Q1.

Introduction:

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Community Benefit Report, required under §19-303 of the Health General Article, Maryland Annotated Code, is the Commission's method of implementing a law that addresses the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals.

The Commission developed a two-part community benefit reporting system that includes an inventory spreadsheet that collects financial and quantitative information and a narrative report to strengthen and supplement the inventory spreadsheet. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. This reporting tool serves as the narrative report. The instructions and process for completing the inventory spreadsheet remain the same as in prior years. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for the fiscal year.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: UM Charles Regional Medical Center	◉	○	
Your hospital's ID is: 210035	◉	○	
Your hospital is part of the hospital system called University of Maryland Medical System.	◉	○	

Q4. The next two questions ask about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. (Optional) Please describe any other community health statistics that your hospital uses in its community benefit efforts.

The 2018 Maryland Vital Statistics Report is used for birth and death data by race, along with life expectancy data, infant mortality data by race. The Maryland Department of Planning is also a source of population data for Charles County. The Maryland State Health Improvement Process data measures provide information on health disparities and hospitalization/ED visit rates by health condition such as diabetes and heart disease prevalence and mental health and substance use ED visit rates. Additionally, cancer incidence and mortality are available through the 2019 Cigarette Restitution Fund Program's Cancer in Maryland Report. The Maryland Behavioral Risk Factor Surveillance System is used to determine estimates for adult obesity and overweight. The Youth Risk Behavior Survey provides an obesity estimate for youth aged 13-18 years. The Maryland Sexually Transmitted Infections Program at the Maryland Department of Health provides Chlamydia and gonorrhea rates for the county. The Maryland Physician Workforce Study provides information on physician shortages in Southern Maryland. Health Professional Shortage Areas are viewed on the HRSA website. Medicaid data is accessed through the e-health Medicaid database for Maryland.

Q6. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

FY20UMCRMCCommunityhealthstatistics.docx
26.9KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q7. Section I - General Info Part 2 - Community Benefit Service Area

Q8. Please select the county or counties located in your hospital's CBSA.

☐ Allegany County	☑ Charles County	☐ Prince George's County
☐ Anne Arundel County	☐ Dorchester County	☐ Queen Anne's County
☐ Baltimore City	☐ Frederick County	☐ Somerset County
☐ Baltimore County	☐ Garrett County	☐ St. Mary's County
☐ Calvert County	☐ Harford County	☐ Talbot County

- [ ] Caroline County
- [ ] Carroll County
- [ ] Cecil County
- [ ] Howard County
- [ ] Kent County
- [ ] Montgomery County
- [ ] Washington County
- [ ] Wicomico County
- [ ] Worcester County

Q9. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q10. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Charles County ZIP codes located in your hospital's CBSA.

- [x] 20601
- [x] 20602
- [x] 20603
- [x] 20604
- [x] 20607
- [x] 20611
- [x] 20612
- [x] 20613
- [x] 20616
- [x] 20617
- [x] 20622
- [x] 20625
- [x] 20632
- [x] 20637
- [x] 20640
- [x] 20643
- [x] 20645
- [x] 20646
- [x] 20658
- [x] 20659
- [x] 20661
- [x] 20662
- [x] 20664
- [x] 20675
- [x] 20677
- [x] 20693
- [x] 20695

Q18. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q32. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.
- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.
- [ ] Based on patterns of utilization. Please describe.
- [x]

Other. Please describe.

The Community Benefit Service Area for the University Of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified above as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county.

Q34. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

The Community Benefit Service Area for the University of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county. Zip code level data shows where the most vulnerable populations reside in Charles County. The zip codes of Waldorf (20601, 20602, 20603), White Plains (20695), and Indian Head (20640) represent the geographic areas where the most vulnerable populations reside in Charles County. The lowest average life expectancy is found in 20640, Indian Head, at 74.7 years. The highest Medicaid enrollment rate was in 20602, Waldorf. The highest percentage of low birth weight babies was in 20695, White Plains. The highest WIC participation rate was in 20602, Waldorf. The WIC participation rate was also high in Indian Head, 20640. The 2006-2011 All-cause mortality for Indian Head was 942.6 per 100,000, above the Maryland state rate. The 2006-2010 heart disease mortality for Indian Head was 232.3, also above the Maryland state rate.

Q35. Section I - General Info Part 3 - Other Hospital Info

Q36. Provide a link to your hospital's mission statement.

https://www.umms.org/charles/about-us/mission-values

Q37. Is your hospital an academic medical center?

- ○ Yes
- ◉ No

Q38. (Optional) Is there any other information about your hospital that you would like to provide?

Q39. (Optional) Please upload any supplemental information that you would like to provide.

Q40. Section II - CHNA Part 1 - Timing & Format

Q41.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- ◉ Yes
- ○ No

Q42. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q43. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/30/2018

Q44. Please provide a link to your hospital's most recently completed CHNA.

https://www.umms.org/charles/community/assessment-implementation-plan

Q45. Did you make your CHNA available in other formats, languages, or media?

- (●) Yes
- ( ) No

Q46. Please describe the other formats in which you made your CHNA available.

The executive summary and health improvement plan are available in paper form. Additionally, the results of the CHNA were presented to the local health improvement coalition with a PowerPoint presentation. The report is available on the Charles County Department of Health website at https://www.umms.org/charles/community/assessment-implementation-plan.

Q47. Section II - CHNA Part 2 - Internal Participants

Q48. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

	CHNA Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	Manager of Population Health is the role at the facility level, no position exist.
CB/ Community Health/ Population Health Director (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	Senior Vice President of Gov't, Regulatory Affairs and Communit
Board of Directors or Board Committee (facility level)	☐	☐	☐	☑	☑	☐	☑	☐	☐	☐	
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Clinical Leadership (facility level)	☐	☐	☑	☐	☑	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (facility level)	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit staff (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Physician(s)	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Nurse(s)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Social Workers	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Community Benefit Task Force	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Hospital Advisory Board	☐	☐	☐	☑	☑	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your expla below:

Q49. Section II - CHNA Part 2 - External Participants

Q50. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Charles County Department of Health	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Partnerships for a Healthier Charles County	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☐	☐	☐	☑	☐	☐	☐	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Maryland Department of the Environment	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Maryland Department of Transportation	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Maryland Department of Education	☐	☐	☐	☐	☐	☐	☐	☑	☐	
Area Agency on Aging -- Please list the agencies here: Charles County Department of Community Services	☐	☐	☐	☐	☑	☐	☑	☑	☐	
Local Govt. Organizations -- Please list the organizations here: Charles County Government	☐	☐	☐	☐	☑	☐	☑	☑	☐	
Faith-Based Organizations	☐	☐	☐	☐	☑	☐	☑	☐	☐	
School - K-12 -- Please list the schools here: Charles County Public Schools	☐	☑	☑	☐	☑	☑	☑	☑	☐	
School - Colleges and/or Universities -- Please list the schools here: College of Southern Maryland	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here: Charles County Department of Health's Substance Use and Mental Health Clinics, Charles County Local Behavioral Health Authority, Center for Children	☐	☐	☐	☐	☑	☐	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here: Charles County Department of Social Services	☐	☐	☐	☐	☑	☐	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Post-Acute Care Facilities -- please list the facilities here: Sagepoint, Fenwick Landing, The Charleston Senior Community, Genesis, Restore Health, Morningside, Hospice of Charles County	☐	☐	☐	☐	☑	☐	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here: United Way of Charles County, Health Partners Inc., local extension service, Lifelong Learning Center	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here: Lifestyles of Maryland, Inc. , Charles County Service and Advocacy Council	☐	☐	☐	☐	☑	☐	☑	☑	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here: White Plains Primary Care, Cambridge Pediatrics	☐	☐	☐	☐	☑	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated in the development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q51. Section II - CHNA Part 3 - Follow-up

Q52. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q53. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

06/25/2018

Q54. Please provide a link to your hospital's CHNA implementation strategy.

https://www.umms.org/charles/community/assessment-implementation-plan

Q55. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q56. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

- ☐ Access to Health Services: Health Insurance
- ☑ Access to Health Services: Practicing PCPs
- ☐ Access to Health Services: Regular PCP Visits
- ☐ Access to Health Services: ED Wait Times
- ☐ Access to Health Services: Outpatient Services
- ☐ Adolescent Health
- ☐ Arthritis, Osteoporosis, and Chronic Back Conditions
- ☑ Behavioral Health, including Mental Health and/or Substance Abuse
- ☑ Cancer
- ☐ Children's Health
- ☐ Chronic Kidney Disease
- ☐ Community Unity
- ☐ Dementias, Including Alzheimer's Disease
- ☑ Diabetes
- ☐ Disability and Health
- ☑ Educational and Community-Based Programs
- ☐ Environmental Health
- ☐ Family Planning
- ☐ Food Safety
- ☐ Global Health
- ☑ Health Communication and Health Information Technology
- ☐ Health Literacy
- ☐ Health-Related Quality of Life & Well-Being
- ☑ Heart Disease and Stroke
- ☐ HIV
- ☐ Immunization and Infectious Diseases
- ☐ Injury Prevention
- ☐ Lesbian, Gay, Bisexual, and Transgender Health
- ☐ Maternal & Infant Health
- ☑ Nutrition and Weight Status
- ☐ Older Adults
- ☐ Oral Health
- ☑ Physical Activity
- ☐ Respiratory Diseases
- ☐ Sexually Transmitted Diseases
- ☐ Sleep Health
- ☐ Telehealth
- ☐ Tobacco Use
- ☐ Violence Prevention
- ☐ Vision
- ☐ Wound Care
- ☐ Housing & Homelessness
- ☐ Transportation
- ☐ Unemployment & Poverty
- ☑ Other Social Determinants of Health
- ☑ Other (specify) Unnecessary Hospital Utilization

Q57. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

In 2015, the Charles County Community Health Needs Assessment Committee used the Hanlon Method as a way to prioritize the most critical health needs and become more focused on community wide initiatives. Three priorities were chosen: Chronic Disease Prevention and Management, Behavioral Health, and Access to Care. Within Chronic Disease Prevention and Management, health topics include Diabetes, Cancer, Heart Disease, Cancer, using Education and Community based programs that are evidence-based. Under Access to Care, the topics include Physician Recruitment and Retention, Social Determinants of Health, and Unnecessary Hospital Utilization. Finally, the Behavioral Health priority includes Substance use disorders and Mental Health disorders. In 2018, a similar process was employed. The Charles County Community Health Needs Assessment Committee used the Hanlon Method as a way to prioritize the most critical health needs and become more focused on community wide initiatives. Three priorities were chosen: Chronic Disease Prevention and Management, Behavioral Health, and Access to Care. Within Chronic Disease Prevention and Management, health topics include Diabetes, Heart Disease, Obesity, and Hypertension, using Education and Community based programs that are evidence-based. Under Access to Care, the topics include Physician Recruitment and Retention, Social Determinants of Health, and Unnecessary Hospital Utilization. Finally, the Behavioral Health priority includes Substance use disorders and Mental Health disorders. Cancer was not chosen as a priority under Chronic Disease; previous initiatives led to a decrease in disease rate that is below the goal set in the 2015 CHNA implementation plan.

Q58. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q59. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q60. Section III - CB Administration Part 1 - Internal Participants

Q61. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

	Activities										
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☐	☐	☐	☐	Manager of population health management
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☐	☑	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☐	☑	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Physician(s)	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Nurse(s)	☐	☐	☐	☑	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Workers	☐	☐	☐	☑	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit Task Force	☐	☐	☑	☑	☑	☑	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Hospital Advisory Board	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other (specify)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q62. Section III - CB Administration Part 1 - External Participants

Q63. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities									
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Charles County Department of Health	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Partnerships for a Healthier Charles County	☐	☑	☑	☑	☐	☐	☑	☑	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☐	☐	☐	☑	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of the Environment	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Education	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Area Agency on Aging -- Please list the agencies here: Charles County Office on Aging	☐	☑	☑	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Govt. Organizations -- Please list the organizations here: Charles County Government	☐	☑	☑	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations	☐	☑	☑	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - K-12 -- Please list the schools here: Charles County Public Schools	☐	☑	☑	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Colleges and/or Universities -- Please list the schools here: College of Southern Maryland	☐	☑	☑	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Nursing School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here: Charles County Department of Health's Substance Use and Mental Health Clinics. Local Behavioral Health Authority, Center for Children	☐	☑	☑	☐	☐	☐	☐	☐	☐	
Social Service Organizations -- Please list the organizations here: Charles County Department of Social Services	☐	☑	☑	☐	☐	☐	☐	☐	☐	
Post-Acute Care Facilities -- please list the facilities here: Sagepoint, Fenwick Landing, The Charleston Senior Community, Genesis, Restore Health, Morningside, Hospice of Charles County	☐	☑	☐	☐	☐	☐	☐	☐	☐	
Community/Neighborhood Organizations -- Please list the organizations here: Health Partners Inc, United Way of Charles County, Lifelong Learning Center, UMd Extension	☐	☑	☐	☐	☐	☐	☐	☐	☐	
Consumer/Public Advocacy Organizations -- Please list the organizations here: Lifestyles of Maryland Inc, Charles County Service and Advocacy Council	☐	☑	☐	☐	☐	☐	☐	☐	☐	
Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q64. Section III - CB Administration Part 2 - Process & Governance

Q65. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- ☑ Yes, by the hospital's staff
- ☐ Yes, by the hospital system's staff
- ☐ Yes, by a third-party auditor
- ☐ No

Q66. Does your hospital conduct an internal audit of the community benefit narrative?

