Howard County General Hospital
Fiscal Year 2017
Community Benefits Report
Narrative

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Johns Hopkins Health System

Fiscal Year 2017 Community Benefit Report Narrative

Howard County General Hospital

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I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Primary Service Area.

Table I	
Bed Designation:	264
Inpatient Admissions:	17,121
Primary Service Area Zip Codes:	20707, 20723, 20794, 21042, 21043, 21044, 21045, 21046, 21075
All other Maryland Hospitals Sharing Primary Service Area:	Sheppard Pratt (Psychiatry only), Laurel Regional Hospital (20707)
Percentage of Hospital's Uninsured Patients:	1.52% of patients discharged in FY17 were uninsured.[1]
Percentage of Hospital's Patients who are Medicaid Recipients:	14.18% of patients discharged in FY17 had Medicaid as their primary payer.[2]
Percentage of Hospital's Patients who are Medicare beneficiaries:	34.9% of patients discharged in FY17 had Medicare as their primary payer.[3]

2. Community Benefits Service Area.

a. Description of Community Benefit Service Area:

Howard County, located between Baltimore and Washington D.C., is a relatively affluent, educated and healthy community inhabited by 317,233 residents. The county is home to urban, suburban, and rural communities. Howard County continues to rank as one of the healthiest counties in the state of Maryland, according to the Robert Wood Johnson Foundation/University of Wisconsin County Health Rankings. The largest city in Howard County, Columbia, was also recognized by Money Magazine in fall 2016 as the best place to live in America due to its diversity and inclusiveness, high-quality schools, educated populace, economic opportunity, and relatively low median home price for the area.[4]

Due to these factors, Howard County is increasing in popularity for young families as well as those aging in place, and the population is growing accordingly. Between 2017 and 2035, the overall population is estimated to increase by 26.6%. During the same time period, those age 50 and older will increase by 60.7%, which is more than double the aging rate for the total county

[1] Howard County General Hospital Finance and Revenue Cycle data
[2] Howard County General Hospital Finance and Revenue Cycle data
[3] Howard County General Hospital Finance and Revenue Cycle data
[4] http://time.com/money/collection-post/4480692/columbia-maryland/

population. An estimated 38% of county residents will be 50 or older by 2035.[5] In the next 5 years alone, the 65 and older population of Howard County, currently making up 13.2% of the county's population, is projected to grow by nearly 25%.[6]

The increase in the aging population is likely to correspond with higher rates of chronic disease and a need for innovation in provision of healthcare services to maximize the value of each healthcare dollar spent. Prevention must be targeted and individualized, focusing on evidence based interventions to be able to shift this group toward healthier lifestyles.

Howard County ranks as one of the healthiest counties in Maryland, and is overall meeting or exceeding most state health targets. The county has lower rates than those of Maryland overall of chronic disease risk factors, including adult smoking, obesity, and physical inactivity.[7] Howard County has the among the lowest rates of emergency department visits due to hypertension (112.1/100,000 compared to the state target of 234.0/100,000) and diabetes (102.1/100,000 compared to state target of under 186.3/100,000) in the state.[8] The county is also performing well overall on social and economic determinants such as unemployment, children in poverty, violent crime, and high school graduation rates.[9]

However, Howard County still has improvements to make in outcomes across racial groups for some State Health Improvement Process (SHIP) measures. Of particular note is the cancer mortality rate – Howard County's overall rate is lower than the state and has decreased over the past several years, but among Black Non-Hispanic residents the cancer mortality rate is higher than the state rate (169.6/100,000 compared to Maryland goal of 147.4/100,000) and has actually increased since 2014 (from 165.1 to 169.6/100,000).[10] This must remain an area of focus in targeting community education, lifestyle changes, and early detection so that all residents of the county are able to reach their full health potential.

In the past year, Howard County General Hospital transitioned two programs from a local non-profit (Healthy Howard, Inc.) to the hospital's Population Health department. This program serves as both an internal care team organization and a partnership with several community groups, such as with mental health provider Way Station Inc. to provide rapid access to behavioral health providers, elder-care provider Gilchrist Services to provide home visits to elderly patients, and multiple faith-based communities to offer health education in a familiar setting. These partnerships allow HCGH and its partners to reach out to Howard County's most vulnerable, chronically ill, and/or high-utilizing community members and provide connections to resources, home-based care, and community support. HCGH is also working with multiple organizations throughout the community on integrated health efforts, such as leveraging Howard County's broadband network to expand care access by bringing telemedicine to school-based health centers in six Title I schools.

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[5] Maryland Department of Planning, 2013

[6] Truven Market Expert

[7] http://www.countyhealthrankings.org/app/maryland/2017/rankings/howard/county/outcomes/overall/snapshot

[8] http://ship.md.networkofcare.org/indicator_maps/Maryland-SHIP-InteractiveAtlas/atlas.html

[9] http://www.countyhealthrankings.org/app/maryland/2017/rankings/howard/county/outcomes/overall/snapshot

[10] http://howard.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship26

Howard County is fortunate to have a very engaged population and is home to many organizations that seek collaboration and partnership throughout the county. Howard County's Local Health Improvement Coalition is remarkably active and serves as an excellent connector of resources and organizations; the hospital and health department work very closely together both in the LHIC and in many other capacities in the community. The success that the county has had in improving health disparities, promoting healthy lifestyles, and increasing access to care has been in major part to these active and ongoing partnerships with individuals and organizations residing in Howard County.

b. Demographics.

Table II	
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	Full CBSA: 20707, 21042, 21043, 21044, 21045, 21046, 21075, 20723, 20777, 21041, 21150, 21029, 21797, 21036, 20763, 20759, 21794, 20794, 21765, 21738, 21737, 21723 Most vulnerable populations (Medicare/uninsured): 21042, 21043, 21044, 21045, 21075, 20723
Median Household Income within the CBSA	$142,202[11]
Percentage of households with incomes below the federal poverty guidelines within the CBSA	In Howard County, 5.1% of the population is below the poverty line ($23,850 for a family of four): • 6.1% of children • 4.8% of seniors • 9.6% of Black or African Americans • 10.7% of Hispanic or Latinos[12] Data is not available for the CBSA.
For counties within the CBSA, what is the percentage of uninsured for each county?	In Howard County, 4.0% of the population is uninsured. In Prince George's County, 10.3% of the population is uninsured.[13]
Percentage of Medicaid recipients by County within the CBSA.	40,852 / 9.7%[14]
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	The Howard County life expectancy baseline is 82.9 years at birth; White: 82.7; African American: 81.4

[11] 2017 Truven Market Expert
[12] http://familyleague.org/wp-content/uploads/2016/01/Maryland-Povery-Profiles-2016.pdf
[13] http://planning.maryland.gov/msdc/American_Community_Survey/2016ACS.shtml
[14] 2017 Truven Market Expert

	All are above the State baseline at 79.7.[15]
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	**Heart Disease Deaths per 100,000:** [16] Maryland: 169.4 Howard County: 122.8 Black Non-Hispanic: 138.6 White Non-Hispanic: 129.8 Asian/Pacific Islander Non-Hispanic: 71.9 **Cancer Deaths per 100,000:** Maryland: 159.3 Howard County: 131.3 Black Non-Hispanic: 169.6 White Non-Hispanic: 136.3 Asian/Pacific Islander Non-Hispanic: 79.1 **Infant Mortality Rate per 1,000 births:** Maryland: 6.7 Howard County: 7.6 White: 4.8 Black: 13.9
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	**Access to Healthy Food** 7.5% of Howard County residents reported food insecurity at some point during the year (2014). Of these residents, 45% were below threshold for SNAP or other nutrition programs.[17] Overall, Howard County ranks among the best in the state in access to healthy food and grocery stores.[18] Only 0.66% of housing units in the county are more than one mile from a supermarket or large grocery store and have no car. 20% of students in Howard County public schools are eligible for free or reduced price lunch.[19] **Transportation** In terms of transportation, 81.8% of Howard County residents drive alone to work; 3.0% use public transportation to commute to work, while 7.6% carpool and 0.8% walk. Mean travel time to work for

[15] http://ship.md.networkofcare.org/ph/
[16] http://ship.md.networkofcare.org/ph/
[17] http://map.feedingamerica.org/county/2014/overall/maryland/county/howard
[18] www.countyhealthrankings.org/app/maryland/2017/rankings/howard/county/outcomes/overall/snapshot
[19] http://planning.maryland.gov/msdc/American_Community_Survey/2016ACS.shtml

	Howard County residents is 30.7 minutes. 3.5% of households in Howard County do not have a vehicle available.[20] **Housing** 72.8% of housing units in Howard County are owner-occupied and 27.2% are renter-occupied. Of the occupied housing units in the county, 0.2% are lacking complete plumbing facilities, 0.7% are lacking complete kitchen facilities, and 2.1% have no telephone service available. 37.8% of Howard County renters are paying 35% or more of their household income in rent monthly.[21] **Educational attainment in CBSA, age 25 and over:** Less than High School: 2.1% Some High School: 3.4% High School Diploma: 17.0% Some College/Associate's Degree: 22.1% Bachelor's Degree or Greater: 55.4%[22] 8% of teens and young adults ages 16-24 in Howard County are neither working nor in school.[23] **Environmental Factors:** The average daily density of fine particulate matter in the air in Howard County as of 2012 was 10.7 micrograms per cubic meter. This is higher than the Maryland rate of 9.5 and the national rate of 9. Howard County has not had any health-related drinking water violations during the reporting period.[24]
Available detail on race, ethnicity, and language within CBSA.	**CBSA Total Population:** 422,799[25] **Sex:** Male: 209,545 (49.6%) Female: 213,254 (50.4%) **Age:** 0-14: 18.6%

[20] http://planning.maryland.gov/msdc/American_Community_Survey/2016ACS.shtml
[21] http://planning.maryland.gov/msdc/American_Community_Survey/2016ACS.shtml
[22] 2017 Truven Market Expert
[23] http://ship.md.networkofcare.org/ph/
[24] www.countyhealthrankings.org/app/maryland/2017/rankings/howard/county/outcomes/overall/snapshot
[25] 2017 Truven Market Expert

	15-17: 4.4% 18-24: 9.2% 25-34: 12.0% 35-54: 28.6% 55-64: 13.8% 65+: 13.4% **Race/Ethnicity, CBSA:** 58.4% White Non-Hispanic 16.9% Black Non-Hispanic 6.3% Hispanic 14.8% Asian and Pacific Islander, Non-Hispanic 3.6% Other[26] **Language Spoken at Home, Howard County:** 73% English Only 5.4% Spanish 7.6% Other Indo-European Languages 10.5% Asian and Pacific Islander languages 3.5% Other Languages[27] 22.5% of Howard County residents were foreign-born. Of this population, 62.3% are naturalized US citizens and 37.7% are not US citizens. The largest group is those born in Asia (58.4%), followed by Latin America (18.7%).[28]
Other	**ALICE Households, Howard County** ALICE is an acronym for Asset Limited, Income Constrained, Employed. This measures households that earn more than the U.S. poverty level, but less than the basic cost of living for the state. The United Way calculates basic survival needs for a resident of the county and their family, including housing, food, child care, transportation, healthcare, cell phone, taxes, and other miscellaneous expenses and determines the salary needed to cover these expenses. According to the ALICE report put out by the United Way, 22% of households in Howard County are below the ALICE threshold of $60,000 per year for households under 65 years and $50,000 for households

[26] 2017 Truven Market Expert
[27] http://planning.maryland.gov/msdc/American_Community_Survey/2016ACS.shtml
[28] http://planning.maryland.gov/msdc/American_Community_Survey/2016ACS.shtml

	65 years and older. This is broken down by race as follows: • 23% of Asian households • 33% of Black households • 41% of Hispanic households • 19% of White households[29] Howard County is rated by the ALICE report as "Fair" for housing affordability and "Good" for job opportunities and community resources.[30]

[29] http://www.uwcm.org/main/wp-content/uploads/2017/01/16UW-ALICE-Report_MD_1.6.17_Hires1.pdf
[30] http://www.uwcm.org/main/wp-content/uploads/2017/01/16UW-ALICE-Report_MD_1.6.17_Hires1.pdf

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?

