factors, service utilizations and community resource needs, as well as gaps and service suggestions.

Listed below in alphabetic order by last name are the community stakeholders.

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

Name	Organization
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

Appendix H: Community Organizations and Partners

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center came together to conduct a community health needs assessment (CHNA). As leading healthcare providers, JHH and JHBMC are dedicated to understanding community needs and offering and enhancing quality programs to address those needs and promoting population wellness.

The primary data collected in the CHNA provided invaluable input and ongoing dedication to assisting JHH and JHBMC in identifying community health needs priorities and building a foundation upon which to develop strategies that will address the needs of residents in East Baltimore City and southeast Baltimore County.

The listings below are the community organizations that assisted JHH and JHBMC with the primary collection for the CHNA.

	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

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Appendix J: Executive Planning Committee Members & Task Force/Working Group Members

The Johns Hopkins Institutions' Executive Planning Committee is comprised of leadership from The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center. The Executive Planning Committee is charged with providing input, feedback and advice on the identified health needs and health priorities from the 2015-2016 community health needs assessment and the implementation planning efforts. Below are members of the Executive Planning Committee in alphabetical order.

Executive Planning Committee Chairs:

1. Dr. Richard Bennett, President, Johns Hopkins Bayview Medical Center
2. Dr. Redonda Miller, Sr. Vice President Medical Affairs, Johns Hopkins Health System

Executive Planning Committee Members:

3. Dr. Renee Blanding, Vice President, Medical Affairs, Johns Hopkins Bayview Medical Center
4. Dr. Tina Cheng, Chief and Professor, General Pediatrics and Adolescent Medicine, Johns Hopkins University School of Medicine
5. Dr. Lisa Cooper, Vice President, Health Care Equity, Johns Hopkins Medicine
6. Amy Deutschendorf, Vice President, Care Coordination & Clinical Resource Management, Johns Hopkins Health System
7. Dr. Linda Dunbar, Vice President, Population Health & Care Management, Johns Hopkins HealthCare
8. Sherry Fluke, Financial/Project Manager, Government & Community Affairs, Johns Hopkins Institutions
9. Dr. Sherita Golden, Executive Vice Chair, Department of Medicine, Endocrinology, Johns Hopkins University School of Medicine
10. Kenneth Grant, Vice President, General Services, Johns Hopkins Health System
11. Jennifer Halbert, Project Administrator, Center to Eliminate Cardiovascular Health Disparities, Johns Hopkins University School of Medicine
12. Dr. Dan Hale, Special Advisor, Office of the President, Johns Hopkins Bayview Medical Center
13. Anne Langley, Senior Director, Health Planning & Community Engagement, Johns Hopkins Health System
14. Sharon Tiebert-Maddox, Director, Strategic Initiatives, Government & Community Affairs, Johns Hopkins Institutions
15. Scott Newton, Director of Nursing, Department of Emergency Medicine, The Johns Hopkins Hospital
16. Selwyn Ray, Director, Community Relations, Health and Wellness, Johns Hopkins Bayview Medical Center
17. Melissa Richardson, Director, Care Coordination, Johns Hopkins Health System

18. Dr. Laura Herrera Scott, Medical Director, Population Health and Community Health Programs, Johns Hopkins HealthCare
19. Dr. Eric Strain, Director, Johns Hopkins Center for Substance Abuse Treatment & Research

Members of the task force/working group were charged with providing direct feedback, comments and assisted in providing direction to Tripp Umbach to completing the necessary project pieces for the CHNA and implementation planning. Members of the task force/working group are listed below.

Task Force/Working Group Members:

1. Dr. Redonda Miller, Sr. Vice President Medical Affairs, Johns Hopkins Health System
2. Dr. Richard Bennett, President, Johns Hopkins Bayview Medical Center
3. Tom Lewis, Vice President, Government & Community Affairs, Johns Hopkins Institutions
4. Sharon Tiebert-Maddox, Director, Strategic Initiatives, Government and Community Affairs, Johns Hopkins Institutions
5. Dr. Dan Hale, Special Advisor, Office of the President, Johns Hopkins Bayview Medical Center
6. Selwyn Ray, Director, Community Relations, Health and Wellness, Johns Hopkins Bayview Medical Center
7. Sherry Fluke, Financial/Project Manager, Government & Community Affairs, Johns Hopkins Institutions

Appendix K: Hand Survey (English and Spanish Version)

The Johns Hopkins Institutions

Please answer all of the questions to the best of your ability. Circle responses to the questions where it applies.