- ◉ Yes
- ○ No

Q67. Please describe the community benefit narrative audit process.

CFO, Albert Zanger: Oversees all HSCRC and 990 Reporting; internally audits Community Benefit reports; Allocates resources for CB operations. The CFO reviews the report (narrative and spreadsheet) and presents the final report to the Finance Committee of the Board of Directors for approval. The Finance Committee of the Board conducts the review and approval of the report and a summary of key points are presented to the full Board. Vice President, Planning, Clive Savory: Administers CB reporting operations including plan implementation, collaborates with strategic community partners; Oversees data collection and reporting; provides management for LHIC; Compiles reports Decision Support Analysts Jim Clague: Inputs financial data into CB data collection tool for reporting; assists with internal auditing Revenue Integrity Analyst, Ruth Case: Inputs salary data into CB data collection tool. Community Outreach Specialist, Cristalle Madray: Implements community benefit qualifying activities and community outreach programs; collaborates with strategic community partners; Trains departmental CB reporters and manages data collection tool; provides management for LHIC Epidemiologist, Amber Starn, MPH: Provides data and reporting for CB planning; monitors and reports outcomes of CB Strategic Plan, Reports SHIP data to CCDOH

Q68. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (●) Yes
- ( ) No

Q69. Please explain:

This question was not displayed to the respondent.

Q70. Does the hospital's board review and approve the annual community benefit narrative report?

- (●) Yes
- ( ) No

Q71. Please explain:

This question was not displayed to the respondent.

Q72. Does your hospital include community benefit planning and investments in its internal strategic plan?

- (●) Yes
- ( ) No

Q73. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

UM CRMC's current strategic plan, which covers fiscal years 2018 through 2022, includes provisions for significant investments in programs and initiatives that benefit members of our community who are disenfranchised. Under Goal #2 (Leader in Innovation and Integrated Care Delivery), our strategic plan outlines efforts for CRMC to work collaboratively with key community stakeholders such as Partners for a Healthier Charles County to address chronic disease issues, mental health, substance abuse and access to care. Many of the individuals who are targeted to benefit from these initiatives are uninsured, so the hospital and its partners absorb the costs of treatment. Our Mobile Integrated Health visitation program is an example of community benefits planning and investment. This program, which is geared to reduce readmissions and over utilization of emergency services, is jointly funded by financial support from CRMC and the Charles County Government. Further, the CRMC's annual budget includes approximately $1 million to cover the cost of providing charity care for the disenfranchised in our community. Our population health initiatives, which include health literacy, chronic care management, education and training for our patients are additional examples that demonstrate our efforts at strategic community benefit planning.

Q74. (Optional) If available, please provide a link to your hospital's strategic plan.

Q75. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

Q76. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Q77. Based on the implementation strategy developed through the CHNA process, please describe *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q78. Section IV - CB Initiatives Part 1 - Initiative 1

Q79. Name of initiative.

Charles County Mobile Integrated Healthcare

Q80. Does this initiative address a community health need that was identified in your most recently completed CHNA?

- (●) Yes
- ( ) No

Q81. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Practicing PCPs, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Educational and Community-Based Programs, Health Communication and Health Information Technology, Heart Disease and Stroke, Nutrition and Weight Status, Physical Activity, Other Social Determinants of Health, Other (specify)
Other: Unnecessary Hospital Utilization

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Access to Health Services: Outpatient Services
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [x] Behavioral Health, including Mental Health and/or Substance Abuse
- [x] Cancer
- [ ] Children's Health
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [x] Health Communication and Health Information Technology
- [x] Health Literacy
- [ ] Health-Related Quality of Life & Well-Being
- [x] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [x] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Housing & Homelessness
- [x] Transportation
- [ ] Unemployment & Poverty
- [x] Other Social Determinants of Health
- [x] Other (specify) Unnecessary hospital utilization,

Q82. When did this initiative begin?

August 28, 2017

Q83. Does this initiative have an anticipated end date?

- ( ) No, the initiative has no anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( )

The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

- [ ] The initiative will end when external grant money to support the initiative runs out. Please explain.
- [x] The initiative will end when a contract or agreement with a partner expires. Please explain.

The Memorandum of Understanding between the University of Maryland Charles Regional Medical Center, the Charles County Department of Health, and the Charles County Department of Emergency Services will end on June 30, 2023. At that time, the three agencies will re-evaluate the data measures and make a determination whether to continue the program.

- [ ] Other. Please explain.

Q84. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

An analysis of ED utilization was conducted in December 2015 using the time frame January 1-November 30, 2015. The criteria for inclusion were any patient with 20 or more visits to the emergency department during the specified time period. The data were queried by the transition nurse case manager using the HSCRC database. From January 1, 2015 through November 30, 2015, a total of 20 patients made at least 20 visits or more to the University of Maryland Charles Regional Medical Center Emergency Department. They accounted for a total of 643 visits. That is an average of 32 visits per patient. Visit counts ranged from 20 visits to 124 visits per patient in the 11-month time frame. The majority of the patients had either Medicaid (55%) or Medicare (35%) as their primary health insurance. The average number of visits among patients with Medicaid was 25 visits per patient. The average number of visits among patients with Medicare was 82 visits per patient. Managing their conditions in the primary care and home setting could lead to a reduction in hospital visits and a needed reduction in the 30-day readmissions rate to avoid penalties. Most of the high utilizers were discharged to their homes for self -care after they had been treated in the acute hospital setting. The most commonly reported reasons for their visits included pain, shortness of breath/trouble breathing, chest pain, and behavioral health conditions. These patients could greatly benefit from community resources to help them self-manage their disease processes and how changes to the home environment can improve their health.

Q85. Enter the estimated number of people this initiative targets.

239

Q86. How many people did this initiative reach during the fiscal year?

44

Q87. What category(ies) of intervention best fits this initiative? Select all that apply.

- [ ] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [ ] Social determinants of health intervention
- [ ] Community engagement intervention
- [ ] Other. Please specify.

Q88. Did you work with other individuals, groups, or organizations to deliver this initiative?

◉ Yes. Please describe who was involved in this initiative.

The Charles County Department of Health, the University of Maryland Charles Regional Medical Center, and the Charles County Department of Emergency Services, collectively implement the Charles County Mobile Integrated Healthcare project to address the health/social determinants leading to repeated use of emergent care.
The Mobile Integrated Healthcare (MIH) Team includes a paramedic employed by Emergency Services and a registered nurse and community health worker, employed by the health department. The MIH team has offices at both the Charles County Department of Health and the Charles County Department of Emergency Services. During the initial visit, the MIH team assesses the patient's vital signs, reviews discharge paperwork, evaluates compliance with discharge instructions, completes a medication evaluation/reconciliation, conducts an environmental scan of the home for safety issues, and provides health education and chronic disease self management information when appropriate. After the initial visit, the community health worker provides the high touch needed to keep the patients engaging in this program and out of the emergency department.

Additionally, grant funding for this project has been secured by the Charles County Department of Health, Maryland Department of Health, and the Charles County Government.
Other sources of referral to MIH include Health Partners Inc., the Charles County Office on Aging, Greater Baden Medical Center, the University of Maryland Charles Regional Medical Group.

○ No.

Q89. Please describe the primary objective of the initiative.

Reduce Emergency Department (ED) utilization and Emergency Medical Services (EMS) transports of high utilizers by linking them with care coordination and community health services.

Q90. Please describe how the initiative is delivered.

Enrollment: • Must be: ▫ 18 years of age, or older (and) ▫ Charles County resident (and) ▫ 1 or more chronic health conditions *ALL 3 MUST APPLY* Criteria for Hospital and Emergency Medical Services Inclusion: • 3 or more visits to the ED in 3 months • 3 or more calls to EMS in 3 months Criteria for Primary Care Clinic Inclusion: Must display one or more • 2 missed appointments/no-show's to scheduled appointments (and/or) • Have not followed up with recommended specialists/agencies pertaining to health needs (and/or) • Poor medication adherence Criteria for Office on Aging Inclusion: • Individuals on the Senior Care Waiting List with Chronic Conditions and Lower Acuity Levels Initial Visits: • Medical history review • Individual concerns regarding health conditions • Social and Emotional Health Questionnaire • Physical Assessment ▫ Vital signs ▫ Respiratory/Neuro/Integumentary/GI/GU Cardiovascular/Musculoskeletal/Pain Assessments • Immunization history review • Assessment of ADL's • Medication reconciliation ▫ Ability to safely dispose of unused/unwanted medications ▫ Carbon copied lists for convenience • Thorough Home Safety Assessments ▫ Ability to address safety needs with little to no cost to patient Smoke detectors / Carbon Monoxide detectors • Individualized "To-Do" lists for patients • Recognize needs for IDT discussions where applicable • File of Life • Personalized binders with accessible educational materials/references for clients health conditions ▫ Zone Sheets; BP, FSBS, weight charts Follow-up after Initial Visit: • Make contact with appropriate resources ▫ Maryland Access Point line, dental, mental health ▫ Schedule appointments • Arrange transportation when necessary ▫ Contact staff for MA Transportation Forms to be completed • Send "needs list" to providers offices regarding needs of patient ▫ Refill requests, referrals, requests, etc. • Insurance companies ▫ Coverage specifications ▫ Case Manager access • Schedule for home safety modifications when applicable Discharge Process: • First month: ▫ MIH is "hands-on," doing tasks for clients/family and informing them before and after tasks are completed (i.e.- appointment scheduling, etc.) • Second month: ▫ Clients/family are encouraged to take initiative in completing necessary tasks to manage healthcare needs, reflecting level of involvement from MIH in first month • Third month - onward: ▫ MIH monitors ability of client/family to manage healthcare needs independently and provides assistance/guidance when needed ▫ Discharge (successful/unsuccessful) Self-manages, or remains non-compliant

Q91. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

☑ Count of participants/encounters : Number of participants referred from hospital, Number of participants referred from EMS, number of participants referred from community agencies, number of patient encounters

☑

Other process/implementation measures (e.g. number of items distributed) | Number of home visits, number of environmental scans, number of phone calls/emails to patients, number of phone calls/emails to outside resources, number of referrals to community services, number of referrals to primary care, number of referrals to specialists, number of people given health education, number of people with contact 48 hours after discharge or referral, number of successful discharges, number of discharges due to non-compliance

- [x] Surveys of participants: Customer satisfaction surveys are completed at time of discharge from program
- [x] Biophysical health indicators: Blood pressure readings, weight, blood glucose logs
- [ ] Assessment of environmental change:
- [ ] Impact on policy change:
- [x] Effects on healthcare utilization or cost: Changes in ED utilization, Changes in inpatient admissions, changes in 30 day readmissions, changes in EMS utilization, cost savings due to reductions in ED, inpatient, 30 day admissions, and EMS utilization
- [ ] Assessment of workforce development:
- [ ] Other:

Q92. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

Referrals: FY20 1a) EMS 5 1b) UMCRMC 7 1c) Health Dept. 0 1d) Other 32 1e) Total: 44 Support delivered by: 2a) Home Visits 100 2b) Public Encounters 60 2c) Phone/Email (to patient) 1068 2d) Phone/Email (outside resources) 499 2e) Total: 1727 Linking participants to outside resources: 3a) 48h post hospital d/c contact 44 3b) Home Environment Scans 39 3c) Health Education 70 3d) Primary Care (new/old) 3 3e) Social/Comm. Svc (new/old) 13 3f) Specialty Care (new/old) 8 3g) Total: 177 The program is tracking the number of ED visits and inpatient admissions by program participants, as a reduction in hospital use is a key outcome measure to document program impact. At the time of data analysis, there were 130 clients with 3 months pre and post data for evaluation. In the 3 months prior to MIHealth participation, these 130 patients had a total of 259 visits to the CRMC emergency department. After MIHealth, the number of ED visits among participants 3 months post dropped 61% to a total of 102 ED visits. The number of inpatient admissions dropped 65% from a total of 96 inpatient admissions 3 months prior to MIHealth to 34 inpatient admissions 3 months after MIH enrollment. The number of 30-day readmissions dropped from 22 to 6 (73% reduction). From November 1, 2019 to April 30, 2020, there were a total of 23 ED visits, 7 inpatient admissions, and 1 30-day readmissions among MIHealth active participants. EMS call volume reduced by 49% from pre and post MIH participation. Looking at the data for 135 MIH clients, they had 276 911 calls in the 3 months prior to their MIH enrollment date. There have been 135 calls to 911 from MIHealth participants 3 months after MIH enrollment. From May 1,2019 to October 31, 2019, the number of EMS calls among MIH participants was 12 calls. This is a huge decrease from the last reporting period. There are a couple theories for this reduction. Those active MIH clients did not previously over utilize the EMS 911 system. There is a reduction in 911 calls at this time due to COVID-19. People are fearful to use emergent care such as EMS and the emergency department due to the perceived potential for exposure. 64 out of 135 MIHealth saw a reduction in EMS utilization after enrollment (47%). Several other MIH clients either had no EMS call utilization before and after enrollment or their call volume remained the same.

