Howard County General Hospital
Fiscal Year 2014
Community Benefits Report Narrative

Johns Hopkins Health System

Fiscal Year 2014 Community Benefit Report Narrative

Howard County General Hospital

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Primary Service Area.

Table I

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:
253	16,261	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)	3.27% (Source: 2014 Truven Market Expert)	8.83% (Source: 2014 Truven Market Expert)

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 302,784 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 will be of particular importance as this population will be more likely to develop chronic diseases and potentially consume more health dollars for the treatment of them. The 2014 racial/ethnic distribution in Howard County is 56% White, 19% Black, 15% Asian, and 7% Hispanic and shows the community growing in diversity.

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. However, despite a low prevalence of risk factors, residents are not immune to chronic disease risks. High cholesterol (41% vs 37% state vs 37% national) and overweight (35% vs 36% state and national) are risks which are linked with chronic disease. Chronic disease remains the leading cause of death in Howard

County (60%) (Maryland Department of Health and Mental Hygiene. Burden of Chronic Disease: Howard County. 2011).

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 Black and Hispanic clients and a lower proportion of White and Asian clients when compared to the general population of the County. In 2014 with the Affordable Care Act in place, Howard County saw a decrease in the number of uninsured residents (from 5.1% to 3.3%) and an increase in the number of Medicaid recipients (from 7% to 8.8%). Yet, access to care remains a concern as the healthcare community examines whether high copays and language barriers could delay and/or prohibit 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 targets three priority areas: increasing Access to Care, promoting Healthy Weight for all residents and improving Behavioral Health resources to reduce and prevent acute interventions. 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 and more are on the horizon.

b. Demographics.

Table II

Community Benefit Service Area (CBSA) Target Population (# of people in target population, by sex, race, ethnicity, and average age)	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 Total Population : 302,784

	(Source: 2014 Truven Market Expert) Sex: Male: 149,814/ 49.5% Female: 152,970/50.5% Race/Ethnicity: White Non-Hispanic: 169,294/ 55.9% Black Non-Hispanic: 57,973/ 19.1% Hispanic: 20,125/ 6.6% Asian and Pacific Islander Non- Hispanic: 44,518/ 14.7% All Others: 10,874/ 3.6% Age: 0-14: 58,052/19.2% 15-17: 13,597/4.5% 18-24: 26,936/8.9% 25 – 34: 37,042/12.2% 35-54: 91,961/30.4% 55-64: 39,925/13.2% 65+: 35,271/11.6% (Source: 2014 Truven Market Expert)
Median Household Income within the CBSA	$136,181 (Source: 2014 Truven Market Expert)

Percentage of households with incomes below the federal poverty guidelines within the CBSA	2,577/3.15% (howardhealthcounts.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	9,910/ 3.27% (Source: 2014 Truven Market Expert)
Percentage of Medicaid recipients by County within the CBSA.	26,727/ 8.83% (Source: 2014 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 81.9 years at birth, (White - 81.7 and Black – 81.1) All are above the State baseline at 79.3. (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: 150.1 -White: 160.5 -Black: 154 Maryland:182 -White:174.2 -Black:216.8 Cancer Deaths per 100,000: Howard County: 145.6 -White:153.4 -Black:145.6 Maryland: 170.9 -White:166.1 -Black:197.0 Infant Mortality Rate per 1,000 births: Howard County: 5.8 -White: 4.1 -Black: 13.1 Maryland: 6.7 -White:4.2 -Black: 11.8

	(http://dhmh.maryland.gov/ship)
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	Low–income and Low Access to Grocery Store: Low-income families living more than 1 mile from a Grocery Store – 1.7% MD SHIP data target – 5.5% Transportation: Workers commuting by public transportation – 3.8% Healthy People 2020 target – 5.5% By Race: American Indian/Alaska Native – 11.9% Black/African America – 6.5% Asian – 3.8% Hispanic or Latino – 3.2% White, non-Hispanic – 3.2% Education, population Age 25+: Less than High School – 3.1% Some High School – 2.7% High School Degree – 15.1% Some College – 20.6% BS degree or higher – 58.5% Housing: Renters spending more than 30% of Income on Rent: 46.8% (howardhealthcounts.org)
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions.	Language at Home: Only English: 77.8% Other than English: 22.2% Spanish: 4.9% Asian/PI: 9.0% Indo-European: 7.0% Other: 1.2% (howardhealthcounts.org) 2013

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?