   _x_ Yes
   ____No

   Provide date here. 06/30/2016

   If you answered yes to this question, provide a link to the document here. (Please note: This may be the same document used in the prior year report).
   http://www.hopkinsmedicine.org/howard_county_general_hospital/_downloads/FY2016_CHNA_FINAL.pdf

2. Has your hospital adopted an implementation strategy that conforms to the IRS requirements detailed on pages 3-4 of Narrative Instructions?

   _x_ Yes Enter date approved by governing body here: 06/15/2016
   ___ No

   If you answered yes to this question, provide the link to the document here.
   http://www.hopkinsmedicine.org/howard_county_general_hospital/_downloads/FY2016_CHNA_FINAL.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

a. Are Community Benefits planning and investments part of your hospital's internal strategic plan?

_x_ Yes
___ No

If yes, please provide a description of how the CB **planning** fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

Community Benefits activities are included in the "Integration" Strategic Pillar in the Johns Hopkins Medicine five-year strategic plan. In this area, HCGH set specific goals related to our health priorities as identified in the Community Health Needs Assessment.

These health priorities are as follows: Access to Affordable Care; Behavioral Health; Healthy Aging; and Healthy Weight, Exercise, and Nutrition. These priorities are integrated into HCGH's ongoing initiatives.

Howard County General Hospital set three strategic objectives for FY2017 to support these priorities:

Strategic Objective – Access to Care: Update intake and coding processes for advanced care planning information, including refinement to standard work to account for new electronic registry for health care agents.		
Process/Outcome Metric	**Completion Date**	**Final Status**
Lean project completed, training policy updated, advanced directive status codes updated in Epic.	06/30/17	• Lean Rapid Improvement Event held 12/21/16. • Policies updated. • Codes and other features for advanced care planning will be available with Epic upgrade in September 2017. • Project plan developed for FY18 to be ready for Horizon Foundation's public Speakeasy Campaign.
Strategic Objective – Behavioral Health: Establish formal referral and care coordination programs to community-based providers for patients discharged with behavioral health needs. At least one program should focus on the pediatric population.		
Process/Outcome Metric	**Completion Date**	**Final Status**
2 new programs implemented.	06/30/17	• Two Pediatric rapid access programs developed and implemented. • Peer Support Specialist program for substance use support developed with Health Department and implemented.

Strategic Objective: Collaborate with community partners to transition community programs from stand-alone community programs to HCGH run and funded programs.		
Process/Outcome Metric	**Completion Date**	**Final Status**
Two programs fully transitioned – Community Care Team and Journey 2 Better Health	06/30/17	• Two programs fully transitioned. • Positions created, posted, and staff hired and trained. • CCT and J2BH are fully operational.

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. _x_ CEO
2. _x_ CFO
3. _x_ Other (please specify)
   Shafeeq Ahmed, M.D., VP of Medical Affairs;
   Karen Davis, VP of Nursing;
   Elizabeth Kromm, VP of Population Health and Advancement

Senior leadership directs, oversees and approves all community benefit work, including the allocation of funds that support community outreach directed at underserved and high-need populations in the CBSA. This high level review and evaluation sets the priorities of the hospital's outreach work and ensures the effective, efficient usage of funds to achieve the largest impact in improving the lives of those who live in the communities we serve. This group conducts the final review and approval of the report's financial accuracy to the hospital's financial statements, alignment with the strategic plan and compliance with regulatory requirements.

ii. Clinical Leadership

1. _x_ Physician
2. _x_ Nurse
3. _x_ Social Worker
4. ___Other (please specify)

Individual clinical leaders, along with administrators, make decisions on community benefit programs that each department supports/funds through their budget. Clinical leaders will also identify and create strategies to tackle community health needs that arise in the CBSA, and oversee department programs for content accuracy, adherence to department protocols and best practices.

HCGH Clinical Leadership support areas identified through HCGH's community health needs assessment:

- Access to Care: Laura Hagan, Nurse Manager for the Pediatric Unit, and David Monroe, MD, Medical Director of the Pediatric Emergency Department, oversee the Telemedicine program in Title I schools in Howard County at HCGH.

- Behavioral Health: Andrew Angelino, MD, Chair of the Department of Psychiatry, and Laura Torres, LCSW-C, Behavioral Health Program Manager, build partnerships in the community to expand access to needed behavioral health services. They played a key role in the development of the Rapid Access Program (RAP) and serve in an oversight capacity on an ongoing basis.
- Healthy Aging: A multidisciplinary team at HCGH, including HCGH unit nursing staff, social workers, case management, physicians, and the Community Care Team (CCT), identify inpatients for referral to programs that promote aging in place and identifying community resources.

iii. Population Health Leadership and Staff

1. _x_ Population health VP or equivalent
   Patricia M.C. Brown, Senior VP of Managed Care and Population Health, JHM
2. _x_ Other population health staff
   Elizabeth Edsall Kromm, VP of Population Health and Advancement, HCGH
   Cindi Miller, Director of Community Health Education, HCGH
   Tracy Novak, Director, Population Health Programs, HCGH
   Laura Hand, Director of Strategic Planning, HCGH

Patricia M.C. Brown, Senior VP of Managed Care and Population Health, JHM is responsible for directing the Johns Hopkins Medicine (JHM) population health strategies, including care management, disease management and preparation for health care reform for all JHM hospitals and provider groups.

Elizabeth Edsall Kromm, VP of Population Health and Advancement, assesses hospital data, partners with community organizations and determines CB programs and initiatives based upon the four HCGH Community Health Priorities. She links the Executive Leadership Team with key initiatives, allowing for organizational integration.

Cindi Miller, Director of Community Health Education, integrates community outreach and community health improvement priorities.

Tracy Novak, Director of Population Health Programs, oversees the operations of interventions linked to specific community health needs.

Laura Hand, Director of Strategic Planning, integrates community health needs assessment priorities into the hospital's strategic plan.

iv. Community Benefit Operations

1. _x_ Individual (please specify FTE)
   2 FTEs: Senior Project Manager of Regulatory Compliance and the Senior Revenue Analyst support the CB tracking and reporting.
   0.32 FTE: VP of Population Health and Advancement
   0.2 FTE: Director of Community Health Education
   0.2 FTE: Director of Strategic Planning
2. ___ Committee (please list members)
3. ___ Department (please list staff)
4. ___ Task Force (please list members)

5. _x_ Other (please describe)
   See Appendix VI for Community Benefit Team and Task Force Membership

The Senior Project Manager of Regulatory Compliance and the Senior Revenue Analyst compile and analyze data that support the Community Benefit (CB)at HCGH. They provide the annual CB Financial Inventory report for HCGH.

The VP of Population Health and Advancement assesses the hospital data, partners with community organizations and determines CB programs and initiatives based upon the four HCGH Community Health Priorities. The VP provides oversight for the annual CB Narrative.

The Director of Strategic Planning and the Director of Community Health Education develop the annual CB Narrative.

All above staff are members of the JHM Community Health Improvement Strategy Council.

c. Is there an internal audit (i.e., an internal review conducted at the hospital) of the Community Benefit report?)

Spreadsheet	_x__ yes	_____no
Narrative	_x__ yes	_____no

If yes, describe the details of the audit/review process (who does the review? Who signs off on the review?)

There are several levels of audit and review in place at Johns Hopkins Health System (JHHS). Members of the CB team conduct the initial review for accuracy of information submissions, analyze the financial data variances year over year, review reports for data inconsistencies and/or omissions and contact program reporters to verify submitted information and/or provide additional details. The CB team meets with senior hospital finance leadership to discuss, review and approve the CB financial reports. The CB team also meets with the senior compliance officer to review and audit for regulatory compliance. After the hospital specific audit/review is completed, the JHHS CB Workgroup attends a meeting with all of the JHHS CFOs to review system wide data and final reports for the Health System president. In the final review meeting before submission, the hospital CFOs present to the health system president and discuss strategic alignment, challenges and opportunities discussed during the CB process.

d. Does the hospital's Board review and approve the FY Community Benefit report that is submitted to the HSCRC?

Spreadsheet	_x_ yes	_____no
Narrative	_x__yes	_____no

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

_x_ Yes _____No

HCGH's Strategic Transformation Plan includes four major goals:

1) Care Coordination

2) Population Health Analytics

3) Provider Alignment

4) Behavioral Health

Of these goals, Care Coordination and Behavioral Health are closely aligned with the community benefit work undertaken by the hospital. The Community Care Team, which transitioned from the Howard County Health Department to the hospital in FY17, is a key portion of the care coordination strategy to ensure a smooth transition for admitted patients discharged to home, and is supported by hospital investment as well as the Regional Partnership.

In terms of Behavioral Health, HCGH is funding a partnership with Way Station, Inc. to provide urgent access appointments to patients in a behavioral health crisis within 48 hours of presentation to the HCGH emergency department. This investment is directly tied to HCGH's strategic transformation plan goal of improving access to urgent care mental health services.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners:

_x_ Other hospital organizations
_x_ Local Health Department
_x_ Local health improvement coalitions (LHICs)
_x_ Schools
_x_ Behavioral health organizations
_x_ Faith based community organizations
_x_ Social service organizations
_x_ Post-acute care facilities

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

The following, along with Howard County General Hospital, were members of the 2016 CHNA Survey Planning Committee.

