

Howard County General Hospital
Fiscal Year 2015
Community Benefits Report
Narrative



JOHNS HOPKINS
M E D I C I N E

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I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Primary Service Area.

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
266	16,527	21042, 21043, 21044, 21045, 21046, 21075, 20723, 20777, 21041, 21150, 21029, 21797, 21036, 20763, 20759, 21794, 20794, 21765, 21738, 21737, 21723	Sheppard Pratt (Psychiatry only)	Anne Arundel 11.4% Baltimore 16.4% Carroll 9.9% Howard 16.0% Montgomery 17.3% Prince George's 22.9% Source: JHM Market Analysis and Business Planning	Anne Arundel 0.7% Baltimore 0.9% Baltimore City 1.8% Carroll 0.8% Howard 1.0% Montgomery 1.0% Prince George's 0.9% Source: JHM Market Analysis and Business Planning

Table I

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 307,260 residents. According to the 2010 Census, the age distribution of Howard County was similar to the state, yet the over-55 age group will continue to increase over the next years. This, in fact, is currently happening. There was a .5% increase in the Howard County 65+ population over the past year. With this increase comes the probability that they may have chronic diseases that could consume more health dollars and less likelihood that prevention interventions will be possible.

The 2015 racial/ethnic distribution in Howard County is 54.8% White, 18.7% African American, 16.1% Asian, and 6.7% Hispanic and shows the community remains very diverse. There was a decrease in the White (-1.1%), the African American (-.4%) and the Latino

(+.1%) populations while there was the strongest growth in the Asian/ Pacific Islander (+1.4%) population.

Howard County's mortality and morbidity indicators are overall positive compared to most Maryland jurisdictions. The County demonstrates a relatively low prevalence of chronic disease risk factors including physical inactivity, smoking, high blood pressure, and diabetes. While cancer and heart disease mortality rates both decreased, cancer is now the leading cause of death in Howard County. Targeting lifestyle changes of improved nutrition and increased physical activity will continue to be areas of intervention.

Promoting a healthy community has been a priority for Howard County. Healthy Howard, a county sponsored health initiative, was launched in 2008. The outreach to underserved residents was to increase access to care. Health disparities exist within the county. The Howard County Health Department reports serving a higher proportion of African American and Hispanic clients and a lower proportion of White and Asian clients when compared to the general population of the County. In 2015, Howard County saw another decrease in the number of uninsured residents (from 3.27% to 2.62%) and an increase in the number of Medicaid recipients (from 8.8% to 10.6%). Yet, access to care remains a concern as the healthcare community sees the potential for high copays and language barriers delaying or prohibiting treatment.

County wide initiatives are underway to identify areas for intervention and opportunities to expand community resources to better serve all residents. The Local Health Improvement Coalition, a part of the State Health Improvement Plan (SHIP), was formed in 2012 and is responsible for guiding local health planning, specifically as it relates to addressing health disparities and inequities in the local community. Howard County General Hospital (HCGH) is an active member. The Coalition decided to add a new priority area this past year. The areas are now: increasing Access to Care, promoting Healthy Weight for all residents, improving Behavioral Health resources to reduce and prevent acute interventions and promoting Healthy Aging.

Engaging the support of over 50 community organizations, members are working to improve the health of our community. After two years of combined efforts, focused interventions have occurred, groups are working more cohesively together and expectations of improved outcomes are anticipated over time.

b. Demographics.

Table II

<p>Community Benefit Service Area (CBSA) Target Population (# of people in target population, by sex, race, ethnicity, and average age)</p>	<p>Howard County zip codes: 20701, 20723, 20759, 20763, 20777, 20794, 20833, 21029, 21036, 21042, 21043, 21044, 21045, 21046, 21075, 21076, 21104, 21163, 21723, 21737, 21738, 21771, 21784, 21794, 21797</p> <p>Total Population : 307, 260 (Source: 2015 Truven Market Expert)</p> <p>Sex: Male: 152,265/ 49.5% Female: 154,995/50.4%</p> <p>Race/Ethnicity: White Non-Hispanic: 168,266/ 54.8% Black Non-Hispanic: 57,401/ 18.7% Hispanic: 20,628/ 6.7% Asian and Pacific Islander Non-Hispanic: 49,454/ 16.1% All Others: 11,511/ 3.7%</p> <p>Age: 0-14: 58,081/ 18.9% 15-17: 13,708/ 4.5% 18-24: 27,536/ 9.0% 25 – 34: 37,848/ 12.3% 35-54: 92,308/ 30.0% 55-64 – 40,611/ 13.2% 65+: 37,168/ 12.1%</p> <p>(Source: 2015 Truven Market Expert)</p>
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Median Household Income within the CBSA	\$143,668 (Source: 2015 Truven Market Expert)
Percentage of households with incomes below the federal poverty guidelines within the CBSA	13,400/ 4.59% (Source: http://assessment.communitycommons.org)
Please estimate the percentage of uninsured people by County within the CBSA. This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html ; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	8,056/ 2.62% (Source: 2015 Truven Market Expert)
Percentage of Medicaid recipients by County within the CBSA.	32,433/ 10.6% (Source: 2015 Truven Market Expert)
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	The Howard County Life Expectancy baseline is 82.6 years at birth, (White - 82.3 and African American - 81.4) All are above the State baseline at 79.6. (http://dhmh.maryland.gov/ship)
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Heart Disease Deaths per 100,000: Howard County: 127.3 -White: 137.3 - African American: 125 -Non Hispanic Asian/PI: 67.2 Maryland: 171.7 -White: 169.8 - African American: 201.7 Non-Hispanic Asian/PI: 75.2 Hispanic: 66.3 Cancer Deaths per 100,000: Howard County: 143.1 -White: 148.4 - African American: 168.5 -Non Hispanic Asian/PI: 93.8 Maryland: 163.8 -White: 164.8 - African American: 186.7 - Non Hispanic Asian/PI: 87.1