   __x_Yes
   ____No

   Provide date here. 10_/_3_ /_12_

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

   http://www.howardcountyhealthsurvey.com/wp-content/uploads/2013/05/Howard-Health-Survey-Executive-Summary.pdf

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

   _x Yes _06_/ _18_/_13_Enter date approved by governing body here:
   ___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?

      _x_Yes
      ___No

   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. __x_CEO
2. _x__CFO
3. _x__Other (please specify)
   V.P. Medical Affairs; Sr. V.P. Planning and Marketing; Chief Nursing Officer, Sr. V.P. Outcomes

ii. Clinical Leadership

1. _x__Physician
2. ___Nurse
3. x__Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. x___Individual (please specify FTE) 2 FTEs support the CB tracking and reporting.
2. __x_Committee (please list members) Fran Moll, Scott Ryan, Regulatory Compliance and Cindi Miller, R.N., M.S., Community Education
3. __x_Other (please describe) See Appendix V for Community Benefit Team and Task Force members

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

Spreadsheet	___x__yes	_____no
Narrative	___x__yes	_____no

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

Spreadsheet	___x__yes	_____no
Narrative	___x__yes	_____no

If you answered no to this question, please explain why.

IV. 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 HCGH CHNA Task Force identified the following as the top four community health improvement priorities:

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 and also current overcrowded conditions.
   In FY14, the Healthy Howard Connector enrolled 13,824 Howard County residents into primary care. This enrollment produced an increase in the Medicaid population by 9,259 residents. HCGH will continue to watch this trend and along with the LHIC look for other possible limiting factors (such as high copays and language) that may affect treatment.

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, 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 Body Mass Index (BMI) education and screening, programs on healthy eating and reduction of sugary beverage consumption. New infrastructure networking began (to partner) with other non-profits and bring a new healthy lifestyle program to the North Laurel area (southern Howard County.)

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.

   The HCGH behavioral health Emergency Department (ED) admissions by African Americans are 50% greater than that of Whites. It is believed that by increasing the number of behavioral health resources in the county, there would be a decrease in the need to receive acute intervention in the ED. HCGH is an active member of the LHIC and the Behavioral Health Work Group. Infrastructure development was the key pillar for change. This was accomplished primarily through the sharing of current ED admission data that provided evidence supporting the need for more out-patient community behavioral health resources and the assistance in the writing of a proposal to the Howard County Government for new crisis intervention staff at Grassroots, a local non-profit.

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 re-admission rate at HCGH. Several intervention strategies were initiated. The HCGH Case Management Department met with a local Skilled Nursing Facility (SNF) to enhance the hospital transfer process. Deterrents to patient compliance post discharge can be solved by dissolving barriers to the discharge plan. One such barrier is communication with the primary care team and communication with the Emergency Department (ED) when a patient is sent to the ED from the SNF for evaluation. A new trial form to enhance continuity of care and communication with the ED team was designed and is in the testing phase. The desired result will be better communication between the ED and the SNF, so unnecessary readmissions can be avoided.

   A second strategy was also designed to impact senior compliance with treatment plans. Working with the local health department, HCGH was one of several partnering organizations that supported the new Community Care Team. Based on repeat admission data, local areas of county residents were identified. A Community Care Team (CCT) was created to integrate trusted health workers into the respective community locations and reduce the number of high utilizers to the ED department. They began accepting referrals in January 2014. A new process of flagging potential clients, who have been hospitalized twice in the past 60 days, this has increased incoming referrals. The CCT team works with clients in hospital, and in the home post discharge. They work to connect clients with their Primary Care Physician and needed community resources. They also seek to reduce barriers to health compliance.

