



Serving Our Communities

The Johns Hopkins Health System

Community Benefit Report | FISCAL YEAR 2022

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A Continuing Commitment to Our Community

Johns Hopkins Medicine is committed to improving the health and wellness of the residents in the neighborhoods we serve. We seek partners who share our values and mission to empower and educate our patients, staff, neighbors, and communities. As students, educators, physicians, and nurses, our continuing commitment to patient care and discovery is exemplified by our community initiatives. Embracing the diversity of leadership available in the community and recognizing the wealth of existing experience and value it brings, we commit to empowering individuals and strengthening partnerships through open dialogue and collaboration.

We understand that in each community we serve that there are distinctive challenges but also opportunities. At each of the health system's hospitals – The Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Howard County Medical Center, Johns Hopkins Suburban in Montgomery County,

Sibley Memorial Hospital in Washington, D.C., and Johns Hopkins All Children's Hospital in St. Petersburg, Florida – we have developed meaningful partnerships that enhance our ability to improve the health and vitality of our neighbors and the communities we serve.

This report highlights a few of these partnerships and the accomplishments achieved through our collaborations.

At Johns Hopkins, we know that by supporting community institutions – congregations, schools, nonprofit organizations, and neighborhood centers – we reach those with the greatest needs. We are committed to strengthening connections through increased dialogue and collaboration to help strengthen our communities.

The Johns Hopkins Health System is committed to listening and learning from the communities we serve. With the insights gained from listening to our neighbors, we strive to bring innovation, research insights, and peerless health care professionals to improve community health in the neighborhoods we call home.

Johns Hopkins Health System— Overview

Since its founding in 1889, Johns Hopkins has been committed to serving the residents in the communities where it operates. Over the years the health system has grown from its original home at The Johns Hopkins Hospital to include a network of six nonprofit hospitals operating in Maryland, Florida, and Washington D.C. This publication highlights a few of the FY 2022 community engagement programs included in the hospitals' annual community benefit reports.



The Johns Hopkins Health System Hospitals

THE JOHNS HOPKINS HOSPITAL

1800 Orleans Street | Baltimore, Maryland 21287

Nationally recognized and internationally renowned, The Johns Hopkins Hospital serves as the principal teaching hospital for the Johns Hopkins University School of Medicine and is an unparalleled center for medical research. Future health professionals gain world-class knowledge and expertise working with global leaders in their fields. The campus has state-of-the-art technologies and facilities designed to accommodate patients of all ages and needs. The hospital delivers care beyond its East Baltimore campus through a network of outpatient centers and community health workers and operates over 300 programs designed to benefit local residents including health education and access to care for those in need.

SIBLEY MEMORIAL HOSPITAL

5255 Loughboro Road | N.W. Washington, D.C. 20016

Sibley Memorial Hospital is a full-service community hospital with 200 private rooms. As part of Johns Hopkins Medicine, our programs include the Johns Hopkins Proton Therapy Center, the Johns Hopkins Kimmel Cancer Center, the Johns Hopkins Center for Bariatric Surgery, Johns Hopkins Maternal-Fetal Medicine, our Behavioral Health program, a nationally recognized orthopaedics program, and a large women's and infants' services program. Grand Oaks is our assisted living residence, and the Renaissance houses the Center for Rehabilitation Medicine, a skilled nursing care unit and a residential Alzheimer's unit. Named "Reader's Pick, Best Place to Have a Baby" by *Bethesda Magazine* 2023 and the "Best Hospital" in *Washington City Paper's* 2022 Best of D.C. issue for the ninth year in a row.

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4940 Eastern Avenue | Baltimore, Maryland 21224

Johns Hopkins Bayview Medical Center, a vibrant academic medical center, has been caring for the citizens of Baltimore for nearly 250 years. The 130-acre medical campus is home to the Johns Hopkins Burn Center, as well as several centers of excellence, including the Stroke Center, Memory and Alzheimer's Treatment Center, Hip and Knee Replacement Program, Lung Cancer Program, and the Johns Hopkins Center for Bariatric Surgery, to name a few. Johns Hopkins Bayview continues to be an integral part of the neighborhood, and is dedicated to community involvement, including revitalization in East and Southeast Baltimore City and Baltimore County.

JOHNS HOPKINS HOWARD COUNTY MEDICAL CENTER

5755 Cedar Lane | Columbia, Maryland 21044

Johns Hopkins Howard County Medical Center is a comprehensive, acute-care medical center serving the Howard County region. With 226 licensed beds JHHCMC offers a full range of services, including neonatology, oncology, outpatient treatment and critical care. In the past year, the hospital's dedicated staff of nearly 1,000 physicians and allied health professionals and more than 1,800 employees, provided care to over 140,000 people including over 69,000 in the emergency department and the delivery of 2,755 babies. In addition, over 12,000 people in the community benefitted from outreach, health promotion, and wellness programs. As Howard County's trusted health and wellness source, JHHCMC is building programs and working with community partners to meet the health needs of our community.

