Johns Hopkins Bayview Medical Center

Implementation Strategy

In response to the

JHBMC Community Health Needs Assessment

Fiscal Year 2013

Introduction

The Johns Hopkins Bayview Medical Center Implementation Strategy is a companion report to the JHBMC 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 Community Relations (Gayle Adams, Director) with oversight by Dr. Richard Bennett (President, Johns Hopkins Bayview Medical Center) and involved the contributions of over 330 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 Bayview Medical Center 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 JHBMC 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), JHBMC 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 four ZIP codes surrounding JHBMC: 21219, 21222, 21224 and 21052. This area accounts for approximately 40% 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, JHBMC has focused on certain target populations, such as the elderly, at-risk children and adolescents, uninsured individuals and households, underinsured and low-income individuals and households, and the growing Latino population.

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.

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

- Obesity (including complications)
- Addiction (including complications)
- Access to Health Care for Latino and other non-English speaking populations
- Mental Health

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 JHBMC 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 JHBMC Implementation Strategy.

Johns Hopkins Bayview Medical Center Needs Assessment Implementation Strategy
Implementation Plan Mid-term Report on Indicators
July 1, 2013 – December 31, 2013

#	Community Health Need	Target Population	Action Plan	Goal(s)	Measures	Responsibility
OBESITY						
1-1	Obesity (including complications)	Children	Educate school-age children about the health benefits of physical activity and nutrition.	Provide FRESH education to at least 14 schools in our area. Aggregate improvement in knowledge via pre and post assessment and teacher evaluations	# of children: 3,289 # of schools: 18 # of classes: 219 # of scout troops: 15 # of scouts: 115 Program evaluation by teachers: 0 (To be completed at end of school year) Summer programs: # of Children served: 481 Programs: 9 Classes: 41 Other programs: Safe Kids Walk to School Day– 350 student participants Anti-bullying event – 150 student participants (John Ruhrah ES)	Source: Pat Carroll, Community Relations

#	COMMUNITY HEALTH NEED	TARGET POPULATION	ACTION PLAN	GOAL(S)	MEASURES	RESPONSIBILITY
1-2	Obesity (including complications)	Adults	Provide weight loss information sessions/online sessions and free monthly support groups for those considering bariatric surgery.	Increase the number of people expressing interest, number of attendees at the seminars and the number seeking clinical intervention.	# seminar attendees: **208** # patients – bariatric surgeries performed: **175** # support group sessions: **12** # support group attendees: **244**	Sources: Shannon Weaver, Michele Mehrling, Eva Kelly, Bariatrics program
1-3	Obesity (including complications)	Children	Assist children who need help controlling their weight.	Increase program awareness; assure the program is at capacity.	Childhood Obesity Clinic # patients: **6** # sessions patients **received: 87 total treatment interventions** Community Psychiatry # patients seen: 1 # of services provided**: 3**	Source: Susan Cohn-Klein, Children's Center Source: Tom Marshall, Community Psychiatry

#	Community Health Need	Target Population	Action Plan	Goal(s)	Measures	Responsibility
1-4	Obesity (including complications)	Neighbors and employees	Provide nutrition education in the community in order to help parents plan and prepare healthy meals	Help parents provide more nutritious meals for their families	# of community participants : **24** # of training sessions provided to HCP Lay Health Educators: **16** # of hours: **20 hours of instruction** Education through marketing materials: **Health & Wellness News (Fall 2013) article, *Taking the First Step,* informed community members about bariatric surgery** Distribution: **165,000 readers**	Source: Dan Hale, Healthy Community Partnership Source: Sandy Reckert, Marketing

#	Community Health Need	Target Population	Action Plan	Goal(s)	Measures	Responsibility
1-5	Obesity (including complications)	Neighbors and employees	Increase participation in the campus farmer's market, campus walk, path to health walk; enhance healthy eating opportunities on campus.	Promote a healthy lifestyle and encourage healthy eating to the neighbors and employees of the medical center.	# receiving health education at community Farmers Markets: **260** # of Farmers Market events: **5** # farmers market sessions at JHBMC: **7** Other health promotion events: **Global Strides Path to Health - 70 participants** **4 Labyrinth Walks - 27 total participants** **Wellnet Walks: 1 annual campus event at JHBMC and weekly walking groups April - November**	Sources: Linda Paren, Food Services and Pat Carroll, Community Relations Source: Paula Teague, Pastoral Care
1-6	Obesity (including complications	Neighbors and employees	Increase the amount of healthy meal selections available in the cafeteria	Provide a variety of healthy food options available for our employees and guests.	# healthy meals **Healthy baked options daily; vegetables at the Home Bar daily.** ***Cooking Light* options served twice per week; *Grab n Go* healthy items in the to-go case; low fat yogurts, hummus, skim milk and other healthy options available; small portions of tuna salad and chicken salad and to-go salads** # salad offerings: **25 salad bar options**	Source: Linda Paren, Food Services

