
# Community Benefit Narrative Report

## *Fiscal Year 2012*

**Community Benefit Narrative Report**
**Maryland General Hospital**
**Fiscal Year 2012**

## I. General Hospital Demographics and Characteristics

**Table 1**

| | |
|---|---|
| **Bed Designation (FY12) Licensed Beds** | 164 |
| **Inpatient Admissions**<br>Excludes Newborns | Total MGH Discharges: 8,880<br>PSA MGH Discharges: 5,616 |
| **Primary Service Area Zip Codes (PSA)** | 21201<br>21215<br>21216<br>21217<br>21218<br>21223<br>21229 |
| **All other Maryland Hospitals Sharing Service Area** | Bon Secours Hospital<br>Good Samaritan Hospital<br>Harbor Hospital<br>Johns Hopkins Hospital<br>Johns Hopkins Bayview<br>Maryland General Hospital<br>Mercy Medical Center<br>Union Memorial Hospital<br>University of MD Medical Center<br>St. Agnes Hospital |
| **Total MGH Medicaid Patients**<br>**Total MGH Uninsured Patients**<br>Excludes Newborns | 44.5%<br>6.2% |

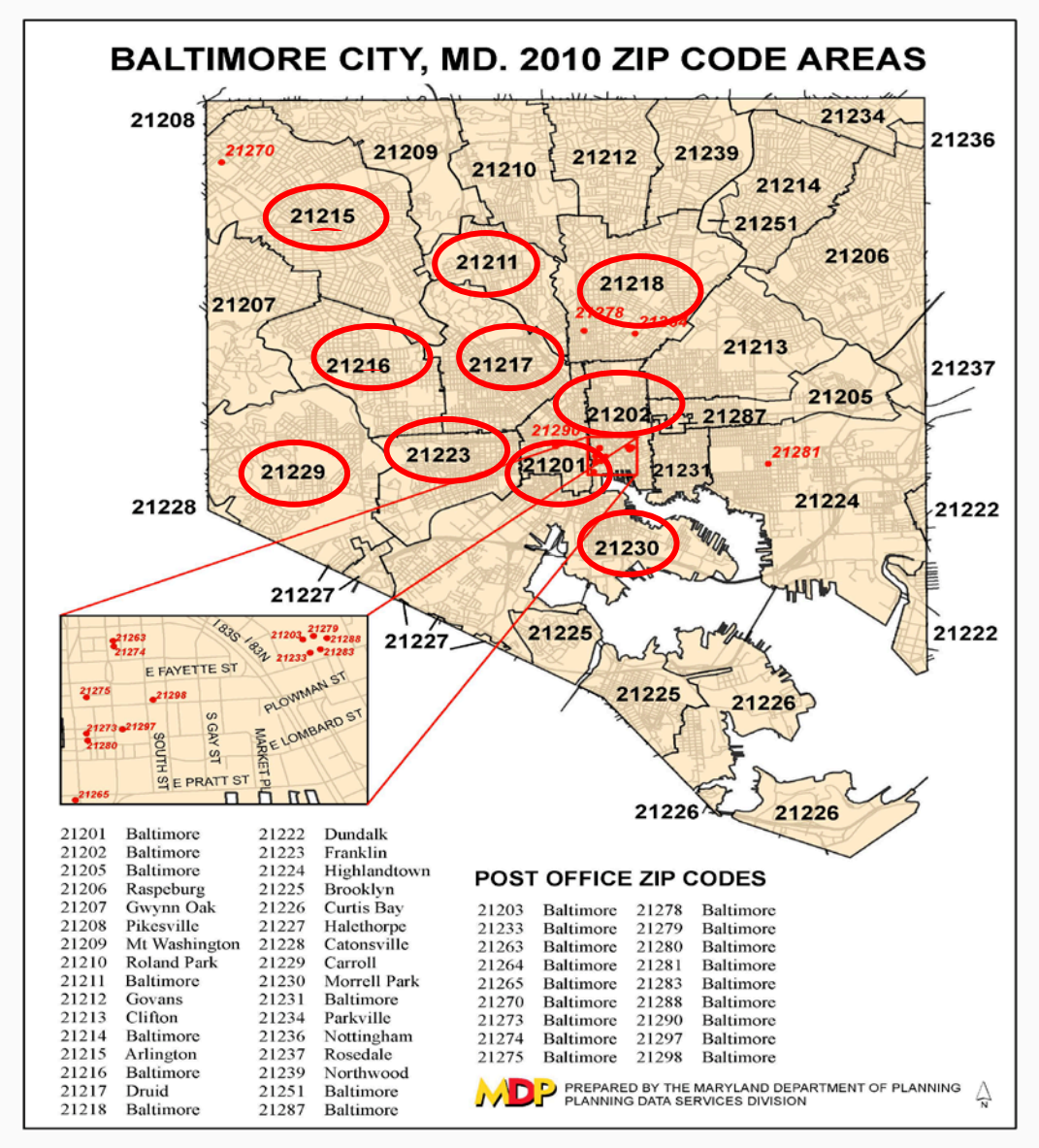
2.a.