	<p>Infant Mortality Rate per 1,000 births: Howard County: 4.7 -White: 3.1 - African American: 13.7</p> <p>Maryland: 6.6 -White: 4.6 - African American: 10.6</p> <p>(http://dhmh.maryland.gov/ship)</p>
<p>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). See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx</p>	<p><u>Healthy Food</u></p> <p>Low-income and Low-Access to Grocery Store:</p> <ul style="list-style-type: none"> • Low-income families living more than 1 mile from a Grocery Store – 1.7% (2013 data (howardhealthcounts.org)) <p>Free school lunch eligibility: 13.1% State: 33.4% (2011)</p> <p>http://dhmh.maryland.gov/ship/SitePages/measures.aspx</p> <p><u>Transportation to Work</u></p> <p>Public Transportation: 3.7% Drove alone: 80.9% Carpooled: 7.6% Walked: 1.6%</p> <p><u>Education, population Age 25+:</u></p> <p>Less than High School – 2.2% Some High School – 2.9% High School Degree – 14.8% Some College – 21.1% BS Degree or Higher – 59%</p> <p>(Source: 2015 Truven Market Expert)</p>

	<p><u>Housing</u></p> <p>Housing without car and greater than 1 mile from grocery store: .66% http://dhmh.maryland.gov/ship/Sitepages/measures.aspx</p> <p>Owner Occupied: 73.6% Renter Occupied: 26.4% Renters spending more than 30% of income on rent: 46.1%</p> <p>(http://planning.maryland.gov/msdc/American_Community_Survey/2009_ACS.shtml)</p>
<p>Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions.</p>	<p>Language at Home:</p> <p>Only English: 77.3%</p> <p>Other than English: 22.6%</p> <p> Spanish: 5.2%</p> <p> Asian/PI: 9.4%</p> <p> Indo-European: 7.0%</p> <p> Other: 1.0%</p> <p>(http://planning.maryland.gov/msdc/American_Community_Survey/2009_ACS.shtml)</p>
<p>Other</p>	<p>Income</p> <p>Less than \$14,999: 3.8% \$15,000 - \$24,999: 3.5% \$25,000 - \$34,999: 5.5% \$35,000 - \$49,999: 7.5% \$50,000 - \$74,999: 15.4% \$75,000 - \$99,999: 13.2% \$100,000 - \$149,999: 21.7% \$150,000 and greater: 29.4%</p> <p>(http://planning.maryland.gov/msdc/American_Community_Survey/2009_ACS.shtml)</p>

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?

Yes
 No

Provide date here. 10/03/12 and 8/18/14

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/CommunityHealthNeedsAssessment_FY13.pdf

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?

Yes Enter date approved by governing body here (mm/dd/yy): 06/18/13
 No

If you answered yes to this question, provide the link to the document here.

http://www.hopkinsmedicine.org/howard_county_general_hospital/downloads/CommunityHealthNeedsAssessment_FY13.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

1. Decision making process of determining which needs in the community would be addressed through community benefits activities of the Hospital.

- a. Is Community Benefits planning part of your hospital's strategic plan?

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 roll up into the "Integration" Strategic Objective for Johns Hopkins Medicine. As a result, HCGH set specific goals relating to our health priorities.

The four health priorities that were approved by the Howard County General Hospital Board of Trustees in 2013, Access to Care, Obesity (reduction), Behavioral Health and Elderly Health Improvement integrate all priorities into ongoing initiatives.

Howard County General Hospital set two goals which support this integration.

- Mental Health Goal – collaborate with community partners to establish programs that reduce emergency department mental health visits for Howard County residents.
- Obesity – collaborate with community partners to establish programs that reduce childhood obesity among Howard County residents.

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 provide additional information if necessary):

i. Senior Leadership

1. CEO (President)
2. CFO
3. Other (please specify)
VP Medical Affairs, Sr. VP Outcomes Management, Sr. Director
Population Health and Community Relations, VP Nursing, VP Operations.

Describe the role of Senior Leadership.

Role of Senior Leadership: 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 final report's financial accuracy to the hospitals' financial statements, alignment with the strategic plan and compliance with regulatory requirements.

ii. Clinical Leadership

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

Describe the role of Clinical Leadership

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 the four HCGH health priorities most impactful in:

- Behavioral Health Priority – Andrew Angelino, M.D. is a member of the Local Health Improvement Coalition (LHIC) adding to the ongoing dialog on the issues facing Howard County. He is also building partnerships in the community to expand providers and patient access.
- Elderly Health Improvement – the Nurse Manager of the 4P Acute unit works in concert with the Director of Social Work to identify and refer seniors who will benefit from the Community Care Team. These patients, who agree to the referral, receive 90-day support upon discharge.

iii. Community Benefit Operations

1. Individual (please specify FTE) 2 FTEs, Senior Project Manager Regulatory Compliance and the Senior Revenue Analyst support the CB tracking and reporting. .32 FTE Sr. Director Population Health and Community Relations and .2 FTE Director, Community Health Education
2. Committee (please list members)
3. Department (please list staff)
4. Task Force (please list members)
5. Other (please describe)

See Appendix V for Community Benefit Team and Task Force Membership

Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

Sr. Director of Population Health and Community Relations assesses the hospital data, partners with community organizations and determines CB programs and initiatives based upon the four HCGH Community Health Priorities. The Director of Community Health Education integrates community outreach into the community health improvement priorities.

The Senior Project Manager Regulatory Compliance and the Senior Revenue Analyst compile and analyze data that support the Community Benefit at Howard County General Hospital.

All above staff are members of the JHM Community Benefit Workgroup.

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

Spreadsheet Yes No
Narrative 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 Community Benefits (CB) team conduct the initial review of accuracy of information submissions, analyze 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 hospital specific audit/review is completed the JHHS Community Benefit Workgroup attends a meeting with all of the JHHS CFOs to review system wide data and final reports to 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 Yes No
 Narrative Yes No

Prior to its submission to the HSCRC, the Community Benefit Report (CBR) is reviewed in detail by the CFO, CEO and the president of the Johns Hopkins Health System. The completed report is reviewed by the Board.

The Community Health Needs Assessment and Implementation Strategy incorporated in the CBR were approved by the HCGH Board of Trustees in 2013. Follow-up reports were made to the Board highlighting activities, programs and impact made in the identified health priority areas.