1. You are: ① female ② male

2. You are: ___ ___ ___ years old

3. Your zip code is: ___ ___ ___ ___ ___

4. What area do you live in?
   ① Baltimore City
   ② Baltimore County
   ③ Other

5. Would you say your health is: (circle one):
   ① Excellent ② Good ③ Fair ④ Poor

6. Do you have a doctor/primary care provider?
   ① Yes ② No

   6a. If **NO**, why? (circle all that apply)
   ① Can't afford one ④ Don't need one
   ② Can't find one ⑤ Doesn't accept my
   ③ No Transportation insurance

7. What is the primary place that you seek medical care?
   ① Clinic ④ Doctor's office
   ② Urgent Care ⑤ Pharmacy
   ③ Emergency room ⑥ Other

8. When was the last time you had an appointment with a doctor/ primary care provider or medical clinic for any reason?
   ① Within the past year ④ 5 or more years ago
   ② Within the past 2 years ⑤ Don't know/Not sure
   ③ Within the past 5 years

9. Do you have health insurance?
   ① Yes ② No

   9a. If **NO**, Why don't you have health insurance? (circle all that apply)
   ① I don't qualify ④ I do not want it
   ② I can't afford it ⑤ I have not applied
   ③ I do not need it ⑥ I had insurance but lost it

   9b. If **NO**, Does not having health insurance affect your ability to get services?
   ① Yes ② No

   9c. If **NO**, Do you not seek care because of lack of insurance?
   ① Yes ② No

10. What is the primary place you seek dental care?
    ① Clinic ④ Dentist's office
    ② Urgent Care ⑤ I don't go to dentist
    ③ Emergency room ⑥ Other

11. When was the last time you had an appointment with a dentist or a dental clinic for any reason?
    ① Within the past year
    ② Within the past 2 years
    ③ Within the past 5 years
    ④ 5 or more years ago
    ⑤ Don't know / Not sure

12. How did you pay for dental services?
    ① Dental insurance coverage ③ Out-of-pocket
    ② Did not pay for services ④ Other

13. Have you ever been told by a health professional that you are overweight or obese?
    ① Yes ② No

14. Have you ever been told you have high blood pressure?
    ① Yes ② No

15. Have you ever been told you have diabetes?
    ① Yes ② No

16. Have you ever been told that you may have heart problems?
    ① Yes ② No

17. Do you have any difficulties that affect your daily activities? (circle all that apply)
    ① Physical ③Social
    ② Mental/Emotional ④ I have none

18. If you have children or grandchildren do you experience any difficulty keeping their immunizations (shots) up to date?
    ① Yes ③ Don't know
    ② No ④ Doesn't apply to me

19. How often do you do the following? Please **circle** your answer

Chew tobacco/snuff	Always	Sometimes	Never
Smoke cigarettes	Always	Sometimes	Never
Use illegal drugs	Always	Sometimes	Never
Drink more than 3 alcoholic drinks a day	Always	Sometimes	Never
Get exposed to people smoking at your work or home	Always	Sometimes	Never
Eat fast food more than one time a week	Always	Sometimes	Never
Use a seat belt	Always	Sometimes	Never
Use a car seat If you travel with children (If you do not have children skip question)	Always	Sometimes	Never
Wear sunscreen	Always	Sometimes	Never
Get a flu shot (once a year)	Always	Sometimes	Never
Drive the speed limit if you drive (If you do not drive skip question)	Always	Sometimes	Never
Wash your hands before making food	Always	Sometimes	Never
Eat at least 2 servings of vegetables a day	Always	Sometimes	Never
Eat at least 2 servings of fruit a day	Always	Sometimes	Never
Get at least 6-8 hours of sleep every night	Always	Sometimes	Never
Wash your hands after using the bathroom	Always	Sometimes	Never
Feel satisfied with your life	Always	Sometimes	Never
Practice safe sex	Always	Sometimes	Never
Participate in 30 minutes of physical activity or exercise daily	Always	Sometimes	Never
Do self-exams for breast cancer or cancer of the testicles, monthly	Always	Sometimes	Never

20. How do you find out about information in your community? (circle all that apply)
    - ① Newspaper
    - ② TV
    - ③ Internet
    - ④ Word of mouth
    - ⑤ Faith/religious organization
    - ⑥ Radio
    - ⑦ Clinics
    - ⑧ Library
    - ⑨ Other _____

21. What is your main form of transportation?
    - ① Public Transportation
    - ② My car
    - ③ Family/Friend's car
    - ④ Taxi/Cab
    - ⑤ Walk
    - ⑥ Bicycle
    - ⑦ Other

22. Do you feel safe in your neighborhood/ community in the day or night?
① Extremely safe ③ Not at all safe
② Somewhat safe ④ Don't know