Maryland General Hospital (MGH), part of the University of Maryland Medical System (UMMS), is a non-profit, 164-bed urban community teaching hospital located in West Baltimore with a network of services providing care to approximately 152,000 patients each year. Founded in 1881, Maryland General is located in West Baltimore and provides inpatient and outpatient care to over 152,000 patients each year. In FY 2012, the hospital had 8,880 inpatient discharges (excluding newborns), 9,468 (including newborns) and 111,949 outpatient visits, including 31,313 visits to the emergency room. Maryland General Hospital was one of the first hospitals in Baltimore to establish an outreach program offering education, prevention and screening, serving individuals who face significant barriers in obtaining high quality and affordable care. Eighty-eight percent (88%) of all admissions to Maryland General Hospital originate from Baltimore City, with 63% originating from the primary service area of West Baltimore. Maryland General Hospital serves an urban population with one of the highest percentage of Medicaid patients of all hospitals in Maryland. Fifty-one percent (51%) of Maryland General Hospital's patients use Medicaid or are uninsured.

For purposes of community benefits programming and this report, the Community Benefit Service Area (CBSA) of MGH is now defined following the completion of our Community Health Needs Assessment in FY'12 using the following Baltimore City 10 zip codes:

21201 21202
21211 21215
21216 21217
21218 21223
21229 21230

(See Map 1). The following tables outline specifics for the CBSA.




2.b.

| Pop Facts: Demographic Snapshot (Part 1) | Targeted ZIP List | |
|---|---|---|
| **Population** | | |
| 2017 Projection | 325,113 | |
| 2012 Estimate | 335,167 | |
| 2000 Census | 364,099 | |
| 1990 Census | 417,097 | |
| | | |
| Growth 2012-2017 | -3.00% | |
| Growth 2000-2012 | -7.95% | |
| Growth 1990-2000 | -12.71% | |
| | | |