   HCGH continues to gather monthly hospital readmission rates. As the above interventions continue, tracking of data will provide feedback over time and also within seasons. Currently readmissions in winter months are the highest.

   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 results are in the process of being analyzed. Of particular interest will be the results that address the above identified four community health improvement priorities.

Table III, Initiative 1. Access to Care

Identified Need Access to Care	Adults with less than a high school education. In particular foreign-born residents (Asian, African American, and Hispanic residents).
Hospital Initiative	• 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. • Identify local Hotspots to improve access using Camden Model.
Primary Objective	Increase the percentage of local residents with access to affordable care.
Single or Multi-Year Initiative Time Period	Multi-year initiative.
Key Partners in Development and/or Implementation	-Howard County Health Department -Horizon Foundation -Healthy Howard, Inc. -Chase Brexton Health Services -Foreign Information Referral Network -MD Access Point -State Health Insurance Assistance Program -United Way of Central Maryland -Local Health Improvement Coalition
How were the outcomes evaluated?	Number of dollars spent for charity care.
Outcomes (Include process and impact measures)	• 13,824 new Howard County Health Insurance enrollees through the Healthy Howard Connector. • Invited Healthy Howard to annual Latino Health Fair – March 2014. 70 Latino participants stopped by the table for information.

	• Provide Self-pay patients in ED with options – Chase Brexton, Healthy Howard Inc., Financial Assistance.	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative Financial - Healthy Howard - $765,749.64 Total Charity Dollars FY14 - $6,010,720 Total Cost Eligibility Expense- $376,931	B. Direct offsetting revenue from Restricted Grants $0

Table III, Initiative 2. Obesity

Identified Need Obesity	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.
Hospital Initiative	• Develop and execute strategies to reduce consumption of sugary beverages. • Promote LHIC obesity prevention strategies to community, staff. • Expand dietary counseling capacity in Wellness Programs • Develop and execute pilot walking fitness 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
Key Partners in Development and/or Implementation	Howard County Health Department -Horizon Foundation -Local Health Improvement Coalition (LHIC) -Howard County Recreation and Parks
How were the outcomes evaluated?	Number of initiatives achieved. Obesity rate decrease as reported by biennial survey.
Outcomes (Include process and impact measures)	• Sugary beverage reduction material distributed at health fairs - 27 • 21 BMI screenings at health fairs and B/P screenings • 1 additional registered dietician hired for counseling in February 2014 • 14 Free obesity prevention programs held in Wellness Center • 2 obesity prevention outreach programs held in southern Howard County – 37 attended. • 1 TEENS afterschool program – 43 teens attended • Meetings held in August to plan for Laurel walking program. Program development underway with target start date for March 2015. <u>Initial analysis of the 2014 survey:</u> At the 95% confidence level, we could not conclude that there is a statistical difference of overweight/obesity rates between 2012 and 2014 for any region. Interestingly, percent overweight/obese decreased significantly among African Americans and increased significantly among Whites. The other race/ethnicity

	categories, while not significant (probably due to smaller sample sizes), show movement as well. HCGH will continue to implement programs currently underway to reduce obesity among all residents.	
Continuation of Initiative	Yes	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A.Total Cost of Initiative Health Fair staffing - $2100 B/P - $4860 Meetings - $300 Wellness Programs – Marketing - $30,000 Room Use - $2,100 Staffing - $2,800 Walking program - $400 TEENS program - $500 T= $43,060	B. What amount is Restricted Grants/Direct offsetting revenue. $0

Table III, Initiative 3. Behavioral Health

Identified Need Behavioral Health Resources	Community Resources for Behavioral Health needs must be expanded to limit acute admissions to inpatient settings.
Hospital Initiative	Integrate primary care and behavioral health services Promote mental health screening in pediatric primary care practices.
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 Partners in Development and/or Implementation	Chase Brexton Health Services HCGH Primary Care Physicians HCGH Pediatricians Howard County Government Local Health Improvement Coalition (LHIC)
How were the outcomes evaluated?	Decrease in number of ED Behavioral Health admissions once community outpatient behavioral resources are expanded.
Outcomes (Include process and impact measures)	HCGH is a member of the LHIC and the Behavioral Health committee. Meetings were held monthly to plan for an initiative targeting HCGH ED admissions. HCGH supported the writing of an MOU sent to the Howard County Executive requesting funding for FY 15. ED Behavioral health admission data was obtained and shared with behavioral health committee. Free Depression Screening
Continuation of Initiative	Yes

