The Johns Hopkins Hospital

Implementation Strategy

In response to the

JHH Community Health Needs Assessment

Fiscal Year 2013

JOHNS HOPKINS

MEDICINE

Introduction

The Johns Hopkins Hospital Implementation Strategy is a companion report to the JHH Community Health Needs Assessment (CHNA) as required by the Treasury Department ("Treasury") and the Internal Revenue Service (IRS) in response to new regulations set forth in the Affordable Care Act (ACA).
The ACA, enacted on March 23, 2010, requires not-for-profit hospital organizations to conduct a CHNA once every three taxable years that meets the requirements the Internal Revenue Code 501(r) set forth by the ACA. It also requires each hospital to adopt an Implementation Strategy that addresses the community health needs identified in the CHNA.

The development of the CHNA and the Implementation Strategy was led by the Office of Government and Community Affairs (Tom Lewis, Vice President) and Redonda Miller (JHH Vice President for Medical Affairs) and involved the contributions of over 350 individuals through direct interviews, surveys and focus groups. Key stakeholder groups included but were not limited to, community residents, members of faith based organizations, health care providers, neighborhood association leaders, elected officials, health professionals, Johns Hopkins Medicine leadership and other experts both internal and external to Johns Hopkins.

The CHNA is a report based on epidemiological, qualitative and comparative methods that assesses the health issues in a hospital organization's community and that community's access to services related to those issues. The Implementation Strategy is a list of specific actions and goals that demonstrate how Johns Hopkins Hospital plans to meet the CHNA-identified health needs of the residents in the communities surrounding the hospital, i.e. the Community Benefit Service Area (CBSA). This Implementation Strategy has been prepared for approval by the JHH Board of Trustees.

IRS Requirements

The requirements outlined by the Treasury and the IRS for the Form 990 Schedule H submission state that the Community Health Needs Assessment (CHNA) must contain:

- A separate written report for each hospital
- Description of the community served by the hospital, i.e. the Community Benefit Service Area (CBSA) and how that community is defined
- Description of the process and methods used to conduct the CHNA

- Information gaps that may impact ability to assess needs
- Identification of any collaborating partners
- Identification and qualifications of any third parties assisting with CHNA
- Description of how input from community was used
- Prioritized description of all community health needs identified through the CHNA
- Description of existing health care facilities within the community available to meet the needs identified

The Implementation Strategy which is developed and adopted by each hospital must address each of the needs identified in the CHNA by either describing how the hospital plans to meet the need or identifying it as a need not to be addressed by the hospital and why. Each need addressed must be tailored to that hospital's programs, resources, priorities, plans and/or collaboration with governmental, non-profit or other health care organization. If collaborating with other organizations to develop the implementation strategy, the organizations must be identified. The board of each hospital must approve the Implementation Strategy within the same fiscal year as the completion of the CHNA.

The Community We Serve

For purposes of defining a Community Benefit Service Area (CBSA), JHH focused on specific populations or communities of need to which the hospital has historically allocated resources through its community benefits plan. The hospital uses geographic boundary and target population approaches to define its CBSA. The CBSA is defined by the geographic area contained within the seven ZIP codes surrounding JHH: 21202, 21205, 21206, 21213, 21218, 21224 and 21231. This area accounts for approximately 25% of the inpatient discharge population of the hospital, and most of the recipients of the hospital's community outreach projects and contributions reside in this area. Within this CBSA, JHH has 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.

Health Priorities

From a broad list of health concerns gathered from primary (interviews, focus groups, surveys) and secondary (federal, state, local health databases) sources, larger categories of health concerns were identified. For example, high blood pressure and cholesterol, as well as other health issues related to the cardiovascular system, were collapsed into "cardiovascular disease." Those concerns that did not fall within the identified definition of a health priority, social determinants of health for example, were put aside to be discussed in conjunction with the health priorities that they aligned with.

As a result of the CHNA, the following ten health needs have been determined as the priorities in the JHH CBSA.

