

**Johns Hopkins Health System**  
**Fiscal Year 2018 Community Benefits Report Narrative**  
**Johns Hopkins Bayview Medical Center**

## **I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:**

### **Hospital Characteristics:**

1. Hospital ID: 210029
2. Hospital name: Johns Hopkins Bayview Medical Center
3. Hospital system name (if applicable): Johns Hopkins Health System
4. Total number of licensed beds: 342
5. The list of zip codes in the hospital's primary service area (PSA) as defined in the hospital's global budget: 21202, 21205, 21213, 21219, 21222, 21224
6. A list of all other hospitals sharing the PSA: JHH, Medstar Franklin Square, Medstar Union Memorial, Mercy Medical Center, University Maryland Medical Center

### **Community Benefit Service Area:**

1. List all of the ZIP codes in the hospital CBSA: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231
2. Describe how the hospital identified its CBSA:

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

The CBSA covers approximately 27.9 square miles within the City of Baltimore or approximately thirty-four percent of the total 80.94 square miles of land area for the city and 25.6 square miles in Baltimore County. In terms of population, an estimated 305,895 people live within CBSA, of which the population in City ZIP codes accounts for thirty-eight percent of the City's population and the population in County ZIP codes accounts for eight percent of the County's population (2016 Census estimate of Baltimore City population, 620,961, and Baltimore County population, 831,026).

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

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

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

Between the two hospitals, in southeast Baltimore City, the CBSA population demographics have historically trended as white middle-income, working-class communities, Highlandtown, Southeastern, Orangeville/E. Highlandtown; however, in the past few decades, Southeast Baltimore has become much more diverse with a growing Latino population clustered around Patterson Park, Highlandtown, Orangeville/E. Highlandtown. Median incomes in these neighborhoods range from significantly below the City median in Southeastern to well above the median in Highlandtown. In Baltimore County, largely served by JHBMC, Dundalk, Sparrows Point, and Edgemere have been predominantly white with increasing populations of Hispanic and African American residents.

Since the end of the Second World War, the population of Baltimore City has been leaving the city to the surrounding suburban counties. This demographic trend accelerated in the 1960s and 1970s, greatly affecting the neighborhoods around 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. ZIP codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.

## **Community Health Statistics and Demographics**

Please see attached PDF

## II. COMMUNITY HEALTH NEEDS ASSESSMENT

Our hospital's most recent community health needs assessment was completed on 05/18/2018

[https://www.hopkinsmedicine.org/johns\\_hopkins\\_bayview/community\\_services/health\\_needs\\_initiatives/community\\_health\\_needs\\_assessment.html](https://www.hopkinsmedicine.org/johns_hopkins_bayview/community_services/health_needs_initiatives/community_health_needs_assessment.html)

Our hospital's most recent implementation strategy was adopted on 05/18/2018

[https://www.hopkinsmedicine.org/johns\\_hopkins\\_bayview/community\\_services/health\\_needs\\_initiatives/community\\_health\\_needs\\_assessment.html](https://www.hopkinsmedicine.org/johns_hopkins_bayview/community_services/health_needs_initiatives/community_health_needs_assessment.html)

## III. COMMUNITY BENEFIT ADMINISTRATION

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

Yes  
 No

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

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

### Reference:

#### **JHM Strategic Plan 2014-2018**

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

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

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

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

a. Senior Leadership - JHHS

- i.  Kevin Sowers, President
- ii.  Ronald J. Werthman, CFO/Treasurer and VP, Finance
- iii.  John Colmers, VP, Health Care Transformation and Strategic Planning
- iv.  Ed Beranek, Senior Director, Regulatory Compliance

Senior Leadership - JHBMC

- v.  Richard C. Bennett, President and CEO
- vi.  Carl Francioli, CFO

Other (please specify)

- vii.  Renee Blanding, M.D., Vice President of Medical Affairs
- viii.  Craig Brodian, Vice President, Human Resources
- ix.  Anita Langford, Vice President, Care Management Services
- x.  Dan Hale, Ph.D., Special Advisor to the President

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

b. Clinical Leadership

- i.  Physicians
- ii.  Nurses
- iii.  Social Workers
- iv.  Physician Assistants

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

c. Population Health Leadership and Staff

- i.  Patricia M.C. Brown, Senior VP, Managed Care and Population Health
- ii.  Carol Sylvester, VP, Care Management Services