Organization	Name of Key Collaborator	Title	Collaboration Description
Local Health Improvement Coalition (LHIC)	Maura Rossman, M.D.	Health Officer and LHIC co-chair	More than 40 member organizations voted in November 2014 to determine the health priorities for calendar years 2015-2017.
	Steve Snelgrove	HCGH President and LHIC co-chair	

	Kelly Kessler, M.S., CHES	LHIC, Director	
Howard County Health Department	Maura Rossman, M.D.	Howard County Health Officer	Staff provided input for the survey on questions of interest that were reflective of community health needs. Assistance was given in the outreach to the community about the survey, as well as a point of contact for the data analysis.
	Felicia Pailen	Director, Policy and Planning	
	Jacqueline Douge, M.D.	Director, Child Health	
Columbia Association	Shawni Paraska	Director, Community Health Sustainability	Provided input on questions concerning healthy behaviors and physical activity.
Horizon Foundation	Glenn Schneider	Chief Program Officer	Provided coordination of the survey process, input into pertinent questions for the survey and was the agency contact for the consultant group performing the survey.
	Tiffany Callender	Senior Program Officer	
Johns Hopkins Medicine	Steve Arenberg	Director, Marketing Research	Provided advice on marketing research.
	Elizabeth Edsall Kromm, PhD.	VP, Population Health and Advancement	Provided input on HCGH Community Health Needs.
	Cindi Miller, R.N., M.S.	Director, Community Health Education	Provided input on HCGH Community Health Needs.
OpinionWorks, LLC	Steve Rabe	President	Provided expertise in survey question development, data collection and data summary.

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?

_x_ yes _____no

HCGH President Steve Snelgrove is the co-chair of the Howard County LHIC, along with Maura Rossman, M.D., Howard County Health Officer.

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

_x_ yes _____no

Howard County LHIC members include: Steve Snelgrove, President; Elizabeth Kromm, VP of Population Health and Advancement; Laura Hand, Director of Strategic Planning; Cindi Miller, Director of Community Health Education; Tracy Novak, Director of Population Health Programs.

Elizabeth Edsall Kromm, VP Population Health and Advancement, serves on the LHIC executive committee. Hospital staff are members of each of the four working groups

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

This Information should come from the implementation strategy developed through the CHNA process.

1. Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured.

Community Health Needs Assessment Key Community Initiatives

The top health priorities identified in the 2016 HCGH CHNA were:

1. Access to Care
2. Behavioral Health
3. Healthy Weight
4. Healthy Aging

These areas are also the four LHIC priorities identified for 2015-2017. All four priority areas are interconnected: for example, management of chronic disease is connected with maintaining a healthy weight and aging in a healthy manner, but is also dependent on access to timely and affordable health care. Community behavioral health needs can only be met if patients are able to access care in a timely manner and in a non-cost-prohibitive setting. HCGH has developed programmatic offerings around each of these priorities, with the goal of reducing the burden of disease and improving the quality of life for residents throughout Howard County.

Table III consists of four major community benefit activities that are provided to the CBSA of Howard County. All initiatives were developed in response to the needs identified during the 2016 and prior CHNA processes.

Table III

Initiative 1: Telemedicine in Howard County Schools	
Identified Need	**Access to Care** Access to Care is one of the four identified areas of the 2016 HCGH Community Health Needs Assessment. The assessment identified that in 2016 there were 15,229 residents of Howard County without health insurance coverage. Among households making less than $50,000 a year, only 88% of respondents had coverage.[31] Additionally, education status impacted whether someone was insured: among residents with some college, 8% were uninsured; of residents with a high school education, 10% were uninsured, and among those with less than a high school education, 24% were uninsured.[32] Further, even if residents have health insurance, they may not be able to access care in a timely manner. 13% of respondents to the Howard County Health Assessment Survey reported that they did not have a doctor that they saw regularly, and 8% of residents stated they went to the ER because they couldn't

[31] HCGH 2016 CHNA.

[32] http://www.howardcountyhealthsurvey.com/results/access-to-affordable-care/

	get a doctor's appointment (that number increases to 10% of residents with children).[33] Former Howard County Health Executive Ken Ulman believed that health disparities in lower-income parts of the county could be causing differences in student achievement, which could be ameliorated by improved access to care.[34] Title 1 school students who become ill at school could miss additional school time and have unnecessary emergency room visits if they cannot get access to a healthcare provider in a timely manner.
Hospital Initiative	School-Based Wellness Centers Telemedicine Program (Partnership with Howard County Schools)
Total Number of People within Target Population	The telemedicine program was active in six Howard County Title 1 elementary schools in FY17: Bryant Woods, Ducketts Lane, Phelps Luck, Running Brook, Stevens Forest, and Talbott Springs.[35] Total student enrollment for the schools in FY17 was 3,374 students.[36]
Total Number of People Reached by Initiative	1,522 students were enrolled in the telemedicine program. There were 217 pediatric student encounters in FY17.[37]
Primary Objective	In response to a need for increased access to timely appointments for students and fewer missed school hours for children in economically disadvantaged areas, Howard County General Hospital has partnered with the Howard County Health Department, Howard County Public School System, and two area primary care practices to offer on-demand telemedicine appointments in partnership with school nurses in 6 Title 1 elementary schools in Howard County. Using telemedicine technology including video monitoring, cameras, and digital stethoscopes and otoscopes, pediatricians at HCGH and the primary care practices are available to examine ill students, provide a quick diagnosis and prescribe medicine when needed. Even when students must leave school due to a contagious illness, this quick access to an appointment and diagnosis means less school time is missed. The primary goal of the program is to increase access to care in a timely manner for elementary school students in Title 1 schools and to reduce the number of children missing school for medical appointments and emergency department visits. This will be measured by number of students reached and rate of return to the classroom after a visit.

[33] http://www.howardcountyhealthsurvey.com/results/access-to-affordable-care/
[34] http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/01/04/telemedicine-in-schools-helps-keep-kids-in-the-classroom
[35] http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/01/04/telemedicine-in-schools-helps-keep-kids-in-the-classroom
[36] Howard County Health Department, Enrollment and Visit Data SY16-17
[37] Howard County Health Department, Enrollment and Visit Data SY16-17

Single or Multi-Year Initiative Time Period	Multi-year initiative. The program started in 2015 and is ongoing. Telemedicine consults are available during school hours throughout the academic year.	
Key Collaborators in Delivery	Howard County Public School System, Howard County Health Department, Columbia Medical Practice, Klebanow & Associates (medical practice)	
Impact of Hospital Initiative	1,522 of the 3,374 students in the 6 schools enrolled in the program (45.1%). There were 217 encounters with 155 unique students, 192 of which were with Howard County General Hospital. The adjusted return to class rate (excluding 62 patients sent home with fever, bacterial conjunctivitis, or strep throat as required by HCPSS policy) was 96.8% of students; however, even when a child must be taken out of school, having a diagnosis made quickly and a prescription given significantly reduced the time the child must be absent from school.[38]	
Evaluation of Outcome (Include process and impact measures)	The number of students enrolled in the program increased from 1,144 students in FY16 to 1,522 students in FY17, an increase of nearly 25%. This indicates an increase in access to care within the school system. Additionally, the high adjusted return to class rate indicates that this program has been able to effectively provide care for students without resorting to costly and time-consuming emergency department visits.	
Continuation of Initiative	Yes, this initiative will continue in FY18. A barrier was identified with low enrollment at the Bryant Woods school, partially due to the small number of students at the school. The program was therefore switched to the Deep Run Elementary school for the next school year since this school has a greater need and nearly three times the student population. HCGH is continuing to work with HCHD and HCPSS to ensure that staffing needs are being met.	
Expense A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative: $9,600	B. Direct offsetting revenue from Restricted Grants $0

[38] Howard County Health Department, Enrollment and Visit Data SY16-17

Initiative 2: Rapid Access Program	
Identified Need	**Behavioral Health** Behavioral health was one of four areas identified in the 2016 Community Health Needs Assessment. The percent of residents reporting presently taking medicine or receiving treatment from a health professional for a mental health condition or emotional problem increased to 11% in 2016 (7% in 2014). When split out by gender, 7% of men and 15% of women are seeking treatment for a mental health or emotional problem.[39] Access to behavioral health treatment is also a concern – 3% of residents reported needing behavioral health treatment in the past 12 months but didn't get it.[40] Many residents also report binge drinking in the past month– these rates are highest in adults ages 18-44 (35%) followed by those ages 45-64 (18%) and those 65+ (7%).[41] Another issue that Howard County residents report is stress about having enough money for vital living expenses. This problem is most notable among the African American population (18%), followed by Hispanics (13%), Whites (10%), and Asians (5%).[42] Howard County is not meeting the SHIP goal (<3,152.6/100,000) for emergency department visits related to mental health conditions among the Black Non-Hispanic population (3,223.3/100,000) and is higher than the state rate for this population.[43] Howard County is also not meeting the SHIP goal (<9.0) for suicide rates among White Non-Hispanics (9.6) and men (10.6).[44] Eleven percent of Howard County residents reported they were presently taking medicine or receiving treatment from a health professional for a mental health condition or emotional problem. This is an increase from 7% in 2014 and 9% in 2012.[45]
Hospital Initiative	Rapid Access Program
Total Number of People within Target Population	The target population are adult residents of Howard County, as anyone may present to the emergency department with urgent behavioral health needs. The population of Howard County aged 18 and over is 239,194 people.[46]

[39] http://www.howardcountyhealthsurvey.com/results/mental-health-and-addictions/
[40] http://www.howardcountyhealthsurvey.com/results/mental-health-and-addictions/
[41] http://www.howardcountyhealthsurvey.com/results/mental-health-and-addictions/
[42] http://www.howardcountyhealthsurvey.com/results/mental-health-and-addictions/
[43] http://howard.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship34
[44] MD DHMH Department of Vital Statistics
[45] Howard County General Hospital 2016 Community Health Needs Assessment
[46] https://www.census.gov/quickfacts/fact/table/howardcountymaryland,US#viewtop

