Johns Hopkins Health System

Fiscal Year 2018 Community Benefits Report Narrative

The Johns Hopkins Hospital

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

Hospital Characteristics:

1. Hospital ID: 210009
2. Hospital name: The Johns Hopkins Hospital
3. Hospital system name (if applicable): Johns Hopkins Health System
4. Total number of licensed beds: 1,091
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, 21231
6. A list of all other hospitals sharing the PSA: JHBMC, 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 Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) merged their respective Community Benefit Service Areas (CBSA) in order to better integrate community health and community outreach across the East and Southeast Baltimore City and County region. The geographic area contained within the nine ZIP codes includes 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, and 21231. This area reflects the population with the largest usage of the emergency departments and the majority of recipients of community contributions and programming. Within the CBSA, JHH and JHBMC have focused on certain target populations such as the elderly, at-risk children and adolescents, uninsured individuals and households, and underinsured and low-income individuals and households.

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

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

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

Neighborhoods farther north of the Johns Hopkins Hospital include Belair-Edison, Cedonia/Frankford, Claremont/Armistead, 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. 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.

Community Health Statistics and Demographics

(.pdf insert next page)

II.   **COMMUNITY HEALTH NEEDS ASSESSMENT**

Our hospital's most recent community health needs assessment was completed on 06/15/2018

https://www.hopkinsmedicine.org/the_johns_hopkins_hospital/about/in_the_community/community_health_needs_assessment.html

Our hospital's most recent implementation strategy was adopted on 06/15/2018

https://www.hopkinsmedicine.org/the_johns_hopkins_hospital/about/in_the_community/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.

     _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_ Kevin Sowers, President, JHHS
        ii. _X_ Dr. Redonda Miller, President, JHH
        iii. _X_ Daniel J. Smith, Vice President and CFO, JHH
        iv. _X_ John Colmers, Senior VP, Health Care Transformation and Strategic Planning
        v. _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

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 - JHH CBR Team
            Sherry Fluke
            Sudanah Gray
            Sharon Tiebert-Maddox
            William Wang

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 Health Improvement Strategy Council

- o 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

- o 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

- o 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

- o 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

- o 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

o All Children's Hospital
  - Stephanie Bovis, Program Coordinator
  - Kimberly Berfield, VP, Government and Community Affairs

o Johns Hopkins Health System
  - Christopher Davis, Senior Director, Tax Compliance
  - Bonnie Hatami, Senior Tax Accountant
  - Albert Galinn, Senior Director, Revenue Cycle Management
  - 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 JHCHISC conduct the initial review of accuracy of information submissions, analyze financial data variances year over year, review reports for data inconsistencies and/or omissions and contact program reporters to verify submitted information and/or provide additional details. The CBR team meets with senior hospital finance leadership to discuss, review and approve the CBR financial reports. The CBR team also meets with the senior compliance officer to review and audit for regulatory compliance. After hospital specific audit/review is completed the JHHS Community Health Improvement Strategy Council attends a meeting with all of the JHHS CFOs to review system wide data and final reports to the Health System president. In the final review meeting before submission, the hospital CFOs present to the health system president and discuss strategic alignment, challenges and opportunities discussed during the CBR process.

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

Prior to its submission to the HSCRC, the Community Benefit Report (CBR) is reviewed in detail by the CFO and the president of the Johns Hopkins 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.

5. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

　　　__X___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 Urgent Care, 2) Care Coordination across the Continuum, and 3) Patient/Family Engagement.

Health Leads, The Access Partnership, and Mary Harvin Transformation Center are Community Benefit investments that will support both Access to Urgent Care, Care Coordination and Patient/Family Engagement (see Section V. Initiatives for descriptions of each program). In particular, the health education programs offered at the Mary Harvin Transformation Center are specifically designed to "equip patients and families with the necessary knowledge and capacity to participate in self-care management" in support of the Patient/Family Engagement goal in the Strategic Transformation Plan. One good example of this was the Heart Healthy month (February) programming that provided weekly awareness and management sessions, including blood pressure screenings.

Aftercare Clinic, Remote Patient Monitoring, and Patient Access Line programs will support Care Coordination goals by providing patients with easy to access follow-up care in a non ED or inpatient environment, as well as direct access to a healthcare provider for follow-up care and medical questions.

Behavioral Health Intervention Teams will support the Care Coordination goal by providing expedited consults for psychiatry/substance use.

Baltimore Population Health Workforce Collaborative will support the Access to Urgent Care and Care Coordination goals 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: Baltimore Population Health Work Force Collaborative