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

d. Community Benefits Department/Team

- i.  Individuals
  - a)  Carl Francioli, CFO
  - b)  Kim Moeller, Director, Financial Analysis/Special Projects
  - c)  Selwyn Ray, Director, Community Relations
  - d)  Pat Carroll, Manager, Community Relations
  - e)  Sudanah Gray, Budget Analyst

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

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

#### JHHS Community Health Improvement Strategy Council

- The Johns Hopkins Hospital
  - Sherry Fluke, Senior Financial Analyst, Govt. & Community Affairs (GCA)
  - Sudanah Gray, Budget Analyst, GCA
  - Sharon Tiebert-Maddox, Director, Strategic Initiatives, GCA
  - William Wang, Associate Director, Strategic Initiatives, GCA
- Johns Hopkins Bayview Medical Center
  - Patricia A. Carroll, Manager, Community Relations
  - Kimberly Moeller, Director, Financial Analysis and Special Projects
  - Selwyn Ray, Director, Community Relations JHBMC, Health and Wellness
- Howard County General Hospital
  - Elizabeth Edsall-Kromm, Vice President, Population Health and Advancement
  - Laura Hand, Director, Strategic Planning
  - Fran Moll, Manager, Regulatory Compliance
  - Scott Ryan, Senior Revenue Analyst
- Suburban Hospital
  - Eleni Antzoulatos, Supervisor, Community Health and Wellness Operations, Community Health and Wellness
  - Sara Demetriou, Coordinator, Health Initiative and Community Relations, Community Health and Wellness

- Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget and Reimbursement, Finance and Treasury
  - Kate McGrail, Program Manager, Health Outcomes and Evaluation, Community Health and Wellness
  - Patricia Rios, Manager, Community Health Improvement, Community Health and Wellness
  - Monique Sanfuentes, Administrative Director, Community Affairs & Population Health, Community Health and Wellness
  - Sunil Vasudevan, Senior Director of Finance and Treasury, Finance and Treasury
- Sibley Memorial Hospital
    - Marti Bailey, Director, Sibley Senior Association and Community Health
    - Courtney Coffey, Community Health Program Manager
    - David Rutherford, Financial Analyst
    - Marissa McKeever, Director, Government and Community Affairs
    - Honora Precourt, Community Program Coordinator
  - All Children’s Hospital
    - Stephanie Bovis, Program Coordinator
    - Kimberly Berfield, VP, Government and Community Affairs
  - Johns Hopkins Health System
    - Christopher Davis, Senior Director, Tax Compliance
    - Bonnie Hatami, Senior Tax Accountant
    - Albert Gallinn, Senior Director, Revenue Cycle
    - Anne Langley, Senior Director, Health Policy Planning and Community Engagement
    - Kimberly Scott, Manager

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

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

There are several levels of audit and review in place at Johns Hopkins. Members of the JCHISC conduct the initial review of accuracy of information submissions, analyze financial data variances year over year, review reports for data inconsistencies and/or omissions and

contact program reporters to verify submitted information and/or provide additional details. The CBR team meets with senior hospital finance leadership to discuss, review and approve the CBR financial reports. The CBR team also meets with the senior compliance officer to review and audit for regulatory compliance. After hospital specific audit/review is completed the JHHS Community Health Improvement Strategy Council attends a meeting with all of the JHHS CFOs to review system wide data and final reports to the Health System president. In the final review meeting before submission, the hospital CFOs present to the health system president and discuss strategic alignment, challenges and opportunities discussed during the CBR process.

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

Prior to its submission to the HSCRC, the Community Benefit Report (CBR) is reviewed in detail by the CFO and the president of the Johns Hopkins Bayview Medical Center, and the president of the Johns Hopkins Health System. Although CBR annual approval by the Board of Trustees is not a legal requirement, the completed report as well as annual progress reports are presented and reviewed by the JHBMC Board of Trustees by the JH Board of Trustees Joint Committee on External Affairs and Community Engagement. The Community Health Needs Assessment and Implementation Strategy incorporated in the CBR were formally approved by the JHBMC Board on May 18, 2018.

5. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?  
 Yes     No

If yes, please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

Community Benefit investments will support the Hospital's Strategic Transformation goals of 1) Access to Care and 2) Care Coordination across the Continuum.

Health Leads, The Access Partnership, Care-a-Van, and Mary Harvin Transformation Center programs are Community Benefit investments that will support both Access to Care and Care Coordination (see Section V. Initiatives for a description of each program).