	Of this population, 2,313 patients presented to the ED with a psychiatric condition in FY17.[47]
Total Number of People Reached by Initiative	In FY17 there were 589 total enrollees in the RAP program. From the program's inception in August 2015, the following data were collected on the program enrollees: Gender: • Male: 46% • Female: 54% Age: • <39: 64% • 40-59: 26% • 60+: 10% Insurance: • Medicaid: 37% • Commercial: 35% • Medicare: 11% • Other: 10% • Unknown: 7%
Primary Objective	The goal of the Rapid Access Program (RAP) is to prevent further emotional distress/decompensation for people in need of mental health treatment which could result in accessing more acute levels of care. The program provides outpatient crisis stabilization within two business days of referral, regardless of ability to pay, and connects patients to treatment. Patients are first identified when they present to Howard County General Hospital either in the ED or as an inpatient. They are assessed with a psychiatric evaluation by a nurse practitioner, and if they require urgent outpatient psychiatric care, RAP is presented as an option. If the patient is interested in enrolling, they sign a consent form and their appointment is scheduled on the spot. Services during the episode of care include: • Initial psychiatric evaluation with a Nurse Practitioner at HCGH • Evaluation and 2 medication management sessions with a psychiatric nurse practitioner • 6 psychotherapy sessions with a licensed therapist During the episode of care, the NP and therapist work with the patients to stabilize their condition, which includes medication management and development of treatment goals. They also assist the patient in finding resources for obtaining health insurance, and provide bridge therapeutic

[47] HCGH Emergency Department Dashboard, Tableau Server

	services until the patient connects with their former provider. Finally, the program will refer patients to a higher level of care if they find it is necessary.
Single or Multi-Year Initiative Time Period	This is a multi-year initiative. RAP began in August 2015 and is ongoing.
Key Collaborators in Delivery	Howard County Mental Health Authority; Way Station, Inc.; Local Health Improvement Coalition –Behavioral Health Work Group; Grassroots Crisis Intervention Center; National Alliance for Mental Illness (NAMI) Howard County; The Horizon Foundation; Howard County Health Department; HC Drug Free; On Our Own Howard County; MD Chapter, American Academy of Pediatrics
Impact of Hospital Initiative	Of the 589 clients who enrolled in the program and had visits with a Way Station provider, 420, or 71.3%, were seen within 2 days of discharge from HCGH. This meets the stated program goal of decreasing the time patients must wait in order to get an urgent mental health appointment.
Evaluation of Outcome (Include process and impact measures)	In looking at aggregate Howard County data, three percent of residents said there was a time during the prior 12 months when they needed mental health treatment or counseling, but did not get it. This number is unchanged from 2014. However, in 2016 there was an increase in the percentage of residents, (7% in 2014 to 11% in 2016), taking medication or receiving treatment from a health professional for a mental health condition or emotional problem.[48] Internally, the number of patients enrolled in RAP increased from 305 in FY16 to 589 in FY17. Additionally, a study of patients enrolled once in the program in FY16 and FY17 demonstrated that when compared to the 12 months prior to enrollment in the program, visits to any Maryland hospital in the 12 months after enrollment decreased by 24.2%.[49] This demonstrates that these patients are likely utilizing the emergency department less frequently for their mental health treatment.
Continuation of Initiative	This initiative will continue in FY18. One barrier identified is the challenges patients have in attending appointments scheduled while they are in the emergency department. This may be due to the fact that they are given the next available appointment without discussion on whether this is feasible for the patient to make. Due to this feedback, the staff referring patients have been given a clearer script to ask patients about the reason for referral, what to expect at the referral and how it can help them, and what time/day is best for the patient. Another barrier was that the after-visit summary from the emergency department did not always accurately reflect the referral information that the patient was given by their clinician. This was rectified in HCGH's electronic

[48] www.howardcountyhealthsurvey.com/results/mental-health-and-addictions/

[49] CRISP Pre/Post Data Analysis

	medical record, and clinicians are now more proactive in ensuring the attending physician has the correct information to include. Finally, it can be challenging to obtain outcome data for patients due to the restrictions on data sharing for patients with behavioral health diagnoses. HCGH is working on data capture methodologies to ensure that outcomes data, including readmissions, is appropriately measured.	
Expense C. Total Cost of Initiative for Current Fiscal Year D. What amount is Restricted Grants/Direct offsetting revenue	C. Total Cost of Initiative $75,000	D. Direct offsetting revenue from Restricted Grants $0

Initiative 3: Journey to Better Health	
Identified Need	**Healthy Weight** Healthy Weight was one of the four priorities identified in the 2016 HCGH Community Health Needs Assessment. According to the Howard County Health Assessment Survey, 60% of Howard County respondents reported BMI scores that classify them as overweight or obese, which demonstrates an increase from 56% in 2014.[50] Additionally, many survey respondents reported behaviors that can contribute to unhealthy weight, such as lack of exercise and unhealthy diet. Only 64% of respondents ate fruit daily and 68% ate vegetables daily, and only 4% ate the full recommended 5 servings per day.[51] The Maryland SHIP metrics confirm this data, showing that Howard County is barely meeting the state goals for increasing physical activity in all populations (50.7% compared to the state goal of >50.4%) and is not meeting the SHIP goal among Hispanics (31.1%) and females (46.7%)[52]. Additionally, Howard County is not meeting the SHIP goal for adolescents who have obesity among Black Non-Hispanics (12.5% compared to the state goal of <10.7%), and Adults who are not overweight or obese among Black-Non-Hispanics (15.8% compared to the state goal of >36.6%).[53] In terms of the impact of weight and diet problems on health, there were many residents reporting chronic illnesses that are impacted by healthy diet and exercise. Overall, 26% of Howard County residents reported having high blood

[50] www.howardcountyhealthsurvey.com/results/healthy-weight-nutrition-and-exercise/
[51] www.howardcountyhealthsurvey.com/results/healthy-weight-nutrition-and-exercise/
[52] Maryland BRFSS
[53] Maryland BRFSS

	pressure, 31% had high cholesterol, and 14% had diabetes or pre-diabetes.[54] When broken out by race, 34% of black residents have high blood pressure, followed by 26% of white residents, 20% of Hispanic residents, and 16% of Asian residents.[55] 10% of black residents have diabetes, followed by 8.3% of Asian residents, 6.3% of white residents, and 5% of Hispanic residents.[56]
Hospital Initiative	Journey to Better Health, a faith-based healthcare partnership with HCGH
Total Number of People within Target Population	10 congregations in the community participated in the Journey to Better Health program. These congregations collectively have approximately 10,000 active members.
Total Number of People Reached by Initiative	476 people were screened for prediabetes, hypertension, and obesity; all screened individuals were referred to evidence based classes. 87 individuals enrolled in evidence-based health education classes. 88 members enrolled in the Member Care Support Network.
Primary Objective	Journey to Better Health (J2BH) is a faith-based initiative that works with congregations to support the health of their members and other Howard County residents. After the pilot year of the program, outreach was extended from just 21044 and 20145 (Columbia) to all zip codes in Howard County. Faith-based organizations partnered with Journey to Better Health as outlined in a signed partnership agreement to offer chronic disease prevention and management strategies to their members. Program strategies included: **Chronic Disease Screenings and Education:** Conduct screenings for hypertension, obesity and pre-diabetes and classes on chronic disease self-management within the congregations. Class offerings included Living Well with Chronic Disease, Living Healthy with Hypertension, and Living Well with Diabetes (Spanish). **Support network to prevent readmissions:** Develop a Member Care Support Network which aims to pair members with trained volunteer Community Companions from their congregation for support during and after a hospitalization. The primary objective of Journey to Better Health (J2BH) is to empower self-management of chronic disease in community members.
Single or Multi-Year Initiative Time Period	Multi-year: this initiative is ongoing.

[54] www.howardcountyhealthsurvey.com/results/chronic-diseases/
[55] www.howardcountyhealthsurvey.com/results/chronic-diseases/
[56] www.howardcountyhealthsurvey.com/results/chronic-diseases/

Key Collaborators in Delivery	Howard County Health Department; Abiding Savior Lutheran Church; Atholton Seventh Day Adventist; New Hope SDA Church; St. John Baptist Church; Columbia Community Church; Unitarian Universalist Congregation of Columbia; Muslim Family Center; Celebration Church; Locust United Methodist Church; Iglesia de Dios Pentecostal; Howard County Office on Aging and Independence
Impact of Hospital Initiative	One new congregation was added in FY17, to bring the total number of participating congregations to 10. Three congregations hosted screening events, and four congregations hosted evidence-based health classes for their members. Six congregations were engaged with the Member Care Support Network. The evidence-based classes offered in FY17 were as follows: • Chronic Disease Self-Management: 9 classes offered, 65 enrollees • Diabetes Self-Management: 1 class offered, 7 enrollees • Living Healthy with Hypertension: 2 classes offered, 15 enrollees
Evaluation of Outcome (Include process and impact measures)	476 individuals were screened at 11 screening events (hosted at congregations, at HCGH, and in the community). Of these screened individuals, 50% were at risk for prediabetes, 55% were at risk for Hypertension, and 56% were at risk for obesity. 100% of screened individuals were referred to evidence-based classes. The evidence-based classes had the following completion rates: • Chronic Disease Self-Management: 79% completion rate • Diabetes Self-Management: 100% completion rate • Living Healthy with Hypertension: 100% completion rate The Member Care Support Network recruited 14 new volunteers in FY17 with 12 of those volunteers trained. 88 members were enrolled in the MCSN in FY17.
Continuation of Initiative	The initiative will continue in FY18. In the area of outreach, the team identified a need for consisted, targeted outreach efforts with resources for marketing and communications. They identified a barrier with the partnership agreement process and are moving to make this process based more on actions rather than signed agreements. The needs assessment tool used with congregations was also limited, so the team is working to create a useable evaluation tool to inform programming efforts. In terms of the Member Care Support Network, the team intends to improve relationships with other hospital departments to enhance referral sources, especially with the hospital clergy for faith leadership support of health improvement. The team also intends to develop metrics to support tracking activities to inform success and any remaining gaps.