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:

Other hospital organizations

- Local Health Department
- Local health improvement coalitions (LHICs)
- Schools
- Behavioral health organizations
- Faith based community organizations
- Social service organizations

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).

A second Community Health Needs Assessment was completed in August 2014. The following, along with Howard County General Hospital, are members of the CHNA Survey Planning Committee. The LHIC provided provided input on priorities during the membership meeting in November 2014. At that time they voted to continue the three previous priorities and add a fourth priority, Healthy Aging.

Organization	Name of Key Collaborator	Title	Collaboration Description
LHIC	Dr. Maura Rossman Jeananne Sciabarra, MPP	Co – Chair Program Director, Local Health Improvement Coalition Healthy Howard, Inc.	The 51 organization membership voted to determine the health priorities for the next two years in November 2014. The health priorities expanded to include Access to Care, Behavioral Health, Healthy weight and a new area, Healthy Aging.

			LHIC has a diverse membership representing health interests in Howard County.
Howard County Health Department	Dr. Maura Rossman	Howard County Health Officer	Staff provided input on questions of interest for the survey 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.
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 agency contact for the consultant group

			performing the survey.
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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?

Yes No

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?

Yes No

In addition to the Co-Chair, membership also includes: Eric Aldrich, M.D., Andrew Angelino, M.D., Elizabeth Edsall Kromm, PhD., and Cindi Miller, R.N., M.S.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

1. Description of implementation strategy and initiatives.

After careful evaluation and extensive discussion and debate surrounding the available data, information and expert opinion, the 2012 HCGH CHNA Task Force identified the following as the top four community health improvement priorities which were approved by the Hospital Board of Trustees.

1. Access to Care: Increase the percentage of local residents with access to affordable health care.

Disparities exist in the HCGH's emergency department usage across racial and ethnic groups. It is believed this is due partially to limited access to primary care. Improving access to primary care through various initiatives will potentially reduce ED admissions as well as current overcrowded conditions.

Recently, from November 2014 – August 2015, the Healthy Howard Connector enrolled 8,614 Howard County residents into primary care. While the number of residents who are uninsured has decreased from 9,910 to 8,056 Howard County continues to reach out through agencies and our financial policies to assure access to care by all residents. Concern over the possible delay of treatment due to high co-pays remains. Effective January 1, 2015 the Johns Hopkins Health System amended language in its Financial Policy so Medical Debt may include co-payments, co-insurance and deductibles of patients who purchased insurance through a Qualified Health Plan.

2. Obesity: Enable people of all ages to achieve and maintain a healthy weight through healthy eating and physical activity.

Obesity is a major contributing factor to chronic diseases such as diabetes and heart disease. The results of the 2012 Howard County Health Assessment Survey indicated an obesity rate of 55% in Whites and 70% in African Americans. In addition the southern Howard County corridor had a higher percent of obesity reported. Programming continued to address obesity prevention in the county as a whole. Target areas included BMI education and screening, programs on healthy eating and reduction of sugary beverage consumption.

The LHIC Healthy Weight Workgroup targeted several projects including support of a new healthy lifestyle, walking program in North Laurel area (southern Howard County.) Howard County General Hospital partnered with Healthy Howard, Inc., We Promote Health and LHIC to make this program possible and launched in March 2015.

With the 2014 CHNA Survey, obesity rates increased in the White population (59%) and decreased in the African American population (61%). While both are under the State rate of 64%, efforts to decrease obesity and increase healthy weights among residents remain. The 3 year LHIC goal is to increase healthy weight in adults by 5% from the 2014 rate of 44.1% to 46.3%.

3. Behavioral Health (Mental Health and Addictions): Ensure access to affordable and quality behavioral health services for residents of all ages and decrease the number of hospital emergency visits for behavioral health issues.

Beginning in October 2014, the County Executive established a Behavioral Health Task Force and appointed members, who met until March 2015. The CEO of HCGH and the Medical Director of Psychology were both on this task force. The significant outcomes of this Task Force were a series of recommendations that would fill the gaps in consumer care.

4. Elderly Health Improvement: Improve case management services and coordinated health care for senior citizens to reduce repeat hospitalizations and increase the number of seniors living independently at home.

The local senior population (65+) is projected to double in the next 20 years. The senior population consumes a disproportionate share of health care resources. Coordination of care across the health delivery community holds tremendous potential for improving the lifestyle of seniors, and at the same time reducing the senior readmission rate at HCGH. Several intervention strategies were initiated. One strategy this past year was to raise the awareness of this issue within the community. As a result, the Local Health Improvement Coalition determined Elder Health was going to be an additional focus area. A new workgroup was created to keep these health issues in the forefront of the Coalition.

A second initiative was identified as the need to expand the Howard County Health Department Community Care Team (CCT) role in the community. The goal of the CCT is to empower individuals to better manage their chronic health conditions in the community and avoid unnecessary hospitalizations. It is an intervention of up to 90 days, primarily in the client's home and the community, by a Community Health Worker, a Community Health Nurse and, when appropriate, a Community Social Worker. The client's Community Care team integrates with their existing providers including the PCP, specialists, the hospital, home health and other caregivers. The team's work with providers includes regular communication, attending appointments, joint care planning and problem solving. The Community Health Nurses conduct medication reconciliation in the home and provide that information back to the client's PCP. The Community Health Workers help clients overcome social barriers like a lack of transportation, difficulty navigating the health care system, the need for durable medical equipment, and social isolation. The Community Social Worker supports

the team by addressing mental health and substance abuse issues and helping clients connect to long-term behavioral health providers.

An HCGH Nurse Manager and Social Worker worked with the CCT to provide referrals (FY15 – 274) for this program.

HCGH continues to gather monthly hospital readmission rates. As the above interventions continue, tracking of data will provide more detailed feedback.

In 2012, HCGH partnering with The Horizon Foundation, the Howard County Health Department and the Columbia Association, agreed to fund a biennial Howard County Health Assessment Survey. This agreement provided a baseline assessment of the health needs in our community and provided the opportunity to chart the progress on our health priorities. Recently, the 2014 survey was completed and the data is being shared and integrated into the community.