Called to Care will support the Care Coordination goal by establishing active participation in health decisions and care management for family and friend caregivers.

Baltimore Population Health Workforce Collaborative will support the Access to Care and Care Coordination strategies by providing additional community health workers and peer recovery specialists to assist in connecting communities to resources and bridging behavioral health care.

**IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES (DESCRIBE THREE)**

Initiative 1. Care-A-Van

<p>Does this initiative address a need identified in your CHNA?</p>	<p>Access to Health Services</p> <p>Focusing on healthcare for Latino and other non-English speaking patients and the uninsured as identified in the 2016 JHBMC CHNA</p> <p>The growth in the Latino population in Baltimore is reflected in the trends among Latino patients receiving care at JHBMC. Data obtained from the Johns Hopkins Health System data analysis unit showed that from 2000 to 2010 there was a six-fold increase in Hispanic admissions at JHBMC. The highest utilization of services by Latino patients occurred in the Department of Pediatrics and Department of Obstetrics where Latino patients accounted for approximately 1/3 of all inpatient admissions for Pediatrics and Ob/Gyn, 35% of outpatient Pediatric visits, and 21% of outpatient Ob/Gyn visits in 2010. About 11% of the residents in the CBSA area are Latino, with greater concentration in the 21224 ZIP code. Forums with families and leaders indicated a number of language-related barriers to care.</p>
<p>When did this begin (mo/yr)?</p> <p>Does it have an end date or trigger event that will end it?</p>	<p>On the road since June 1999. New van in November 2016</p> <p>Multi-year/ongoing</p>
<p>What population does this initiative target? (# of people and describe target population)</p>	<p>151,309 people in the total population of the following four ZIP codes: 21231, 21224, 21222, 21213 with a focus on the 73,278 underrepresented minorities and/or</p>
<p>Total Number of People Reached by Initiative</p>	<p>1,018 people reached by Care-A-Van</p> <ul style="list-style-type: none"> <li>• Over 678 patients tested for HIV/Syphilis</li> <li>• 75% Latino patients</li> <li>• 935 new OB patients referred for prenatal care, WIC and Medicaid and provided with access to prenatal vitamins</li> </ul>

What category of intervention best fits this initiative?	Condition-agnostic intervention: Treatment and prevention Social determinants of health intervention Community engagement intervention
Does your hospital work with other groups to deliver this, if so list?	Children's Medical Practice's Latino Family Advisory Board Crianza Y Salud {Parenting and Health}
Primary Objective	The program focuses on children and women of childbearing age and gives access particularly to people who may have transportation and financial limitations. The Care-A- Van, with bilingual providers, is frequently used by Latino patients for primary care or as an entry point to access hospital services.
How initiative is delivered?	A mobile van that brings ambulatory care services and health screenings to the community.
What kind of evidence for success or effectiveness of the initiation is evaluated? Select all that apply and describe.	Count of participants/encounters: Count of people reached Surveys of participants: Patient satisfaction, Patient needs surveys
Describe outcome of the initiative?	The Care-A-Van provides access to free primary medical care to uninsured children and pregnant woman. Provides linkage to affordable prenatal care.
Describe how the outcome of the initiative addresses community health needs?	Children provided with needed vaccines, physicals and lead screening to enroll in school. Increased rates of prenatal care for uninsured women
Total Cost of Initiative for Current FY (include total dollars, donations, grants)	\$246,892

Initiative 2: Baltimore Population Health Work Force Collaborative

<p>Does this initiative address a need identified in your CHNA?</p>	<p>Yes, Social Determinants of Health (Employment), Chronic Disease, and Behavioral Health/Substance Abuse</p>
<p>When did this begin (mo/yr)?</p> <p>Does it have an end date or trigger event that will end it?</p>	<p>January 2017</p> <p>An initial end of June 30, 2019, which may be extended based on evaluation by HSCRC</p>
<p>What population does this initiative target? (# of people and describe target population)</p>	<p>Unemployed in Baltimore City 35,275 and Individuals who did not work (including disabled and students) 63,747</p> <p>From American Community Survey, 2017</p> <p>Targeted neighborhoods are those in hospital Community Benefit Service Areas (CBSA) that have higher poverty and unemployment rates than Baltimore City overall. BPHWC will focus on the following 24 zip codes representing CBSA's of the 9 partner hospitals: 21201, 21202, 21205, 21206, 21207, 21211, 21213, 21214, 21215, 21216, 21217, 21218, 21221, 21222, 21223, 21224, 21225, 21226, 21227, 21229, 21231 and 21239.</p> <p>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.</p>
<p>Total Number of People Reached by Initiative</p>	<p>21 individuals trained for Essential Skills and Technical Training</p> <p>5 new hires; 2 retained employees</p>