- Asthma
- Cancer
- Cardiovascular Disease
- Diabetes
- Health Care Access and Availability
- Infectious Disease (HIV/AIDS, STDs)
- Maternal and Child Health
- Mental Health
- Obesity
- Substance Abuse

Johns Hopkins Medicine Affiliate Hospitals

Each of the Johns Hopkins Health System hospitals must submit a separate CHNA and board approved Implementation Strategy. While each report varies greatly due to the distinct characteristics and needs of each hospital's CBSA and the research and discovery process used to determine the community health needs, a workgroup of representatives from each of the JHHS hospitals collaborated to determine a consistent format and approach to the CHNA and Implementation Strategy.

Implementation Strategy Additional Notes

The Implementation Strategy is not intended to be a comprehensive catalog of the many ways the needs of the community are addressed by each hospital but rather a representation of specific actions that the hospital commits to undertaking and monitoring as they relate to each identified need. Only a few internal and external partners have been included in the line item entries on the Implementation Strategy charts; however, many JHH clinical departments will be partnering in the collaborative efforts and specific actions that address the goals of "meeting the health needs of the community" whether that entails involvement in a clinical program or protocol or if it is an individual or group sharing knowledge in an educational outreach opportunity.

The following charts reflect the actions identified for measurement and tracking for the JHH Implementation Strategy.

Johns Hopkins Hospital Implementation Strategy

#	Community Health Need	Target Population	Action Plan	Goal(s)	Partnering Organization(s)
1-1	Asthma	Children with asthma who reside in the CBSA	In accordance with the DHMH Asthma Action Plan, regarding pediatric asthma care, provide free spacers for metered dose asthma inhalers at the Harriet Lane Clinic to children diagnosed with asthma	Increase the consistency of care for children with asthma using inhalers	**External:** Maryland Department of Health and Mental Hygiene (DHMH) **Internal**: Harriet Lane Clinic; Office of East Baltimore Community Affairs; JH Office of Community Health (OCH)
1-2	Asthma	Children with asthma who reside in the CBSA	Become a partner in the JH Dept of Asthma and BCHD program to provide HEPA filters to families containing members who smoke and children with asthma	Decrease exposure to second hand smoke to children with asthma who live in the CBA	**External:** Baltimore City Health Department; JH School of Medicine **Internal:** Center for Childhood Asthma in the Urban Environment; Office of East Baltimore Community Affairs; JH Office of Community Health (OCH)
1-3	Asthma	CBSA residents diagnosed with asthma	Educate the community to keep their asthma clinic follow-up appointments which typically occur every 3 to 6 months until stable lung function	Improve the health of diagnosed asthma patients by increasing the number of patients who keep their follow-up appointments	**Internal:** Johns Hopkins Pediatric Clinic
2-1	Cancer	CBSA residents who are smokers	Increase CT scans for smokers	Increase early identification of suspicious nodules and thereby increase early cancer detection	**Internal:** Relevant JHH Clinical Departments
2-2	Cancer	Women ages 40-74 years living in the CBSA	Increase percentage of female population in CBSA receiving mammograms	Make progress towards the National Cancer Institute guidelines for breast cancer screenings	**Internal:** OB-GYN clinical care outlets (Procedure to be tracked in EPIC)
3-1	Cardiovascular Disease	CBSA residents	Increase the number of families who know how to perform CPR. (400 families will be receiving training through an outreach program with faith based organizations in FY14)	Reduce the health disparity in the CBSA of those receiving emergency bystander CPR by increasing the number of CBSA residents who have been trained to administer it	**External:** East Baltimore Faith Based Organizations **Internal:** JH Office of Community Health (OCH) - Gotta Have Heart Program
#	Community Health Need	Target Population	Action Plan	Goal(s)	Partnering Organization(s)

