Serving Our Communities

The Johns Hopkins Health System

Community Benefit Report | FISCAL YEAR **2023**

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTH SYSTEM

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 2023 community engagement programs included in the hospitals' annual community benefit reports.

The Johns Hopkins Health System Hospitals

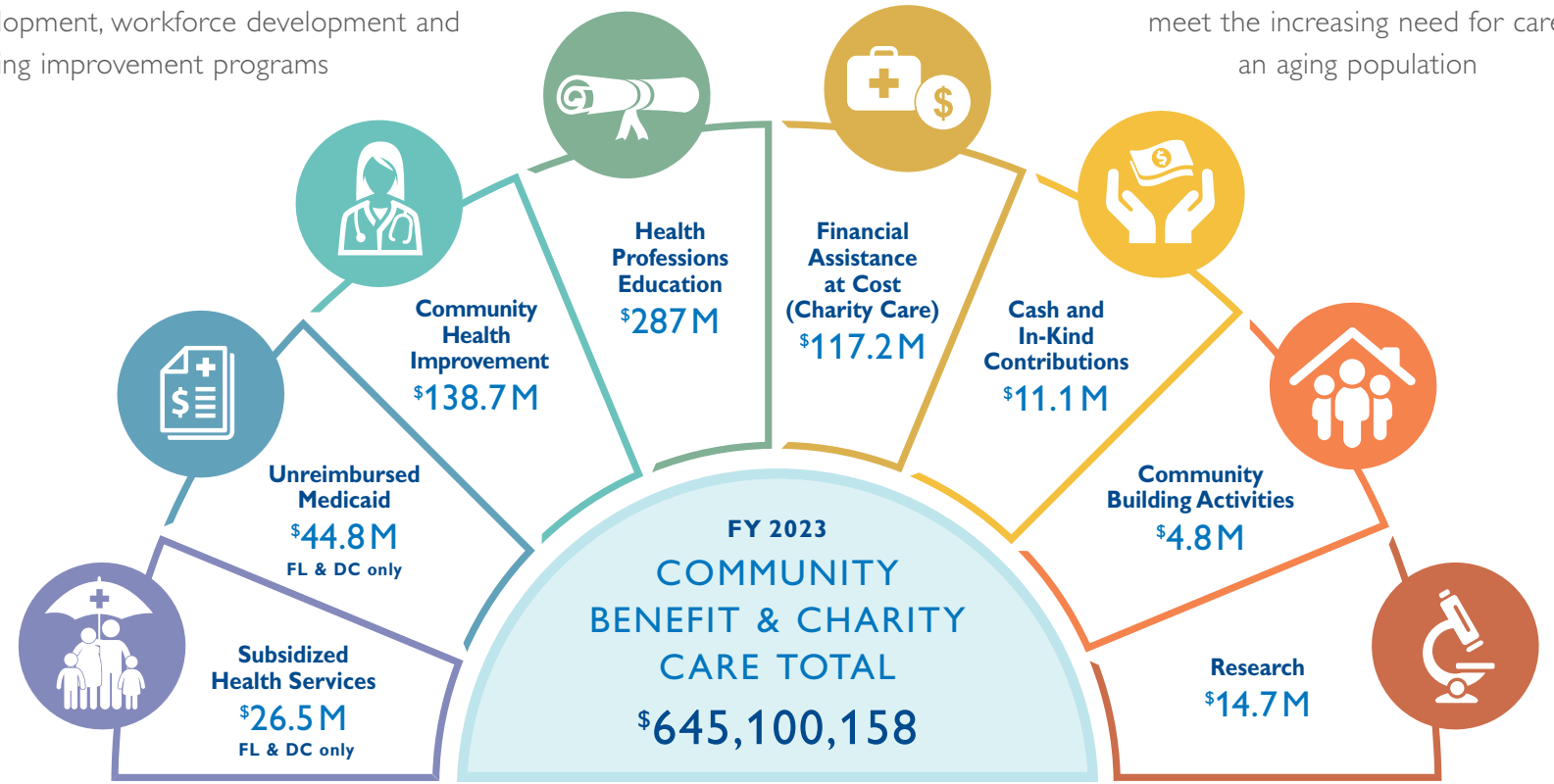
Fiscal Year 2023 Community Benefit Activities Summary