Q93. Please describe how the outcome(s) of the initiative addresses community health needs.

The outcomes of this initiative directly impact the Access to Care priority and its focus on unnecessary hospital utilization by addressing social determinants of health.

Q94. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Total FY20 cost - $10,794. In FY21, UM Charles Regional Medical Center will make another financial contribution of $80,000 to continue to support the cost of facilitating this program.

Q95. (Optional) Supplemental information for this initiative.

Q96. Section IV - CB Initiatives Part 2 - Initiative 2

Q97. Name of initiative.

Transportation to Wellness Pilot project

Q98. Does this initiative address a need identified in your most recently completed CHNA?

- (•) Yes
- ( ) No

Q99. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Practicing PCPs, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Educational and Community-Based Programs, Health Communication and Health Information Technology, Heart Disease and Stroke, Nutrition and Weight Status, Physical Activity, Other Social Determinants of Health, Other (specify)
Other: Unnecessary Hospital Utilization

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [x] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [x] Access to Health Services: Outpatient Services
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [ ] Children's Health
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [ ] Diabetes
- [x] Disability and Health
- [ ] Educational and Community-Based Programs
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health Literacy
- [x] Health-Related Quality of Life & Well-Being
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [x] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Nutrition and Weight Status
- [x] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Housing & Homelessness
- [x] Transportation
- [ ] Unemployment & Poverty
- [x] Other Social Determinants of Health
- [ ] Other (specify)

Q100. When did this initiative begin?

September 2019

Q101. Does this initiative have an anticipated end date?

- ( ) No, the initiative does not have an anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ( )

The initiative will end when external grant money to support the initiative runs out. Please explain.

- [ ] The initiative will end when a contract or agreement with a partner expires. Please explain.

- [x] Other. Please explain.

No, this initiative will continue to be implemented in the community once the grant funds are spent. To ensure sustainability, UM CRMC will work to integrate transportation into future operational budgets or costs may be supported through grants and other fundraising efforts.

Q102. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

Based on results from the 2018 Community Health Needs Assessment, a majority (20%) of respondents felt “access to care” and not having health insurance were the biggest health-related issues they face. When asked what problems prevent them from getting the health care they need, 22 % indicated they had “no transportation” and 13 % said the “doctor is too far away from my home.” Respondents most likely to encounter transportation barriers are older adults, individuals with a disability, those with low-income, and residents that live in towns outside of Waldorf and La Plata. Approximately 12.9% of Charles County residents are over age 65, 5% do not have health insurance, and 7.4% live below the poverty level. In 2018, UM CRMC had 6,541 admissions and 54,575 emergency department visits. About 7 percent of visits were uninsured (18 in-patient and 4,315 Emergency). Uninsured patients are more likely to have transportation barriers and need financial assistance. The counties served are transportation disadvantaged and have medically underserved areas.

Q103. Enter the estimated number of people this initiative targets.

225

Q104. How many people did this initiative reach during the fiscal year?

143

Q105. What category(ies) of intervention best fits this initiative? Select all that apply.

- [ ] Chronic condition-based intervention: treatment intervention
- [ ] Chronic condition-based intervention: prevention intervention
- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [ ] Community engagement intervention
- [ ] Other. Please specify.

Q106. Did you work with other individuals, groups, or organizations to deliver this initiative?

- [x] Yes. Please describe who was involved in this initiative.

Yes, this project is implemented with grant funds from Rural Maryland Council and vehicles and qualified drivers were provided by a private transportation provider, Lyft Health.

- [ ] No.

Q107. Please describe the primary objective of the initiative.

Reduce the rate of missed or cancelled post hospitalization appointments due to transportation barriers. Increase access to non-emergency medical transportation services for low income transportation-disadvantaged residents of Charles, St. Mary's, and Calvert counties.

Q108. Please describe how the initiative is delivered.

Transportation to Wellness is a pilot program that serves eligible patients that live in Charles, St Mary's, or Calvert County. The project provides free, on-demand, curb-to-curb non-emergency medical transportation services to a patient's home after discharge from UM Charles Regional Medical Center (UM CRMC), and to post-hospitalization medical appointments. To qualify, eligible patients must be 1) over age 65, 2) have a mobility related disability, 3) be a recipient of nurse navigation services (high utilizers), and/or 4) low income. In addition, the patient must live in Charles, Calvert, or St. Mary's County. UM CRMC staff coordinated transportation for the patients, and made payments directly to the Lyft Health service provider. The goal of the Transportation to Wellness Pilot project is to improve access to healthcare for low-income, disadvantaged Charles, St. Mary's, and Calvert County residents by reducing transportation barriers.

Q109. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters — Number of patients who received transportation for hospital discharge; Number of patients who received transportation to and/or from post hospitalization appointments; Total number of safe rides provided
- [x] Other process/implementation measures (e.g. number of items distributed) — age, city/county of residence, disability status, insurance status, risk status, low income status
- [x] Surveys of participants — Participant pre and post number of appointments missed or cancelled due to transportation barriers
- [ ] Biophysical health indicators
- [ ] Assessment of environmental change
- [x] Impact on policy change
- [x] Effects on healthcare utilization or cost — Number of readmissions avoided; number of discharge delays prevented by access to the transportation service
- [ ] Assessment of workforce development
- [ ] Other

Q110. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

Number of individuals served: 143 individuals served Number of instructional hours delivered: 4 hours Number of Services Delivered: 161 safe rides provided Number of jobs created/retained: 1 job created/ 1 job retained The Transportation to Wellness Pilot project provided 125 patients with safe rides home after discharge from the inpatient units or emergency department. UM CRMC arranged 18 unique patients' transportation to their first primary care or specialist appointment post discharge. These were patients that were either low income, had mobility challenges, and/or were senior residents. These patients do not have other options for transportation and using the Lyft rides coordinated by UM CRMC fills this need for transportation. For the first 143 individuals served, 90% lived in Charles, 7% lived in St. Mary's and 5% lived in Calvert County. 23% were over the age of 65, 8% were uninsured, 69% were high risk, 73% were low income, and 48% have a mobility-related disability. 95% of the patients that had transportation assistance attended their appointments. All participants had a history of missed appointments, due to lack of transportation, prior to this assistance. 47/143 or 33% have prior missed appointments at their doctors' offices due to transportation and 30/125 or 24% have had prior delays with hospital discharges due to transportation barriers. In the first 9 months of this program we provided 18 patients with round trip (36) rides and one patient with a one way ride to Lifestyles of Maryland. During this time, we also prevented discharge delays for 124 patients. Helping patients not miss appointments post discharge is one of the best practices for readmission reduction. Our hospital readmission rate hovers in the 9% range. About 1 out of every 5 Medicare patients are readmitted within 1 month of their last hospital discharge. 6 of the 18 patient-provided trips to their doctors post hospitalization were prior readmissions. At this time only one of the other patients has returned as a readmission since the last discharge. This is a 33% improvement over their prior hospital utilization. The Transportation to Wellness program was used to help 6 of our patients avoid readmissions back to the hospital. Due to the COVID-19 pandemic, UM CRMC had significant drops in volumes of patients which lowered our use of Lyft rides in April through June, 2020. There was a concurrent increase in the use of telehealth to avoid patients needing to go to their community providers' offices in person, lowering our need to set-up

Q111. Please describe how the outcome(s) of the initiative addresses community health needs.

Assessing the need and usage of this service has made it clear that it is a critically needed resource for our counties, particularly for those patients who do not have funds for cab rides or bus vouchers. Non-emergency medical transportation (NEMT), such as through the Transportation to Wellness Pilot project, is essential to helping disadvantaged patients gain access to care and get to and from medical appointments.

Q112. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Total FY20 Cost - $38,706

Q113. (Optional) Supplemental information for this initiative.

Q114. Section IV - CB Initiatives Part 3 - Initiative 3

Q115. Name of initiative.

Charles County Efforts to Reduce the Incidence and Mortality of Diabetes

Q116. Does this initiative address a need identified in your most recently completed CHNA?

- (●) Yes
- ( ) No

Q117. In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Practicing PCPs, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Educational and Community-Based Programs, Health Communication and Health Information Technology, Heart Disease and Stroke, Nutrition and Weight Status, Physical Activity, Other Social Determinants of Health, Other (specify)
Other: Unnecessary Hospital Utilization

Using the checkboxes below, select the needs that appear in the list above that were addressed by this initiative.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Access to Health Services: Outpatient Services
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [ ] Children's Health
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health Literacy
- [ ] Health-Related Quality of Life & Well-Being
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Housing & Homelessness
- [ ] Transportation
- [ ] Unemployment & Poverty
- [ ] Other Social Determinants of Health
- [ ] Other (specify)

Q118. When did this initiative begin?

January 1, 2015

Q119. Does this initiative have an anticipated end date?

- (●) No, the initiative does not have an anticipated end date.
- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( )

The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

- [ ] The initiative will end when external grant money to support the initiative runs out. Please explain.
- [ ] The initiative will end when a contract or agreement with a partner expires. Please explain.
- [ ] Other. Please explain.

Q120. Please describe the population this initiative targets (e.g. diagnosis, age, insurance status, etc.).

8.3% of the Charles County adult population has diabetes. The 2018 adult population of Charles County is 122,742. 8.3% is 10,187 people. Describe the characteristics of the target population. The 2016-2018 death rate for people in Charles County with diabetes mellitus 26.3 per 100,000 people. This is higher than the state average of 19.8 per 100,000. (2018 MD Vital Statistics Report). Approximately 10.8% of CC adults report having diabetes (2018 MD BRFSS). 2017 Emergency Department visit rates due to diabetes show a disparity among Charles County African Americans: 359.2 per 100,000 for African Americans and 151.2 for Whites. The same is true for Maryland African Americans. Therefore, this priority has been established by the Maryland State Health Improvement Process.

Q121. Enter the estimated number of people this initiative targets.

10187

Q122. How many people did this initiative reach during the fiscal year?

1145

Q123. What category(ies) of intervention best fits this initiative? Select all that apply.

- [ ] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [ ] Social determinants of health intervention
- [x] Community engagement intervention
- [ ] Other. Please specify.

Q124. Did you work with other individuals, groups, or organizations to deliver this initiative?

- [ ]

Yes. Please describe who was involved in this initiative.

Charles County Department of Health, the Partnerships for a Healthier Charles County, Charles County Office on Aging all played an active role in the implementation of this initiative.

- [ ] No.

Q125. Please describe the primary objective of the initiative.

1. Offer Stanford University's Diabetes Self-Management (DSMP). Offer the CDCs Diabetes Prevention Program (DPP) in the county. 2. Promote the University of Maryland Charles Regional Medical Center's efforts to provide diabetes education and other chronic disease management and support groups to the community.

Q126. Please describe how the initiative is delivered.

This is a multi-faceted approach with both community-level and individual-level initiatives aimed at reducing the incidence and burden of diabetes in Charles County. Community Outreach and Education: The Chronic Disease Prevention and Management Team used the Charles County Fair Friday as the location for diabetes awareness event. Members were set up under tents and disseminated information on the diabetes support group, the Diabetes Prevention Program, the Diabetes Education Center, as well information on the importance of good nutrition and physical activity. There were a total of 1033 encounters at community events. UMCRMC also participated in other community events throughout FY20 to promote programs on diabetes management and to promote a healthy lifestyle. Community education and outreach activities were suspended in early 2020 due to the COVID-19 pandemic. Diabetes Community Events 7/2019 through 6/2020 Date Event Notes 9/14 Charles County Fair 1000 encounters for outreach and information dissemination to the general public on the Center for Diabetes Education, the Diabetes Support Group, and information on physical activity and nutrition 10/1/2019 Community Resource Day Jaycees Community Center Diabetes Risk Screening and Nutrition Guidance Participants: 18 6—at risk 3 with diabetes—nutrition guidance 3 without diabetes—nutrition guidance Total Time: 6 hours 11/12/19 Speaker to the Lifestyles Homeless Safe Nights Participants Subject: Be a Healthier You; Take care of your Diabetes Speaker: Teri White, RN Participants: 7 12/11/19 Community Talk for the Foundation Subject: "Be Happy and Healthy for the Holidays" Speaker: Cindy Adams Event 2.0 hours Participants: 8 Total Time: 3 hours Diabetes Prevention Program: UMCRMC partners with the Charles County Department of Health to implement the National Diabetes Prevention Program, a yearlong CDC-recognized lifestyle change program for individuals with pre-diabetes. Diabetes Support Group: The UMD CRMC Center for Diabetes Education sponsors a Diabetes Support Group for adults with Diabetes or Prediabetes. Available to everyone, the sessions provide a way for people with diabetes and their guests to come and learn more about diabetes in a fun, informal setting. Guest speakers, cooking demonstrations, raffle items…you never know what might be happening at the next meeting! The purpose of the Diabetes Support Group is to help people with diabetes feel more comfortable with knowing what to eat, how to keep blood sugar under control and prevent complications of diabetes. Diabetes Support Groups began in 2018 with afternoon sessions and expanded in 2019 to include evening sessions for those who work during the day. Evening and daytime sessions are now available, usually meeting every other month for 1.5 hours. These sessions are appropriate for people with prediabetes or type 2 diabetes. The Diabetes Support Groups are free events that highlight a subject that will be of interest to people with prediabetes or diabetes. The support groups feature special speakers with handouts and opportunities to ask questions. Diabetes-friendly refreshments are usually provided. Sessions are held every other month. Each month focusses on a specific subject. Past subjects include, Nutrition (including cooking demonstrations and sampling different foods), Exercise, Continuous Glucose Monitors, Diabetes and Foot Care, Weight Loss Strategies, Stress management, Fast Food, and Healthy Holiday Eating. Participants are encouraged to suggest subjects for future meetings. Diabetes Self Management Program: The hospital in conjunction with the Charles County Department of Health conducted Stanford's Diabetes Self Management Program. This program is a 6-week long evidence-based intervention to help individuals with diabetes to set goals and to learn to self manage their diseases processes.