23. If you don't feel safe, why don't you feel safe? (circle all that apply)
① Abandoned buildings ⑤ Lack of resources
② Violence ⑥ Crime
③ Fires ⑦ Drugs
④ Lack of police response ⑧ Other _____

24. Do you have any of the following?
① Problems remembering things or concentrating
② Uncontrollable eating binges
③ Eating too little / difficulty eating enough
④ Depression
⑤ Anxiety, Nervousness, Panic Attacks
⑥ Other _____

25. In the past 12 months, did you get services or treatment for a mental health issue?
① Yes ② No

25a. If **YES**, where did you get services?
① Community or neighborhood organization
② Hospital/Emergency Room
③ Mental health counselor or provider
④ Primary care doctor or health clinic
⑤ Other _____

26. In the past 12 months, have you needed but didn't get services or treatment for mental health?
① Yes ② No

26a. If **YES**, why didn't you get services / treatment you needed? (circle all that apply)
① My insurance does not cover mental health
② I didn't know where to go for services
③I preferred alternative forms of treatment
④I wanted to make it on my own without treatment
⑤I was afraid to seek the services
⑥I became overwhelmed or confused by the system
⑦It took too long to get an appointment
⑧The counseling/medication is too expensive
⑨Treatment options against my culture/religion
⑩ Other _____

27. What do you think are the biggest health concerns in your community? (Circle **no more** than 5 choices)

☐ Access to Affordable Healthy Food	☐ Diabetes/Sugar Levels	☐ Mental Health/Illness
☐ Adolescent Health	☐ Domestic (Family) Violence	☐ Obesity/Overweight
☐ Affordable Housing/Homelessness	☐ Drug & Alcohol Use/Addiction	☐ Prenatal/Infant Care
☐ Asthma/Breathing Problems	☐ Family Planning/Birth Control	☐ Sexually Transmitted Diseases
☐ Cancer	☐ Heart Disease	☐ Stroke
☐ Child Abuse/Neglect	☐ High Blood Pressure	☐ Teen Pregnancy
☐ Crime/Assault	☐ Hepatitis	☐ Tobacco Use
☐ Dental Health	☐ HIV/AIDS	☐ Other _____

28. What is your race or ethnicity? (circle all that apply)
① American Indian or Alaska Native
② Asian
③ Black or African American
④ Hispanic, Latino
⑤ Native Hawaiian or other Pacific Islander
⑥ White or Caucasian
⑦ Other _____
⑧ Prefer not to answer

29. Highest grade or degree completed: _____

30. Number of years of education completed:
_____

31. What is your yearly household income?
① Less than $5,000
② $5,000 to $24,999
③ $25,000 to $49,999
④ $50,000 to $99,999
⑤ More than $100,000
⑥ Don't know/Prefer not to answer

32. Do you have any other comments? (Use the reverse side of this page if you need more space

_____

The Johns Hopkins Institutions

Responda a todas las preguntas lo mejor posible. Encierre en un círculo las respuestas a las preguntas donde corresponda.

1. Usted es: ① mujer ② hombre

2. Usted tiene: ___ ___ ___ años

3. Su código postal es: ___ ___ ___ ___ ___

4. ¿En qué área vive?
   ① Baltimore City
   ② Baltimore County
   ③ Otro

5. Diría que su salud es: (encierre una opción en un círculo):
   ① Excelente ② Buena ③ Aceptable ④ Mala

6. ¿Tiene un médico/proveedor de atención primaria?
   ① Sí ② No

   6a. Si **NO** tiene, ¿por qué? (encierre en un círculo todas las que correspondan)
   ① No tengo dinero para pagarlo
   ② No puedo encontrar uno
   ③ No tengo transporte
   ④ No lo necesito
   ⑤ No lo acepta mi seguro

7. ¿Cuál es el lugar principal donde acude para recibir atención médica?
   ① Clínica ④ Consultorio médico
   ② Atención urgente ⑤ Farmacia
   ③ Sala de emergencias ⑥ Otro

8. ¿Cuándo fue la última vez que tuvo una cita con un médico/proveedor de atención primaria o acudió a una clínica médica por cualquier razón?
   ① Dentro del último año
   ② Dentro de los últimos 2 años
   ③ Dentro de los últimos 5 años
   ④ Hace 5 o más años
   ⑤ No sabe/No está seguro

9. ¿Tiene seguro de salud?
   ① Sí ② No

   9a. Si la respuesta es **NO**, ¿por qué no tiene seguro de salud? (encierre en un círculo todas las que correspondan)
   ① No reúno los requisitos
   ② No tengo dinero suficiente para pagarlo
   ③ No lo necesito
   ④ No lo quiero
   ⑤ No lo he solicitado
   ⑥ Tenía seguro pero lo perdí