SUBURBAN HOSPITAL

8600 Old Georgetown Road | Bethesda, Maryland 20814

Suburban Hospital is a community-based hospital serving Montgomery County and the surrounding area. Affiliated with the National Institutes of Health, Suburban has a distinguished, cutting-edge stroke program, designated regional Level II trauma center and centers of excellence in cardiac care, orthopedics, neurosciences and oncology. Suburban is the only hospital in Montgomery County to achieve Magnet designation for its nursing excellence from the American Nurses Credentialing Center. In FY22 Suburban's extensive community health and wellness initiatives included 2,109 health improvement programs, classes and community building activities reaching 54,095 individuals.

JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

501 6th Avenue South | St. Petersburg, Florida 33701

An academic medical campus, family-centered care and over 3,000 professionals dedicated to advancing child health make Johns Hopkins All Children's Hospital (JHACH) a destination for advanced pediatric care in multiple specialties. JHACH was fully integrated into the Johns Hopkins Health System in 2011, expanding teaching, research, and pediatric health care. Exceptional patient care distinguishes the services at the hospital's Cancer and Blood Disorders Institute, Heart Institute, Institute for Brain Protection Sciences, and Maternal, Fetal and Neonatal Institute. All Children's offers many resources and programs to support the well-being of children and families in the communities it serves.



\$324.7
Million in
Community
Benefit

Source: 2022 IRS Schedule H (Form 990)

BREAK THE CYCLE – HOSPITAL-BASED VIOLENCE INTERVENTION

The Johns Hopkins Hospital’s Break the Cycle Hospital Violence Intervention Program (BC-HVIP) is an innovative approach to violence reduction through direct engagement with the patient at the time of injury. The program implements targeted interventions incorporating a trauma-informed, healing-centered care approach based on patient/clients’ readiness to change to prevent or reduce the risk of a future violent injury. Critical to the success of the program is the understanding that the trauma from violence affects all aspects of a person’s life. The program follows clients beyond hospitalization until such time as they are successfully transitioned to community-based programs for long-term trauma-informed support. Break the Cycle serves patients who come to JHH with gunshot wounds or stab wounds between the ages of 15 and 35. Within the hospital, BC-HVIP works in an integrated manner with care coordination teams to address the client’s needs, in particular social determinants of health, and provide connection and referral to community agencies and nonprofits that can address those needs.



Infographic from HAVI website:
<https://www.thehavi.org/what-is-an-hvip>

Break the Cycle works with Roca Baltimore, UMB Rebuild, Overcome and Rise (ROAR), Safe Streets, the Mayor’s Office of Neighborhood Safety and Engagement, and the Baltimore City Health Department, and is a member of the Health Alliance for Violence Intervention.

HOPKINS COMMUNITY CONNECTION (HCC)

Hopkins Community Connection (HCC) works to identify and address patients’ essential social needs and connect them with the basic resources they need to be healthy. These social determinants of health — which can range from access to healthy food, safe housing and education to safe neighborhoods and freedom from discrimination — can directly impact patients’ health, putting them at greater risk for chronic illnesses like diabetes, cardiovascular disease and asthma. “We really serve the whole health picture, not just of the patient, but of the family,” says Kristin Topel, Hopkins Community Connection’s program manager. “Families could have questions about their insurance, where to get food or how to get the lights back on. And, no matter who they ask, they’ll be connected to a resource to solve the problem.”

Hopkins Community Connection volunteers sort donations for distribution to clients in need.



Formerly known as Health Leads™, HCC identifies patient's essential resources needs through additional screening during their routine medical appointments and uses student volunteers and community health workers to navigate them to community resources. Through the program, students become trained as future leaders poised to enhance the effectiveness of the health system by routinely addressing these needs as a standard part of quality care. The service is located at The Johns Hopkins Hospital's Outpatient Center, the Harriet Lane Clinic, Johns Hopkins Bayview Children's Medical Practice and Comprehensive Care Practice and Hopkins' partner organization, East Baltimore Medical Center. In FY22, HCC volunteers completed over 1,700 social needs screenings. The top five needs presenting were food access, financial need, utilities, transportation, and household goods. Nearly 4,000 unique patients and families were assisted by HCC, and 7,633 referrals to social service and community assistance organizations were made.