Table III, Initiative I. Access to Care

<p>Identified Need CHNA Priority</p>	<p>Adults with less than a high school education and Asian, African American, and Hispanic residents may not have the access to care, some because they do not qualify for coverage and others because the co-pays may be unaffordable.</p> <p>8,056 residents currently do not have health insurance coverage. While this number has decreased by 1,854 since 2014, there is still a need in our county. Additionally, our community population of foreign born increased in FY15 among the Asian (+1.4%) and Latino (+.1%) populations. We saw a slight decrease (-.4%) in the African American population.</p>
<p>Hospital Initiative</p>	<p>Increase the percentage of adults reporting having health insurance. (SHIP)</p> <ul style="list-style-type: none"> • Develop pilot initiatives aimed at increasing the percentage of county residents with access to primary care, affordable health care and access to the right level of care at the right time. <ol style="list-style-type: none"> 1) Partner with the Office on Aging and hold Medicare informational programs in the Wellness Center. 2) Provide one annual Latino health fair to provide health screenings and resources to improve health care access for Hispanic population. 3) Connect uninsured Emergency Department patients to Chase Brexton.
<p>Total Number of People within Target Population</p>	<p>8,056 Uninsured patients</p>
<p>Total Number of People Reached by Initiative</p>	<p>351 attended the Medicare information programs.</p> <p>Latino Health Fair in March 2015 had 8 booths to share access to care information with attendees. Healthy Howard (38 contacts), DSS (62 contacts), Mental Health (18 contacts), Health Choice (35 contacts), JH Community Physicians (110 contacts), MD Insurance Plan (25 contacts), Priority Partners (35 contacts) and Chase Brexton (115 contacts).</p>
<p>Primary Objective</p>	<p>Increase the percentage of local residents with access to affordable care.</p>
<p>Single or Multi-Year Initiative Time Period</p>	<p>Multi-year initiative</p>

Key Collaborators in Delivery	<p>-Howard County Health Department</p> <p>-Horizon Foundation</p> <p>-Healthy Howard, Inc.</p> <p>-Chase Brexton Health Services</p> <p>-Foreign Information Referral Network</p> <p>-MD Access Point</p> <p>-State Health Insurance Assistance Program</p> <p>-United Way of Central Maryland</p> <p>-Local Health Improvement Coalition</p>	
Impact/Outcome of Hospital Initiative	<ul style="list-style-type: none"> • Invited Healthy Howard to annual Latino Health Fair – March 2015. 38 Latino participants stopped by the table for information. • Provide self-pay patients in ED with options – Chase Brexton, Healthy Howard Inc., Financial Assistance. 	
Evaluation of Outcome (Include process and impact measures)	<p>2014 SHIP data showed overall percent for Howard County at 92.9%.</p> <p>2014 Community Health Needs Assessment (CHNA) showed an increase to 93.9%. However, disparities exist among ethnicities. White (96.1%), Asian (96.7%), Hispanic (90%) and African American (89.8%).</p> <p>8 Medicare education sessions held – 351 participants attended.</p>	
Continuation of Initiative	<p>Yes – Ongoing</p> <p>CHNA 2014 showed a 1% increase in residents who have health insurance. New data was surveyed in 2014 based on ethnicity. The 2016 survey will be able to assess this data for improvement.</p>	
Expense	<p style="text-align: center;">A. Total Cost of Initiative</p> <p>Total Charity Dollars FY15 –</p> <p>\$3,169,655.23</p> <p>Healthy Howard</p> <p>\$2,799.48</p> <p>Latino Health Fair - \$7,000</p>	<p style="text-align: center;">B. Direct offsetting revenue from Restricted Grants</p> <p style="text-align: center;">\$0</p>

Table III, Initiative 2. Obesity

Identified Need CHNA Priority	56% of Howard County population is identified as obese or overweight. Higher percentages are in the Laurel and Elkridge areas. Higher percentage is among African American residents. •Approximately 300,000 deaths per year may be attributable to obesity (Office of the Surgeon General).
Hospital Initiative	<ul style="list-style-type: none"> • Increase the % of adults who are at a healthy weight (SHIP) • Develop and execute strategies to reduce consumption of sugary beverages. • HCGH decreased the availability of sugary beverages in the hospital cafeteria and promoted a healthy beverage initiative to staff and to the community. • Promote LHIC obesity prevention strategies to community, staff. • Expand dietary counseling capacity in Wellness Programs • Develop and execute pilot walking fitness program.
Total Number of People within Target Population	56% of Howard County respondents reported BMI scores in the overweight or obese range.
Total Number of People Reached by Initiative	<ul style="list-style-type: none"> • Over 400 adults/parents reached about sugary beverage reduction at 9 outreach events and their children participated in the healthy nutrition game. • We Walk For Wellness program began in North Laurel in March. 36 participants enrolled and attended throughout the program.
Primary Objective	Enable people of all ages and incomes to achieve and maintain a healthy weight through healthy eating and physical activity.
Single or Multi-Year Initiative Time Period	Multi-Year - ongoing
Key Collaborators in Delivery	-Howard County Health Department -Horizon Foundation -Local Health Improvement Coalition (LHIC)
Impact/Outcome of Hospital Initiative	LHIC data reports, from 2012 to 2014 the overall percent of adults with a healthy weight increased from 43.6% to 44.1%. African American populations have also seen an increase (9.2%) as did the Asian population (8.6%). Yet, decreased healthy weight occurred in both the white (-4.2%) and Hispanic (-14.3%) populations.
Evaluation of Outcome (Include process and impact measures)	The CHNA from 2012 to 2014 showed an increase in healthy weight overall for all residents (43.6% to 44.1%). By ethnic group, there was an increase in African American residents (29.6% to 38.8%) and in Asian residents (55.2% to 63.8%). There was a decrease in healthy weight in White (45.1% to 40.9%) and Hispanic (61.1% to 46.8%) residents. Current interventions have not been in place for very long and therefore will continue for another two years.