#	Community Health Need	Target Population	Action Plan	Goal(s)	Partnering Organization(s)
3-2	Cardiovascular Disease	CBSA residents with undiagnosed cardiovascular problems	Increase community outreach to engage CBSA residents in education and screening for cardiovascular problems	Increase the number outreach programs on hypertension and other cardio vascular conditions to residents of the CBSA.	**External**: Isaiah Wellness Center, **Internal:** Community Chats (OCH); JHH Heart Hype; Stroke Center Community Outreach (JHH Cerebrovascular)
4-1	Diabetes	CBSA residents living with diabetes	Increase knowledge of and access to diabetes management programs in the CBSA through outreach programs at area schools, churches, community meetings	Increase number of educational outreach encounters in the CBSA	**External**: Comiendo Juntos; Isaiah Wellness Center **Internal:** JH Office of Diversity and Cultural Competence Urban Health Radio; JHOC Diabetes Center
4-2	Diabetes	CBSA residents living with diabetes	Increase education and participation in regular vision monitoring by CBSA patients	Increase number of retinopathy screenings	**Internal:** Wilmer Eye Center Diabetic Retinopathy screening program
4-3	Diabetes	CBSA residents living with diabetes	Increase education outreach opportunities and participation in diabetes management programs	Improve Hemoglobin HbA1c levels in diabetes patients	**External**: Isaiah Wellness Center **Internal:** JHOC Diabetes Center
5-1	Health Care (Access and Availability)	CBSA residents	Identify at risk patients upon admission to JHH or during visit to ED or JHH clinic and link to follow up care	Increase number of patients receiving post discharge and/or post visit follow-up care	**External**: JH Community Physicians (JHCP); JH Health Care LLC (JHHC); JH Home Care Group (JHHCG); Johns Hopkins Community Health Partnership (J-CHiP); **Internal:** The Access Partnership program (TAP)
5-2	Health Care (Access and Availability)	CBSA residents	Through prescription bridging programs and patient assistance programs help patients receive sustained access to needed medications	Increase the number of JHH patients receiving patient services from the JH outpatient pharmacy (prescription services, medication therapy management services and other pharmacy services	**Internal:** Outpatient Medication Assistance Program (OMAP); Patient Assistance Program; Special Needs Program
5-3	Health Care (Access and Availability)	JHH medical staff	Provide annual training for all JHH medical staff on accessing and utilizing interpretive services	Increase skills and sensitivity of JHH medical staff in addressing the differing needs of diverse patient populations.	**External:** Esperanza Center, Latino Providers Network **Internal:** JHM Office of Diversity and Cultural Competence
#	**COMMUNITY HEALTH NEED**	**TARGET POPULATION**	**ACTION PLAN**	**GOAL(S)**	**PARTNERING ORGANIZATION(S)**

#	Community Health Need	Target Population	Action Plan	Goal(s)	Partnering Organization(s)
5-4	Health Care (Access and Availability)	CBSA residents	Offer a bedside delivery service to fill discharge prescriptions with assistance for uninsured residents	Increase access to medications for residents in the CBSA	**External:** Johns Hopkins Home Care Group (JHHCG) **Internal:** JHH Department of Pharmacy
5-5	Health Care (Access and Availability)	CBSA residents	Pilot a post-discharge home visit by a pharmacist to perform medication reconciliation and medication education	Increase access to pharmacist medication management assistance for residents in the CBSA	**External:** Johns Hopkins Home Care Group **Internal:** JHH Department of Pharmacy
6-1	Infectious Disease	CBSA residents at risk (i.e. intravenous drug users, MSM population, sexually active individuals)	Increase knowledge of and access to screening for HIV in CBSA residents at risk through community outreach and primary care intervention.	Increase number of HIV screenings among CBSA adults and adolescents.	**External:** Sisters Together and Reaching (STAR); ODCC Urban Health Radio **Internal:** JH East Baltimore Medical Center
6-2	Infectious Disease	CBSA residents currently living with HIV	Increase access to care and linkage to medication assistance for HIV positive individuals in the CBSA	Increase number of patients who receive same day/next day care when receiving news of a positive HIV diagnosis	**Internal:** JH Moore Clinic; JHH HIV/AIDS Patient Emergency Fund
7-1	Maternal and Child Health	New mothers who reside in the CBSA	Through education and support care – teach the importance of breast feeding newborns for at least their first six months	Increase the number of women who breast feed at 6 weeks and 6 months post-delivery and become the first Maryland hospital to earn the World Health Organization (WHO) baby friendly designation	**External**: World Health Organization **Internal:** Baby Friendly Committee; JHH Wellstart program; Maternal Fetal Medicine clinic
7-2	Maternal and Child Health	New teenage mothers in the CBSA	Promote the use of LARC (Long Acting Reversible Contraception) among teenage new mothers	Increase the percentage of new teenage mothers who receive counseling on the benefits to maternal and child health from LARC before discharge	**Internal:** Baby Friendly Committee; JHH Wellstart program; Maternal Fetal Medicine clinic