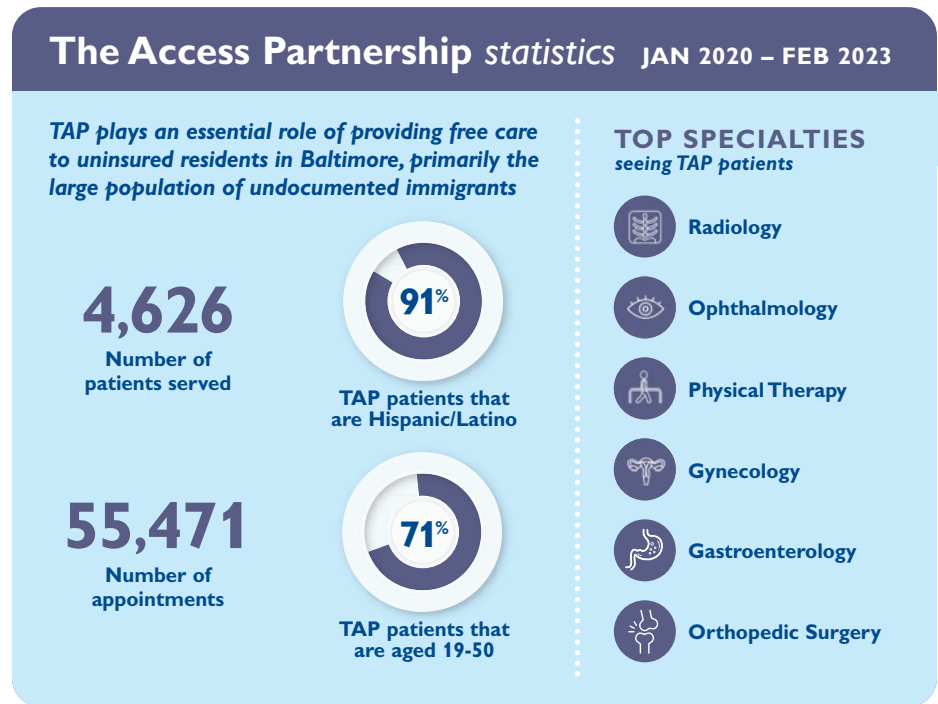
HELPING UP MISSION (HUM)

The Johns Hopkins Hospital provides up to 48 beds at the Helping Up Mission (HUM) for patients, many of whom are homeless or at risk of becoming homeless, battling Substance Use Disease (SUD) while in treatments at the Johns Hopkins Broadway Center for Addiction. By providing stable housing, patients are more likely to maintain adherence to their treatment program and progress in treatment goals. Transportation is provided to the Center multiple times a day. When not engaged in services at the Broadway Center, patients have access to a wide array of 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 workforce development training. Men that reside at HUM can also receive supplemental care using individual and group psychotherapy, and other evidence-based incentives programs for completed goals that are offered under the auspices of the Cornerstone Program, launched in 2012 and directed by Dr. Denis Antoine. Previously available to men

only, in 2021 HUM opened a new facility to serve women. In FY22, The Johns Hopkins Hospital's support helped to serve 245 men at HUM who stayed an average of 56 days for a total of 13,640 bed nights.

THE ACCESS PROGRAM (TAP)

The Access Partnership ("TAP") of Johns Hopkins Medicine provides access to effective, compassionate, evidence-based primary and specialty care for uninsurable residents of the East Baltimore community surrounding The Johns Hopkins Hospital (JHH) and Johns Hopkins Bayview Medical Center (JHBMC) with demonstrated financial need. TAP navigators provide primary and specialty care referrals and services are provided in English and Spanish language. TAP partners include the Esperanza Center, Healthcare for the Homeless, Baltimore Medical Systems, and East Baltimore Medical Center. Between January 2020 and February 2023, the TAP program has served 4,626 unique patients with a total of 55,471 appointments.



TAP information as of Feb 2023



JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER



\$100.8
Million in
Community
Benefit

Source: IRS Schedule H (Form 990)

CONGREGATIONAL DEPRESSION AWARENESS PROGRAM

The Congregational Depression Awareness Program (CDAP), led by Dr. Dan Hale and Dr. Denis Antoine, has trained volunteers from local faith communities to provide education and resources for individuals directly and indirectly impacted by depression. Recently, volunteers collaborated on an initiative for the month of May (Mental Health Awareness Month) that reached more than 6,000 residents.

Drawing on what they learned in CDAP, Bishop Jerry Diggs and Felicia Diggs of the New Israelite Family Worship Center have established a Mental Health Ministry Team and regular mental health forums.



Bishop Jerry Diggs and Felicia Diggs lead a CDAP event at the New Israelite Family Worship Center

MEDICINE FOR THE GREATER GOOD

Medicine for the Greater Good (MGG), formally established in 2013 at Johns Hopkins Bayview, is an initiative and curriculum that trains and educates medical residents in bridging the gap in health disparities between the hospital and the community. MGG volunteers work with schools, churches, and community centers to promote good health practices, such as discussions about diabetes, high blood pressure, and cancer screening.

LAY HEALTH EDUCATOR PROGRAM (LHEP)

The Lay Health Educator Program (LHEP) offers a free course for volunteers from religious communities and social organizations who are interested in addressing today's greatest health challenges. Individuals leave with improved communication of various health topics (e.g., diabetes, cancer, mental health), greater confidence in serving their population, and better awareness for the health concerns around them.

Participants in the Lay Health Educator Program celebrate their graduation



JHBMC SILVER STAY PROGRAM

For many patients a trip to the hospital may result in the inability to ever return safely home to their previous level of functioning. The Department of Care Management works with patients and their families to develop a safe and manageable plan when they are ready to leave the hospital. For some the needs are so complex, many of whom struggle with behavioral health disorders, traumatic brain injury, dementia, poverty and isolation, placement in an assisted care facility must be found. If not, these patients could wait weeks or even months in the highly restrictive environment of

the acute hospital with nowhere to go.

In 2021, The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center Departments of Care Management entered into an agreement with Silver Stay, a for-profit organization that helps to find assisted living care for patients with profound need.