Q127. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: number of encounters at county fair, number of DPP participants, number of DSME participants, number of support group meetings held, number of people in attendance at support group meetings
- [ ] Other process/implementation measures (e.g. number of items distributed)
- [ ] Surveys of participants
- [x] Biophysical health indicators: Change in weight and BMI, Reduction in A1C
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ] Other

Q128. Please describe any observed outcome(s) of the initiative (i.e., not *intended* outcomes).

Community Outreach and Education: There were a total of 1033 encounters at community events. Diabetes Self-Management Program: No Diabetes Self-Management Program workshops were conducted in FY2020. In Fall 2019, the class was canceled due to lack of interest. In early 2020, the class was canceled due to the COVID-19 pandemic when in-person classes were suspended. Diabetes Prevention Program: Number of workshops: 3 Average participants per workshop: 19.0 Number of participants: 57 Participants with attendance data: 57 DPRP-Attend-Qual. Participants: 17 of 57 (30%) DPRP-Qual. Participants: 14 of 57 (25%) Number who are caregivers: 0 of 0 Age Count Percent 0-44 6 11% 44-49 4 7% 50-54 10 18% 55-59 8 14% 60-64 10 18% 65-69 10 18% 70-74 6 11% 75-79 2 4% 80-84 1 2% Attended Session Count Percent 1 47 82% 2 53 93% 3 53 93% 4 52 91% 5 49 86% 6 41 72% 7 41 72% 8 36 63% 9 36 63% 10 35 61% 11 38 67% 12 37 65% 13 36 63% 14 34 60% 15 32 56% 16 31 54% 17 33 58% 18 29 51% 19 29 51% 20 25 44% 21 25 44% 22 15 26% 23 15 26% 24 14 25% 25 12 21% 26 14 25% 27 13 23% 28+ 14 25% Chronic Condition Count Percent Hypertension 27 100% Kidney Disease 1 4% Unknown 30 Completers Count Percent No 40 70% Yes 17 30% Condition Count Count Percent One chronic condition 26 96% Multiple chronic conditions 1 4% Unknown 30 Disabilities Count Percent Diff. walking or climbing stairs 3 5% Visually impaired 3 5% Diff. with errands 2 4% Diff. remembering 1 2% Hearing impaired 1 2% Diff. dressing 1 2% Disability Count Count Percent No disabilities 50 88% One disability 4 7% Multiple disabilities 3 5% Education Count Percent Completed College 23 45% Some College 18 35% Completed High School 8 16% Some High School 2 4% Unknown 6 Ethnicity/Race Count Percent Black or African American 38 69% White/Caucasian 15 27% American Indian or AK Native 2 4% Asian or Asian American 1 2% Unknown 2 GDM Count Percent No 39 68% Yes 4 7% Gender Count Percent Female 43 86% Male 7 14% Unknown 7 How Did You Hear Count Percent Other: Mail or any other 34 60% Family or friends 8 14% Media: Social media (Twitter, Facebook, etc.) 4 7% Primary care provider 3 5% Not reported 2 4% Media: Poster/flyer, etc. 2 4% Non-primary care health professional 1 2% Employer or Employer's wellness program 1 2% Community-based org or comm health worker 1 2% Self 1 2% Insurance Count Percent Medicaid HealthChoice (MCO) 1 50% Aetna 1 50% Unknown 55 Last Session Attended Count Percent 1 2 4% 2 1 2% 3 2 4% 4 2 4% 5 1 2% 6 5 9% 7 4 7% 8 1 2% 9 0 0% 10 0 0% 11 2 4% 12 0 0% 13 1 2% 14 1 2% 15 1 2% 16 0 0% 17 3 5% 18 0 0% 19 1 2% 20 4 7% 21 8 14% 22 1 2% 23 1 2% 24 1 2% 25 0 0% 26 0 0% 27 1 2% 28+ 14 25% Minutes of Activity for DPRP-Qual. Participants Count Percent 0-19 Minutes 0 0% 30-74 Minutes 2 14% 75-149 Minutes 6 43% 150+ Minutes 6 43% Number of Sessions Attended Count Percent 1 2 4% 2 1 2% 3 2 4% 4 2 4% 5 4 7% 6 5 9% 7 3 5% 8 1 2% 9 1 2% 10 0 0% 11 0 0% 12 0 0% 13 2 4% 14 1 2% 15 1 2% 16 0 0% 17 3 5% 18 1 2% 19 2 4% 20 6 11% 21 4 7% 22 0 0% 23 1 2% 24 2 4% 25 1 2% 26 0 0% 27 0 0% 28+ 0 0% 28 2 4% 30 2 4% 32 4 7% 31 2 4% 29 2 4% Organization Count Percent Charles County Department of Health 57 100% Participant County Count Percent Charles, MD 57 100% Payment Source Count Percent Grant funding 47 100% Unknown 10 Percent Weight Change For DPRP-Qual. Participants Count Percent 7.00%+ Loss 5 36% 5.00%-6.99% Loss 2 14% 3.00%-4.99% Loss 3 21% 1.00%-2.99% Loss 3 21% 0.99% Loss-0.99% Gain 1 7% 1.00%-2.99% Gain 0 0% 3.00%-4.99% Gain 0 0% 5.00%-6.99% Gain 0 0% 7.00%+ Gain 0 0% Average Weight Loss Percent 6.41% Prediabetes Count Percent Yes 31 70% No 13 30% Unknown 13 Type of Test Count Percent Risk Test 39 68% A1C 31 54% Fasting Glucose 5 9% OGTT 1 2% Diabetes Support Group: 7 support group meetings were conducted in Fiscal Year 2019. A total of 55 people attended the support group meetings. This included people with diabetes and their guests or caregivers. Each session had a theme. Subjects covered included: Exercise, Healthy Holiday Eating, and COVID-19. Diabetes Support Group Meetings 7/2019 through 6/2020 Date Event Notes 9/24 & 9/25/2019 Diabetes Support Group Subject: Exercise Speaker: Teri White, RN 2 sessions evening and afternoon 2 Events 4 hours total Participants: 30 Total Time: 5 hours 10/8/19 Type 1 Diabetes Support Group Participants: 0 11/13/19 Diabetes Support Group Subject: Healthy Holiday Eating Speaker: Cindy Adams Event 1.5 hours total Participants: 12 Total Time: 5 hours 11/26/19 Diabetes Support Group Subject: Healthy Holiday Eating Speaker: Cindy Adams Event 1.5 hours total Participants: 7 Total Time: 3.5 hours 6/23 & 6/24/20 Diabetes Support Group—two sessions Virtual support group via zoom Subject: COVID-19 Total of 6 people (4 zoom, 2 phone) Event 2 hours total Prep: 2 hours Total Time: 4 hours

Q129. Please describe how the outcome(s) of the initiative addresses community health needs.

Diabetes is a preventable disease. Nearly 1 in 3 adults currently has pre-diabetes. With proper education and lifestyle changes, Diabetes can be prevented. For those with diabetes, support and continued education can lead to better health outcomes and increased life expectancy.

Q130. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Total FY20 cost - $3,519.

Q131. (Optional) Supplemental information for this initiative.

Q132. Section IV - CB Initiatives Part 4 - Other Initiative Info

Q133. Additional information about initiatives.

Q134. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

Q135. Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- (●) Yes
- ( ) No

Q136.
In your most recently completed CHNA, the following community health needs were identified:
Access to Health Services: Practicing PCPs, Behavioral Health, including Mental Health and/or Substance Abuse, Cancer, Diabetes, Educational and Community-Based Programs, Health Communication and Health Information Technology, Heart Disease and Stroke, Nutrition and Weight Status, Physical Activity, Other Social Determinants of Health, Other (specify)
Other: Unnecessary Hospital Utilization

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q137. Why were these needs unaddressed?

This question was not displayed to the respondent.

Q138. Do any of the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? Specifically, do any activities or initiatives correspond to a SHIP measure within the following categories?

See the SHIP website for more information and a list of the measures:
https://pophealth.health.maryland.gov/Pages/SHIP-Lite-Home.aspx

	Select Yes or No	
	Yes	No
Healthy Beginnings - includes measures such as babies with low birth weight, early prenatal care, and teen birth rate	(●)	( )
Healthy Living - includes measures such as adolescents who use tobacco products and life expectancy	(●)	( )
Healthy Communities - includes measures such as domestic violence and suicide rate	(●)	( )
Access to Health Care - includes measures such as adolescents who received a wellness checkup in the last year and persons with a usual primary care provider	(●)	( )
Quality Preventive Care - includes measures such as annual season influenza vaccinations and emergency department visit rate due to asthma	(●)	( )

Q139. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q140. Section V - Physician Gaps & Subsidies

Q141. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

- [ ] No gaps
- [x] Primary care
- [x] Mental health
- [ ] Substance abuse/detoxification
- [ ] Internal medicine
- [ ] Dermatology
- [ ] Dental
- [ ] Neurosurgery/neurology
- [x] General surgery
- [ ] Orthopedic specialties
- [ ] Obstetrics
- [ ] Otolaryngology
- [ ] Other. Please specify.

Q142. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand.

Hospital-Based Physicians	Due to the significant physician shortage in the Southern region, UM CRMC does not have adequate pool of community physicians to provide 24 hour professional and administrative services for many required specialties. Contracts with these physicians and groups are needed to provide 24-hour services for patients regardless of their insurance status or ability to pay and make it necessary for UM CRMC to assure that Contractor receives fair market value compensation for the services it is rendering to or for the benefit of Hospital.
Non-Resident House Staff and Hospitalists	
Coverage of Emergency Department Call	As a result of the prevailing physician shortage (southern Maryland has the highest number of physician specialty shortages in the state); the University of Maryland Charles Regional Medical Center has an insufficient number of specialists within the medical staff. In all of these areas there are not enough physicians to care for patients including uninsured and underinsured in the hospital. Therefore, subsidies are paid to the physicians to provide on call coverage for the Emergency Department and patient care departments.
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	Southern Maryland had the highest percentage of physician shortages of all of the regions in Maryland (89.9%). To address the shortage, the University of Maryland Charles Regional Medical Center hired both a Chief Medical Officer and Physician Recruiter and Liaison who are working to successfully attract and retain physicians to the community. Private practice within the community is preferred, but the hospital will employ those physicians when necessary.
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	

Q143. (Optional) Is there any other information about physician gaps that you would like to provide?

Q144. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Data on Physician Gaps for Charles County.docx
1.5MB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q145. Section VI - Financial Assistance Policy (FAP)

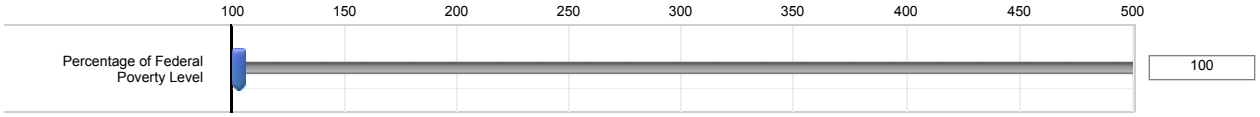
Q146. Upload a copy of your hospital's financial assistance policy.