   9b. Si la respuesta es **NO**, ¿no tener seguro de salud afecta su posibilidad de recibir servicios?
   ① Sí ② No

   9c. Si la respuesta es **NO**, ¿usted no acude para solicitar atención debido a que no tiene seguro?
   ① Sí ② No

10. ¿Cuál es el lugar principal donde acude para recibir atención odontológica?
    ① Clínica ④ Consultorio de un dentista
    ② Atención urgente ⑤ No voy al dentista
    ③ Sala de emergencias ⑥ Otro

11. ¿Cuándo fue la última vez que tuvo una cita con un dentista/en una clínica dental por cualquier razón?
    ① Dentro del año pasado
    ② Dentro de los últimos 2 años
    ③ Dentro de los últimos 5 años
    ④ Hace 5 o más años
    ⑤ No sé / No estoy seguro

12. ¿Cómo pagó los servicios odontológicos?
    ① Cobertura de seguro odontológico
    ② No pagué por los servicios
    ③ Del bolsillo propio
    ④ Otro

13. ¿Alguna vez un profesional de la salud le dijo que tiene sobrepeso u obesidad?
    ① Sí ② No

14. ¿Alguna vez le dijeron que tiene presión arterial alta?
    ① Sí ② No

15. ¿Alguna vez le dijeron que tiene diabetes?
    ① Sí ② No

16. ¿Alguna vez le dijeron que tiene problemas cardíacos?
    ① Sí ② No

17. ¿Tiene alguna dificultad que afecta sus actividades diarias? (encierre en un círculo todas las que correspondan)
    ① Física ③Social
    ② Mental/Emocional ④ No tengo ninguna

18. Si tiene hijos o nietos, ¿tiene problemas para mantener sus vacunas al día?
    ① Sí ③ No sé
    ② No ④ No corresponde a mi caso

19. ¿Con qué frecuencia hace lo siguiente? **Encierre en un círculo** su respuesta

Masticar/inhalar tabaco	Siempre	Algunas veces	Nunca
Fumar cigarrillos	Siempre	Algunas veces	Nunca
Usar drogas ilegales	Siempre	Algunas veces	Nunca
Beber más de tres bebidas alcohólicas por día	Siempre	Algunas veces	Nunca
Exponerse a gente que fuma en su trabajo o en su casa	Siempre	Algunas veces	Nunca
Comer comida rápida más de una vez por semana	Siempre	Algunas veces	Nunca
Usar el cinturón de seguridad	Siempre	Algunas veces	Nunca
Usar un asiento infantil si viaja con niños (Si no tiene hijos omita esta pregunta)	Siempre	Algunas veces	Nunca
Usar protector solar	Siempre	Algunas veces	Nunca
Vacunarse contra la gripe (una vez por año)	Siempre	Algunas veces	Nunca
Conducir dentro del límite de velocidad si conduce (Si no conduce omita esta pregunta)	Siempre	Algunas veces	Nunca
Lavarse las manos antes de preparar la comida	Siempre	Algunas veces	Nunca
Comer al menos dos porciones de vegetales por día	Siempre	Algunas veces	Nunca
Comer al menos dos porciones de frutas por día	Siempre	Algunas veces	Nunca
Dormir durante al menos 6-8 horas todas las noches	Siempre	Algunas veces	Nunca
Lavarse las manos después de usar el baño	Siempre	Algunas veces	Nunca
Sentir satisfacción con su vida	Siempre	Algunas veces	Nunca
Tener relaciones sexuales seguras	Siempre	Algunas veces	Nunca
Participar en 30 minutos de actividad física o ejercicio todos los días	Siempre	Algunas veces	Nunca
Hacerse un autoexamen de cáncer de mama o de testículos mensualmente	Siempre	Algunas veces	Nunca

20. ¿Cómo averigua la información en su comunidad?
(encierre en un círculo todas las que correspondan)
① Periódico
② Televisión
③ Internet
④ Verbalmente
⑤ Fe/organización religiosa
⑥ Radio
⑦ Clínicas
⑧ Biblioteca
⑨ Otro_____

21. ¿Cuál es su principal forma de transporte?
① Transporte público
② Mi automóvil
⑤ Caminar
⑥ Bicicleta

③ Automóvil de su familia/amigo ⑦ Otro
④ Taxi

22. ¿Se siente seguro en su vecindario/comunidad durante el día o la noche?
① Extremadamente seguro ③ Para nada seguro
② No muy seguro ④ No sé