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

In Fiscal Year 2023, the Johns Hopkins Health System hospitals spent nearly $640 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



Source: JHHS Hospitals' IRS Schedule H (Form 990)

JOHNS HOPKINS MEDICINE

THE JOHNS HOPKINS HOSPITAL

$363 Million in Community Benefit

Source: 2022 IRS Schedule H (Form 990)

THE ACCESS PROGRAM (TAP)

The Access Partnership ("TAP") of Johns Hopkins Medicine provides access to effective, compassionate, evidence-based primary and specialty care for low-income 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.

The Access Partnership: JAN 2020 – MAR 2024

TAP plays an essential role of providing free care to uninsured residents in Baltimore, primarily the large population of low-income residents

5,683
Number of patients served

86%
TAP patients that are Hispanic/Latino

78,026
Number of appointments

83%
TAP Patients that are Aged 18-65+

TOP SPECIALTIES
seeing TAP patients

- Radiology
- Physical Therapy
- Internal Medicine
- Ophthalmology
- Oncology
- Cardiology

TAP information as of March 2024

ENDING HOMELESSNESS THROUGH ACIS

Thanks to a unique Medicaid Waiver opportunity entitled Assistance in Community Integration Services (ACIS), JHH and JHBMC are partnering with the State of Maryland, Baltimore City, and other Baltimore hospitals on an exciting public/private partnership at the intersection of housing and health. The City of Baltimore, Health Care for the Homeless, and every hospital in Baltimore implemented a program to deliver the supportive services necessary to provide 300 housing opportunities for vulnerable individuals and families experiencing homelessness. Ten hospitals committed $2 million to the partnership, and when the Hilltop Institute reviewed the program, they found that the ACIS pilot housed 200 individuals and families with children. 94% remained stably housed.

The ACIS pilot was renewed for another five years and will expand to service 100 more households in Baltimore, or 300 households over the next few years.

- **52% reduction in overall visits.**
- **77% reduction in readmissions.**
- **60% reduction in ED visits.**
- **63% reduction in avoidable hospital visits.**
- **53% reduction in in-patient admissions.**

SUPPORT EVERY STEP OF THE WAY

Health Care for the Homeless takes clients through every step of the supportive housing process. Case managers help clients apply for housing through the Baltimore City Office of Homeless Services Coordinated Access System. Benefits specialists help clients secure income to pay for housing when applicable. Supportive Housing staff help clients locate and move into housing, provide transportation to appointments and grocery stores, help pay bills and work with landlords. Development team members raise private funds for move-in kits for newly housed clients.

Supportive Housing Works

- **Better connection to primary care**
- **Higher likelihood of staying housed**
- **Better medication management**
- **Fewer ER visits**

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

$104.1
Million in Community Benefit

Source: IRS Schedule H (Form 990)

JHBMC AND BMS PARTNERSHIP – BMS AT YARD 56

The general pediatrics and gynecology/obstetrics clinic at Johns Hopkins Bayview Medical Center (JHBMC) transitioned to the new Baltimore Medical System (BMS) medical center location at Yard 56 in May 2023. Patients remain with their JHBMC health care providers at a new location. BMS operates the largest federally qualified health center (FQHC) system in the Baltimore region, and this partnership supports JHBMC in creating a sustainable model of gynecology/obstetrics and pediatric primary care for the community that JHBMC serves, regardless of ability to pay. BMS at Yard 56 offers enhanced access to social workers and community health workers to address psychosocial needs of patients and families. BMS at Yard 56 also has an onsite pharmacy with affordable medications.

> "BMS at Yard 56 has dedicated financial counselors and onsite Medicaid navigators."

As an FQHC, BMS at Yard 56 also has expanded care navigation resources such referral coordinators to help patients with care continuity and removing barriers to accessing specialty care as needed. And Yard 56 offers behavioral health care through social workers co-located within the clinics as well as access to a variety of healthcare services at one convenient community embedded location.