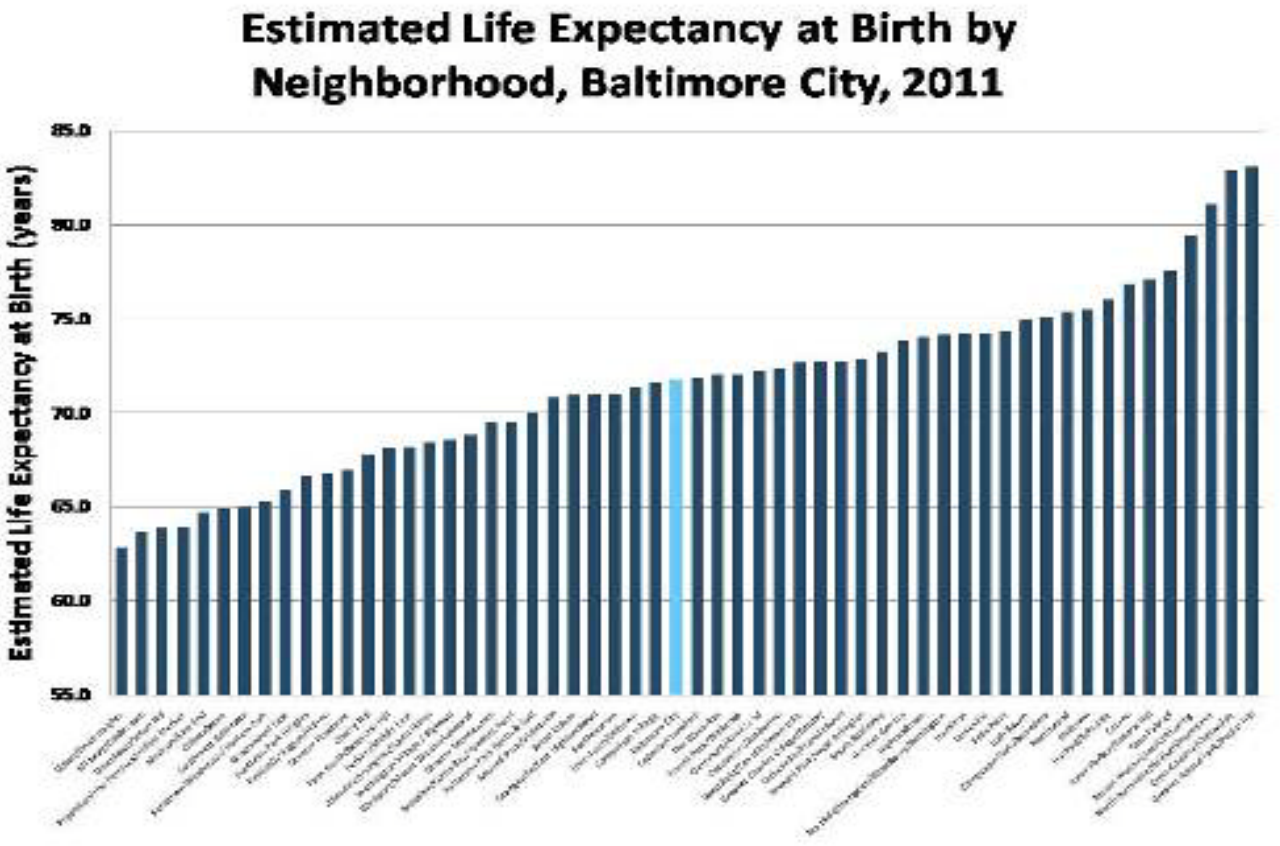
| 2012 Estimated Population by Single Race Classification | 335,167 | |
|---|---|---|
| White Alone | 86,249 | 25.73% |
| Black or African American Alone | 227,539 | 67.89% |
| American Indian and Alaska Native Alone | 994 | 0.30% |
| Asian Alone | 9,953 | 2.97% |
| Native Hawaiian and Other Pacific Islander Alone | 140 | 0.04% |
| Some Other Race Alone | 3,527 | 1.05% |
| Two or More Races | 6,765 | 2.02% |
| | | |
| 2012 Estimated Population Hispanic or Latino by Origin | 335,167 | |
| Not Hispanic or Latino | 325,640 | 97.16% |
| Hispanic or Latino | 9,527 | 2.84% |
| Hispanic or Latino by Origin | 9,527 | |
| Mexican | 2,343 | 24.59% |
| Puerto Rican | 1,431 | 15.02% |
| Cuban | 589 | 6.18% |
| All Other Hispanic or Latino | 5,164 | 54.20% |
| | | |
| 2012 Estimated Population by Sex | 335,167 | |
| Male | 158,132 | 47.18% |
| Female | 177,035 | 52.82% |
| | | |
| 2012 Estimated Population by Age | 335,167 | |
| Age 0 to 4 | 22,829 | 6.81% |
| Age 5 to 9 | 20,090 | 5.99% |
| Age 10 to 14 | 17,033 | 5.08% |
| Age 15 to 17 | 13,324 | 3.98% |
| Age 18 to 20 | 16,231 | 4.84% |
| Age 21 to 24 | 20,445 | 6.10% |
| Age 25 to 34 | 61,804 | 18.44% |
| Age 35 to 44 | 42,332 | 12.63% |
| Age 45 to 54 | 44,831 | 13.38% |
| Age 55 to 64 | 35,069 | 10.46% |
| Age 65 to 74 | 21,629 | 6.45% |
| Age 75 to 84 | 14,228 | 4.25% |
| Age 85 and over | 5,322 | 1.59% |
| | | |
| Age 16 and over | 270,665 | 80.76% |
| Age 18 and over | 261,891 | 78.14% |
| Age 21 and over | 245,660 | 73.29% |

| | | |
|---|---|---|
| Age 65 and over | 41,179 | 12.29% |
| **2012 Estimated Median Age** | **34.32** | |
| | | |
| **2012 Estimated Average Age** | **37.02** | |
| | | |

## Pop Facts:
## Demographic Snapshot (Part 2)

| Pop Facts: Demographic Snapshot (Part 2) | ZIP List | |
|---|---|---|
| **Households** | | |
| 2017 Projection | 134,677 | |
| 2012 Estimate | 137,336 | |
| 2000 Census | 143,615 | |
| 1990 Census | 153,458 | |
| | | |
| Growth 2012-2017 | -1.94% | |
| Growth 2000-2012 | -4.37% | |
| Growth 1990-2000 | -6.41% | |
| | | |
| **2012 Estimated Households by Household Income** | **137,336** | |
| Less than $15,000 | 34,549 | 25.16% |
| $15,000 to $24,999 | 18,835 | 13.71% |
| $25,000 to $34,999 | 16,962 | 12.35% |
| $35,000 to $49,999 | 20,654 | 15.04% |
| $50,000 to $74,999 | 21,517 | 15.67% |
| $75,000 to $99,999 | 11,299 | 8.23% |
| $100,000 to $124,999 | 6,164 | 4.49% |
| $125,000 to $149,999 | 2,807 | 2.04% |
| $150,000 to $199,999 | 2,055 | 1.50% |
| $200,000 to $499,999 | 2,059 | 1.50% |
| $500,000 or more | 435 | 0.32% |
| **2012 Estimated Average Household Income** | **$48,129** | |
| | | |
| **2012 Estimated Median Household Income** | **$34,011** | |
| | | |
| **2012 Estimated Per Capita Income** | **$20,134** | |
| | | |