Continuation of Initiative	Yes	
Expense A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative Health Fairs - \$1,254 We Walk for Wellness - \$4,530 HCGH Screening - \$400	B. Direct offsetting revenue from Restricted Grants \$0

Table III, Initiative 3. Behavioral Health

Identified Need CHNA Priority	Between 2012 and 2014, about the same percentage of residents reported being stressed about money for vital expenses, such as rent, mortgage and food. However, respondents who identified their race as African American, Hispanic, or Native American/Other were more likely to experience this type of stress. 53% of White residents said they were never stressed about money for vital expenses, compared with 42% of African Americans, 28% of Hispanics, and 38% of those in the Native American/Other category.
Hospital Initiative	Reduce hospital ED visits related to behavioral health. (SHIP) Integrate primary care and behavioral health services. Promote mental health screening in pediatric primary care practices.
Total Number of People within Target Population	Approximately 26% of Howard County residents report - sometimes or always stressed - in both the 2012 and 2014 CHNA Surveys.
Total Number of People Reached by Initiative	In FY15 there were 88 patients referred to the Crises Beds at the Way Station. Of those, 28 were able to be placed at this facility.
Primary Objective	Ensure access to affordable and quality behavioral health services for residents of all ages. Decrease the number of hospital emergency visits for behavioral health issues.
Single or Multi-Year Initiative Time Period	Multi-year
Key Collaborators in Delivery	-Chase Brexton Health Services -HCGH Primary Care Physicians -HCGH Pediatricians -Howard County Government -Mental Health Authority -Local Health Improvement Coalition (LHIC) -Way Station
Impact/Outcome of Hospital Initiative	HCGH is a member of the LHIC and the Behavioral Health committee. Three outcomes were achieved in FY15. <ol style="list-style-type: none"> 1.) A Behavioral Health Taskforce met and submitted nine recommendations to the county. Three of the important issues identified included: gaps in service, access to services and timeliness of access. Community action on these has begun. 2.) In March 2015, suicide prevention was also addressed. Money was provided to allow patients admitted for suicide risk at HCGH Emergency Department to be referred into outpatient treatment at the Crisis Intervention Center at Grassroots. This ongoing care will provide treatment and hopefully prevent acute re-hospitalizations. 3.) Another partnership with the Way Station began which provided for 4 Crisis Beds within the County. Initially Crisis Beds were for Medicaid patients only. A grant from the Horizon Foundation was obtained to

	<p>allow for patients with health insurance the opportunity to also utilize this resource. The annual Free Depression Screening at HCGH Wellness Center was held in October 2014.</p>	
Evaluation of Outcome (Include process and impact measures)	<p>Planning process took most of the time in FY15. Impact measure will be determined into next FY16.</p>	
Continuation of Initiative	<p>Yes – Multi year</p>	
Expense A.Total Cost of Initiative for Current Fiscal Year B.What amount is Restricted Grants/Direct offsetting revenue	<p>A. Total Cost of Initiative Investment – In-Kind donation of staff time for Behavior Health Task Force for CEO and Psychiatrist - \$1,140.</p>	<p>B. Direct offsetting revenue from Restricted Grants \$0</p>

Table III, Initiative 4. Elderly Health Improvement

Identified Need CHNA Priority	Frequent admissions of seniors with chronic diseases in ED.
Hospital Initiative	<ul style="list-style-type: none"> • Promote Howard County Office on Aging (HCOA) to hospital patients. • Collaborate with post-acute providers to connect patients with primary care, medical homes or other programs that facilitate more effective transitions of care. • Community Care Team (CCT) – Prior to discharge, HCGH Nurse Manager and Social Worker refer patients to the CCT for follow-up.
Total Number of People within Target Population	The over-65 population in Howard County increased by .5% in FY 15. That total population is 35, 271 and is expected to continue to grow over the next several years.
Total Number of People Reached by Initiative	HCGH Community Care Team referrals = 274. Number of CCT referrals who accepted = 79 (29%). Number of CCT referrals over age 65 = 44 (16%)
Primary Objective	Improve case management services and coordinated health care for senior citizens to reduce repeat admissions and increase the number of seniors living independently at home.
Single or Multi-Year Initiative Time Period	Multi-year
Key Collaborators in Delivery	<ul style="list-style-type: none"> -HCOA -Howard County Health Department -Coalition of Geriatric Services -Local post-acute providers -Healthy Howard, Inc.
Impact/Outcome of Hospital Initiative	<p>Community Care Team (CCT). The HCGH team refers patients to this program to assist with compliance of treatment plans post discharge. Patients must agree to participate, but then receive 90 days of follow-up health support.</p> <p>Assess and track hospital 30 day readmission rates</p>
Evaluation of Outcome (Include process and impact measures)	<p>Evaluation of outcome data of CCT referrals was challenging to track. In FY15, CCT joined the Maryland CRISP exchange which going forward will allow for easier access of participants readmission data.</p> <p>The official readmission report for HCGH shows HCGH FY15 readmission rate as 11.47%, slightly decreasing as compared to the FY13 rate of 11.56% (the accepted state FY comparison year).</p>
Continuation of Initiative	<p>Yes</p> <p>Gaps in tracking data were identified and new participation in CRISP exchange will allow for easier future tracking.</p>

Expense A.Total Cost of Initiative for Current Fiscal Year B.What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative In-Kind time of Social Worker (20 hours), Nurse Manager (20 hours)and Administrative Assistant (400 hours) to identify patients and refer to CCT = \$11,040.	B. Direct offsetting revenue from Restricted Grants \$0
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5. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

While community health needs assessments can point out underlying causes of good or poor health status, health providers and health related organizations—primary users of information found in CHNAs—are not usually in a position to affect all of the changes required to address a health issue. For example, the ability to reduce poverty, improve educational attainment, or affect employment cannot be achieved by a health system alone. Priorities determined to be beyond the scope of hospital focus during the FY 2014-2016 implementation cycle, i.e. beyond the top four issues, included:

- Chronic Disease Management
- Healthy Lifestyles
- Health Education

The Hospital does not plan to explicitly address these health priorities. However, each of these priorities will be employed in tactics addressing priorities 1-4. Moreover, HCGH recognizes that there are numerous organizations addressing community health needs, and in order to leverage resources in a manner to drive maximum impact HCGH will collaborate with other organizations to address these issues and, where feasible, share financial or human resources support to other organization's efforts to address community health improvement needs consistent with their respective missions.