Financial Assistance Policy - Final 10.23.20.docx
195.4KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

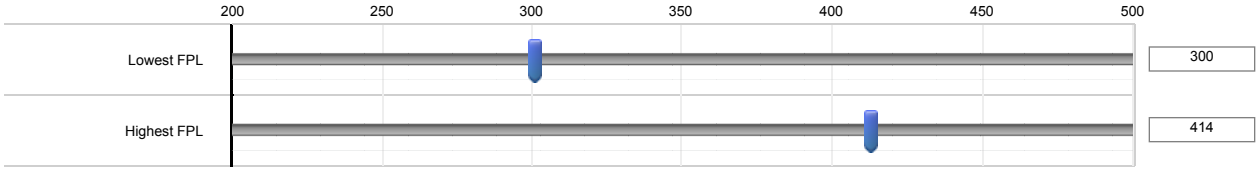
Q147. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

23640_CRMC_PatientInformation-Trifold_OB_R2.pdf
1MB
application/pdf

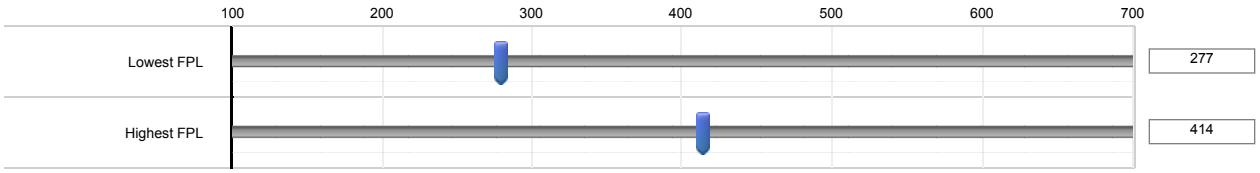
Q148. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL). Please select the percentage of FPL below which your hospital's FAP offers free care.



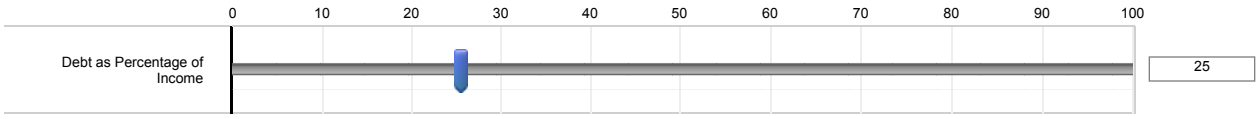
Q149. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.



Q150. Maryland hospitals are required under COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income. Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q151. Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.



Q152. Has your FAP changed within the last year? If so, please describe the change.

- (●) No, the FAP has not changed.
- ( ) Yes, the FAP has changed. Please describe: [ ]

Q153. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

Q154. (Optional) Please attach any files containing further information about your hospital's FAP.

Q155. Summary & Report Submission

Q156.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

Location Data

Location: (39.33610534668, -76.538902282715)

Source: GeoIP Estimation

From:	Hilltop HCB Help Account
To:	kimberly.davidson@umm.edu; djacobs@umm.edu
Cc:	Hilltop HCB Help Account
Subject:	HCB Narrative Report Clarification Request - Charles Regional
Date:	Thursday, May 27, 2021 8:27:05 AM
Attachments:	UM_Charles_Regional_HCBNarrative_FY2020_20210331.pdf

Thank you for submitting the FY 2020 Hospital Community Benefit Narrative report for the University of Maryland Charles Regional Medical Center. In reviewing the narrative, we encountered a few items that require clarification:

- In Question 81 on page 17, it was reported that the "Charles County Mobile Integrated Healthcare" initiative addressed the community needs of "Health Literacy", "Telehealth", and "Transportation", however none of these needs were selected in Question 56 on page 10 as being identified in your most recent CHNA. Please confirm whether these should have been selected for Question 56..
- In Question 99 on page 21, it was reported that the "Transportation to Wellness Pilot project" initiative addressed several community needs. Of these selected needs, however, only "Other Social Determinants of Health" was also selected in Question 56 on page 10 as being identified in your most recent CHNA. Please confirm whether these should be selected for question 56.
- In Question 103 on page 22, the reported number of people targeted by the "Transportation to Wellness Pilot project" initiative seems lower than expected given the description of the target population in Question 102. However, Question 108 on page 23 contains information that helps clarify the number of people targeted. Please clarify the target population of this initiative in Question 103.
- In Question 109 on page 23, please describe the "Impact on policy change" metric used to assess the effectiveness of the "Transportation to Wellness Pilot project" initiative.
- In question 148 on page 29, your answer appears to be out of compliance with regulations. Please confirm that your hospitals FAP offers free care to those with family income below 100% of federal poverty level. Please note that regulations require that such free care be offered to those below 200%.
- In question 149 on page 29, you indicated that your hospital's FAP offers reduced-cost care to those with family income between 300% and 414% of federal poverty level. Please explain how your hospital's FAP addresses those with family income between 100% and 299% of federal poverty level.

Please provide your clarifying answers as a response to this message.

UM CHARLES REGIONAL MEDICAL CENTER FY20 Community Benefit Report Clarifying Questions/Answers- June 2021

- In Question 81 on page 17, it was reported that the "Charles County Mobile Integrated Healthcare" initiative addressed the community needs of "Health Literacy", "Telehealth", and "Transportation", however none of these needs were selected in Question 56 on page 10 as being identified in your most recent CHNA. Please confirm whether these should have been selected for Question 56.

  Yes, "Health Literacy," "Telehealth," and "Transportation" should have been selected for Question 56. These needs fall broadly under our access to care priority.

- In Question 99 on page 21, it was reported that the "Transportation to Wellness Pilot project" initiative addressed several community needs. Of these selected needs, however, only "Other Social Determinants of Health" was also selected in Question 56 on page 10 as being identified in your most recent CHNA. Please confirm whether these should be selected for question 56.

  Yes, "Access to Health Services: Regular PCP Visits," "Access to Health Services: Outpatient Services," "Disability and Health," "Health-Related Quality of Life & Well-Being," "Injury Prevention," "Older Adults," and "Transportation" should have been selected for Question 56. These needs fall broadly under our access to care priority.

- In Question 103 on page 22, the reported number of people targeted by the "Transportation to Wellness Pilot project" initiative seems lower than expected given the description of the target population in Question 102. However, Question 108 on page 23 contains information that helps clarify the number of people targeted. Please clarify the target population of this initiative in Question 103.

  Estimated number of people this initiative targets: 225

  The Transportation to Wellness project targets residents of Charles, Calvert, and St. Mary's County that are over age 65, have a mobility-related disability, high risk for re-hospitalization, and/or low income. Approximately 12% of Charles County residents are over age 65, 5% do not have health insurance, and 7.4% live below the poverty level. In 2018, UM CRMC had 6,541 admissions and 54,575 emergency department visits. About 7 percent of visits were uninsured (18 in-patient and 4,315 Emergency). Uninsured patients are more likely to have transportation barriers and need financial assistance. The budget for the Transportation to Wellness pilot project allows for 25-40 rides per month for a total of 225 eligible patients living in rural communities.

- In Question 109 on page 23, please describe the "Impact on policy change" metric used to assess the effectiveness of the "Transportation to Wellness Pilot project" initiative.

  The "Impact on policy change" metric was not meant to be checked.

- In question 148 on page 29, your answer appears to be out of compliance with regulations. Please confirm that your hospitals FAP offers free care to those with family income below **100%**

of federal poverty level. Please note that regulations require that such free care be offered to those below 200%.

The hospital's FAP offers free care to those with family income below 276%, therefore the tick mark should be moved to 276%.

- In question 149 on page 29, you indicated that your hospital's FAP offers reduced-cost care to those with family income between 300% and 414% of federal poverty level. Please explain how your hospital's FAP addresses those with family income between 100% and 299% of federal poverty level.

  The hospital's FAP offers reduced-cost care to those with family income between 277% and 414% of the federal poverty level. Therefore, the tick marks should be adjusted accordingly.

The Community Benefit Service Area for the University Of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified above as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county.

Geography

Charles County is located 23 miles south of Washington, D.C. It is one of five Maryland counties, which are part of the Washington, DC-MD-VA metropolitan area. At 458 square miles, Charles County is the eighth largest of Maryland's twenty-four counties and accounts for about 5 percent of Maryland's total landmass. The northern part of the county is the "development district" where commercial, residential, and business growth is focused. The major communities of Charles County are La Plata (the county seat), Port Tobacco, Indian Head, and St Charles, and the main commercial cluster of Hughesville-Waldorf-White Plains. Approximately 60 percent of the county's residents live in the greater Waldorf-La Plata area. By contrast, the southern (Cobb Neck area) and western (Nanjemoy, Indian Head, Marbury) areas of the region still remain very rural with smaller populations.

Population

Charles County has experienced rapid growth since 1970, expanding its population from 47,678 in 1970 to 120,546 in the 2000 census and 146,551 in the 2010 census. The current 2019 Census Bureau estimates the population at 163,257. The magnitude of growth can be seen in the changes in population density. The 1990 census showed that there were 219.4 individuals per square mile, which increased to 261.5 individuals per square mile by 2000, an increase of 19.2%, and to 320.2 individuals per square mile by 2010, an increase of 22.5%.

Source: 2000 and 2010 US Census Bureau's Census and 2019 American Community Survey one-year estimate

Transportation

The percent change in the population growth for Charles County has been slightly greater than the change seen in the Maryland population growth. This growth has created transportation issues for the
County, in particular for the "development district" in the northern part of the county where many residents commute to Washington D.C. to work. The average work commute time for a Charles County resident is 44.4 minutes which is higher than the Maryland average of 32.9 minutes (Source US Census Bureau's 2014-2018 American Community Survey 5 year estimates). Public transportation consists of commuter buses for out-of-county travel and the county-run Van Go bus service for in-county transportation.

Source: 2014-2018 US Census Bureau's American Community Survey 5 year estimates

Diversity

As the population of the county changes, the diversity of the county also increases. The African American population has experienced the greatest increase. In 2000, African Americans made up 26% of the total Charles County population; by 2019, they comprise 50.1% of the total county population. As of 2019,

minorities comprise roughly 62.8% of the Charles County population. The Hispanic community has also seen increases over the past few years. They now comprise 6.3% of the total county population. This is the one of the highest percentages among the 24 Maryland jurisdictions. Charles County also has one of the largest American Indian/Native American populations in the state of Maryland at 0.8% of the total county population.

The 2019 Charles County gender breakdown is approximately 50/50. Males make up 48.2% of the population, and females make up 51.8% of the county population.
Source: 2019 US Census Bureau's American Community Survey 1 year estimate

Economy

Employment and economic indicators for the county are fairly strong. The 2014-2018 US Census American Community Survey estimates that 66.4% of the Charles County population is currently in the labor work force. The 2014-2018 5-year estimate for Charles County found that approximately 6.6% of Charles County individuals are living below the poverty level; however, this is lower than the Maryland rate of 9.0%. The Charles County median household income was $95,924, well above the Maryland median household income of $81,868. The diversity of the county is also represented in the business community with 46% of all Charles County businesses being minority-owned firms. This is higher than the State of Maryland at 38%.
Source: 2014-2018 US Census Bureau's American Community Survey 5 year estimates

Education

Charles County has a larger percentage of high school graduates than Maryland (93.1% vs. 90.0%); however, Charles County has a smaller percentage than Maryland of individuals with a bachelor's degree or higher (28.9% vs. 39.6%).
Source: 2014-2018 US Census Bureau's American Community Survey 5 year estimates

Housing

There is a high level of home ownership in Charles County (76.5%). There is a greater percentage of home owners in Charles County than the percentage of homeowners for Maryland (76.5% vs. 66.8%). The median value of a housing unit in Charles County is similar to the Maryland average ($302,800 vs. $305,500). The average household size in Charles County is 2.78 persons.
Source: 2014-2018 US Census Bureau's American Community Survey 5 year estimates

Life Expectancy

The life expectancy for a Charles County resident, as calculated for 2018, was 78.5 years. This is slightly below the state average life expectancy of 79.2 years.

Source: 2018 Maryland Vital Statistics Report

Births

There were 1,867 births in Charles County in 2018. Charles County represents 46% of the births in Southern Maryland and 2.6% of the total births in Maryland for 2018.

Minorities made up just over half of the babies born in Charles County in 2018 (66%).

Source: 2018 Maryland Vital Statistics Report

Health Disparities

Health topics where health disparities are seen for the minority population in Charles County:

Health Topic	Indicator	Rate	Source
Heart Disease Prevalence and Mortality	Rate of ED visits for hypertension per 100,000 population Age-adjusted heart disease mortality rate	White: 271.8 Black: 734.9 White: 183.5 Black: 153.3 All races: 166.7	Maryland SHIP Prevalence: HSCRC 2017 and Mortality: 2015-2017 Maryland Vital Statistics Report)
Colon and Rectal Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 39.1 Black: 35.3 All races: 37.1 White: 14.5 Black: 19.4 All races: 16.4	2019 Cigarette Restitution Fund Program Cancer Report (2012-2016 rates)
Breast Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 130.7 Black: 117.4 All races: 123.1 White: 23.5 Black: 28.2 All races: 25.6	2019 Cigarette Restitution Fund Program Cancer Report (2012-2016 rates)
Prostate Cancer	Incidence Rates per 100,000	White: 115.5	2019 Cigarette Restitution Fund

Incidence Mortality	Mortality Rates per 100,000	Black: 194.3 All races: 143.1 White: 17.9 Black: 34.9 All races: 21.7	Program Cancer Report (2012-2016 rates)
Diabetes Prevalence	Unadjusted Diabetes ED Visit Rates by Black or White Race	White: 151.2 Black: 359.2 All races: 245.0	Maryland 2017 HSCRC per SHIP site
Obesity	Unadjusted % Adults at Healthy Weight	Overall: 28.6 White: 25.3 Black: 27.8	Maryland 2018 BRFSS
STD	Rate of Chlamydia infection for all ages per 100,000 (all ages)	Overall: 690.7 Data not available by race and ethnicity	Maryland STD Prevention Program Level data 2018
Asthma	Rate of ED visits for asthma per 10,000	Overall: 72.8 White-50.8 Black-90.5	HSCRC 2017 Per SHIP Site
Infant Mortality	Infant Mortality Rate per 1,000 births	County Overall: 5.4 Black-8.4 White: Rates not calculated due to small case count.	2018 Maryland Infant Mortality Report, Vital Statistics Admin.