A.Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A.Total Cost of Initiative 24 Meetings - $2700 Screening - $2000 T- $ 4700	B.Direct offsetting revenue from Restricted Grants $0

Table III, Initiative 4. Elderly Health Improvement

Identified Need Elder Health Improvement	Frequent admissions of seniors with chronic diseases in ED.
Hospital Initiative	• 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.
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 Partners in Development and/or Implementation	Howard County Office on Aging Howard County Health Department/Community Care Team Coalition of Geriatric Services Local post-acute providers
How were the outcomes evaluated?	Working with the Community Care Team, track re-admission rate trends. Number of meetings with post discharge organizations - 12
Outcomes (Include process and impact measures)	Meetings with Lorien Nursing Home occurred monthly to improve communication. New transfer form designed and in pilot phase. New initiative at HCHD – Community Care Team (CCT). HCGH team working with this program to assist with compliance of treatment plans post discharge. Looks at education, resources and possible barriers to care. The CCT has seen impact on an individual client level as a reduction in hospitalizations. Assess and track hospital 30- day Readmission Rates. **Data -** 30 Day Readmission Rate - Last quarter FY13= 8.10 percent to Last quarter FY14 = 7.13 percent, showing a decrease of .97%

Continuation of Initiative	Yes	
A.Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A.Total Cost of Initiative Meetings - $8000 - monthly meetings, 10- 12 staff. Care Team Meetings.	B. Direct offsetting revenue from Restricted Grants $0

2. Description of community health needs that were identified through the CHNA that were not addressed by the hospital.

   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 – This will be included in the Obesity Priority.
   - Health Education - This will be a component of all four health priorities.

   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.

V. PHYSICIANS

1. 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.

Through a grant to The Horizon Foundation, HCGH supported the establishment of the Chase Brexton Health Services (CBHS) federally qualified health center in the county. Since CBHS opened its doors in Howard County in 2008 HCGH has collaborated with CBHS to streamline referrals of uninsured and underinsured patients between the two health providers. Most recently this included placement of a CBHS case manager in the HCGH emergency department to facilitate continuity of care after the emergency visit for targeted individuals lacking a primary care physician.

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 2014 HCGH paid a total of $8,911,916 in subsidies to physicians for the following services, general surgery, otolaryngology, orthopedic surgery, urology, cardiology, oral and maxillofacial surgery, neurology, obstetrics/gynecology, psychiatry and anesthesiology. A significant portion of these subsidies were for call coverage in the emergency department (ED). The physician services provided through these subsidies are critical to the accomplishment of the HCGH mission to serve the health care needs of our entire community.

VI. APPENDICES

Appendix I. Description of Financial Assistance Policy
Appendix II. Financial Assistance Policy
Appendix III. Patient Information Sheet
Appendix IV. Mission, Vision, Value Statements
Appendix V. Community Benefit Team and Task Force Members

APPENDIX I. DESCRIPTION OF FINANCIAL ASSISTANCE POLICY

HCGH provides necessary emergency medical care to all people regardless of their ability to pay. Financial assistance is available for those patients who cannot pay the total cost of hospitalization due to the lack of insurance coverage and/or inability to pay. If you do not have insurance, our financial counselors will schedule an interview with you to determine payment arrangements and/or assist you in completing a Medical Assistance application. Non-citizens are also eligible for financial assistance. For additional information, call a financial counselor at 410-740-7675. (Source: HCGH Patient Welcome Book)

HCGH informs its patients about the Financial Assistance policy through a number of tactics including:

- Signs in English and Spanish are posted in patient waiting and registration areas that summarize the policy.

- A copy of the policy or a summary thereof with financial assistance contact information, is provided to every patient upon admission.