	Finally, the program intends to expand the types of classes and screenings offered, as well as promote and provide their resources at existing congregation events. A gap was identified in mental health class offerings, so the team is planning to bring Mental Health First Aid classes to this program.	
Expense E. Total Cost of Initiative for Current Fiscal Year F. What amount is Restricted Grants/Direct offsetting revenue	E. Total Cost of Initiative $293,115	F. Direct offsetting revenue from Restricted Grants $290,000

Initiative 4: Community Care Team	
Identified Need	**Healthy Aging** Healthy Aging was one of the four priorities identified in the 2016 HCGH Community Health Needs Assessment. Howard County is aging at a faster rate than the state and country – it is estimated that the population aged 65+ will grow nearly 25% in the next 5 years.[57] The HCGH CHNA identified higher rates of chronic illness in older residents: respondents aged 50-64 reported having high blood pressure (35%), diabetes (10%), and COPD or other breathing conditions (4%), while residents ages 65+ reported higher rates of these chronic conditions – 61% reported high blood pressure, 24% reported having diabetes, and 6% reported having COPD.[58] Among adults ages 55 and older, 65% reported that they were overweight or obese.[59] In addition to increasing healthcare needs, the aging population in Howard County faces some issues with access to care. While 98% of residents ages 55 and older report having health care coverage, only 88% have a personal healthcare provider, and 5% report that they could not see a doctor due to cost. Additionally, 7% reported going to the emergency department when they were not able to get a doctor's appointment.[60]
Hospital Initiative	Community Care Team

[57] Truven Market Expert
[58] HCGH Community Health Needs Assessment.
[59] www.howardcountyhealthsurvey.com/results/health-and-aging/
[60] www.howardcountyhealthsurvey.com/results/health-and-aging/

Total Number of People within Target Population	The Community Care team targets patients who are Howard County residents over the age of 18 who have Medicare as their primary payer (or are dually eligible for Medicare and Medicaid). They must also have had at least 2 HCGH encounters in the past 365 days (this can be through an inpatient stay, observation stay, or ED visit). There are 2,610 unique patients that meet these criteria.
Total Number of People Reached by Initiative	There were 744 referrals to CCT in FY17, with a 43% acceptance rate into the program. There were 247 unique enrollees in the program in FY17. The patients who qualify for a CCT intervention are clustered in 5 zip codes: 21044, 21045, 21043, 21042, and 21075. 80% are 65 years or older (51% are 80 years or older), and 66% have multiple chronic conditions. Of the hospital encounters in this group, 42% of visits are for chronic issues or conditions that could be managed outside of a hospital.
Primary Objective	The Community Care Team (CCT) is a part of the Howard Health Partnership, which is funded through a Transformation Implementation Program (TIP) from the HSCRC. CCT is designed to improve chronic disease self-management of frequently hospitalized Howard County residents. The target population are Howard County residents who are Medicare (or dual eligible) beneficiaries and have had two or more hospital encounters in the last 12 months at HCGH. The overarching goals of the program are to increase the patient experience of care, improve patient health outcomes, and reduce total health care costs. CCT empowers patients to better manage their chronic conditions outside the hospital. CCT provides community-based, comprehensive support and coordination using a patient-centered approach. Patients and their caregivers generally receive benefits from the program for 30-90 days after a hospitalization or ED visit with frequent home visits and/or phone contact from a multi-disciplinary care team. The first conversation with a CCT member occurs around the time of discharge from the hospital. CCT connects patients to primary, behavioral, and specialty care; coordinates home care; and addresses social needs by linking patients and their caregivers to appropriate community resources. The multidisciplinary CCT team consists of a Community Health Nurse, a Community Health Worker, and a Licensed Clinical Social Worker. The team assists their clients in developing a care plan and following their progress. The team focuses on social determinants in addition to health care needs; there is also a primary care coordination program that refers appropriate patients from community practices to CCT.
Single or Multi-Year Initiative Time Period	Multi-year: this initiative is ongoing.

Key Collaborators in Delivery	Howard County Health Department; Horizon Foundation; LHIC; CRISP; Howard County Office on Aging and Independence; Way Station Inc; Gilchrist Services; Lorien Health Systems; Johns Hopkins Home Care Group; Department of Social Services; Primary Care Practices (Columbia Medical Practice; Centennial Medical Group, Johns Hopkins Community Physicians, Maryland Primary Care Physicians, Personal Care Physicians)	
Impact of Hospital Initiative	247 unique patients were served by the CCT program in FY17. 88% of these patients were contacted within 3 days of referral, and 91% of patients had a care plan established within 14 days of enrollment.	
Evaluation of Outcome (Include process and impact measures)	Of the 247 patients served in FY17, 89% graduated from the program to self-management of their conditions. The median intervention length for the program decreased from 70 days at the beginning of FY17 to 37 days at the end of the fiscal year. Preliminary high-level pre/post analyses of program participants indicate a reduction in hospital utilization after graduation from CCT; program staff continue to refine their data collection methodology to provide more precise outcomes data.	
Continuation of Initiative	The initiative will continue in FY18. The team identified one barrier in terms of patients and caregiver inability to attend Chronic Disease Self-Management courses due to inability to pay. They are pursuing funding sources for this opportunity. Additionally, there could be an expansion of the program to 25,000 additional Medicare beneficiaries if a geographic model is pursued by the hospital – in that case there would be a need to hire 26 incremental FTEs. The team is undertaking scenario and budget planning for this potential option.	
Expense G. Total Cost of Initiative for Current Fiscal Year H. What amount is Restricted Grants/Direct offsetting revenue	G. Total Cost of Initiative $660,942	H. Direct offsetting revenue from Restricted Grants $591,942

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not?

   Dental Health is an area identified as a health need. Eighty percent of residents indicated they had visited a dentist/dental clinic within the past 12 months; residents are less likely to have had a dental visit in the past 12 months if they are aged 25 to 34, are lower income, have less than a college degree, or are widowed or never married.[61] Nine percent of residents reported having a dental problem and would have liked to see a dentist but did not. The main reason they did not see the dentist was due to cost (49%). Residents in the Elkridge (51%) and Laurel (73%) areas

[61] 2016 HCGH Community Health Needs Assessment

indicated cost was a greater concern than did other areas of Howard County. Currently, the LHIC Access to Care workgroup includes improving access to oral health in their 2015 –2017 Action Plan. The hospital is not directly involved in these efforts but does work with partner organizations in the community to address these needs. HCGH is also represented on the LHIC and participates in the strategic planning and goal-setting processes.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

   The CHNA priorities of HCGH, detailed through initiatives in Table III, link directly with LHIC priorities/initiatives. All work done through the LHIC is based on SHIP measures and reported to the State through the Howard County Health Department. The Behavioral Health initiative seeks to reduce hospital ED visits related to behavioral health, which is directly related to the SHIP metric "ED visits related to mental health conditions." The Healthy Weight initiative seeks to increase the percentage of adults who are at a healthy weight, which is tied to the SHIP metric "Adults who are not overweight or obese." The Access to Care initiative is tied to the SHIP metric "Uninsured ED visits." The Healthy Aging initiative is tied to several SHIP metrics, including "ED visit rate due to diabetes" and "ED visit rate due to hypertension."

VI. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

   HCGH has subsidized physicians in several specialties to incentivize them to accept on-call coverage responsibilities, serving both the Hospital's ED, and consultation and treatment of Hospital inpatients. One of the issues compelling physicians to refuse hospital call, without financial subsidy, is the burden of the uninsured, and limited reimbursement for Medical Assistance patients.

   Many physician practices, in nearly every specialty in Howard County, either limit the number of uninsured and Medical Assistance patients in their panels, or refuse to accept non-paying patients altogether. The Hospital's precise knowledge of this practice, in the community-based, private physician setting, is limited to information that physicians voluntarily report on their registration profile of the Hospital's physician referral service, and "telephone mystery shopping" conducted to ascertain their acceptance of new patients. Few physicians complete this segment of the referral service profile. The Hospital's physician referral service periodically receives calls from individuals who report that they have been unable to find a physician willing to accept patients who are uninsured and/or covered by Medical Assistance.

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

Table IV – Physician Subsidies

Category of Subsidy	Explanation of Need for Service
Hospital-Based physicians	In FY17, the Hospital contributed $2,888,583 for ED On-Call, OB/GYN ED/IP, Psych ED/IP to provide coverage for their services. In addition, the following services were supported by HCGH for call coverage: • Otolaryngology On-Call: $212,583 • Interventional Cardiology On-Call: $465,000 • Anesthesia On-Call: $1,386,759 • Cardiology On-Call: $163,967 • Perinatology On-Call: $304,401

	Payments incentivize on-call coverage responsibilities, serving both the Hospital's Emergency Department (ED) and consultation and treatment of Hospital inpatients. Physicians no longer take calls unless compensated for this service.
Non-Resident House Staff and Hospitalists	The Hospital staffs a team of hospitalists and intensivists to provide primary care for patients, working collaboratively alongside specialists and patients' primary care physician. In total, the Hospital supported $4,965,762 for these hospital-based physicians.
Coverage of Emergency Department Call	See above
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	

VII. APPENDICES

APPENDIX I. DESCRIPTION OF FINANCIAL ASSISTANCE POLICY

JHHS hospitals publish the availability of Financial Assistance on a yearly basis in their local newspapers, and post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. These notices are at a reading comprehension level appropriate to the CBSA's population and are in English and in non-English languages prevalent in the CBSA.

Notice of availability is mentioned during oral communications. The hospital has multilingual staff to assist non-English speaking patients.

Notice of availability and financial assistance contact information is also prominently noted on patient bills and statements at a reading comprehension level appropriate to the CBSA's population. For Spanish speaking patients, when the hospital is aware of patient's limited language skills, statements and letters are sent in Spanish.

A Patient Billing and Financial Assistance Information Sheet is provided to inpatients before discharge and will be available to all patients upon request. This Information Sheet is at a reading comprehension level appropriate to the CBSA's population and is in English and in non-English languages prevalent in the CBSA.

Financial Assistance Applications and Medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and those patients are notified in writing, as well as verbally.

Notice of availability of financial assistance is posted on each hospital website. The Financial Assistance Policy and Application and Medical Financial Hardship Application are posted on the hospital's website in English and in non-English languages that are prevalent to the CBSA's population. The application is printable.

JHHS has staff available to discuss and assist patients and/or their families with the availability of various government benefits, such as Medicaid or State programs, and assists patients with qualification for such programs, where applicable.

APPENDIX II. Description of How Hospital's Financial Assistance Policy has changed since ACA became effective on January 1, 2014

Effective January 1, 2015, JHHS expanded its definition of Medical Debt to include co-payments, co-insurance and deductibles of patients who purchased insurance through a Qualified Health Plan.

> In JHHS FAP a Qualified Health Plan is defined as:
> Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

At The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (JHBMC), the policy expanded eligibility for Financial Assistance. Previously, eligibility was limited to patients who were citizens of the United States of America or a permanent legal resident (must have resided in the USA for a minimum of one year). Effective January 1, 2015, this was expanded to include patients who reside within the geographic area described in the hospital's Community Health Needs Assessment. The ZIP codes for JHH and JHBMC are: 21202, 21205, 21206, 21213, 21218, 21219, 21222, 21224, 21231, and 21052.

Notice of financial assistance availability was posted on each hospital's website and mentioned during oral communications. Policy was changed to state this is being done. This change is in response to IRS regulation changes.

Previously patients had to apply for Medical Assistance as a prerequisite for financial assistance. JHHS added that the patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements.