JHBMC is providing a community benefit grant to Baltimore Medical System (BMS) to support a portion of uncompensated costs incurred by BMS in providing comprehensive primary and preventative health services in pediatrics and obstetrics & gynecology at Yard 56 to medically underserved populations, regardless of the individual's or family's ability to pay for such services.

JHBMC COMMUNITY FOOD PANTRY

There is not one "pull at the heart string" story to be told. The JHBMC Community Food Pantry serves employees, patients and community for various emergent needs that require social determinant interventions that take a while to be addressed and corrected. Examples of the context for individual food insecurity needs include:

- An employee who suffered a house fire
- Newly discharged patients with no opportunity to stock their pantry
- Unexpected bills and expenses that reduce the funds for food
- Mental health conditions that impact proper management of food

For the most recent year, the pantry served 209 adults and 70 children, provided 98 individual bags and 83 family bags of food – totaling 3,834 pounds of food. These bags provide an emergency 3-day supply of food. Beneficiaries of the food pantry are referred from partner organizations and JHBMC social work department. The food pantry allows clients to received food assistance two times in a 12-month period addressing the immediate food insecurity. Other assistance is provided to help individuals and families to establish a more sustainable food source.

The pantry served 209 adults and 70 children, provided 98 individual bags and 83 family bags of food – totaling 3,834 pounds of food.

The hospital's food pantry has been managed by the Community Relations Department for over 40 years, and is self-sustaining — supported by employees and partnering community groups with cash donations and 3,895 pounds of donated food in the past year. In the most recent year, Maryland Corps/Service Year interns Amaya Sparks and Robbie McDermott provided volunteer support for food pantry operations. The JHBMC nutrition department plays a role of periodically reviewing the bag contents to be sure we are providing a nutritional supply of foods.

JOHNS HOPKINS
MEDICINE

Johns Hopkins Howard County Medical Center

$34.5
Million in
Community
Benefit

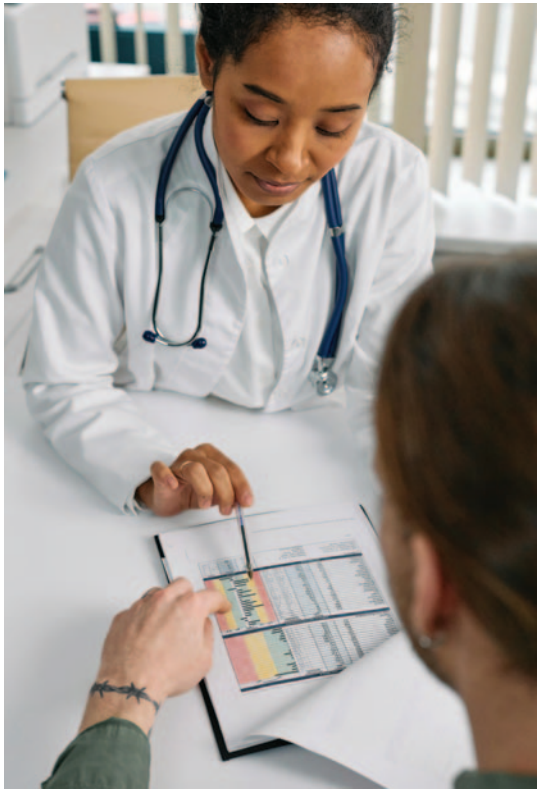
Source: IRS Schedule H (Form 990)

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 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.

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 1,600 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 to 90 days following a hospitalization or 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 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.