- A summary of the policy, with contact information for financial counselors, is provided to every patient without insurance who presents to the Emergency Department.

- All patients indicating a need for financial assistance are referred to a financial counselor who reviews with them the availability of various government benefits and programs, and assists them with application to such programs.

APPENDIX II. FINANCIAL ASSISTANCE POLICY

JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Policy & Procedure	Policy Number	FIN034H
		Effective Date	10-23-13
	Subject: FINANCIAL ASSISTANCE	Page	1 of 21
		Supersedes	05-15-13

POLICY

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

Purpose

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

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

JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, 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

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

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.

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

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

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

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

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

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

11. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patients representative requests an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.

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

13. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application (Exhibit A) unless they meet Presumptive Financial Assistance

Eligibility criteria (see Appendix A-1). If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

14. 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.

REFERENCE[1]

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

Charity Care and Bad Debts, AICPA Health Care Audit Guide

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

[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.

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.

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

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.

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 2/1/14

# of Persons in Family	Income Level*	Upper Limits of Income for Allowance Range				
1	**$ 23,340**	$ 25,674	$ 28,008	$ 30,342	$ 32,676	$ 35,010
2	**$ 31,460**	$ 34,606	$ 37,752	$ 40,898	$ 44,044	$ 47,190
3	**$ 39,580**	$ 43,538	$ 47,496	$ 51,454	$ 55,412	$ 59,370
4	**$ 47,700**	$ 52,470	$ 57,240	$ 62,010	$ 66,780	$ 71,550
5	**$ 55,820**	$ 61,402	$ 66,984	$ 72,566	$ 78,148	$ 83,730
6	**$ 63,940**	$ 70,334	$ 76,728	$ 83,122	$ 89,516	$ 95,910
7	**$ 72,060**	$ 79,266	$ 86,472	$ 93,678	$ 100,884	$ 108,090
8*	**$ 80,180**	$ 88,198	$ 96,216	$ 104,234	$ 112,252	$ 120,270
**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.)

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.

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 Carebilled 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

- Other forms of assistance available through JHM affiliates

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

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

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

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

Factors for Consideration

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

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

Exceptions

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

Evaluation Method and Process

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

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

MEDICAL HARDSHIP FINANCIAL GRID

Upper Limits of Family Income for Allowance Range

TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES

Effective 2/1/14

# of Persons in Family	Income Level**		
# of Persons in Family	300% of FPL	400% of FPL	500% of FPL
1	**$ 35,010**	$ 46,680	$ 58,350
2	**$ 47,190**	$ 62,920	$ 78,650
3	**$ 59,370**	$ 79,160	$ 98,950
4	**$ 71,550**	$ 95,400	$ 119,250
5	**$ 83,730**	$ 111,640	$ 139,550
6	**$ 95,910**	$ 127,880	$ 159,850
7	**$ 108,090**	$ 144,120	$ 180,150
8*	**$ 120,270**	$ 160,360	$ 200,450
Allowance to Give:	50%	35%	20%

*For family units with more than 8 members, add $12,180 for each additional person at 300% of FPL, $16,240 at 400% at FPL; and $20,300 at 500% of FPL.

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

Purpose

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

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

Inpatient/Outpatient cases

All Chase Brexton inpatients are screened by the Howard County General Hospital's Financial Counselor for possible medical assistance. Appointments are made with Howard County General Hospital's in-house medical assistance Case Worker 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.

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.

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.

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 A

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

JOHNS HOPKINS
MEDICINE

Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

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

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

Name	Age	Relationship

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

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

Exhibit A

I. Family Income

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

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

II. Liquid Assets

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

III. Other Assets

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

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

IV. Monthly Expenses

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

Do you have any other unpaid medical bills? Yes No

For what service? _____

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

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

_____ _____

Applicant signature Date

_____

Relationship to Patient

Exhibit B

PATIENT FINANCIAL SERVICES
PATIENT PROFILE QUESTIONNAIRE

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #:_____

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

   Family Size:

   Individual: $2,500.00

   Two people: $3,000.00

   For each additional family member, add $100.00

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

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

Exhibit C

MEDICAL FINANCIAL HARDSHIP APPLICATION

HOSPITAL NAME: _____

PATIENT NAME: _____

PATIENT ADDRESS: _____
(Include Zip Code)

MEDICAL RECORD #:_____

Date: _____

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

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

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

All documentation submitted becomes part of this application.