1. 2019 Charles County Current Population Survey Data. United States Census Bureau. Available at: www.census.gov.

2. 2018 Maryland Vital Statistics Report. Charles County Demographic and Population Data. Maryland Department of Health. Available at www.vsa.maryland.gov.

3. 2014-2018 US Census Bureau, American Community Survey 5 year estimates, Charles County and Maryland. Available at www.census.gov.

4. Maryland State Health Improvement Process Measures. Accessed on October 2020. Available at: https://pophealth.health.maryland.gov/pages/ship-lite-home.aspx.

5. 2019 Maryland Cigarette Restitution Fund Program's Cancer Report. Maryland Department of Health. Available at: https://phpa.health.maryland.gov/cancer/SiteAssets/Pages/surv_data-reports/2019%20CRF%20Cancer%20Report.pdf.

6. 2018 Adults with Healthy Weight by Race. Maryland Behavioral Risk Factor Surveillance System. Maryland Department of Health. Available at:

7. 2018 Chlamydia Infection Rates by Race. Maryland STI Annual Report. Maryland Department of Health. Center for Sexually Transmitted Infection Prevention. Available at: https://phpa.health.maryland.gov/OIDPCS/CSTIP/CSTIPDocuments/Reports/STI%202018%20Annual%20Report%20Maryland.pdf.

8. 2018 Maryland Infant Mortality Report. Maryland Vital Statistics Administration. Available at: https://health.maryland.gov/vsa/Pages/reports.aspx.

Table II: Service Area Demographic Characteristics and Social Determinants:

Demographic Characteristic	***Description***	***Source***
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	*The Community Benefit Service Area for the University of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county.* *The zip codes of Waldorf (20601, 20602, 20603), White Plains (20695), and Indian Head (20640) represent the geographic areas where the most vulnerable populations reside in Charles County.* *The lowest average life expectancy is found in 20640, Indian Head, at 74.7 years.* *The highest Medicaid enrollment rate was in 20602, Waldorf.* *The highest percentage of low birth weight babies was in 20695, White Plains.*	*2006-2010 Maryland Vital Statistics* *2007-2011 MD Medicaid Program* *2007-2011 MD WIC Program*

	The highest WIC participation rate was in 20602, Waldorf. The WIC participation rate was also high in Indian Head, 20640. *The 2006-2011 All-cause mortality for Indian Head was 942.6 per 100,000, above the Maryland state rate.* *The 2006-2010 heart disease mortality for Indian Head was 232.3, also above the Maryland state rate.*	
Median Household Income within the CBSA	*$95,924*	*2014-2018 US Census American Community Survey 5 year estimate*
Percentage of households with incomes below the federal poverty guidelines within the CBSA	*6.1%*	*2014-2018 US Census American Community Survey 5 year estimate*
For counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://census.gov/hhes/www/hlthins/data/acs/aff.html http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	*4.7%*	*2014-2018 American Community Survey 5-Year Estimate*
Percentage of Medicaid recipients by County within the CBSA.	*18.3%*	*Fiscal Year 2019 Maryland Medicaid e-Health Statistics:* *Medicaid Enrollment Rates*
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	*The life expectancy from birth for a Charles County resident as calculated for 2016-2018 was 78.5 years. This is slightly below the state average life expectancy of 79.2 years.*	*2018 Maryland Vital Statistics Report. Charles County Demographic and Population Data. MDH*

	White: 78.3 *Black: 78.2*	
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	*All-cause death rate for Charles County for 2018 is 712.1 per 100,000 population. This is below the Maryland state average death rate of 838.5 per 100,000.* *White: 1022.2* *Black: 560.0* *Asian/PI: 276.1* *American Indian: 575.7* *Hispanic: 184.5* *The rate among the White population is greater than the other races because they make up the majority of the aging population in the county. Two-thirds of the 65+ population in Charles County (66%) are White. The minority populations are moving into Charles County and are a younger population; therefore, they have lower mortality rates. The median age in Charles County is 34 years.*	*2018 Charles Co. Death data, 2018 Maryland Vital Statistics Report*
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)	***Access to healthy food**:* • *3 Census tracts with low income and low access to food: 2 in Indian Head and 1 in Waldorf (Both primary service area zip codes)* ***Transportation:*** • *Mean travel time to work: 44.4 min* ***Environmental Factors:*** • *# of days Air Quality Index exceeds 100: 1.7* • *% of children tested who have blood lead levels ≥ 10 mg/dl: 0.10% (2017) (Goal: .288)* ***Housing:*** • *Home ownership: 76.5%* • *Renter occupied housing: 23.5%* • *Affordable housing: the % of houses sold that are affordable on a median teacher's salary: 35.8%*	*USDA 2016,* *Food Access Research Maps* *2014-2018 US Census ACS* *2017 MD Department of Planning from Maryland SHIP* *2014-2018 US Census Data, American Community Survey 5 year estimates,* *2016 Maryland Department of Planning from Maryland SHIP* *2018 Charles County Health Needs Assessment*

	Access to Care:
	
	• *75.37% of Charles County residents travel outside of the county for medical care at some point.*
	
	• *% Mothers who received prenatal care 1st trimester; 62.2%*
	  ○ *White/NH: 68.0%*
	  ○ *Black: 60.8%*
	  ○ *Hispanic: 45.5%*
	  ○ *Asian/Pacific Islander: 68.9%*
	  ○ *American Indian: 60.0%*
	• *Infant Mortality Rate: 5.4 per 1000 live births*
	  ○ *White/NH: Not calculated due to small case count*
	  ○ *Black: 8.4*
	• *Number of federally designated medically underserved areas in Charles County: 6*
	  ○ *Brandywine*
	  ○ *Allens Fresh*
	  ○ *Thompkinsville*
	  ○ *Hughesville*
	  ○ *Marbury*
	  ○ *Nanjemoy*
	• *Number of physician shortage specialties in Southern Maryland: 28*
	Physician-to-population ratios in Southern Maryland below the HRSA benchmark for all types of physician
	
	Education:
	
	• *93.1% persons 25+ high school graduates*
	• *28.9% persons 25+ bachelor's degree or higher*
		2018 Maryland Vital Statistics Report
		
		2018 Maryland Vital Statistics Report
		
		HPSA MUS/MUP Designations as of October 22, 2020
		
		2007 Maryland Physician Workforce Study
		
		2011 MD workforce Study Health Resources and Services
		
		2014-2018 US Census Bureau's American Community Survey 5 year estimates

Available detail on race, ethnicity, and	***Population****: 163,257* ***Sex****:*	*2014-2018 US Census , American Community Survey 5 year estimate*

language within CBSA	• *Female 51.8%* • *Male: 48.2%* ***Race and Ethnicity:*** • *White 41.6%* • *Black 50.1%* • *American Indian and Alaska native 0.8%* • *Asian alone 3.4%* • *Native Hawaiian and Other Pacific Islanders 0.1%* • *Person reporting 2 or more races 4.0%* • *Hispanic or Latino 6.3%* • *White not Hispanic 37.2%* ***Age:*** • *Persons under 5 years 5.9%* • *Persons under 18 years 23.8%* • *Persons 65 years and over 12.9%* ***Language:*** • *Language other than English spoken at home: 7.5%*	*and 2019 1 year estimates*

Data on Physician Gaps for Charles County:

2011 Maryland Health Care Workforce Study:

2011 Maryland Health Care Commission (MHCC)'s Physician Workforce Study highlighted the physician workforce in Maryland. This study looked at the HRSA Area Health Resource File for 2009 and 2010 to determine the supply of physicians in Maryland and its regions. Charles County has been included in the Southern Maryland region with Calvert and St Mary's Counties.

As illustrated by the table below, Southern Maryland has physician to population ratios significantly below the HRSA benchmark for all types of physicians.

Table 10: Maryland Supply by Type of Physician and Region, 2009/2010

	Total	Primary Care	Medical Specialties	Surgical Specialties	All Other
Maryland physicians per 1000, residents excluded, with all adjustments					
Baltimore Metro	2.85	0.86	0.48	0.61	0.90
Eastern Shore	1.86	0.62	0.27	0.39	0.57
National Capital	2.25	0.72	0.41	0.48	0.64
Western	2.17	0.73	0.39	0.42	0.63
Southern	1.34	0.53	0.25	0.26	0.30
Total	2.44	0.77	0.42	0.52	0.74
Memo: HRSA baseline, interns excluded, with all adjustments	1.93	0.69	0.27	0.43	0.53
Percent difference from HRSA baseline					
Baltimore Metro	48%	24%	76%	41%	70%
Eastern Shore	-4%	-10%	0%	-11%	8%
National Capital	17%	4%	49%	11%	21%
Western	12%	5%	41%	-4%	19%
Southern	-31%	-24%	-8%	-40%	-43%
Total	27%	11%	54%	19%	39%

Source: Analysis of Maryland 2009/2010 license renewal database, calculations from HRSA 2008, population counts from U.S. Bureau of the Census

The Maryland physician supply ratios were adjusted to account for variation in average patient-care hours. Even with the adjustment, Southern Maryland continued to see low physician to population ratios. Southern Maryland region had a 26% total physician deficiency versus the HRSA standard. This

was the only region in Maryland to have such a significant deficiency. The Southern Maryland region also had physician supply deficiencies for primary care (19%), medical specialties (7%), surgical specialties (34%), and all other physicians (39%). Four out of the five physician supply deficiencies are greater than 10% below the HRSA standard.

Maryland Physician Supply Versus HRSA Standard, All Adjustments					
Region	**Total**	**Primary Care**	**Medical Specialties**	**Surgical Specialties**	**All Other**
Entire State	27%	11%	54%	19%	39%
Baltimore Metro	44%	21%	69%	40%	66%
Eastern Shore	4%	0%	8%	-2%	13%
National Capital	18%	4%	56%	8%	23%
Western	20%	12%	48%	3%	29%
Southern	-26%	-19%	-7%	-34%	-39%
Key: Green = >10%, Yellow = -10% to 10%, Red = <-10%					

Note: Positive percentage indicates supply in excess of HRSA Standard, and negative percent indicates a supply deficit compared to the HRSA Standard. Southern: Charles, Calvert, and St Mary's Counties

Study implications for Southern Maryland from the 2011 Maryland Physician Workforce Study include:

Residents are likely to travel out of area for care:

- Physicians in Southern Maryland provide about 67% of Medicare beneficiary's total Medicare physician care. Residents receive 14% of physician care in Mont/PG counties and 12% in out-of-state (probably DC)

Table 14: Intrastate Travel for Care, Medicare Fee-for-Service Part B Beneficiaries, 2009								
Maryland Residents, Physician Services Spending Per Capita								
	Physician Location							
Beneficiary Residence	Baltimore Metro	Eastern Shore	National Capital	Western	Southern	Out of state	Total	% of spending in own region
Baltimore Metro	$ 2,503	$ 12	$ 56	$ 23	$ 7	$ 74	$ 2,675	94%
Eastern Shore	$ 299	$ 1,712	$ 26	$ 6	$ 2	$ 318	$ 2,362	72%
National Capital	$ 159	$ 4	$ 2,335	$ 15	$ 73	$ 595	$ 3,181	73%
Western	$ 121	$ 8	$ 101	$ 1,834	$ 3	$ 224	$ 2,290	80%
Southern	$ 182	$ 4	$ 378	$ 6	$ 1,806	$ 316	$ 2,692	67%
Source: Analysis of Medicare 5% sample limited data set standard analytic files and denominator file, 2009								

- Southern Maryland physicians are as likely as physicians overall to participate in Medicaid/Medicare and to accept new patients.