Silver Stay works with a curated group of licensed assisted living facilities in the region to carefully place patients in supportive environments based on their individual circumstances. This care is not initially funded by any form of health insurance so the hospital covers the cost via a contract with Silver Stay. Silver Stay then provides ongoing care coordination to ensure that

the patient is receiving quality care and avoiding unnecessary readmissions while working on solutions to transition from hospital funding to social security coverage or Medicaid waivers.

In the past two years, JHBMC has safely transitioned 19 high-need patients into safe and welcoming care through Silver Stay. The partnership has been an incredible help for the hospital social workers and nurse case managers who continue to work within a very limited resource pool for this population of patients.



Johns Hopkins Bayview Medical Center patient Scott Keimig celebrating his birthday at Alfred House Assisted Living

COMMUNITY CALLS

During the COVID-19 pandemic, Healthy Community Partnership (HCP) and MGG efforts came together to provide weekly virtual platforms to share information on the status of COVID-19, from variants to community prevalence to local resources for vaccines, treatments, and other health care services. More than 670 community members participate in weekly Zoom sessions and emails.

Community members participating on the weekly community calls were informed of a donation from 3M of 64,800 masks. Masks were quickly sought after by many community organizations, churches, and senior housing developments. Eighty organizations requested and received face masks.

COMMUNITY CPR AND 'STOP THE BLEED' CLASSES

MGG hosts CPR and 'Stop the Bleed' classes in the community to equip and empower bystanders to help in a bleeding or cardiac emergency. The initiative gathers health professionals to teach the course to high

school students, church members, or non-profit/ housing organizations.



Executive director of the Mr. Mack Lewis Foundation, Gregory Lewis, Dr. Galiatsatos, and American Heart Association philanthropist, Bert Hash, performing CPR in the boxing gym.



Crystal Parker, President of the North Avenue and Hilton Street Business and Community Task Force, showcasing their COVID-19 room with donated face masks.

Howard County Medical Center



\$31.1
Million in
Community
Benefit

Source: IRS Schedule H (Form 990)



JOURNEY TO BETTER HEALTH

The Journey to Better Health (J2BH) program at Johns Hopkins Howard County Medical Center, through funding support from the Howard County Health Department, works with Howard County faith-based organizations to advance the health of Howard County residents. Partnerships with faith communities have shown to influence health behavior changes, health care practices and health care planning, especially in high-risk populations. Members of partnered congregations participate in health screenings and attend evidence-based chronic disease self-management education that supports improved control of conditions such as diabetes and hypertension. Community Companions are faith community and lay volunteers that provide support through the Member Care Support Network (MCSN), which is free and available to Howard County residents. Trained to conduct home and hospital visits, volunteers provide companionship, connection to social resources, and personalized support after a hospitalization or health crisis. J2BH has worked with over 30 congregations and reached over 1,300 people through screenings and other interactions.

“The blood pressure and pre-diabetes classes are very beneficial; we often hear comments about the excellent instruction participants receive.”

- Rev. Ostein B. Truitt
Assistant Pastor, St. John Baptist Church

ADVANCED CARE PLANNING

Naming a health care agent and having a plan for care preferences is important for all adults, and is especially vital for patients nearing the end of life, when many care decisions are made. In Howard County, many adults do not have an Advance Directive (AD) document and/or a document naming a

health care proxy or agent. In order to address this gap, Johns Hopkins Howard County created a program focused on ensuring that patients have an Advance Directive with a designated Health Care Agent and that expresses their end-of-life wishes. An Advanced Care Plan (ACP) Coordinator can meet patients at the bedside, provide them with education, and assist with the creation and collection of advanced directives during hospitalization or post-discharge. The ACP Coordinator also holds monthly office hours, which are open to the public and provide community members with the opportunity to learn more about Advance Directives, complete them and have them uploaded into Johns Hopkins Howard County's medical record system. The ACP Coordinator has engaged with about 3,200 patients and family members over the last two years.

Johns Hopkins Howard County Medical Center ACP Coordinator discusses Advance Directives with patients.



BEHAVIORAL HEALTH

When surveyed, many Howard County residents have reported needing, but not having access to, behavioral health treatment. Due to the challenges in accessing behavioral health appointments in a timely manner, many residents in crisis come to the Emergency Department (ED) at Johns Hopkins Howard County for treatment. To improve access to behavioral health treatment in the community, Johns Hopkins Howard County partnered with the Howard County Government to hire two Behavioral Health Navigators (BHN). The Behavioral Health Navigators connect patients with behavioral health issues (mental illness and/or substance use disorder) in the ED to appropriate community-based services and providers in a timely fashion. This includes referrals and linkages to mental health treatment, substance use treatment, support groups and resources that address social determinants of health that negatively impact the patients' well-being. BHN services consist of a screening that identifies non-medical needs, completion of referrals, assistance with scheduling post discharge mental health or drug treatment appointments, and follow-up phone calls within 48 hours of discharge from the ED to ensure linkages have successfully occurred. The program has seen over 1,340 patients and connected almost 80% of them with community resources and services.