<p>What category of intervention best fits this initiative?</p>	<p>Chronic condition-based intervention: Prevention</p> <p>Social determinants of health intervention</p>
<p>Does your hospital work with other groups to deliver this, if so list?</p>	<p>Internal: Johns Hopkins Hospital</p> <p>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.</p>
<p>Primary Objective</p>	<p>BPHWC is designed to provide the training needed to fill new health care jobs, while also improving the health of high poverty communities</p>
<p>How initiative is delivered?</p>	<p>A consortium of four major health systems that includes nine hospitals trains and hires individuals from high poverty communities in the Baltimore Metropolitan area to be community healthcare workers (CHWs), peer outreach specialists (PRSs), and certified nursing /geriatric nursing assistants (CNAs/GNAs).</p> <p>The hospitals partner with the Baltimore Alliance for Careers in Healthcare (BACH), which coordinates the recruitment and training of individuals from the community. BACH works with several community organizations to select, screen, and provide essential skills training to the potential recipients of the PWSDA program. They also recruit hospital employees from “high poverty communities” to train and promote them to positions with a “career ladder.” The hospital collaborative works with BACH to screen, select, and train individuals in essential skills over three years. For the CHA and PRS positions, individuals will complete 160 and 50 hours, respectively, of occupational skills training before being recruited. For the CNA position, training and certification takes place at the Baltimore County Community College.</p>

<p>What kind of evidence for success or effectiveness of the initiation is evaluated? Select all that apply and describe.</p>	<p>Count of participants/encounters: #s trained, successfully credentialed, and hired/retained</p> <p>Assessment of workforce development: BACH tracks workforce training effectiveness</p>
<p>Describe outcome of the initiative?</p>	<p>21 individuals were trained and 5 hired as CHW, CNA, and CNA/GNA positions. 2 individuals were retained and full time employed as CHW, PRS, CNA and CNA/GNA positions.</p>
<p>Describe how the outcome of the initiative addresses community health needs?</p>	<p>CHWs provide an opportunity to combat health disparities by promoting and supporting healthy behaviors; they can assist with care management activities to directly prevent or manage chronic disease. With the focus of health care shifting from the hospital setting to the community, CHWs can improve healthcare outcomes in the US including 30-day readmission as well as preventing and managing chronic diseases. CHWs help promote healthy behaviors and are connectors with the health care system to increase access to care to reduce health disparities and identify/navigate patients with unmet social needs to appropriate health care. CHWs are most effective when they serve the communities from which they come and thus provide continuity between healthcare systems and the community. PRSs have experienced substance use disorder (SUD) or mental illness and recovery and can help persons with behavioral health issues by serving as a link between the clinical setting and the community to enhance access to and participation in treatment services to prevent relapse.</p> <p>PRS services are an important wrap-around to clinical services. CNA/GNAs expand the current homes support reach in the community. They will also serve hospital discharged patients who need personal care at home, but cannot afford it to avoid readmission.</p> <p>The goal of BPHWC is to concomitantly improve the socio-economic status of disadvantaged communities and promote population health in the Baltimore region. We will do this by improving the continuity and healthcare of the communities where CHWs and PRSs work, thus providing income through jobs that impact the health and well-being of the workers.</p>

Total Cost of Initiative for Current FY (include total dollars, donations, grants)	\$1,043,379
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Initiative 3: Health Leads

Does this initiative address a need identified in your CHNA?	Yes, Social Determinants of Health
When did this begin (mo/yr)?  Does it have an end date or trigger event that will end it?	January 1, 2006  No end date. Hospital will support this program as long as the need exists.
What population does this initiative target? (# of people and describe target population)	63,036 persons with below median household incomes (estimate from American Community Survey), as well as undocumented residents, homeless individuals and families.
Total Number of People Reached by Initiative	2,813
What category of intervention best fits this initiative?	Social determinants of health intervention
Does your hospital work with other groups to deliver this, if so list?	Health Leads Baltimore, Johns Hopkins Hospital, Johns Hopkins University
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.