For Medical Hardship: Medical Debt is defined as out of pocket expenses for medical costs for Medically Necessary Care billed by the Hopkins hospital to which the application is made, the out of pocket expenses mentioned above do not include co-payments, co-insurance and deductibles, unless the patient is below 200% of Federal Poverty Guidelines.

Policy was changed to add an Appendix and language advising that the Appendix lists physicians that provide emergency and medically necessary care at the hospitals and whether the doctor is covered under the hospital's Financial Assistance policy. The Appendix will be updated quarterly and is posted on the hospital website. The policy and the website instruct patients to direct any questions they may have concerning whether a specific doctor has a financial assistance policy separate and apart from the hospital's policy. This change is in response to IRS regulation changes.

APPENDIX III. FINANCIAL ASSISTANCE POLICY

JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Policy & Procedure	Policy Number	FIN034H
		Effective Date	04-01-16
	Subject: FINANCIAL ASSISTANCE	Page	1 of 21
		Supersedes	10-23-13

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: Howard County General Hospital (HCGH) and Suburban Hospital (SH).

Purpose

JHHS is committed to providing financial assistance to patients who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or excessive Medical Debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, and will also be sent to patients on patient bills. A Patient Billing and Financial Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. Review for Medical Financial Hardship Assistance shall include a review of the patient's existing medical expenses and obligations (including any accounts placed in bad debt) and any projected medical expenses. Financial Assistance Applications and medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted so long as other requirements are met.

FINANCIAL ASSISTANCE FOR PHYSICIANS PROVIDING CARE NOTICE:
Attached as EXHIBIT D is a list of physicians that provide emergency and medically necessary care as defined in this policy at HCGH and SH. The lists indicates if the doctor is covered under this policy. If the doctor is not covered under this policy, patients should contact the physician's office to determine if the physician offers financial assistance and if so what the physician's financial assistance policy provides.

Definitions

Medical Debt	Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the JHHS hospital to which the application is made. Out of pocket expenses do not include co-payments, co-insurance and deductibles unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements. Medical Debt does not include those hospital bills for which the patient chose to be registered as Voluntary Self Pay(opting out of insurance coverage, or insurance billing)
Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. A safe harbor of $150,000 in equity in patient's primary residence shall not be considered an asset convertible to cash. Equity in any other real property shall be subject to liquidation. Liquid

	Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non qualified deferred compensation plans.
Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.
Medically Necessary Care	Medical treatment that is absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient. Medically necessary care for the purposes of this policy does not include elective or cosmetic procedures.
Family Income	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.
Qualified Health Plan	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each marketplace in which it is sold.

PROCEDURES

1. An evaluation for Financial Assistance can begin in a number of ways:

   For example:

   - A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
   - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
   - A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.

2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Administrative staff, Customer Service, etc.

3. Designated staff may meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

a. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income, as defined by Medicaid regulations. To help applicants complete the process, a statement of conditional approval will be provided that will list the paperwork required for a final determination of eligibility.

b. Applications received will be sent to the JHHS Patient Financial Services Department for review; a written determination of probable eligibility will be issued to the patient.

c. At HCGH, complete applications with all supporting documentation submitted at the hospital are approved via the appropriate signature authority process. Once approved and signed off on, the approved applications will be sent to the JHHS Patient Financial Services Department's to mail patient a written determination of eligibility.

4. To determine final eligibility, the following criteria must be met:

   a. The patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its' designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. The Patient Profile Questionnaire (Exhibit B) is used to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

   b. All insurance benefits must have been exhausted.

5. To the extent possible, there will be one application process for all of the Maryland hospitals of JHHS. The patient is required to provide the following:

   a. A completed Financial Assistance Application (Exhibit A) and Patient Profile Questionnaire (Exhibit B).

   b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).

   c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.

   d. A Medical Assistance Notice of Determination (if applicable).

   e. Proof of disability income (if applicable).

   f. Reasonable proof of other declared expenses.

   g. Non-U.S. citizens must complete the Financial Assistance Application (Exhibit A). In addition, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After

obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO (HCGH) or Director of PFS and/or CFO (SH) to determine if additional information is necessary.

h. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc...

6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive Medical Debt. Medical Debt is defined as out of pocket expenses excluding copayments, coinsurance and deductibles for medical costs billed by a JHHS hospital unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on JHMI guidelines. At HCGH, the Financial Counselor will forward to Director, Revenue Cycle for review and final eligibility based upon JHMI guidelines.

   a. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments for reconsideration to the CFO (HCGH) or Director PFS and CFO (SH) for final evaluation and decision.

   b. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH) will have a final determination made no later than 30 days from the date the application was considered complete. The Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH) will base their determination of financial need on JHHS guidelines.

7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

8. Services provided to patients registered as Voluntary Self Pay do not qualify for Financial Assistance.

9. A department operating programs under a grant or other outside governing authority (i.e.: Psychiatry Program) may continue to use a government-sponsored application process and associated income scale.

10. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient makes a good-faith payment at the beginning of the Financial Assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set forth in Appendix B, JHHS shall make a payment plan available to the patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may be extended.

11. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimated income amounts

for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patients representative requests an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.

12. Financial Assistance Applications may only be submitted for/by patients with open and unpaid hospital accounts.

13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application (Exhibit A) unless they meet Presumptive Financial Assistance Eligibility criteria (see Appendix A-1). If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

14. Patients who receive coverage on a Qualified Health Plan and ask for help with out of pocket expenses (co-payments and deductibles) for medical costs resulting from medically necessary care shall be required to submit a Financial Assistance Application if the patient is at or below 200% of Federal Poverty Guidelines.

15. If a patient account has been assigned to a collection agency, and patient or guarantor requests financial assistance or appears to qualify for financial assistance, the collection agency shall notify PFS and shall forward the patient/guarantor a financial assistance application with instructions to return the completed application to PFS for review and determination and shall place the account on hold for 45 days pending further instruction from PFS.

16. Beginning October 1, 2010, if within a two (2) year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $25. If hospital documentation demonstrates the lack of cooperation of the patient or guarantor in providing information to determine eligibility for free care, the two (2) year period herein may be reduced to 30 days from the date of initial request for information. If the patient is enrolled in a means-tested government health care plan that requires the patient to pay-out-of pocket for hospital services, then patient or guarantor shall not be refunded any funds that would result in patient losing financial eligibility for health coverage.

17. This Financial Assistance policy does not apply to deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient. Johns Hopkins will file a claim in the decedents' estate and such claim will be subject to estate administration and applicable Estates and Trust laws.

REFERENCE[1]

JHHS Finance Policies and Procedures Manual
Policy No. FIN017 - Signature Authority: Patient Financial Services
Policy No. FIN033 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

Code of Maryland Regulations COMAR 10.37.10.26, et seq
Maryland Code Health General 19-214, et seq
Federal Poverty Guidelines (Updated annually) in Federal Register

RESPONSIBILITIES - HCGH, SH

Financial Counselor (Pre-Admission/Admission/In-House/ Outpatient) Customer Service Collector Admissions Coordinator Any Finance representative designated to accept applications for Financial Assistance	Understand current criteria for Assistance qualifications. Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form. On the day preliminary application is received, send to Patient Financial Services Department's for determination of probable eligibility. Review preliminary application (Exhibit A), Patient Profile Questionnaire (Exhibit B) and Medical Financial Hardship Application (Exhibit C), if submitted, to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments. If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review. Review and ensure completion of final application. Deliver completed final application to appropriate management. Document all transactions in all applicable patient accounts comments. Identify retroactive candidates; initiate final application process.

[1] NOTE: Standardized applications for Financial Assistance, Patient Profile Questionnaire and Medical Financial Hardship have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A, B and C.

Management Personnel (Supervisor/Manager/Director)	Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies. Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.] Notices will not be sent to Presumptive Eligibility recipients.
Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent) CP Director and Management Staff	Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

SPONSOR

CFO (HCGH, SH)
Director of Revenue Cycle (HCGH)
Director, PFS (SH)

REVIEW CYCLE

Two (2) years

APPROVAL

_____ _____
Sr. Vice President and Chief Financial Officer, JHM Date

APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES

1. Each patient requesting Financial Assistance must complete a JHM/Financial Assistance Application (also known as the Maryland State Uniform Financial Assistance Application) Exhibit A, and Patient Profile Questionnaire, Exhibit B. If patient wishes to be considered for Medical Financial Hardship, patient must submit Medical Financial Hardship Application, Exhibit C.

2. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.

3. The patient must apply for Medical Assistance and cooperate fully with the Medical Assistance team or its designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. A Patient Profile Questionnaire (see Exhibit B) has been developed to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

4. Proof of income must be provided with the final application. Acceptable proofs include:
   (a) Prior-year tax return;
   (b) Current pay stubs;
   (c) Letter from employer, or if unemployed documentation verifying unemployed status; and
   (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
   (e) For non-U.S. citizens, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO to determine if additional information is necessary.

5. Patients will be eligible for Financial Assistance if their maximum family (husband and wife, same sex married couples) income (as defined by Medicaid regulations) level does not exceed each affiliate's standard (related to the Federal poverty guidelines) and they do not own Liquid Assets in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.

6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify. If it is clear that a non-U.S. citizen will not be eligible for Medical Assistance, a Medical Assistance Notice of Determination will not be necessary.

7. Patients who chose to become voluntary self pay patients do not qualify for Financial Assistance for the amount owed on any account registered as Voluntary Self Pay.

8. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and private room accommodations that are not medically necessary. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is an "Elective Admission" or a "Medically Necessary Admission," the patient's admitting physician shall be consulted and the matter will also be directed to the physician advisor appointed by the hospital.

9. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days of the day when the application was satisfactorily completed and submitted. The Financial Counselor will issue the final eligibility determination.

10. Documentation of the final eligibility determination will be made on all (open-balance) patient accounts. A determination notice will be sent to the patient.

11. A determination of eligibility for Financial Assistance based on the submission of a Financial Assistance Application (Exhibit A) will remain valid for a period of six (6) months for all necessary JHM affiliate services provided, based on the date of the determination letter. Patients who are currently receiving Financial Assistance from one JHM affiliate will not be required to reapply for Financial Assistance from another affiliate.

12. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.

Exceptions
The Vice President, Finance/CFO may make exceptions according to individual circumstances.