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

$35.4
Million in Community Benefit

Source: IRS Schedule H (Form 990)

DINE, LEARN & MOVE: STRONGER, HEALTHIER, HAPPIER

Dine, Learn & Move (DLM) is a multifaceted, interactive program geared to prevent and manage cardiovascular risks associated with poor diet and physical inactivity. Since 2008, DLM's collaborative approach has been a success at leveraging innovative efforts to improve health outcomes across vulnerable populations experiencing health disparities. DLM is supported by two health system partners, Suburban Hospital and the University of Maryland Capital Region Health (UMD). The Prince George's County (PGC) Health Department and the Maryland-National Capital Park and Planning Commission, Department of Parks and Recreation Prince George's County (PG Parks) are also key partners of DLM; all four partners are invested in improving equitable solutions to address health disparities and promote healthy lifestyles through nutrition, physical activity, and health education.

> "This program has a great impact on my life both mentally, emotionally and physically. I lost 10 lbs."

Focused on adults wanting to learn how to adopt and maintain a healthy and empowered lifestyle, the average DLM participant is African American, female, age 65 or greater and lives in PGC. Lack of physical activity, as well as poor diets, has led adults in PGC to suffer from higher rates of obesity than those across the state and nation.

> "Nearly 97% of PGC residents live in close proximity to exercise opportunities, but just 50.5% of adults participate in the recommended amount of aerobic activity per week."

> "DLM is certainly turning me into a much stronger, healthier, and happier person, and I'm loving it!! My knowledge is steadily increasing, and when you know better, you do better and I feel absolutely great and wonderful."

This 90-minute, virtual program operates in three separate but cohesive sections, combining both nutrition and fitness education - a 20-minute live movement session led by a certified exercise instructor, followed by guidance and nutrition tips from a registered dietician from the Health Department, and finally a 40-minute live cooking demonstration by a local chef who offers recipes that are heart healthy, diabetes-friendly, with easily-accessible and affordable ingredients. Each session ends with an evaluation that impacts planning and sustainability efforts for future sessions, and based on responses received participants remain engaged in healthy behaviors outside of the monthly program, further impacting positive health improvement behaviors.

> "I am reading and understanding the labels better, there was a time I did not pay labels much attention, and my pressure stayed high. Because of Dine and Learn, I now read my labels, exercise more and my pressure became stable."

In FY23, 169 patients received specialty care services and out of the 84 patients who were treated, 70% reported their ethnicity as Hispanic and Latino.

MOBILEMED/NIH ENDOCRINE CLINIC AT SUBURBAN HOSPITAL

In FY23, 59% of clinic patients living with diabetes mellitus saw improvements of their hemoglobin A1C levels.

The MobileMed/NIH Endocrine Clinic at Suburban Hospital was created in 2010 to provide specialty care to those who are uninsured and living with diabetes and other endocrine conditions. The clinic was founded to increase access of specialty care to individuals who would not otherwise receive care; and to reduce the incidence of complications due to endocrine diseases, including diabetes. Suburban aims to achieve this by increasing access to specialty care to uninsured, high-risk Montgomery County safety-net clinic patients, and managing risk factors associated with diabetes.

For the past 12 years, the MobileMed/NIH Endocrine clinic at Suburban Hospital has cared for over 2,500 uninsured patients who may have otherwise not had access or resources to treatment.

The clinic is a Suburban Hospital collaboration with Mobile Medical Care Inc. and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). Physicians, nurses, staff, and administrators from the three partners volunteer one night a week at Suburban Hospital. Referred by MobileMed, uninsured county residents meet with an NIH endocrine fellow who reviews the patient's labs, progress, and individual care plans. As part of its commitment to serving the community, Suburban Hospital defers all costs associated with the clinic, including in-kind support.

SIBLEY MEMORIAL HOSPITAL

JOHNS HOPKINS MEDICINE

$31.7
Million in Community Benefit

Source: IRS Schedule H (Form 990)

DISCUSSING THE FACTS SERIES

In collaboration with New Morning Star Baptist Church, a community of faith in Ward 7 of D.C., the Sibley Senior Association (SSA) offers a monthly health equity talk, elevating the voices of clinicians of color to historically marginalized neighborhoods. While it is open to the broader community, the intent is for attendees to receive important health information from persons they are more likely to trust. In addition, clinicians offer important screening guidelines to reduce late-stage diagnoses and encourage attendees to seek early screening and treatment.