COMMUNITY CARE TEAM

For anyone, but especially older adults, a hospital stay can be a stressful event. Often faced with multiple chronic conditions, limited mobility and social isolation, many older patients need additional help after a hospital stay. Enter the Johns Hopkins Howard County Community Care Team (CCT). CCT provides community-based, patient-centered comprehensive support and coordination to patients and family caregivers for 30-90 days following a hospitalization or emergency department (ED) visit. Through frequent home visits and phone contacts, a multi-disciplinary team of nurses, a social worker and community health workers provide individualized attention and support while delivering services including health education, disease-specific management, medication reconciliation, connection to/coordination with other health care providers, care plan development and extensive social support/advocacy. CCT staff are



Community Care Team at Johns Hopkins Howard County Medical Center

knowledgeable about resources across Howard County and have developed strong partnerships with many community organizations, including the Howard County Health Department, the Howard County Office on Aging and Independence, and transportation programs like Neighbor Ride. Over the last two years, CCT has had almost 2,800 referrals with over 60% of the referrals accepting assistance from the team to gain help in connecting to the right supports and reducing their chance of being re-hospitalized.



Community Care Team Members visiting a patient.

COMMUNITY HEALTH WORKER (CHW) TRAINING PROGRAM

In 2021, Johns Hopkins Howard County also launched a Community Health Worker (CHW) Training Program to help address the need for a

workforce to support community programs and help address and eliminate non-clinical barriers to health. The training consists of over 100 hours of online and virtual real-time sessions that are completed within 14-15 weeks and focuses on nine core competencies such as advocacy, knowledge of local resources, teaching skills to promote healthy behavior change, and care coordination support skills. The Program is accredited by the Maryland Department of Health and Johns Hopkins Howard County is the only hospital in the state with an accredited Community Health Worker Training program. From January 2021 through May 2023, 84 learners have completed the program and every class has been filled.



SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE



\$34.4
Million in
Community
Benefit

Source: IRS Schedule H (Form 990)

THRIVING TO HELP PATIENTS MANAGE THEIR DIABETES

Suburban Hospital's Diabetes Self-Management Training (DSMT) program helps people living with diabetes manage their condition more effectively through a combination of in-person and telemedicine appointments.

Taught by a team of dedicated Certified Care and Education Specialists (CCES), this American Diabetes Association-accredited program works one-on-one with participants to help them make small behavioral changes that translate into big results. Many who have struggled for years trying to control their diabetes notice their A1C improves within months of their initial CCES appointment.

“Often, people don't know why they take medicine,” said CCES, Leni Barry, MA, BSN, RN-BC. “They need to understand why they need to take three different medications. I walk them through the role each one has in managing their diabetes.”

As trained lifestyle coaches, CCES empowers participants to make informed decisions on the self-management and treatment of their diabetes, leading to improved blood sugar levels, blood pressure and cholesterol as well as fewer diabetes-related complications and hospitalizations.

Suburban's DSMT also includes a transition guide nurse and two community health workers, who focus on addressing patients' social needs that serve as barriers to positive health outcomes. They also facilitate the support of wrap-around services, such as transportation, food access, insurance transitions and medication costs.

Since its inception in December 2021, Suburban's DSMT services has cared for 884 patients and community members, with the goal to serve twice this many by the end of year two.

NAVIGATING THE STRUGGLES OF ADDICTION

Overcoming addiction can feel nearly impossible. Recognizing a need to help individuals who are drug-and/or alcohol-dependent and in serious distress, Suburban's Peer Recovery Coaches provide support and motivation to patients, and assist in the referral process for treatment services.



Certified Diabetes Educator, Caitlin Smith coaches individual strategies and goal setting for healthy eating with those living with diabetes through Suburban's Diabetes Self-Management Training.



Team members from Suburban's Behavioral Health Services embraced the opportunity to share resources and spread the message on mental health awareness at the local NAMI walk this past spring.

“When we talk to people, we explain that we’re in long-term recovery ourselves and that helps break down some of the barriers that people face,” Barbara says. “Often when people come to the hospital, they feel stigmatized by their drug use. If they know the person they’re talking to has been in a similar situation, it helps bring their guard down a little bit, and maybe gives them hope they can recover as well.”

- Barbara Sellner, Suburban Hospital Peer Recovery Coach

One of Suburban’s peer recovery coaches, Barbara Sellner, meets with patients in the Emergency Room who are struggling with drugs or alcohol, and discusses treatment options. If patients are open to treatment, she helps them arrange services upon discharge. If the patient is not willing or ready to go into treatment, Barbara continues to see them while they are in the hospital, providing motivation and discussing treatment resources.

Peer Recovery Coaches themselves are recovering from substance addictions, giving them personal experience in the rehabilitation process. They are a powerful resource to bridge the gap in care by engaging patients and their families.

“When we talk to people, we explain that we’re in long-term recovery ourselves and that helps break down some of the barriers that people face,” Barbara says. “Often when people come to the hospital, they feel stigmatized by their drug use. If they know the person they’re talking to has been in a similar situation, it helps bring their guard down a little bit, and maybe gives them hope they can recover as well.”