FREE OR REDUCED COST CARE FINANCIAL ASSISTANCE GRID

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 3/1/16

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	**$ 23,760**	$ 26,136	$ 28,512	$ 30,888	$ 33,264	$ 35,640
2	**$ 32,040**	$ 35,244	$ 38,448	$ 41,652	$ 44,856	$ 48,060
3	**$ 40,320**	$ 44,352	$ 48,384	$ 52,416	$ 56,448	$ 60,480
4	**$ 48,600**	$ 53,460	$ 58,320	$ 63,180	$ 68,040	$ 72,900
5	**$ 56,880**	$ 62,568	$ 68,256	$ 73,944	$ 79,632	$ 85,320
6	**$ 65,160**	$ 71,676	$ 78,192	$ 84,708	$ 91,224	$ 97,740
7	**$ 73,460**	$ 80,806	$ 88,152	$ 95,498	$ 102,844	$ 110,190
8*	**$ 81,780**	$ 89,958	$ 98,136	$ 106,314	$ 114,492	$ 122,670
**amt for each mbr	$8,320	$9,152	$9,984	$10,816	$11,648	$12,480
Allowance to Give:	100%	80%	60%	40%	30%	20%

*200% of Poverty Guidelines
** For family units with more than eight (8) members.

EXAMPLE:

Annual Family Income	$55,000
# of Persons in Family	4
Applicable Poverty Income Level	$48,600
Upper Limits of Income for Allowance Range	$58,320 (60% range)

($55,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

Appendix A-1

Presumptive Financial Assistance Eligibility

There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

- Active Medical Assistance pharmacy coverage
- QMB coverage/ SLMB coverage
- Homelessness
- Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
- Maryland Public Health System Emergency Petition patients
- active enrollees of the Chase Brexton Health Center (See Appendix C) (applicable for HCGH patients)
- Participation in Women, Infants and Children Programs (WIC)*
- Supplemental Nutritional Assistance program (SNAP) or Food Stamp eligibility *
- Households with children in the free or reduced lunch program*
- Low-income household energy assistance program participation*
- Eligibility for other state or local assistance programs which have financial eligibility at or below 200% of FPL
- patients referred to Suburban Hospital by organizations which have partnered with Suburban (See Appendix E)
- Patient is deceased with no known estate
- Health Department moms – For non-emergent outpatient visits not covered by medical assistance
- Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
- Patients returned by SRT as not meeting disability criteria but who meet the financial requirements for Medical Assistance

*These life circumstances are set forth in COMAR 10.37.10.26 A-2. The patient needs to submit proof of enrollment in these programs within 30 days of treatment unless the patient requests an additional 30 days.

APPENDIX B
MEDICAL FINANCIAL HARDSHIP ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance. This determination will be offered to all patients who apply for Financial Assistance.

Medical Financial Hardship Assistance is available for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom:
1.) Medical Debt incurred over a twelve (12) month period exceeds 25% of the Family Income creating Medical Financial Hardship; and
2.) who meet the income standards for this level of Assistance are met.

For those patients who are eligible for reduced cost care under the Financial Assistance criteria and also qualify under the Medical Financial Hardship Assistance Guidelines, JHHS shall apply the reduction in charges that is most favorable to the patient.

Medical Financial Hardship is defined as Medical Debt for Medically Necessary treatment incurred by a family over a twelve (12) month period that exceeds 25% of that family's income.

Medical Debt is defined as out of pocket expenses for medical costs for Medically Necessary Care billed by the Hopkins hospital to which the application is made, the out of pocket expenses mentioned above do not include co-payments, co-insurance and deductibles, unless the patient is below 200% of Federal Poverty Guidelines.

The patient/guarantor can request that such a determination be made by submitting a Medical Financial Hardship Assistance Application (Exhibit C), when submitting JHM/Financial Assistance Application, also known as the Maryland State Uniform Financial Assistance Application (Exhibit A), and the Patient Profile Questionnaire (Exhibit B). The patient guarantor must also submit financial documentation of family income for the twelve (12) calendar months preceding the application date and documentation evidencing Medical Debt of at least 25% of family income.

Once a patient is approved for Medical Hardship Financial Assistance, Medical Hardship Financial Assistance coverage shall be effective starting the month of the first qualifying service and the following twelve (12) calendar months. It shall cover those members of the patient's Immediate Family residing in the same household. The patient and the Immediate Family members shall remain eligible for reduced cost Medically Necessary Care when seeking subsequent care at the same hospital for twelve (12) calendar months beginning on the date on which the reduced cost Medically Necessary Care was initially received. Coverage shall not apply to Elective Admissions or Elective or cosmetic procedures However, the patient or the patient's immediate family member residing in the same household must notify the hospital of their eligibility for the reduced cost Medically Necessary Care at registration or admission.

General Conditions for Medical Financial Hardship Assistance Application:

1. Patient's income is under 500% of the Federal Poverty Level.
2. Patient has exhausted all insurance coverage.
3. Patient account balances for patients who chose to register as voluntary self pay shall not counted toward Medical Debt for Medical Financial Hardship Assistance.
4. Patient/guarantor do not own Liquid Assets in excess of $10,000 which would be available to satisfy their JHHS affiliate bills.

5. Patient is not eligible for any of the following:
   - Medical Assistance
   - Other forms of assistance available through JHM affiliates

6. Patient is not eligible for The JHM Financial Assistance Program or is eligible but the Medical Financial Hardship Program may be more favorable to the patient.

7. The affiliate has the right to request patient to file updated supporting documentation.

8. The maximum time period allowed for paying the amount not covered by Financial Assistance is three (3) years.

9. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the Medical Financial Hardship Assistance program, the patient is still required to file a JHHS Medical Financial Hardship Assistance Application but not to submit duplicate supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Medical Financial Hardship Assistance Application:

- Medical Debt incurred over the twelve (12) months preceding the date of the Financial Hardship Assistance Application at the JHHS treating facility where the application was made.
- Liquid Assets (leaving a residual of $10,000)
- Family Income for the twelve (12) calendar months preceding the date of the Financial Hardship Assistance Application
- Supporting Documentation

Exceptions

The Vice President, Finance/CFO or designee may make exceptions according to individual circumstances.

Evaluation Method and Process

1. The Financial Counselor will review the Medical Financial Hardship Assistance Application and collateral documentation submitted by the patient/responsible party.

2. The Financial Counselor will then complete a Medical Financial Hardship Assistance Worksheet (found on the bottom of the application) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

# of Persons in Family	*300% of FPL	400% of FPL	500% of FPL
1	**$ 35,640**	$ 47,520	$ 59,400
2	**$ 48,060**	$ 64,080	$ 80,100
3	**$ 60,480**	$ 80,640	$ 100,800
4	**$ 72,900**	$ 97,200	$ 121,500
5	**$ 85,320**	$ 113,760	$ 142,200
6	**$ 97,740**	$ 130,320	$ 162,900
7	**$ 110,190**	$ 146,920	$ 183,650
8*	**$ 122,670**	$ 163,560	$ 204,450
Allowance to Give:	50%	35%	20%

For family units with more than 8 members, add $12,480 for each additional person at 300% of FPL, $16,640 at 400% at FPL; and $20,800 at 500% of FPL.

APPENDIX C (HCGH only)
FINANCIAL ASSISTANCE FOR CHASE BREXTON PATIENTS

Purpose

Chase Brexton Health Services, Inc. is a non-profit, community based organization that provides a wide range of medical, psychological and social services on a non-discriminatory basis in Baltimore City, Baltimore County, and Howard County. Chase Brexton offers services to everyone regardless of their ability to pay. Chase Brexton cares for those who are uninsured or under-insured, those with Medicare and Medicaid, and those with commercial insurance. Chase Brexton has Case Managers that work with patients to determine eligibility for care at a low minimum fee, and/or appropriate programs and entitlements available to people with limited resources.

This procedure is for Howard County General Hospital registration sites, verification and scheduling and for Patient Financial Services. It outlines the treatment of patients that have qualified for Chase Brexton Health Services. It is the policy of HCGH to accept patients previously screened by Chase Brexton for financial assistance. Patients will not have to apply for assistance but will need to notify HCGH of their participation in this program.

Inpatient/Outpatient cases
All Chase Brexton inpatients are screened by the Howard County General Hospital's Financial Counselor for possible medical assistance. Appointments are made with Howard County General Hospital's in-house medical assistance Case Worker or MA extender for the application process. If medical assistance is received, the claim is billed to Medical Assistance for payment. If the patient is not eligible for medical assistance, the insurance plan of (2200032) Chase Brexton is assigned to the account. The Financial Counselor will also complete the FPL table based on income information provided by Chase Brexton and the billing indicator upon completion. The claim will be automatically written off to the financial assistance/charity care allowance code when the final bill is released.

PROCEDURE

1. When a patient presents for services at HCGH and states they are associated with the Chase Brexton health center, the registration staff will enter the insurance code of (2200032) Chase Brexton into EPIC if it's not already there. If the Chase Brexton coverage is already in EPIC, the registration staff will select that coverage for the account.

2. The Sr. Financial Counselor has a workqueue in EPIC that contains all patients registered with Chase Brexton.

3. The Sr. Financial Counselor will review all patients in the workqueue daily to validate they are active with the Chase Brexton health center and what level of charity care they qualify for based on their financial information.

4. The Sr. Financial Counselor is responsible for updating the FPL table to reflect the proper level of charity care and collecting the patient balance (if any).

5. The Sr. Financial Counselor is responsible for entering a from and through date into the FPL table that the patient is eligible to receive this level of charity care.

6. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Trainer of Patient Access for corrective action. These accounts will be changed to self pay and or other insurance as appropriate.

APPENDIX D (Suburban Hospital only)
FINANCIAL ASSISTANCE FOR MONTGOMERY COUNTY AND LOCALLY BASED PROGRAMS FOR LOW INCOME UNINSURED PATIENTS

Purpose

Suburban Hospital is partnered with several Montgomery County, MD and locally based programs that offer primary care services and/or connection to local specialty and hospital based care. Based on agreements with these partnered programs, Suburban Hospital provides access to inpatient and outpatient care to patients who would not otherwise be able to access or afford medically necessary care.

Policy

Suburban Hospital shall accept charity referrals for medical necessary care from the following providers: Catholic Charities, Mobile Med, Inc., Montgomery County Cancer Crusade, Primary Care Coalition, Project Access, and Proyecto Salud. Care is provided to such patients based on meeting eligibility requirements for one of the aforementioned local programs.
Patients must provide a program generated referral for care as proof of their enrollment in one of the above programs to qualify for presumptive approval for 100% free care. Suburban Hospital shall base acceptance of such referrals on the referring programs' enrollment of patients using their income based eligibility requirements which for these designated programs is at or below a maximum of 250% of the federal poverty guidelines.

Procedure

1. When a patient is scheduled and/or presents for services at SH, the patient must provide a referral form from one of the above programs as proof of enrollment.

2. Once the referral form is received, the Scheduler or Registrar will apply to the account a designated insurance mnemonic for the referring partnered program.