In the 2014 CHNA Survey, the LHIC membership served as the focus group and the previous four health priority areas remained. Areas of Chronic Disease Management are also being addressed in Elder Health Improvement. Discharged patients are referred to the Community Care Team to assist with compliance of the discharge plan.

6. 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; and Maryland SHIP Selected Population Health Measures)

Howard County General Hospital's (HCGH) Community Benefit operations and activities have become more aligned with the initiatives of the Local Health Improvement Coalition (LHIC) over the past fiscal year.

The LHIC identified three priority areas in their 2012 – 2014 Action Plan with the guidance of a group leader and using several Maryland SHIP Population Health Measures:

- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight

- Reduce hospital ED visits related to behavioral health

Three work groups were formed - Access to Care, Healthy Weight and Behavioral Health. Howard County General Hospital was a member of this group and contributed to the prioritization. All priorities were also to consider the following criteria:

- The level of disparities related to the health outcome.
- How improvement would affect large populations.
- How improvement can improve several health outcomes.
- The opportunity to control high cost and long-term impact while addressing the issue.
- How results could be quantified.

In FY15, significant progress was made. The President of HCGH was elected co-chair of LHIC. This strengthened the relationship between the HCGH, the Howard County Health Department and the entire LHIC membership.

Howard County Survey results in 2014 showed ongoing needs in the current priority areas. Disparities still existed in access to care, with more than 10% of African Americans not having health insurance. Healthy weight improvement was very slight, and there were small changes in Emergency Department visits for behavioral health conditions. Thus, in FY15 the LHIC decision was made to continue the three current priority areas. Yet there was also a decision to add a fourth priority area – Healthy Aging, as the Howard County senior population is increasing every year.

These, now four health priority areas, match the four health priorities identified in the HCGH CHNA in 2013. With the increased focus on the same priority areas, and the ongoing health survey (every two years), the focus will allow for better utilization of financial resources, staff time and it is therefore hopeful that there will be greater movement toward the desired health improvement outcomes.

Anticipating a great ability to enhance community connections and achieve greater health benefit, a planning grant from the Maryland Health Services Cost Review Commission has allowed for the development of a regional partnership for health system transformation. Using the connections of LHIC and HCGH staff, groups have recently formed leadership teams and core committees which will lead the movement for the transformation plan.

VI. PHYSICIANS

1. Description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.

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 Emergency Department (ED) and consultation and treatment of Hospital inpatients. One of the issues (but certainly not the only

issue) compelling physicians to refuse hospital call without financial subsidy, is the burden of uninsured patients.

Many physicians in nearly every specialty practicing in Howard County either limit the number of uninsured patients and patients with Medical Assistance 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 screens of the Hospital's physician referral service, and "telephone mystery shopping" conducted to ascertain status of accepting 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 an uninsured patient without the ability to pay.

2. Physician subsidies.

Howard County General Hospital provides subsidy to physicians for a range of services that they would otherwise not furnish to the hospital. In FY 2015 HCGH paid a total of \$8,957,984 in subsidies to physicians for the following services, Infectious Disease, Pediatric Surgery, Cardiology, Urology, Otolaryngology, Anesthesiology, Orthopedic surgery, Psychiatry, Obstetrics/Gynecology and Hospitalist/Intensivist. A significant portion of these subsidies were for call coverage in the emergency department (ED).

Physicians no longer take call unless compensated for this service. Additionally, Hospital based physicians in OB, Psychiatrics, SIMS, Perinatology and Anesthesiology are in the Hospital 24/7. If not for the subsidy, they would not be here. These physicians see most of our uninsured patients. These above services provided through these subsidies are critical to the accomplishment of the HCGH mission to serve the health care needs of our entire community.

VII. APPENDICES

Appendix I. Description of Financial Assistance Policy

Financial Assistance Policy (FAP) Description:

a) Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's FAP.

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 is 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 because effect on January 1, 2014

Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option 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.

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 patient 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: changed to include italicized verbiage.

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 is being 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 will be 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. Changes expected to be made and approved by the hospital board in December 2015.

Appendix III. Financial Assistance Policy

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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, also 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.

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. 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

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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.

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

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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 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. 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.

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- 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

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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. 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.
15. 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.
16. 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.

REFERENCE¹

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

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.

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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.

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.

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SPONSOR

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

REVIEW CYCLE

Two (2) years

APPROVAL


 Sr/VP of Finance/Treasurer & CFO for JHH and JHHS

11-1-2013
 Date

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**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) 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.

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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 2/1/15						
# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	\$ 23,540	\$ 25,894	\$ 28,248	\$ 30,602	\$ 32,956	\$ 35,310
2	\$ 31,860	\$ 35,046	\$ 38,232	\$ 41,418	\$ 44,604	\$ 47,790
3	\$ 40,180	\$ 44,198	\$ 48,216	\$ 52,234	\$ 56,252	\$ 60,270
4	\$ 48,500	\$ 53,350	\$ 58,200	\$ 63,050	\$ 67,900	\$ 72,750
5	\$ 56,820	\$ 62,502	\$ 68,184	\$ 73,866	\$ 79,548	\$ 85,230
6	\$ 65,140	\$ 71,654	\$ 78,168	\$ 84,682	\$ 91,196	\$ 97,710
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 member	\$8,120	\$8,932	\$9,744	\$10,556	\$11,368	\$12,180
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 \$54,000
 # of Persons in Family 4
 Applicable Poverty Income Level \$47,700
 Upper Limits of Income for Allowance Range \$57,240 (60% range)
 (\$54,000 is less than the upper limit of income; therefore patient is eligible for Financial Assistance.)

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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
- Primary Adult Care Program (PAC) 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)
- active enrollees of the Healthy Howard Program (see Appendix D) (applicable for HCGH patient)
- 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.

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**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.

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

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- 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.