Table 13: Acceptance of Medicaid and Medicare Patients, by Region				
	Medicaid		Medicare	
Region	% of practices accepting Medicaid	Of those, % accepting new Medicaid patients	% of practices accepting Medicare	Of those, % accepting new Medicare
Percent of physicians				
Baltimore Metro	80%	88%	85%	94%
Eastern Shore	89%	90%	91%	94%
National Capital	61%	85%	79%	93%
Western	80%	85%	86%	91%
Southern	86%	86%	89%	93%
Total	75%	87%	84%	94%
Percent difference from state average				
Baltimore Metro	6%	1%	2%	1%
Eastern Shore	18%	4%	8%	1%
National Capital	-19%	-2%	-6%	-1%
Western	6%	-3%	2%	-3%
Southern	15%	-1%	6%	0%
Total	0%	0%	0%	0%
Source: Maryland license renewal survey, 2009/2010				

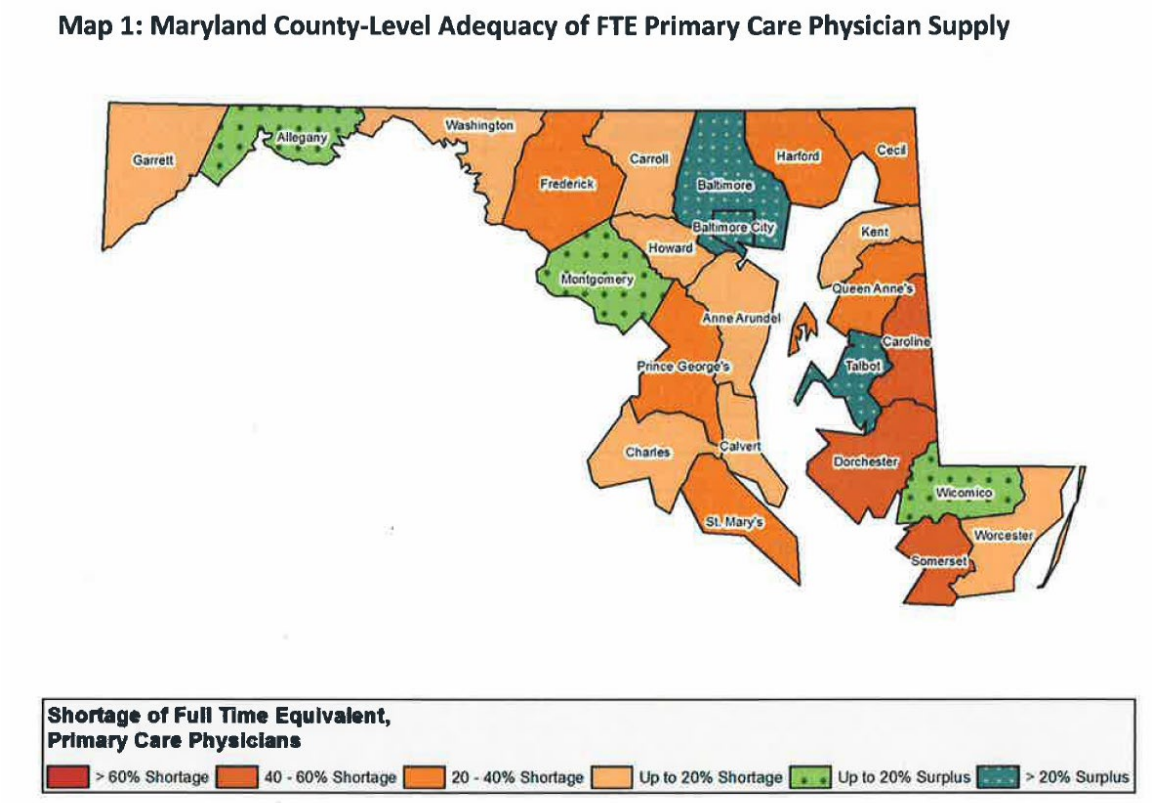
***Maryland Health Workforce Study Phase 2 Report, January 2014*:**

In January 2014, the Maryland Health Care Commission (MHCC) released a second report detailing Phase 2 of the Maryland Health Workforce Study. This study assessed health workforce distribution and the adequacy of supply. Using funding from the Robert Wood Johnson Foundation, the MHCC was able to study the Maryland healthcare workforce on the state and jurisdictional level. Phase II presents estimates of current supply and demand for health professions designated by MHCC as high priority in supporting Maryland's transition to health reform, and for which data were readily available for estimating supply and demand. These professions included primary care specialties and psychiatrists. Current supply estimates were also presented for psychologists, social workers, counselors, physician assistants, pharmacists, registered nurses, and dentists.

Demand modeling: Estimates of the current demand for healthcare providers were developed using the IHS Healthcare Demand Micro-simulation Model. The major components of this model include: 1. A population database that contains characteristics and health risk factors for a representative sample of the population in each Maryland count; 2. Equations that relate a person's characteristics to his or her demand for healthcare services by care delivery setting; and 3. Staffing patterns that convert demand for healthcare services to demand for full time equivalent (FTE) providers.

In Charles County, the primary care physician FTE demand is greater than the primary care FTE supply (7.4 vs. 6.1). There is an 18% shortfall in the primary care services supply to fulfill the current demand. Charles County falls in the “Up to 20% Shortage Area” for primary care physician supply. See Map 1 below.

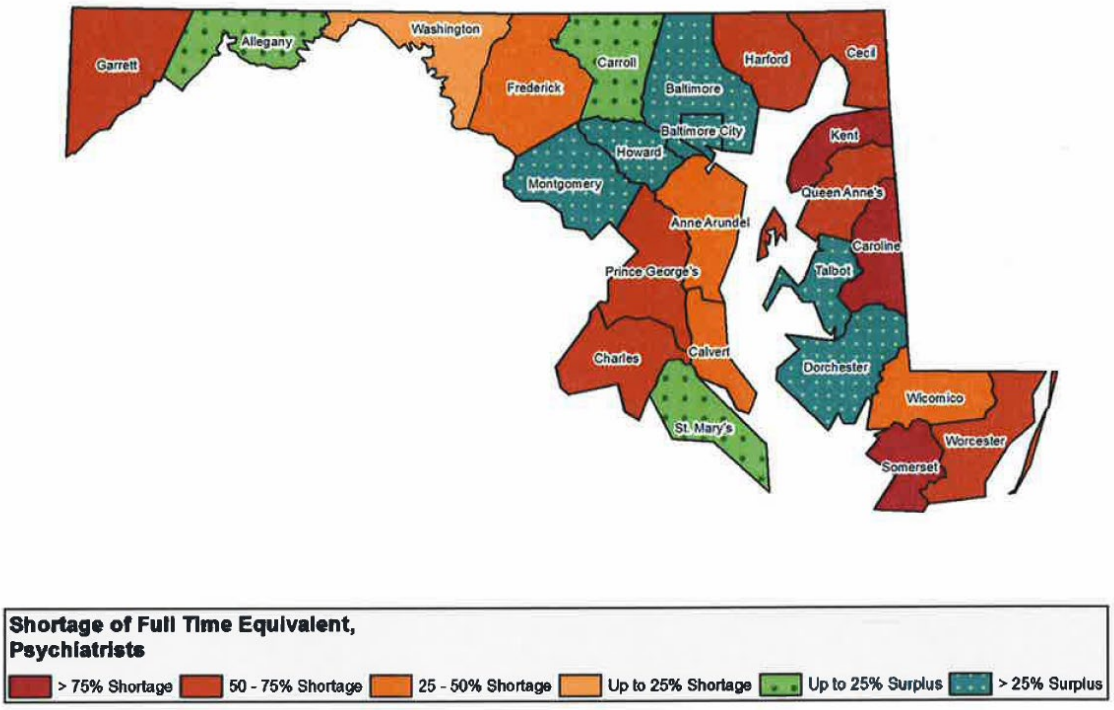
Map 1: Maryland County-Level Adequacy of FTE Primary Care Physician Supply



The FTE per 10,000 supply rates for professional counselors, social workers, and psychologists in Charles County is much lower than the rates for Maryland. The Charles County FTE rate for physician assistants is the only rate that came close to the Maryland state supply rate.

The demand for psychiatrists in Charles County is much higher than the county supply for psychiatry. Charles County has a shortage between 50-75% of full time equivalent psychiatrists. See Map 2 below.

Map 2: Maryland county-Level Adequacy of FTE Psychiatrist Supply



2011 County Physician/Nurse Specialty Data:

The US Department of Health and Human Services' Health Resources and Services Administration publishes information on the number of physicians and nurses by speciality for each state. 2011 data on the number of pediatricians, nurse practitioners, nurse midwives, general surgeons, general practitioners, OBGYN's, internal medicine physicians, and family medicine practitioners were compiled for Maryland and its jurisdictions. Specialities where Charles County is in lower half of the Maryland jurisdictions include OBGYN, nurse practitioners, and general surgeons.

***Primary Care Physicians Ratio*:**

Access to care requires not only financial coverage, but also access to providers. While high rates of specialist physicians have been shown to be associated with higher, and perhaps unnecessary utilization, sufficient availability of primary care physicians is essential for preventive and primary care, and when needed, referrals to appropriate specialty care. Using data from the Area Health Resource File and the American Medical Association, the County Health Rankings were able to provide 2012 primary care physician ratios for all United States counties. For 2012, the Charles County primary care physician ratio was 2035:1. Primary Care Physicians (PCP) is defined as the ratio of the population to total primary care physicians. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The 2012 Charles County PCP ratio is almost twice as high as the Maryland state ratio of 1131:1.

UNIVERSITY of MARYLAND MEDICAL SYSTEM Central Business Office	PAGE: 1 OF 14	POLICY NO: CBO - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 10/19/2020
SUBJECT: Financial Assistance		

KEY WORDS: Financial Assistance

OBJECTIVE/BACKGROUND:

The University of Maryland Medical System ("UMMS") is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

APPLICABILITY:

PROGRAM ELIGIBILITY

Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Specific exclusions to coverage under the Financial Assistance Program:

The Financial Assistance Program generally applies to all emergency and other medically necessary care provided by each UMMS hospital; however, the Financial Assistance Program does not apply to any of the following:

1. Services provided by healthcare providers not affiliated with UMMS hospitals (e.g., durable medical equipment, home health services).
2. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, or Workers Compensation), are not eligible for the Financial Assistance Program.
   a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.

3. Cosmetic or other non-medically necessary services.
4. Patient convenience items.
5. Patient meals and lodging.
6. Physician charges related to the date of service are excluded from this UMMS financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.
   a. A list of providers, other than the UMMS hospital itself, delivering medically necessary care in each UMMS hospital that specifies which such as providers are not covered by this policy (as well as certain such providers that are covered) may be obtained on the website of each UMMS Entity.

Patients may be ineligible for Financial Assistance for the following reasons:

1. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Medical Center due to insurance plan restrictions/limits.
2. Refusal to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.
3. Refusal to divulge information pertaining to a pending legal liability claim.
4. Foreign-nationals traveling to the United States seeking elective, non-emergent medical care.

Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

Unless they meet Presumptive Financial Assistance Eligibility criteria, patients shall be required to submit a complete Financial Assistance Application (with all required information and documentation) and determined to be eligible for financial assistance in order to obtain financial assistance. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application before receiving non-emergency medical care unless they meet Presumptive Financial Assistance Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator and recommendations shall be made to Senior Leadership. 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.

Those with income up to 200% of Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care ("MD DHMH") are eligible for free care. Those between 200% to 300% of MD DHMH are eligible for discounts on a sliding scale, as set forth in Attachment A.

Presumptive Financial Assistance

Patients may also be considered for 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. There is adequate information provided by the patient or through other sources, which 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, UMMS reserves the right to use outside agencies or information 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% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage
b. Specified Low Income Medicare (SLMB) coverage
c. Primary Adult Care (PAC) coverage
d. Homelessness
e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
f. Medical Assistance spend down amounts
g. Eligibility for other state or local assistance programs
h. Patient is deceased with no known estate
i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
j. Non-US Citizens deemed non-compliant
k. Non-Eligible Medical Assistance services for Medical Assistance eligible patients
l. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)

m. Bankruptcy, by law, as mandated by the federal courts
n. St. Clare Outreach Program eligible patients
o. UMSJMC Maternity Program eligible patients
p. UMSJMC Hernia Program eligible patients

Specific services or criteria that are ineligible for Presumptive Financial Assistance include:

a. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

POLICY:

This policy was approved by the UMMS Executive Compliance Committee (ECC) Board on October 19, 2020. This policy applies to the following hospital facilities of the University of Maryland Medical System ("UMMS hospitals"):

- University of Maryland Medical Center (UMMC)
- University of Maryland Medical Center Midtown Campus (MTC)
- University of Maryland Rehabilitation & Orthopaedic Institute (UMROI)
- University of Maryland St. Joseph Medical Center (UMSJMC)
- University of Maryland Baltimore Washington Medical Center (UMBWMC)
- University of Maryland Shore Medical Center at Chestertown (UMSMCC)
- University of Maryland Shore Medical Center at Dorchester (UMSMCD)
- University of Maryland Shore Medical Center at Easton (UMSME)
- University of Maryland Charles Regional Medical Center (UMCRMC)
- University of Maryland Upper Chesapeake Health (UCHS)
- University of Maryland Capital Region Health (UM Capital)

It is the policy of the UMMS hospitals to provide Financial Assistance based on indigence or high medical expenses 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 should be made, the criteria for eligibility, and the steps for processing applications.

UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any) and admissions areas, as well as the Billing Office. Notice of availability will also be sent to the patient with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge, and it (along with this policy and the Financial Assistance Application) will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas. This policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency.

UMMS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, applications to the Financial Clearance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

This policy was adopted for University of Maryland St. Joseph Medical Center (UMSJMC) effective June 1, 2013.

This policy was adopted for University of Maryland Medical Center Midtown Campus (MTC) effective September 22, 2014.