Does this initiative address a need identified in your CHNA?	Yes, Social Determinants of Health (Employment), Chronic Disease, and Behavioral Health/Substance Abuse
When did this begin (mo/yr)? Does it have an end date or trigger event that will end it?	January 2017 An initial end of June 30, 2019, which may be extended based on evaluation by HSCRC
What population does this initiative target? (# of people and describe target population)	Unemployed in Baltimore City 35,275 and Individuals who did not work (including disability, students, etc) 63,747 From American Community Survey, 2017 Targeted neighborhoods are those in hospital Community Benefit Service Areas (CBSA) that have higher poverty and unemployment rates than Baltimore City overall. BPHWC will focus on the following 24 zip codes representing CBSA's of the 9 partner hospitals: 21201, 21202, 21205, 21206, 21207, 21211, 21213, 21214, 21215, 21216, 21217, 21218, 21221, 21222, 21223, 21224, 21225, 21226, 21227, 21229, 21231 and 21239. The highest poverty communities to be specifically targeted include: a) the west side communities of Penn-North, Harlem Park, Sandtown-Winchester, Greater Rosemont, Upton/Druid Heights, Southern Park Heights, Pimlico/Arlington; b) the east side communities of Clifton-Berea, Madison East End, Oldtown-Middle East and Belair-Edison; c) the southern communities of Cherry Hill, Brooklyn, Curtis Bay; d) the northeast communities of Waverly, Greenmount East, Govans and Northwood; and e) the southeast Baltimore County communities of Essex, Dundalk, and Rosedale.
Total Number of People Reached by Initiative	35

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

What kind of evidence for success or effectiveness of the initiation is evaluated? Select all that apply and describe.	Count of participants/encounters: #s trained, successfully credentialed, and hired/retained Assessment of workforce development: BACH tracks workforce training effectiveness
Describe outcome of the initiative?	22 individuals were trained and hired as CHW, CNA, and CNA/GNA positions. 13 individuals were retained and full time employed as CHW, PRS, CNA and CNA/GNA positions.
Describe how the outcome of the initiative addresses community health needs?	CHWs provide an opportunity to combat health disparities by promoting and supporting healthy behaviors; they can assist with care management activities to directly prevent or manage chronic disease. With the focus of health care shifting from the hospital setting to the community, CHWs can improve healthcare outcomes in the US 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. PRS services are an important wrap-around to clinical services. CNA/GNAs expand the current homes support reach in the community. They will also serve hospital discharged patients who need personal care at home, but cannot afford it to avoid readmission. The goal of BPHWC is to concomitantly improve the socio-economic status of disadvantaged communities and promote population health in the Baltimore region. We will do this by improving the continuity and healthcare of the communities where CHWs and PRSs work, thus providing income through jobs that impact the health and well-being of the workers.

Total Cost of Initiative for Current FY (include total dollars, donations, grants)	$1,919,733

Initiative 2: Broadway Center for Addiction and Supportive Housing

Does this initiative address a need identified in your CHNA?	Yes, Social Determinants of Health (Homelessness and Housing) and Behavioral Health - Substance Abuse and Mental Health
When did this begin (mo/yr)? Does it have an end date or trigger event that will end it?	Prior to January 2000 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)	45,133 in Baltimore City region over age 12 with alcohol or substance use disorder (SAMHSA, 2012) 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).
Total Number of People Reached by Initiative	400
What category of intervention best fits this initiative?	Chronic condition-based intervention: Treatment Intervention Social determinants of health intervention
Does your hospital work with other groups to deliver this, if so list?	Alcohol and Drug Abuse Administration, Behavioral Health Systems Baltimore, Baltimore City Substance Abuse Directorate, Helping Up Mission, Wilson House
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 peer recovery support.
How initiative is delivered?	Patients receive treatment 2.5-3 hours/day for 4-5 days/week, with a minimum of 9 hours of clinical services scheduled each week. Patients at this treatment level also begin to work on 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. Wilson House prepares women for re-entry into independent living situations. Housing staff began to work with residents to secure preventative medical appointments, obtain employment or other meaningful activities. Helping Up Mission (HUM) is contracted to provide up to 48 male recovery beds for male patients enrolled in the Broadway Center. All patients are required to maintain excellent attendance and progression in treatment goals at the Broadway Center. Transportation is provided between the HUM and the Broadway Center multiple times per day. The maximum length of stay is 6 months. When not engaged in services at the Broadway Center, patients have access to a wide array of HUM services and programming, such as GED courses, computer literacy classes, faith

	services, peer support groups, art therapy, physical fitness equipment, and a patient library.
What kind of evidence for success or effectiveness of the initiation is evaluated? Select all that apply and describe.	Process measures: Tox screenings, treatment compliance scores Surveys of participants: Patient satisfaction surveys
Describe outcome of the initiative?	Successful recovery from substance use and eventual transition into independent living.
Describe how the outcome of the initiative addresses community health needs?	Broadway Center and the supportive housing programs for men and women directly address the need for substance use treatment in Baltimore City as well as the accompanying homelessness that often results from substance use.
Total Cost of Initiative for Current FY (include total dollars, donations, grants)	$1,259,640

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 Bayview Medical Center, 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.

How initiative is delivered?	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.
What kind of evidence for success or effectiveness of the initiation is evaluated? Select all that apply and describe.	Count of participants/encounters: Monthly measures include clients served, total lives reached, number of resource connections.

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

Surveys of participants: After a case is closed, 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. |
| Describe outcome of the initiative? | 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. |
| Describe how the outcome of the initiative addresses community health needs? | Health Leads directs patients of need to resources that can address social determinants of health.

For FY18, the top five presenting needs for each clinic were as follows:

Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
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%)	

Clients Served	Bayview Children's Medical Practice	Bayview Comprehensive Care Practice	Harriet Lane Clinic
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)	$236,500