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MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES			
Effective 2/1/15			
# of Persons in Family	Income Level**		
# of Persons in Family	300% of FPL	400% of FPL	500% of FPL
1	\$ 35,310	\$ 47,080	\$ 58,850
2	\$ 47,790	\$ 63,720	\$ 79,650
3	\$ 60,270	\$ 80,360	\$ 100,450
4	\$ 72,750	\$ 97,000	\$ 121,250
5	\$ 85,230	\$ 113,640	\$ 142,050
6	\$ 97,710	\$ 130,280	\$ 162,850
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.

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**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 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 FAR.PENDIN, FARB20, FARN40, FARN50, FARN70 FARN80, and FAR100 is assigned to the case and the claim will be automatically written off to the financial assistance/charity care allowance code when the final bill is released. The insurance code assignment is based on the level of charity care the patient has qualified for.

Insurance listed as:	Charity Care	Patient to pay:
FAR.PENDIN	Pending Verification	
FARB20	20% of charges	80% of charges
FARN40	40% of charges	60% of charges
FARN50	50% of charges	50% of charges
FARN70	70% of charges	30% of charges
FARN80	80% of charges	20% of charges
FAR100	100% of charges	0% of charges

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 FAR.PENDIN into Meditech if the patient hasn't been seen within the last 6 months. If the patient is in the system with a service date within the last 6 months and the patient was already identified as a Chase Brexton patient that met a certain level of charity care the registrar can allow the insurance code of (FARB20, FARN40 etc.) to be pulled forward.
2. The Sr. Financial Counselor receives a daily report with all patients registered with a FAR code.
3. The Sr. Financial Counselor will review all patients on the report daily to validate they are active with the Chase Brexton health center and what level of charity care they qualify for.

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4. The Sr. Financial Counselor is responsible for updating the insurance code 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 form and through date into Meditech 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 Manager of Admissions for corrective action. These accounts will be changed to self pay and or other insurance as appropriate.

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**APPENDIX D (HCGH only)
FINANCIAL ASSISTANCE FOR HEALTHY HOWARD PATIENTS**

Purpose

The Healthy Howard Access Plan is a new program effective January 1, 2009, designed to connect Howard County residents to affordable health care services and help the community overcome barriers to healthy living. The Plan is not insurance, but offers basic medical and preventative care to eligible residents who would otherwise not be able to afford or obtain health insurance.

This procedure is for Howard County General Hospital registration sites, verification and scheduling, and Patient Financial Services. It outlines the treatment of patients that are enrolled in the Healthy Howard Plan.

Inpatient/Outpatient cases

It is the policy of HCGH to accept Healthy Howard plan patients for referred scheduled services, and emergent/urgent services.

It is the responsibility of the patient to provide their Healthy Howard identification card or inform the registration/scheduling staff of Healthy Howard coverage at the time of service or scheduling.

It is the responsibility of the HCGH registration/authorization staff to verify that coverage is still active by checking eligibility via MCNET (a web based system administered by JHHC).

For Healthy Howard patients utilizing the emergency department, \$100 co-pay is due. However; if admitted or placed into observation the co-pay is waived.

The patient should be registered using the insurance code HLTH.HOW.

The HLTH.HOW insurance code has been programmed to automatically write off the charges to the financial assistance code when the final bill is released.

Procedure

1. When a patient presents for services at HCGH and either presents a Healthy Howard insurance card or notifies the registration staff that they are a member of Healthy Howard the registrar should verify eligibility using MCNET to validate the patient is an active enrollee.
2. If active, the Admission Counselor will register the patient with the insurance code HLTH.HOW.
3. If not active, notify the patient of ineligibility and ask if there is other insurance or means to pay. If not, provide the patient with the HCGH financial assistance application.
4. The Sr. Financial Counselor prints a report on a daily basis of all patients registered with HLTH.HOW.
5. The Sr. Financial Counselor will review all patients on the report to validate they are active with Healthy Howard.
6. The Sr. Financial Counselor is responsible to monitor Healthy Howard in-house inpatient admissions to determine if at some point the patient may become eligible for MD Medical Assistance. If so, the Sr. Financial Counselor will meet with the patient to assist in the application process.
7. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Manager of Admissions for corrective action. These accounts will be corrected as appropriate.

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**APPENDIX E (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 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?
If not a Maryland resident, in what state does patient reside? _____ Yes or No
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.

Applicant's signature _____ Date: _____

Relationship to Patient _____

For Internal Use: Reviewed By: _____ Date: _____

Income: _____ 25% of income= _____

Medical Debt: _____ Percentage of Allowance: _____

Reduction: _____

Balance Due: _____

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:	Mail correspondence/Insurance Information	For Patient Financial Services directly to
	Customer Service:	Customer Service email:
Johns Hopkins Health System	Johns Hopkins Health System	
P.O. Box 417714 3910 Keswick Road, Suite S-5100	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.hopkinsmedicine.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 Task Force and Community Benefit Work Group

Johns Hopkins Health System Community Benefits Leadership

Fiscal Year 2015

Community Benefits Workgroup

Description: The Workgroup 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 Workgroup meets monthly to discuss data collection, community benefit planning and evaluation.

The JHHS Community Benefit Workgroup 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. Workgroup 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.

The Johns Hopkins Hospital

- Sherry Fluke, Finance Manager, Government and Community Affairs
- Sharon Tiebert-Maddox, Director, Strategic Initiatives, Government and Community Affairs
- William Wang, Associate Director, Strategic Initiatives, Government and Community Affairs

Johns Hopkins Bayview Medical Center

- Patricia A. Carroll, Community Relations Manager
- Kimberly Moeller, Director, Financial Analysis
- Selwyn Ray, Director, Community Relations

Howard County General Hospital

- Elizabeth Edsall Kromm, Senior Director, Population Health and Community Relations
- Cindi Miller, Director, Community Health Education
- Fran Moll, Manager, Senior Project Manager Regulatory Compliance
- Scott Ryan, Senior Revenue Analyst

Suburban Hospital

- Eleni Antzoulatos, Coordinator, Health Promotions and Community Wellness, Community Health and Wellness