Health topics have included:

- Depression
- Hepatitis C
- Movement as Medicine
- Stress
- Diabetes
- Domestic Violence
- Prostate Health and Medication
- Nutrition

CLUB MEMORY®

Club Memory, a social support group for people with cognitive problems and their caregivers, continues to reach new heights over the past year. Attendance has increased 30% beyond pre-pandemic levels using a hybrid program of in-person and virtual sessions. Through the support of a

grant from the D.C. Department of Aging and Community Living (DACL), the program reached a total of 663 persons across six Senior Wellness Centers and five churches through in-person programming, bi-monthly mailings, weekly phone calls, informational e-mails and virtual meetings. In addition, they've reached an additional 150 seniors and care partners residing in Wards 2 and 3 of the District of Columbia, through a grant funded by Sibley Memorial Hospital. As part of Sibley's mission to promote health equity, 45% of Club Memory members served reside in Wards 7 and 8.

966 persons attended our 7 support groups

Nearly 6,000 virtual attendees and 671 in-person attendees

32% from Wards 7 & 8

In FY23 made 15,477 check-in calls and the program reaches 663 persons

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
ALL CHILDREN'S HOSPITAL

$76

Million in Community Benefit

Source: IRS Schedule H (Form 990)

HEALTHY START AT JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

Healthy Start, a maternal child and health program, is inclusive of supporting fathers. Johns Hopkins All Children's Hospital (JHACH) hosted a Father's Day event that focused on men's mental health and communication styles that was attended by 75 fathers across multiple generations. Supporting fathers is not only important but also essential in fostering healthier families and communities.

Addressing mental health in fathers is crucial as it is often overlooked as a part of their overall well-being. By providing a platform for fathers to openly discuss their mental health challenges, the process of breaking down stigmas and encouraging support begins. This can lead to improved mental health outcomes for fathers that positively impact not only their own lives but also their relationships with partners, children, and peers.

Focusing on communication skills acknowledges the importance of healthy interaction within families. Effective communication between fathers and their children is vital for building strong relationships, fostering trust, and promoting emotional intelligence. Fathers who are equipped with better communication skills are more likely to understand their children's needs, provide necessary support, and navigate conflicts constructively. This can result in a more supportive and nurturing family environment where children feel valued, heard, and understood.

Healthy Start at Johns Hopkins All Children's Hospital not only supported individual growth but also contributed to building more compassionate and resilient communities.




JHACH SUPPORTS FOOD SECURITY FOR PATIENTS AND FAMILIES:

Johns Hopkins All Children's Hospital continues to address food insecurity by providing support and access to healthy foods for students and their families. Food distribution efforts are ongoing in local high schools and at Johns Hopkins All Children's Hospital. The community health team works to make sure families have fresh and healthy food at no cost. The high school food pantries provide food, each Friday, to cover the weekend meal gaps. Students and their families were provided with more than 25,000 meals throughout the year.


GIBBS HIGH SCHOOL PANTRY SUPPORTED BY JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

At Johns Hopkins All Children's Hospital, the Allkids Campus Market provides access to fresh produce and shelf stable items to patient families and employees. When surveyed, 87% of market participants self-reported that access to fresh produce on campus helped increase their overall vegetable consumption. In addition to the campus market, emergency food bags are provided to clinical providers for patient families. This year included a special distribution during the winter holidays with more than 250 bags provided to patient families during the Winter Wonderland event. Even dog Brea, a JHACH Facility Animal, jumped in to supervise the bag packing efforts.



JOHNS HOPKINS
MEDICINE

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

The Johns Hopkins Hospital
Government, Community and Economic Partnerships | 443-997-5999

Johns Hopkins Bayview Medical Center
Government, Community and Economic Partnerships | 410-550-0289

Johns Hopkins Howard County Medical Center
Community Education | 410-740-7601

Suburban Hospital
Community Health and Wellness | 301-896-3844

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

Johns Hopkins All Children's Hospital
Community Relations | 727-767-2328

FY 2023 JHHS Community Benefit Brochure produced by
Government, Community and Economic Partnerships
https://gce.jhu.edu