During Barbara’s nearly four years at Suburban, one patient who was in his early 50s and came to the hospital with encephalopathy made a lasting impression. At first, this patient was reluctant to try treatment. He had tried in the past to get sober, but was never successful.

After speaking with his physicians and Barbara, the patient finally decided it was time to enter treatment. His motivation was to be there for his young son. Seven months after Barbara saw the patient in the hospital, he had maintained his sobriety and was able to receive a life-saving liver transplant.

In FY22, 703 patients received navigation and resource services by Suburban’s Peer Recovery Coaches.

PEP: BUILDING FAMILY RESILIENCY

For over a decade, Suburban Hospital has supported the Parent Encouragement Program (PEP), which equips parents in Montgomery County with skills and tools to navigate critical issues facing families today.

To address the deteriorating mental health of children, the PEP Family Resiliency program provides parents and caregivers with tools to help children cope with stress and anxiety. Parents also learn how to strengthen their relationships and communications with their children, exploring limit-setting, problem-solving skills and more. Offered in English and Spanish, the program features engaging video instruction and small ‘support-group’ style live facilitation, with content provided by Suburban Hospital.

Since inception in Fall 2022, 184 parents completed the six-week program, reaching close to 423 children.



Dr. Dominique Foulkes, medical director and chair of pediatrics at Suburban Hospital shares her expertise and knowledge as a presenter in PEP’s Family Resiliency videos where she describes the signs and symptoms of increased anxiety, stress and depression in children.



SIBLEY MEMORIAL
HOSPITAL

JOHNS HOPKINS MEDICINE



\$29.7

Million in
Community
Benefit

Source: IRS Schedule H (Form 990)

WARD INFINITY

Ward Infinity's mission has been to partner with change agents in Washington, D.C.'s most underserved communities, Wards 7 and 8, to magnify and accelerate their capacity to radically improve the health and well-being of underinvested communities. Ward Infinity aims to radically reduce health disparities through the creation of community-driven solutions that address social determinants of health.

Ward Infinity invites people to apply, provides mentors, business support and education, community building, and both a stipend to the team and an opportunity to compete for a prize in a pitch competition. In fiscal year 2022, Sibley selected a cohort of 16 people to work on 5 projects in one the following categories: increasing availability and/or access to nutritious food, creating strong bonds and enhancing emotional well-being, as well as shaping healthy places where residents live, work, and play.



Ward Infinity – Dynamic Solutions for the Aging

Ward Infinity conducted post-program listening sessions to understand the needs of the cohort members and surrounding community with regard to business development, public health programs and support for future cohorts and the community East of the River. In collaboration with the Johns Hopkins Carey Business School, a survey was developed and implemented so the next cohort will benefit from the experiences of their predecessors.

The Community Collaborative (CC) was created to respond to those communicated needs with business education, foster collaborative community connections, and increase the awareness of Ward Infinity with early-stage health entrepreneurs. CC continued with social innovators living in Wards 7 and 8 by leveraging the networks within Sibley and the Johns Hopkins Health System.

Ward Infinity Cohort Introductions



ENGAGING AND EDUCATING OLDER ADULTS

Partnering with a Ward 7 church, the Sibley Senior Association (SSA) developed a monthly webinar series called Discussing the Facts. Designed specifically to reach an underserved audience that often has a mistrust of the medical establishment, the program attempts to increase trust by elevating the voices of people of color to present on important issues such as diabetes, prostate health, aging and age-related changes, depression, domestic violence, heart health, medication adherence, movement as medicine, normal aging and the brain, and stress. All speakers address health with a focus on promoting health equity.

CLUB MEMORY® EXPANSION

Club Memory supported over 900 seniors in underserved wards to stay engaged, inspired, and mentally stimulated during pandemic isolation by offering weekly virtual sessions and bi-monthly activity



Evelyn "Evie" McKenly

handouts mailed to their homes. Packets included health information, including current information about COVID-19 and vaccines, as well as inspirational quotes, activities, and tips on self-care. They included important resources and connected members to dementia navigators

“I love the wellness center and drive there three times a week to keep my mind sharp. Club Memory is really a great brain exercise.”

- Evelyn "Evie" McKenly actively participates in our Club Memory programs

for help with issues such as advance care planning and telemedicine. Club Memory expansion continued popular virtual programs such as the monthly Saturday Exercise Class and the quarterly Book Discussions on Race and increased outreach to care partners by offering two new support groups at churches in Wards 5 and 7.

A special highlight was the celebration of the 102nd birthday of one of our members in November, 2021. Evelyn "Evie" McKenly actively participates in our Club Memory programs. She states, "I love the wellness center and drive there three times a week to keep my mind sharp. Club Memory is really a great brain exercise."

REDUCING ISOLATION DURING THE PANDEMIC

As the pandemic wore on, the Sibley Senior Association increased the number of virtual programs and the frequency to provide resources, support, and ways to help reduce isolation and help maintain physical, emotional, and cognitive health. The number and frequency of support groups increased to serve a larger number of people with chronic illnesses and their care partners. SSA also provided technical assistance to older adults as programing and communications moved increasingly to an online format.