3. If no referral form is received by the patient, the account will be registered as self pay. The patient has 30 days to produce a referral or proof of enrollment in one of the partnered programs. An additional 30 days will be allowed upon request from the patient.

4. A Financial Counselor and/or Registrar will check the real time eligibility or Maryland EVS System to verify enrollment in Maryland Medicaid. If enrolled, Medicaid will prevail and free care presumptive approval will not apply.

5. Each hospital account with a designated insurance mnemonic for one of the partnered programs will be subject to final review for the existence of a program referral prior to application of the program driven charity adjustment. Presumptive approval for 100% free care applies to a single episode of care (account) only.

Exhibit A

Howard County General Hospital
3910 Keswick Road, Suite S-5100
Baltimore, MD 21211

Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

Social Security Number _____-____-_____ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

Exhibit A

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____		Approximate value	_____
Automobile	Make _____	Year _____	Approximate value	_____
Additional vehicle	Make _____	Year _____	Approximate value	_____
Additional vehicle	Make _____	Year _____	Approximate value	_____
Other property			Approximate value	_____
		Total		_____

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? Yes No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant signature Date

_____

Relationship to Patient

Exhibit B

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #:_____

1. What is the patient's age? _____
2. Is the patient a U.S. citizen or permanent resident? Yes or No
3. Is patient pregnant? Yes or No
4. Does patient have children under 21 years of age living at home? Yes or No
5. Is patient blind or is patient potentially disabled for 12 months or more from gainful employment? Yes or No
6. Is patient currently receiving SSI or SSDI benefits? Yes or No
7. Does patient (and, if married, spouse) have total bank accounts or assets convertible to cash that do not exceed the following amounts? Yes or No

   Family Size:

   Individual: $2,500.00

   Two people: $3,000.00

   For each additional family member, add $100.00

   (Example: For a family of four, if you have total liquid assets of less than $3,200.00, you would answer YES.)

8. Is patient a resident of the State of Maryland? Yes or No
   If not a Maryland resident, in what state does patient reside? _____
9. Is patient homeless? Yes or No
10. Does patient participate in WIC? Yes or No
11. Does patient receive Food Stamps? Yes or No
12. Does patient currently have:
    Medical Assistance Pharmacy Only Yes or No
    QMB coverage/ SLMB coverage Yes or No
    PAC coverage Yes or No
13. Is patient employed? Yes or No
    If no, date became unemployed. _____
    Eligible for COBRA health insurance coverage? Yes or No

Exhibit C

MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #:_____

Date: _____

Family Income for twelve (12) calendar months preceding date of this application: _____

Medical Debt incurred at The Johns Hopkins Hospital (not including co-insurance, co-payments, or deductibles) for the twelve (12) calendar months preceding the date of this application:

Date of service	Amount owed
_____	_____
_____	_____
_____	_____
_____	_____

All documentation submitted becomes part of this application.

All the information submitted in the application is true and accurate to the best of my knowledge, information and belief.

_____ Date: _____
Applicant's signature

_____
Relationship to Patient

For Internal Use: Reviewed By:
_____Date:_____

Income: _____ 25% of income=_____

Medical Debt: _____Percentage of Allowance: _____

Reduction: _____

Balance Due: _____

Exhibit B

Monthly Payment Amount:_____ Length of Payment Plan:_____month

APPENDIX IV. PATIENT INFORMATION SHEET

JOHNS HOPKINS HEALTH SYSTEM
PATIENT BILLING & FINANCIAL ASSISTANCE INFORMATION

YOUR RIGHTS AND RESPONSIBILITIES:

We make every effort to see that your account is properly billed. You are responsible for making sure the insurance information provided to us is correct. However, we cannot guarantee payment from your insurance company. All unpaid charges on the statement will be your responsibility.

We provide a reasonable amount of our services for free, or at a reduced charge to eligible persons who cannot afford to pay for medical care. Financial Assistance eligibility is based upon documented family circumstances and family size. Additionally, to qualify for this assistance, all other sources of payment must be exhausted, including Medical Assistance. In certain circumstances, Medical Financial Hardship Assistance may also be available. Financial Assistance Eligibility applications can be obtained by contacting Customer Service between 8:30 AM to 4:30 PM, Monday through Friday, at the numbers listed below.

If you have any questions concerning this bill and charges for services rendered by our hospitals, please call our Customer Service office between 8:30 AM to 4:30 PM, Monday through Friday at 443-997-3370 or toll-free at 1-855-662-3017, or you may email us at the address listed below. Questions regarding your account should include your account number, patient name, date of service, statement date and insurance information.

Mail payments only to:
Johns Hopkins Health System
P.O. Box 417714

Mail correspondence/Insurance information
Customer Service:
Johns Hopkins Health System
3910 Keswick Road, Suite S-5100

For Patient Financial Services directly to
Customer Service email:
pfscs@jhmi.edu BOSTON, MA 02241-7714 Baltimore, MD 21211

For information concerning Maryland Medical Assistance Program contact your local Department of Social Services at 1-800-332-6347, TTY: 1-800-925-4434 or visit: www.dhr.state.md.us.

For information concerning DC Medical Assistance Program contact your local Department of Social Services at 1-202-727-5355, TTY: 711 or visit: http://dhcf.dc.gov/service/medicaid

Payment remitted by check will be applied from oldest to newest account billed on this statement. If you wish to direct your payment to a specific account or accounts, you must do so by paying on line at www.hopskinsmedicine.org or by calling Patient Financial Services Customer Service at 443-997-3370.

Any payment that is sent by check that is sent to Hopkins for less than the full balance due that is marked "Paid in Full" or contains similar notation, or that is otherwise sent in full satisfaction of a disputed amount must be sent to the correspondence address listed above.

If any checks are returned due to NSF (Non-Sufficient Funds) or stop payment, you will be charged the maximum fee permitted by law.

HOSPITAL STATEMENTS DO NOT INCLUDE PHYSICIAN FEES OR CHARGES:

This statement represents only those charges for services billed through our hospitals. Services rendered by your doctors are billed separately. Questions concerning physician fees must be directed to the physician's office at the phone number listed on the physician's bill.

CORRECTIONS OR CHANGE OF NAME, ADDRESS, OR HEALTH INSURANCE INFORMATION (Please Print)

Name Change:	New Street Address:		
City:	State:	Zip Code:	New Phone Number:
Insured's Name: / Social Security:	Patient's DOB: / /		Relationship to Insured (circle one): Self Spouse Child Other
Insurance Company Name and Address:	Policy Number:		Group Number:
Effective Date:	Insurance Company Phone Number:		
Signed: Date:	I authorize the release of medical information necessary to process this claim. I assign and authorize direct payment to Johns Hopkins Health System of any insurance or other benefits otherwise payable to me or the patient.		

APPENDIX V. MISSION, VISION, VALUE STATEMENTS

MISSION
Provide the highest quality of care to improve the health of our entire community through innovation, collaboration, service excellence, diversity and a commitment to patient safety.

VISION
To be the premier community hospital in Maryland.

VALUE STATEMENT
Our values are rooted in providing unsurpassed service to everyone we encounter – patients, their families and caregivers, and our co-workers. These values – Communication, Anticipation of and Response to other's needs, Respect, and Engagement with others – reduced to the acronym CARE, are our credo for interactions with our patients and visitors as well as our co-workers.

APPENDIX VI. COMMUNITY BENEFIT WORK GROUP AND COMMUNITY BENEFIT TASK FORCE

Johns Hopkins Health System Community Benefits Leadership
Fiscal Year 2017

JHHS Community Health Improvement Strategy Council

Description: The Council is responsible for collecting and reporting community benefit activities to the president of JHHS, their respective hospital president and chief financial officer, the HSCRC for all Maryland Hospitals, and IRS annually. The Council meets monthly to discuss data collection, community benefit planning and evaluation.

The JHHS Community Health Improvement Strategy Council convenes monthly to bring Community Benefit groups together with Tax, Financial Assistance, and Health Policy staff from across the Health System to coordinate process, practice, and policy. Council members discuss issues and problems they face in community benefit reporting, regulatory compliance to state and federal community benefit requirements, and technical aspects of administering and reporting community benefit systems. When needed, a designated representative from the group contacts the governing agency for clarification or decision regarding the issues in question to ensure that all hospitals reports are consistent in the interpretation of regulations.

JHHS Community Health Improvement Strategy Council

- o The Johns Hopkins Hospital
  - • Sherry Fluke, Senior Financial Analyst, Govt. & Community Affairs (GCA)
  - • Sudanah Gray, Budget Analyst, GCA
  - • Sharon Tiebert-Maddox, Director, Strategic Initiatives, GCA
  - • William Wang, Associate Director, Strategic Initiatives, GCA

- o Johns Hopkins Bayview Medical Center
  - • Patricia A. Carroll, Manager, Community Relations
  - • Kimberly Moeller, Director, Financial Analysis and Special Projects
  - • Selwyn Ray, Director, Community Relations JHBMC, Health and Wellness

- o Howard County General Hospital
  - • Elizabeth Edsall-Kromm, Vice President, Population Health and Advancement
  - • Laura Hand, Director, Strategic Planning
  - • Fran Moll, Manager, Regulatory Compliance
  - • Scott Ryan, Senior Revenue Analyst

- o Suburban Hospital
  - • Eleni Antzoulatos, Supervisor, Community Health and Wellness Operations, Community Health and Wellness
  - • Sara Demetriou, Coordinator, Health Initiative and Community Relations, Community Health and Wellness

- Paul Gauthier, Senior Financial Analyst, Financial Planning, Budget and Reimbursement, Finance and Treasury
- Lucas McCormley, Manager of Budget and Financial Planning, Finance and Treasury
- Kate McGrail, Program Manager, Health Outcomes and Evaluation, Community Health and Wellness
- Patricia Rios, Manager, Community Health Improvement, Community Health and Wellness
- Monique Sanfuentes, Director, Community Health and Wellness
- Sunil Vasudevan, Senior Director of Finance and Treasury, Finance and Treasury

o Sibley Memorial Hospital
- Marti Bailey, Director, Sibley Senior Association and Community Health
- Courtney Coffey, Community Health Program Manager
- Cynthia McKeever, Manager, Finance Decision Support
- Marissa McKeever, Director, Government and Community Affairs
- Honora Precourt, Community Program Coordinator

o All Children's Hospital
- Jill Pucillo, Accounting Manager
- Alizza Punzalan-Randle, Community Engagement Manager

o Johns Hopkins Health System
- Janet Buehler, Senior Director, Tax Compliance
- Bonnie Hatami, Senior Tax Accountant
- Sandra Johnson, Vice President, Revenue Cycle Management
- Anne Langley, Senior Director, Health Policy Planning and Community Engagement