#	COMMUNITY HEALTH NEED	TARGET POPULATION	ACTION PLAN	GOAL(S)	MEASURES	RESPONSIBILITY
1-7	Obesity (including complications)	Latino population	Provide prenatal education focusing on healthy eating	Decrease pediatric obesity in Latino children	# childbirth education sessions: **6 (12 hours each)** # participants: **36** # of breastfeeding classes: 2 sessions (2 hours each) # participants: 18	Source: Melissa Eichelberger Lindia Holmes (0-3094) Inpatient Obstetrics
1-8	Obesity (including complications)	Adults and Pediatrics	Provide nutrition and weight loss counseling for overweight and obese adults and children.	Increase program awareness and the number seeking clinical intervention.	# patients seen for weight management: **513** # of nutrition visits: **1,239**	Source: Melanie Brooks, Nutrition Services
ADDITIONS						

#	Community Health Need	Target Population	Action Plan	Goal(s)	Measures	Responsibility
2-1	Addictions (including complications)	Substance abusers	Provide access to inpatient detox, including for those without insurance	Provide effective substance abuse treatment	# patient discharges from CDU: **1,295;** # uninsured: **976** **# of unique patients: 1,238: 1,185 had one admission and 53 had multiple admissions** Comprehensive Care Center – Total # of substance abuse patient visits: **669** (7/1/13 – 12/31/14); Total # of discount/ uninsured patients seen: **396** (7/1/13 – 1/31/14); Community Psychiatry **# of patients seen: 179** **# of services provided: 1083** **# of patients w no insurance: 4**	Source: Datamart (populated from Meditech) Gregg Burleyson, Finance Dept. Source: Howard Rothenburg, Information Services Source: Tom Marshall, Community Psychiatry
2-2	Addictions (including complications)	People with mental illness and substance abusers	Provide services through primary care and specialty services	Provide effective substance abuse treatment and make community aware buprenorphine is available	# patients treated # buprenorphine patients: **65 doses of Buprenorphine to 7 unique patients at the Comprehensive Care Clinic**	Source: Datamart (populated from Meditech) Gregg Burleyson, Finance Dept

#	Community Health Need	Target Population	Action Plan	Goal(s)	Measures	Responsibility
2-3	Addictions (including complications)	School-aged children	Provide health education to children and youth to discourage their use of tobacco products	Reduce the rate of smoking among youth	# of children **651** # of schools: **18** # of classes: **219** # of scout troops: **15** # of scouts: **115**	Source: Patricia Carroll, Community Relations
2-4	Addictions (including complications)	Patients who smoke	Provide smoking cessation information	Reduce the number of patients who smoke	# of IP with ICD code for smoking: **3,212** # of ED with ICD code for smoking: **2,515** # of Observation patients with ICD code for smoking: **58** # of OP patients (excludes clinics) with ICD code for smoking : **40** Discharge instructions for every patient says smoking is harmful, to speak with your primary care provider, or call a number for free medicine and support	Source: Janet McIntyre (see page 13)
2-5	Addictions (including complications	Neighbors and community members who smoke	Provide smoking cessation information	Reduce the number of smokers in the community	# smoking information provided by CR: **22,079** # events: **37** Demographic statistics on smokers	Source: Patricia Carroll, Community Relations
ACCESS TO HEALTHCARE						