Many new programs have been added, including a support group for Adult Children Caring for Parents, a no reservations required Drop-In Group where weekly presentations were offered on a topic of interest, a Spanish Conversation Group where native Spanish speakers conversed around a topic and shared stories about their country of origin, and a Poetry Group where members shared poems and discussed meaning and relevance to their lives in a changing world. A new Grief Support Group was designed exclusively for former care partners who lost their loved one during the pandemic.

In response to the need for additional support due to increased isolation, established care partner support groups transitioned from twice a month to weekly meetings. These programs encourage conversation, engagement, participation, community, and intellectual stimulation.



JOHNS HOPKINS
M E D I C I N E

JOHNS HOPKINS
ALL CHILDREN'S HOSPITAL



\$66.7
Million in
Community
Benefit

Source: IRS Schedule H (Form 990)

LOCAL SCHOOL PARTNERSHIPS WITH JOHNS HOPKINS ALL CHILDREN'S COMMUNITY HEALTH

Healthy schools support healthy students and healthy students are more likely to reach their full potential both in and out of the classroom. The Johns Hopkins All Children's Community Health and Wellness team supports several school-based programs, including the Lakewood HS Health Squad, Allkids in the Kitchen culinary education, and food security support for students and families in need. Through these programs, Johns Hopkins All Children's experts visit classrooms, as well as local community locations, to provide support, guidance, and resources. Activities are created with the help and input directly from teachers and students, with the goal of promoting and supporting healthy habits on campus as well as providing important resources that can be taken home to families. Through these health, fitness, and food security programs, the Community Health Team reaches more than 25,000 individuals. The two following examples provide a snapshot of the work being done to support food security and promote wellness for local students and families.

Lakewood High Health Squad

To stir-up school spirit, encourage physical activity, students and staff at Lakewood High School participated in a kickball tournament, culminating in a nail-biting match between the students and teachers. More than 120 boys and girls engaged in an elimination



Finalists in the Lakewood High School Health Squad Kickball Tournament

tournament to determine the team of students to face teachers. On the last day, over 200 spectators gathered to watch the students defeat the teachers in a 17-16 victory. Johns Hopkins All Children's support of the Student Health Squad helped provide over 500 students with culinary education and fitness activities.

Campbell Park Elementary Mother's Day Grocery Give Away

Johns Hopkins All Children's Community Health holds an annual mobile pantry grocery drive for families at Campbell Park Elementary. The school sits just 1 mile



Dr. Jamee Walters and Johns Hopkins All Children's Marketing and Community Health staff distributing food during the Mother's Day Grocery Give Away event.

from Johns Hopkins All Children's Hospital, and 88% of its enrolled students are impacted by financial hardship. This year, the Grocery Give Away event reached 693 individuals including 375 children.

COMMUNITY HEALTH AND THE HEALTHY START PROGRAM

Healthy Start, a program of Johns Hopkins All Children's Hospital (JHACH), works to reduce disparities in maternal and infant health in high-risk communities. Focusing on communities with infant mortality rates at least 1.5 times the national average, Healthy Start supports women before, during, and after pregnancy by addressing their health and social service needs, strengthening father and family resilience and engaging community partners to enhance systems of care. The program works to ensure individuals receive cultural humility through family-centered and comprehensive health, and social services for women, men, infants and their families. Healthy Start programs provide a forum for a community voice and they participate in Community Action Networks (CANs) that mobilize health care, social service, and other providers to coordinate services, and steer local action to address social determinants of health related to poor birth outcomes.



Members of the panel leading a community discussion on maternal and infant health disparities in the Black community.

As part of the Healthy Start program, JHACH hosts community discussions aimed at raising awareness of challenging issues and engaging in an open conversation to

explore ways the hospital and community can work together to address critical needs. One event example is a community screening of a powerful documentary on Black maternal mortality entitled "Aftershock." The film explored the devastating impact of systemic racism and health care disparities on the health and well-being of Black mothers and their babies. Through compelling personal stories and expert interviews, "Aftershock" drew attention to this urgent issue and calls for action to address the root causes of this crisis. Following the screening, there was a panel discussion about the film and how community and clinicians can contribute to making maternal health care more equitable and just. The panel was comprised of a doula, mental health clinician, director of nursing, local historian, high-risk physician and one of the documentary's featured fathers.



Mother's Day Lunch

Another Healthy Start at Johns Hopkins All Children's outreach event was "Taking care of your physical and mental Self," a Pre-Mother's Day brunch event. In addition to providing a healthy brunch, the event included discussions on healthy eating, mental and physical health, and cross communication methods. Healthy food samples and other items to promote self-care were given to the ~100 participants. Johns Hopkins All Children's events like this are receiving high praise from participants, some of whom shared it is an opportunity to discuss ways of becoming their best selves.