- Sara Demetriou, Coordinator, Health Initiative and Community Relations, Community Health and Wellness
- Lucas McCormley, Senior Financial Analyst, Financial Planning, Budget, and Reimbursement
- Alan Poole, Senior Financial Analyst, Financial Planning, Budget, and Reimbursement
- Patricia Rios, Supervisor, Community Health Improvement, Community Health and Wellness
- Monique Sanfuentes, Director, Community Health and Wellness
- Sezelle Gabriel Banwaree, Department Director, Finance and Treasury

Sibley Memorial Hospital

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

All Children's Hospital

- Jeff Craft, Administrative Director of Finance
- Alizza Punzalan-Randle, Community Engagement Manager

Johns Hopkins Health System

- Janet Buehler, Senior Director of Tax
- Desiree de la Torre, Director, Community Health Improvement
- Bonnie Hatami, Senior Tax Accountant
- Anne Langley, Senior Director, Health Policy Planning

Community Benefits Advisory Council

Description: The Community Benefit Advisory Council is comprised of hospital leadership and is responsible for developing a systematic approach that aligns community benefit objectives with JHM strategic priorities. The Advisory Council meets quarterly to discuss how JHM intends to fulfill both its mission of community service and its charitable, tax-exempt purpose.

- John Colmers*, Vice President, Health Care Transformation and Strategic Planning, Johns Hopkins Health System
- Deidra Bishop, Director, East Baltimore Community Affairs, Johns Hopkins University
- Elizabeth Edsall Kromm, Senior Director, Population Health and Community Relations, Howard County General Hospital
- Kenneth Grant, Vice President of General Services, The Johns Hopkins Hospital
- Dan Hale, Special Advisor, Office of the President, Johns Hopkins Bayview Medical Center
- Anne Langley, Senior Director, Health Policy Planning, Johns Hopkins Health System
- Amy Maguire, Vice President, Government and Community Affairs, All Children's Hospital
- Marissa McKeever, Director, Government and Community Affairs, Sibley Memorial Hospital
- Adrian Mosley, Community Health Administrator, The Johns Hopkins Hospital
- Cindy Rose, Vice President of Marketing, Branding, and Community Relations, All Children's Hospital
- Monique Sanfuentes, Director, Community Health and Wellness, Suburban Hospital
- Jacqueline Schultz, Executive Vice President and Chief Operating Officer, Suburban Hospital
- Sharon Tiebert-Maddox, Director, Strategic Initiatives, Johns Hopkins Government and Community Affairs

*Chairperson

Community Health Needs Assessment Task Force Members 2012

Kayode Williams, M.D., MBA	Task Force Chair, HCGH Trustee
Shaukat Ashai, M.D.	Community ObGyn physician
Dee Athey	United Way of Central Maryland
Jay Blackman	Chief Operating Officer, HCGH
Evelyn Bolduc	Chair, HCGH Board of Trustees
Vic Broccolino	President and CEO, HCGH
Dayna Brown	Administrator, Ho. Co. Office on Aging
Susan Case	Director of Marketing, HCGH
Kenneth Crawford	Enterprise Foundation
Craig Cummings	Howard County Schools
Desiree De La Torre	Asst. Dir. Health Policy Planning, Johns Hopkins Medicine
Brian England	British American Auto Care, Ho. Co., Citizens Association
Debra Furr-Holden, Ph.D.	Faculty, Johns Hopkins Bloomberg School of Public Health
Hector Garcia	Howard County Foreign Information and Referral Network
Paul Gleichauf	Sr. VP, Planning, HCGH
Lou Grimmel, Jr.	Encore at Turf Valley Assisted Living
Eric Grimmel	Lorien Columbia Skilled Nursing
Nikki Highsmith Vernick	Horizon Foundation
Tanvir Hussain, M.D.	Johns Hopkins Bloomberg School of Public Health
Richard Larison	Chase Brexton Health Services
Nancy Larson, R.N., M.S.N.	Director of Case Management, HCGH
Barbara Lawson	Non-profit consultant
David Lee	Howard County Office of Minority Affairs
David Leichtling, M.D.	Columbia Medical Practice, Family Practice
Ann B. Mech, J.D., R.N.	HCGH Trustee
Matthew Medley	Administrative Fellow, HCGH
Cindi Miller, R.N., M.S.	Director of Community Health Education, HCGH
John Mangione, Jr.	Lorien Elkridge Skilled Nursing
Meredith Page	St. John's Baptist Church, PATH
David Powell	HCGH Trustee
Maura Rossman, M.D.	Howard County Health Officer
Esti Schabelman, M.D.	Emergency Physician, HCGH
Jim Young	Chief Financial Officer, HCGH

Howard County Local Health Improvement Coalition 2014- 2015
2014 Community Benefit Organizations

ACIDD Maryland

African American Community Roundtable of Howard County

Alpha Kappa Alpha Sorority

American Diabetes Association

Association of Community Services

Bridges to Housing Stability

British American Auto Care

Build Haiti Foundation

Chase Brexton Health Services, Inc.

Columbia Association

Community Action Council of Howard County

Delta Sigma Theta

Evergreen Health Care

FIRN

Girls on the Run of Central Maryland

Grassroots Crisis Intervention Center

Guardian Primary Care Services

HC DrugFree

Health Promotion On Call

Healthy Howard

Horizon Foundation

Howard Community College

Howard County Citizens Association

Howard County Dental Association

Howard County Dental Hygienists' Association

Howard County Department of Citizen Services/Office on Aging

Howard County Department of Housing and Community Development

Howard County Department of Social Services

Howard County General Hospital

Howard County Health Department

Howard County Mental Health Authority

Howard County Public School System

Howard County Recreation and Parks
Humanim
Maryland University of Integrative Health
MD Chapter of the American Academy of Pediatrics
NAMI Howard County
Office of the County Executive
On Our Own of Howard County, Inc.
Prospect Believe
Riverside Health
Salvere Health and Fitness
Therapeutic Connections
Transition Howard County
United Health Care Community Plan
United Way of Central Maryland
University of Maryland Extension
Walgreens
Way Station
We Promote Health
Y of Central Maryland