#	Community Health Need	Target Population	Action Plan	Goal(s)	Partnering Organization(s)
8-1	Mental Health	CBSA residents	Enhance access to community mental health services by providing early intervention, detecting and treating early on-set psychosis, offering walk-in clinic hours and mental health educational events	Increase the number of walk-in clinic patients served and educational events	**External:** Baltimore Mental Health Systems (BMHS); Health Care for the Homeless; Esperanza Center (Catholic Charities of Baltimore); Helping Up Mission **Internal:** East Baltimore Medical Center; PAODD Program for Alcohol and Other Dependent Drugs
8-2	Mental Health	CBSA residents seeking mental health and/or substance abuse services	Increase supportive housing census for individuals seeking services for mental health and/or substance abuse	Increase the number of persons who receive adequate housing who are receiving treatment for substance abuse and/or mental health disorders	**External:** Baltimore City Health Department; Helping Up Mission; Healthcare for the Homeless **Internal:** Broadway Center for Addiction; PATCH Psychogeriatrics Assessment and Treatment in City Housing
9-1	Overweight/ Obesity	CBSA residents	Expand access to local healthy food options to residents in food deserts	Increase the percentage of CBSA residents who have access to a food retail outlet that sells a variety of healthy foods	**External:** HEBCAC and Santoni's EB Supermarket Shuttle; BaltiMarket Virtual Grocery; JHM Community Farmers' Market **Internal:** Office of East Baltimore Community Affairs
9-2	Overweight/ Obesity	Johns Hopkins Hospital physicians	Require physicians measure the body mass index (BMI) of their adult patients and provide educational opportunities for physicians to increase self-efficacy discussing behavioral interventions	Increase the number of physicians who regularly measure the BMI of their adult patients	**Internal:** JHOC Clinics; Clinical Departments
9-3	Overweight/ Obesity	CBSA residents	Expand community, childcare, and school-based programs focused on healthy eating habits and physical activity	Increase the number of CBSA residents who have participated in at least one program per year	**External:** Henderson Hopkins School; Youth Fitness Circle Harriet Lane Clinic; Playworks; Meals on Wheels **Internal:** JHH Pediatrics East Baltimore Health Fair; Office of East Baltimore Community Affairs

10-1	Substance Abuse	Physicians who treat opioid dependence with buprenorphine	Provide training opportunity for physicians to become qualified to apply for an "X" number and subsequently prescribe buprenorphine	Increase the number of local physicians eligible to apply to the DEA to prescribe buprenorphine	Drug Addiction Treatment Act of 2000 (DATA 2000); professional organizations (e.g., AAAP, ASAM)
10-2	Substance Abuse	CBSA patients, eligible for J-CHiP, and who have an active substance abuse disorder and a history of high health care use	Targeted case management services provided through the J-CHiP program	Decrease the rate of use for inpatient medical services at JHH/JHBMC	**External:** JH HomeCare Group (JHHCG); Johns Hopkins Community Health Partnership (J-CHiP) program