#	COMMUNITY HEALTH NEED	TARGET POPULATION	ACTION PLAN	GOAL(S)	MEASURES	RESPONSIBILITY
3-1	Access to Healthcare	Latino population	Partner with local congregations to bring health messages around the priorities	Establish a Healthy Community Partnership relationship with Sacred Heart of Jesus Church	Health lectures in Spanish: **15** # of participants in Embajadores de Salud (Community Health Ambassadors) - **102** # of participants in *Mueveton,* Heath Fair & Walk **- 200**	Source: Dan Hale & Gerardo Lopez-Mena, Healthy Community Partnership
3-2	Access to Healthcare	Latino population and Non-English speaking patients	Assure optimal use of interpreters and translation services and other resources	Easier access to services for patients that do not speak English	# patients served with interpreter– IP, OP, ED **Total Interpretations – 17,847** **- In House Spanish: 5,847** **- Cyracom foreign language telephonic: 9,728 (58 languages)** **- On-site interpreters from JHI office: 2206 (44 languages)** # programs with Latino Providers Network: **60**	Source: Laurene Walker, Patient Relations Source: www.lpnmd.org

#	Community Health Need	Target Population	Action Plan	Goal(s)	Measures	Responsibility
3-3	Access to Healthcare	Latino population and Non-English speaking patients	Support Children's Medical Practice Latino Patient & Family Advisory Council	Enhance outreach to the Latino population to increase relationships	CMP Clinic # patients seen: **5,383** Care-A- Van # patients served: **1,133** Ethnicity: **70% Hispanic** **22% African American** **5% Caucasian** **3% Other** Latino Families Advisory Board # meetings: **3** (Aug, Oct, Dec) # attendees:**45** **Funding received for Center of Excellence for Latino Health, a family centered multidisciplinary approach to health (7/2/2013)**	Source: Children's Medical Practice, Melissa McColligan Borger Source: Pat Letke, Care-a-Van Source: Monica Guerrero Vazquez, Centro Sol
3-4	Access to Healthcare	Latino population	Support the Johns Hopkins Bayview Care-A-Van bilingual staff to provide free care in the community	Increase in the number of patients served	Care-A- Van # patients served: **1133** Ethnicity: **70% Hispanic** **22% African American** **5% Caucasian** **3% Other** # referrals to JHB: **300 (272 OB, 28 TAP)**	Source: Pat Letke, Care-a-Van

#	Community Health Need	Target Population	Action Plan	Goal(s)	Measures	Responsibility
3-5	Access to Healthcare	Uninsured pregnant women	Provide prenatal care to uninsured pregnant women		Total # patients: **CAP OB and Acute OB clinics had 5,275 outpatient visits from 1,020 unique patients** # uninsured patients **2,126 outpatient visits from 423 unique patients had no insurance**	Source: Datamart (populated from Meditech) Gregg Burleyson, Finance Dept.
MENTAL HEALTH / VIOLENCE PREVENTION						
4-1	Mental Health	Patients and neighbors with serious mental health needs	Expand ED facilities/space to better serve patients and neighbors with mental health needs	Provide a range of services for seriously mentally ill people	Emergency Department Psychiatry: **Inpatient: 250** **Outpatient: 846** **Total #** patients served:**1,096** Community Psychiatry # patients seen – **1,633** # of services provided: **53,897**	Source: Robert Marshall/Nicole Philips Source: Tom Marshall, Community Psychiatry
4-2	Mental Health	Non-English speaking patients and neighbors with mental health needs	Expand bilingual therapy through the International Mental Health Services Clinic	Increase resources for ESOL patients needing mental health services	# patients – **73 patients seen** # Clinic sessions – **654 services**	Source: Tom Marshall, Community Psychiatry

#	Community Health Need	Target Population	Action Plan	Goal(s)	Measures	Responsibility
4-3	Mental Health/ Violence Prevention	Neighbors with mental illness	Partner with Mental Health Association to provide a seminar for mental health first aid	Provide mental health first aid training to community agency representatives and leaders to help them respond to the mental health needs of the community	# Mental Health First Aid classes provided: **1** # participants: **13** Type participants: **Representatives from social service and community organizations,**	Source: Crystal Evans, Community Psychiatry and Pat Carroll, Community Relations
4-4	Mental Health	Neighbors with mental illness	Provide education and training about mental health resources	Identify those with mental health needs and connect them with services	# of HCP LHE participants : **24** # of training sessions provided to HCP LHE: **16** # of hours: **20 hours of instruction**	Source: Dan Hale, Healthy Community Partnership

Compiled by Community Relations, JHBMC