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

_____ Date: _____
Applicant's signature

_____
Relationship to Patient

For Internal Use: Reviewed By:
_____Date:_____

Income: _____ 25% of income=_____

Medical Debt: _____Percentage of Allowance: _____

Reduction: _____

Balance Due: _____

Monthly Payment Amount:_____ Length of Payment Plan:_____month

APPENDIX III. PATIENT INFORMATION SHEET

JOHNS HOPKINS HEALTH SYSTEM
PATIENT BILLING & FINANCIAL ASSISTANCE INFORMATION

YOUR RIGHTS AND RESPONSIBILITIES:

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

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

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

Mail payments only to:

Johns Hopkins Health System
P.O. Box 417714
BOSTON, MA 02241-7714

Mail correspondence/insurance information directly to Customer Service:

Johns Hopkins Health System
3910 Keswick Road, Suite S-5100
Baltimore, MD 21211

For Patient Financial Services Customer Service email:

pfscs@jhmi.edu

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

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

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

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

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

HOSPITAL STATEMENTS DO NOT INCLUDE PHYSICIAN FEES OR CHARGES:

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

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

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

APPENDIX IV. 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 V. COMMUNITY BENEFIT TEAM and TASK FORCE MEMBERS

Johns Hopkins Health System Community Benefits Leadership

Fiscal Year 2014

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 Johns Hopkins Hospital

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

Johns Hopkins Bayview Medical Center

- Gayle Adams, Director, Community and Government Relations
- Patricia A. Carroll, Community Relations Manager
- Kimberly Moeller, Director, Financial Analysis
- Linda Stewart, Community Relations Coordinator

Howard County General Hospital

- Cindi Miller, Director, Community Health Education
- Fran Moll, Manager, Senior Project Manager Regulatory Compliance
- Scott Ryan, Senior Revenue Analyst

Suburban Hospital

- Eleni Antzoulatos, Program Coordinator, Community Health and Wellness
- Joan Hall, Director, Finance Director, Clinical Economics, Reimbursement and Health Information
- Michelle Hathaway, Cardiovascular Health Promotions Coordinator, Community Health and Wellness
- Patricia Rios, Supervisor, Community Health Improvement, Community Health and Wellness
- Monique Sanfuentes, Director, Community Health and Wellness

Sibley Memorial Hospital

- Marti Bailey, Director, Sibley Senior Association and Community Health
- Mark Long, Director of External Affairs
- Mike McCoy, Associate CFO, Finance Department

All Children's Hospital

- Mary Mahoney, Director of Community Relations and Strategic Engagement
- Jeff Craft, Administrative Director of Finance
- Alizza Punzalan-Randle, Community Relations Manager

Johns Hopkins Health System

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

- Gayle Adams, Director of Community Relations and Government Affairs, Johns Hopkins Bayview Medical Center
- Jay Blackman, Executive Vice President and Chief Operating Officer, Howard County General Hospital
- John Colmers*, Vice President, Health Care Transformation and Strategic Planning, Johns Hopkins Health System
- Deidra Bishop, Director, East Baltimore Community Affairs, Johns Hopkins University
- Kenneth Grant, Vice President of General Services, The Johns Hopkins Hospital
- Dan Hale, Special Advisor, Office of the President, Johns Hopkins Bayview Medical Center
- Mark Long, Director of External 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 of Community Health and Wellness, Suburban Hospital
- Jacqueline Schultz, Executive Vice President and Chief Operating Officer, Suburban Hospital
- Sharon Tiebert-Maddox, Director, Financial Operations, Johns Hopkins Government and Community Affairs

*Chairperson

Community Health Needs Assessment Task Force Members

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