This policy was adopted for University of Maryland Baltimore Washington Medical Center (UMBWMC) effective July 1, 2016.

This policy was adopted for University of Maryland Shore Medical Center at Chestertown (UMSMCC) effective September 1, 2017.

This policy was adopted for University of Maryland Shore Medical Center at Dorchester (UMSMCD) effective September 1, 2017.

This policy was adopted for University of Maryland Shore Medical Center at Easton (UMSMCE) effective September 1, 2017.

This policy was adopted for University of Maryland Charles Regional Medical Center (UMCRMC) effective December 2, 2018.

This policy was adopted for University of Maryland Upper Chesapeake Health (UCHS) effective July 1, 2019

This policy was adopted for University of Maryland Capital Region Health (UM Capital) effective September 18, 2019

PROCEDURE:

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.

2. When possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial

assistance. Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both.

d. If a patient submits a Financial Assistance Application without the information or documentation required for a final determination of eligibility, a written request for the missing information or documentation will be sent to the patient. This written request will also contain the contact information (including telephone number and physical location) of the office or department that can provide information about the Financial Assistance Program and assistance with the application process.
e. The patient will have thirty (30) days from the date this written request is provided to submit the required information or documentation to be considered for eligibility. If no data is received within the 30 days, a letter will be sent notifying the patient that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case by submitting the missing information or documentation 30 days after the date of the written request for missing information/documentation.
f. For any episode of care, the Financial Assistance Application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.
g. Individual notice regarding the hospital's Financial Assistance Policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

3. There will be one application process for UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital. The patient is required to provide a completed Financial Assistance Application orally or in writing. In addition, the following may be required:
   a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...
   b. A copy of their most recent pay stubs (if employed) or other evidence of income.
   c. A Medical Assistance Notice of Determination (if applicable).
   d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.

If a patient submits both a copy of their most recent Federal Income Tax Return and a copy of their most recent pay stubs (or other evidence of income), and only one of the two documents indicates eligibility for financial assistance, the most recent document will dictate eligibility. Oral submission of needed information will be accepted, where appropriate.

4. In addition to qualifying for Financial Assistance based on income, a patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses based on the Financial Hardship criteria discussed below. 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 UMMS guidelines.
    a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.
        i. If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
        ii. If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
            1. A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.

5. Once a patient is approved for Financial Assistance, Financial Assistance coverage is effective for the month of determination and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Assistance eligibility period further into the past or the future on a case-by-case basis. If additional healthcare services are provided beyond the eligibility period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

6. Account balances that have not been paid may be transferred to Bad Debt (deemed uncompensated care) and referred to an outside collection agency or to the UMMS hospital's attorney for legal and/or collection activity. Collection activities taken on behalf of the hospital by a collection agency or the hospital's attorney may include the following Extraordinary Collection Actions (ECAs):
    a. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.
    b. Commencing a civil action against the individual.

c. Placing a lien on an individual's property. A lien will be placed by the Court on primary residences within Baltimore City. The hospital will not pursue foreclosure of a primary residence but my maintain its position as a secured creditor if a property is otherwise foreclosed upon.
d. Attaching or seizing an individual's bank account or any other personal property.
e. Garnishing an individual's wage.

7. ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 120 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 30 days prior to commencement of the ECA. This written notice will indicate that financial assistance is available for eligible individuals, identify the ECAs that the hospital (or its collection agency, attorney, or other authorized party) intends to obtain payment for the care, and state a deadline after which such ECAs may be initiated. It will also include a Patient Billing and Financial Assistance Information Sheet. In addition, the hospital will make reasonable efforts to orally communicate the availability of financial assistance to the patient and tell the patient how he or she may obtain assistance with the application process. A presumptive eligibility review will occur prior to any ECA being taken. Finally, no ECA will be initiated until approval has been obtained from the CBO Revenue Cycle. UMMS will not engage in the following ECAs:
    a. Selling debt to another party.

    b. Charge interest on bills incurred by patients before a court judgement is obtained

8. If prior to receiving a service, a patient is determined to be ineligible for financial assistance for that service, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

9. A letter of final determination will be submitted to each patient who has formally submitted an application. The letter will notify the patient in writing of the eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for the determination. If the patient is determined to be eligible for assistance other than free care, the patient will also be provided with a billing statement that indicates the amount the patient owes for the care after financial assistance is applied.

10. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds will be issued back to the patient for credit balances, due to patient payments, resulting from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.

11. If a patient is determined to be eligible for financial assistance, the hospital (and/or its collection agency or attorney) will take all reasonably available measures to reverse any ECAs taken against the patient to obtain payment for care rendered during the financial assistance eligibility window. Such reasonably available measures will include measures to vacate any judgment against the patient, lift levies or liens on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

12. Patients who have access to other medical coverage (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.

13. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.

14. The Financial Assistance Program will accept all other UMMS hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.

15. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.

16. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.

a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

Financial Hardship

The amount of uninsured medical costs incurred at either, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital will be considered in determining a patient's eligibility for the Financial Assistance Program. The following guidelines are outlined as a separate, supplemental determination of Financial Assistance, known as Financial Hardship. Financial Hardship will be offered to all patients who apply for Financial Assistance and are determined to be eligible.

Medical Financial Hardship Assistance is available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy, but for whom:

1. Their medical debt incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship.

For the patients who are eligible for both, the Reduced Cost Care under the primary Financial Assistance criteria and also under the Financial Hardship Assistance criteria, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital will grant the reduction in charges, which is balance owed that is greater than 25% of the total annual household income.

Financial Hardship is defined as facility charges incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.

Medical Debt is defined as out of pocket expenses for the facility charges incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and/or UM Capital for medically necessary treatment.

Once a patient is approved for Financial Hardship Assistance, coverage will be effective for the month of the first qualifying date of service and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Hardship eligibility period further into the past or the future on a case-by-case basis according to their spell of illness/episode of care. It will cover the patient and the eligible family members living in the household for the approved reduced cost and eligibility period for medically necessary care.

All other eligibility, ineligibility, and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance criteria, unless otherwise stated above.

Appeals

- Patients whose financial assistance applications are denied have the option to appeal the decision.
- Appeals can be initiated verbally or written.
- Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
- Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.
- If the first level of appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
- The escalation can progress up to the Chief Financial Officer who will render a final decision.
- A letter of final determination will be submitted to each patient who has formally submitted an appeal.

ATTACHMENTS:

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

2020 Federal Poverty Limits (FPL) and Maryland Dept of Health & Mental Hygiene (DHMH) Annual Income Eligibility Limit Guidelines			UMMS 100% Charity	UMMS 90% Charity	UMMS 80% Charity	UMMS 70% Charity	UMMS 60% Charity	UMMS 50% Charity	UMMS 40% Charity	UMMS 30% Charity	UMMS 20% Charity	UMMS 10% Charity
			Equals Up to 200% of MD DHMH Annual Income limits	Equals Up to 210% of MD DHMH Annual Income limits	Equals Up to 220% of MD DHMH Annual Income limits	Equals Up to 230% of MD DHMH Annual Income limits	Equals Up to 240% of MD DHMH Annual Income limits	Equals Up to 250% of MD DHMH Annual Income limits	Equals Up to 260% of MD DHMH Annual Income limits	Equals Up to 270% of MD DHMH Annual Income limits	Equals Up to 280% of MD DHMH Annual Income limits	Equals Up to 290% of MD DHMH Annual Income limits
House-hold (HH) Size	2020 FPL Annual Income Elig Limits	2020 MD DHMH Annual Income Elig Limits	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:	If your total annual HH income level is at or below:
Size	Up to	Up to	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max	Up to Max
1	12,490	**$17,620**	$35,240	$37,002	$38,764	$40,526	$42,288	$44,050	$45,812	$47,574	$49,336	$52,859
2	16,910	**$23,797**	$47,594	$49,974	$52,353	$54,733	$57,113	$59,493	$61,872	$64,252	$66,632	$71,390
3	21,330	**$29,974**	$59,948	$62,945	$65,943	$68,940	$71,938	$74,935	$77,932	$80,930	$83,927	$89,921
4	25,750	**$36,167**	$72,334	$75,951	$79,567	$83,184	$86,801	$90,418	$94,034	$97,651	$101,268	$108,500
5	30,170	**$42,344**	$84,688	$88,922	$93,157	$97,391	$101,626	$105,860	$110,094	$114,329	$118,563	$127,031
6	34,590	**$48,521**	$97,042	$101,894	$106,746	$111,598	$116,450	$121,303	$126,155	$131,007	$135,859	$145,562

*All discounts stated above shall be applied to the amount the patient is personally responsible for paying after insurance reimbursements.
*Amounts billed to patients who qualify for Reduced-Cost of Care on a sliding scale (or for Financial Hardship Assistance) will be less than the amounts generally billed to those with insurance (AGB), which in Maryland is the charge established by the Health Services Cost Review Commission (HSCRC). UMMS determines AGB by using the amount Medicare would allow for the care (including the amount the beneficiary would be personally responsible for paying, which is the HSCRC amount; this is known as the "prospective Medicare method".

Effective 7/1/20

POLICY OWNER:

UMMS CBO

APPROVED:

Executive Compliance Committee Approved Initial Policy: 09/18/19
Executive Compliance Committee Approved Revisions: 10/19/2020

Contact Information

If you feel your rights have been violated in any way, please contact Performance Improvement immediately by calling 301.609.4715.

Contact & Phone Numbers:
For customer Service in Billing, the hours of operation are 8:30am—4pm, Monday through Friday. We can be reached at 301.609.4400

Patient Financial Services:
301.609.4400

Maryland Medical Assistance:
800.284.4510

Department of Labor, Licensing and Regulation:
301.645.8712

Notice of Nondiscrimination

University of Maryland Charles Regional Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.301.609.4266 (TTY: 1.800.201.7165).

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1.301.609.4266 (TTY: 1.800.201.7165)

UNIVERSITY of MARYLAND
CHARLES REGIONAL
MEDICAL CENTER

301.609.4000
5 Garrett Avenue, La Plata, MD 20646
UMCharlesRegional.org

Thank you for allowing us to take care of you

Patient Information

UNIVERSITY of MARYLAND
CHARLES REGIONAL
MEDICAL CENTER

Patient's Rights & Obligations

You have the right to:

1. Receive care and treatment at this hospital despite the ability to pay.
2. Receive consideration and respect from the staff during every phase of your care.
3. Be treated with dignity, respecting your spiritual, cultural, and personal values and beliefs.
4. Have respect for your privacy and for the confidentiality of information about you and your medical condition.
5. Be involved in decisions affecting your health care and well-being.
6. Know the name of the physician responsible for directing and coordinating your care as well as the names of other hospital caregivers.
7. Be informed about procedures and treatment and your option to refuse treatment as permitted by law.
8. Have questions answered about your condition and course of treatment.
9. Expect the health care professionals will accept and act upon your reports of pain and will provide education and resources available relating to pain management.
10. Be informed of available resources for resolving disputes, grievances, and conflicts.
11. Receive a written bill stating the Medical Center's charges.

You have the responsibility to:

1. Provide, to the best of your ability, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
2. Ask questions and request clear explanations of your care treatments and service in order to make informed decisions.
3. Follow the care, treatment, and service plan developed.
4. Be responsible for the outcomes if you do not follow the care, treatment, and service plan provided to you.
5. Provide a copy of your advance directives power of attorney or domestic partnership affidavit, if you have created such documents, to those responsible for your care while you are in the hospital.
6. Know and follow hospital rules and regulations, showing respect and consideration for other patients and individuals providing your health care.
7. Meet the financial commitments made with UM Charles Regional.
8. Inform UM Charles Regional as soon as possible if you believe that any of your rights have been or may be violated. You may do this at any time by calling the Office of the President at 301.609.4265 or Performance Improvement at 301.609.4715.

Physician Billing

Hospital billing can be confusing. We hope that this brochure answers some of the questions that you may have regarding billing.

You will receive multiple bills for your visit to the emergency room, as well as multiple bills for outpatient/inpatient services.

UM Charles Regional Medical Center will submit a bill to you or your insurance company for our facility charges and/or the "technical" portion of the services. Your physician, surgeon, anesthesiologist, pathologist, radiologist, cardiologist, and Emergency Department physician will bill you separately for their professional services. Please contact them directly with your billing questions.

Emergency Medical Associates
240.686.2310

University of Maryland Faculty Physicians, Inc.
888.243.8890

Team Health / Base Pointe Billing Center
Anesthesia
877.307.4554

ABEO (Pathology Billing)
240.566.1603

UM Charles Regional Medical Center understands that patients may be faced with a difficult financial situation when they incur medical bills that are not covered by insurance. We encourage every patient and family to pursue all available programs that may be offered through the local Department of Social Services.

Financial Assistance

UM Charles Regional Medical Center can offer financial assistance to our patients who are denied state assistance. Please speak with a Customer Service Representative to determine if you may be eligible for either full or discounted services under this program. You may also contact a Customer Service Representative at 301.609.4400 for further information. Our financial aid programs will only apply to your hospital bills, and again, we encourage you to contact the Department of Social Services for assistance in paying your medical bills.