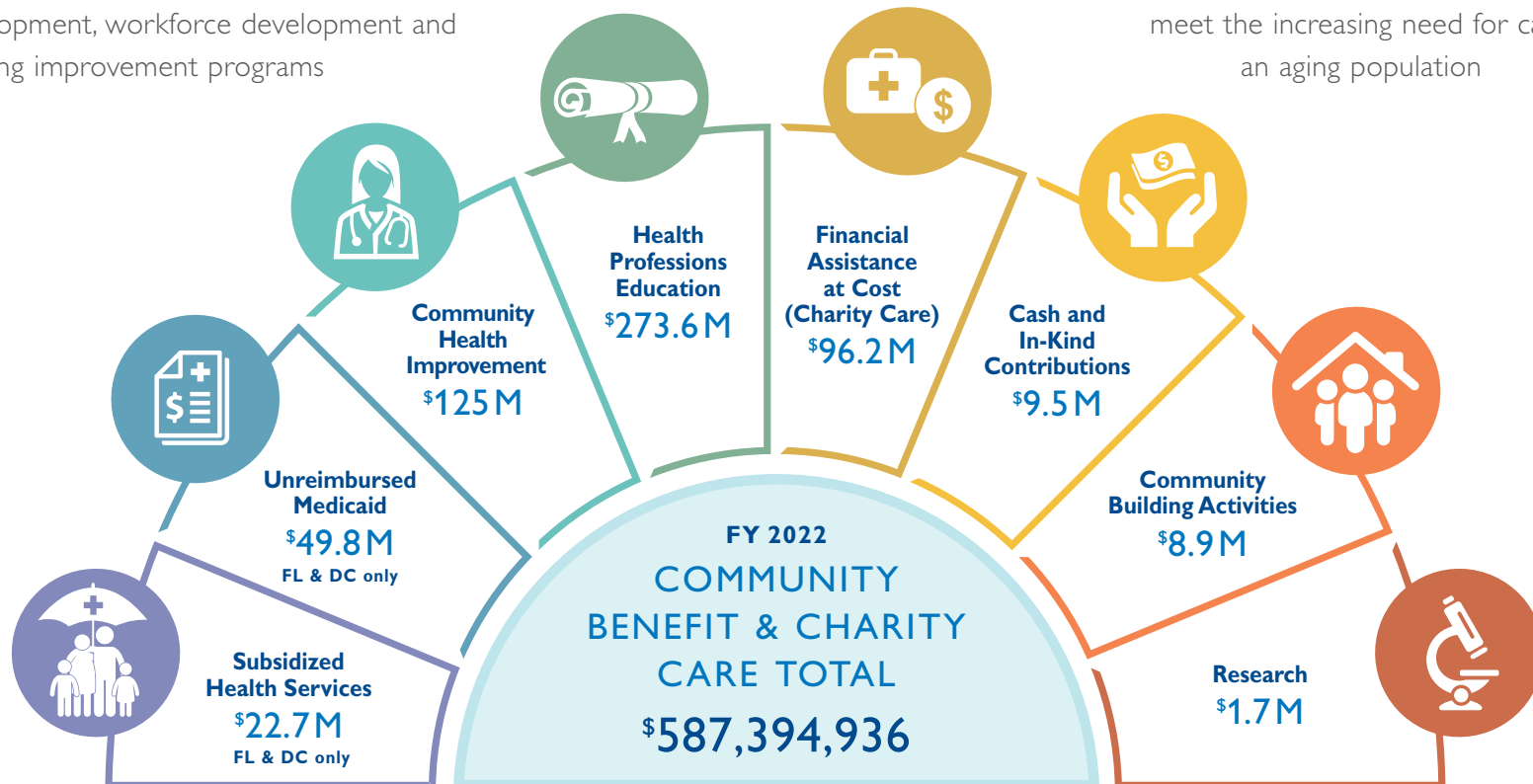
Fiscal Year 2022 Community Benefit Activities Summary

The Johns Hopkins Health System hospitals are committed to improving the health and wellness of the residents in our communities.

In Fiscal Year 2022, the Johns Hopkins Health System hospitals spent nearly \$587 million on activities to strengthen its communities, build strong partnerships and improve the health and wellness of the residents they serve.

Examples of activities which benefit the communities include:

- Direct health services, outreach and education programs including screenings, free clinics, support groups, mobile units etc.
- Contributions to local community organizations to support community outreach work
- Community building activities such as economic development, workforce development and housing improvement programs
- The cost of free or reduced cost “charity care” provided to uninsured and underinsured low-income patients
- Unreimbursed costs for providing community-based services
- Education of health professionals – for example, clinical training of the next generation of health professionals to meet the increasing need for care of an aging population





For more information about this report or the Community Benefit Activities of the Johns Hopkins Health System please contact:

The Johns Hopkins Hospital

Government and Community Affairs | 443-997-5999

Johns Hopkins Bayview Medical Center

Community Relations | 410-550-0289

Johns Hopkins Howard County Medical Center

Community Education | 410-740-7601

Suburban Hospital

Community Health and Wellness | 301-896-3572

Sibley Memorial Hospital

Sibley Senior Association and Community Health | 202-364-7602

Johns Hopkins All Children's Hospital

Community Relations | 727-767-2328

FY 2022 JHHS Community Benefit Brochure produced by
Government, Community and Economic Partnerships
<https://gce.jhu.edu>



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