23. Si no se siente seguro, ¿por qué no se siente seguro? (encierre en un círculo todas las que correspondan)
① Edificios abandonados ⑤ Falta de recursos
② Violencia ⑥ Delitos
③ Incendios ⑦ Drogas
④ Falta de respuesta policial ⑧ Otro motivo_____

24. ¿Tiene alguno de los siguientes?
① Problemas para recordar cosas o concentrarse
② Deseos incontrolables de comer
③ Come muy poco / tiene dificultad para comer suficiente
④ Depresión
⑤ Ansiedad, nerviosismo, ataques de pánico
⑥ Otro _____

25. En los últimos 12 meses, ¿ha recibido servicios o tratamiento para un problema de salud mental?
① Sí ② No

25a. Si la respuesta es **SÍ**, ¿dónde obtuvo esos servicios?
① Comunidad u organización del vecindario
② Hospital/Sala de emergencias
③ Asesor o proveedor de salud mental
④ Médico de atención primaria o clínica de salud
⑤ Otro _____

26. En los últimos 12 meses, ¿ha necesitado pero no ha recibido servicios o tratamiento para un problema de salud mental?
① Sí ② No

26a. Si la respuesta es **SÍ**, ¿por qué no recibió los servicios/tratamientos que necesitaba? (encierre en un círculo todas las que correspondan)
① Mi seguro no cubre la atención de la salud mental
② No sabía a dónde acudir para recibir los servicios
③ Prefería formas alternativas de tratamiento
④ Quería arreglármelas por mí mismo sin tratamiento
⑤ Tenía miedo de solicitar los servicios
⑥ Me sentía abrumado o confundido por el sistema
⑦ Tomaba mucho tiempo obtener una cita
⑧ El asesoramiento o la medicación son muy costosos
⑨ Las opciones de tratamiento están en contra de mi cultura o religión
⑩ Otro _____

27. ¿Cuál cree que son las principales preocupaciones de salud de su comunidad? (Encierre en un círculo un **máximo** de 5 opciones)

☐ Acceso a comida saludable a un precio económico	☐ Diabetes/niveles de azúcar	☐ Enfermedad/Salud mental
☐ Salud de los adolescentes	☐ Violencia doméstica (familiar)	☐ Obesidad/sobrepeso
☐ Casas a un precio accesible/personas sin hogar	☐ Consumo/adicción a drogas y alcohol	☐ Atención prenatal/infantil
☐ Asma/problemas para respirar	☐ Planificación familiar o control de natalidad	☐ Enfermedades de transmisión sexual
☐ Cáncer	☐ Enfermedades cardíacas	☐ Accidente cerebrovascular
☐ Abuso infantil/Abandono infantil	☐ Presión arterial alta	☐ Embarazo adolescente
☐ Delitos/agresiones	☐ Hepatitis	☐ Uso de tabaco
☐ Salud odontológica	☐ VIH/sida	☐ Otro _____

28. ¿Cuál es su raza u origen? (encierre en un círculo todas las que correspondan)
① Indígena americano o nativo de Alaska
② Asiático
③ Negro o afroamericano
④ Hispano, latino
⑤ Nativo de Hawái o de otra de las islas del Pacífico
⑥ Blanco o caucásico
⑦ Otro _____
⑧ Prefiero no responder

29. Nivel educativo o título más alto que completó:
_____

30. Número de años de educación que completó:
_____

31. ¿Cuál es su ingreso familiar anual?
① Menos de $5,000
② $5,000 a $24,999
③ $25,000 a $49,999
④ $50,000 a $99,999
⑤ Más de $100,000
⑥ No sé/Prefiero no responder

32. ¿Tiene algún otro comentario? (Use el reverso de esta página si necesita más espacio)

_____

Appendix L: Tripp Umbach

Consultants

The Johns Hopkins Institutions contracted with Tripp Umbach, a private health care consulting firm headquartered in Pittsburgh, Pennsylvania, with offices throughout the United States, in particular, Maryland, to complete a community health needs assessment (CHNA). Tripp Umbach has worked with more than 200 communities in all 50 states. In fact, more than one in five Americans lives in a community where our firm has worked in the past 20 years

From community needs assessment protocols to fulfilling the new Patient Protection and Affordable Care Act (PPACA) IRS 990 requirements, Tripp Umbach has turned needs assessments into practical action plans with sound implementation strategies, evaluation processes and funding recommendations for hundreds of communities. Tripp Umbach has helped more than 50 hospitals meet their IRS 990 requirements.

Changes introduced as a result of the PPACA have placed an increased level of importance on population health and well-being and on collaborative efforts between providers, public health agencies and community organizations to improve the overall health of communities.