<p>How initiative is delivered?</p>	<p>Health Leads has program staff and student volunteers at Harriet Lane Clinic, Bayview Children’s Medical Practice, and Bayview Comprehensive Care Practice working with each clinic’s care teams. They screen patients for social needs and work to connect patients to resources. The navigation requires regular follow-up with patients, maintaining an up-to-date resource directory, connecting with the clinic care teams, and relationships with community organizations.</p>																		
<p>What kind of evidence for success or effectiveness of the initiation is evaluated? Select all that apply and describe.</p>	<p>Count of participants/encounters: Monthly measures include clients served, total lives reached, number of resource connections.</p> <p>Process measures: Measurable goals like clients served, success rate of needs solved, time to case closure, client follow-up, and % of volunteers with Health Leads experience are tracked by the program and measured against Health Leads national data.</p> <p>Surveys of participants: After a case is closed, Health Leads send text surveys to patients that have agreed to be reached by text. The surveys rate the services they received from Health Leads and ask for additional feedback.</p>																		
<p>Describe outcome of the initiative?</p>	<p>Health Leads does not keep baseline health related data about its clients. As Johns Hopkins efforts to better integrate with Epic continues, it may be possible to conduct analyses to determine if connecting patients with essential needs affects their 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.</p>																		
<p>Describe how the outcome of the initiative addresses community health needs?</p>	<p>Health Leads directs patients of need to resources that can address social determinants of health.</p> <p>For FY18, the top five presenting needs for each clinic were as follows:</p> <table border="1" data-bbox="456 1509 1346 1873"> <thead> <tr> <th data-bbox="456 1509 781 1671"><b>Bayview Children's Medical Practice</b></th> <th data-bbox="781 1509 1024 1671"><b>Bayview Comprehensive Care Practice</b></th> <th data-bbox="1024 1509 1346 1671"><b>Harriet Lane Clinic</b></th> </tr> </thead> <tbody> <tr> <td data-bbox="456 1671 781 1713">Food (33%)</td> <td data-bbox="781 1671 1024 1713">Health (24%)</td> <td data-bbox="1024 1671 1346 1713">Commodities (25%)</td> </tr> <tr> <td data-bbox="456 1713 781 1755">Health (21%)</td> <td data-bbox="781 1713 1024 1755">Food (18%)</td> <td data-bbox="1024 1713 1346 1755">Housing (15%)</td> </tr> <tr> <td data-bbox="456 1755 781 1797">Financial (13%)</td> <td data-bbox="781 1755 1024 1797">Housing (14%)</td> <td data-bbox="1024 1755 1346 1797">Health (13%)</td> </tr> <tr> <td data-bbox="456 1797 781 1839">Commodities (11%)</td> <td data-bbox="781 1797 1024 1839">Utilities (10%)</td> <td data-bbox="1024 1797 1346 1839">Employment (12%)</td> </tr> <tr> <td data-bbox="456 1839 781 1873">Adult Education (7%)</td> <td data-bbox="781 1839 1024 1873">Employment (9%)</td> <td data-bbox="1024 1839 1346 1873">Child-related (10%)</td> </tr> </tbody> </table>	<b>Bayview Children's Medical Practice</b>	<b>Bayview Comprehensive Care Practice</b>	<b>Harriet Lane Clinic</b>	Food (33%)	Health (24%)	Commodities (25%)	Health (21%)	Food (18%)	Housing (15%)	Financial (13%)	Housing (14%)	Health (13%)	Commodities (11%)	Utilities (10%)	Employment (12%)	Adult Education (7%)	Employment (9%)	Child-related (10%)
<b>Bayview Children's Medical Practice</b>	<b>Bayview Comprehensive Care Practice</b>	<b>Harriet Lane Clinic</b>																	
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Adult Education (7%)	Employment (9%)	Child-related (10%)																	

	<b>Bayview Children's Medical Practice</b>	<b>Bayview Comprehensive Care Practice</b>	<b>Harriet Lane Clinic</b>
<b>Clients Served</b>			
Unique Clients	1199	389	1227
Successful Connections	1190	212	1388
Patients successfully accessed a resource	67.7%	35.4%	62.8%
Patients equipped to access a resource	12.2%	30.7%	10.4%
Patients who did not access a resource	2.5%	3.9%	1.2%
Patients disconnected from resources	17.6%	30.1%	25.7%
Total Cost of Initiative for Current FY (include total dollars, donations, grants)	\$108,058		