Source: Nielsen Company, 2012

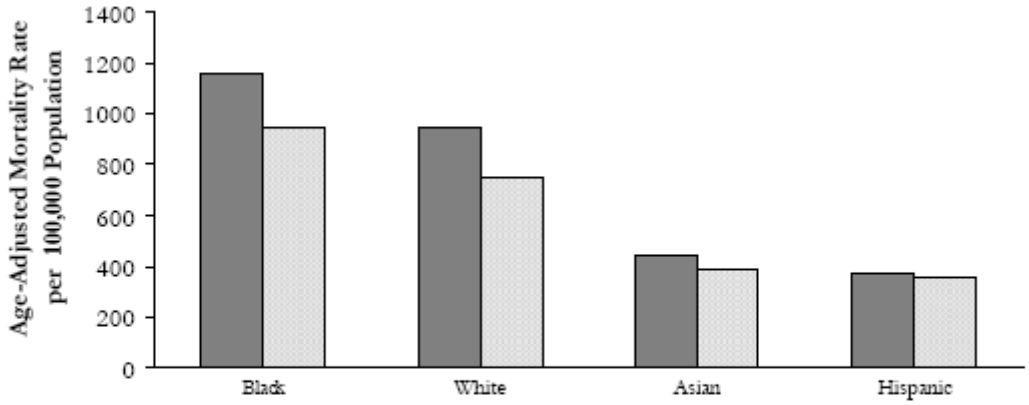



Life Expectancy within Baltimore City
Source: Baltimore City Health Department, Neighborhood Profiles, Retrieved from:

http://www.baltimorehealth.org/neighborhood.html

Mortality Rates by County (Baltimore City)

**All Cause: Age-Adjusted Mortality Rates by Race, Baltimore City and Maryland, 2006**



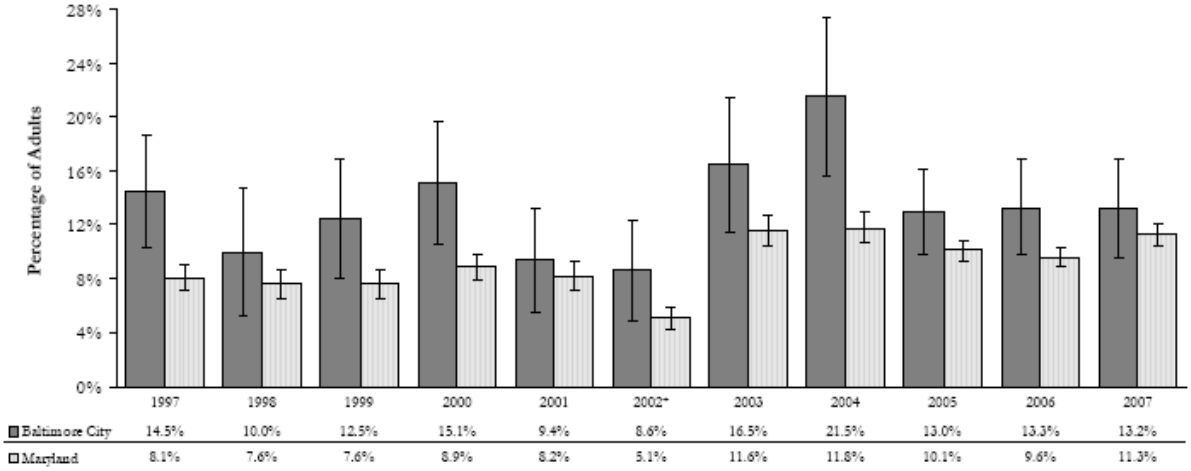

| | Black | White | Asian | Hispanic |
|---|---|---|---|---|
| Baltimore City | 1164.9 | 949.6 | 443.8 | 372.0 |
| Maryland | 944.9 | 754.2 | 392.6 | 353.7 |

*Source: Maryland Department of Health and Mental Hygiene, Vital Statistics Administration - 2006 Maryland Vital Statistics Annual Report; and Baltimore City Health Department analysis of data from the 2006 Maryland Vital Statistics Profile and the 2006 Baltimore City Vital Statistics Profile.*

Access to healthy food, quality of housing, and transportation by County (Baltimore City) 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)

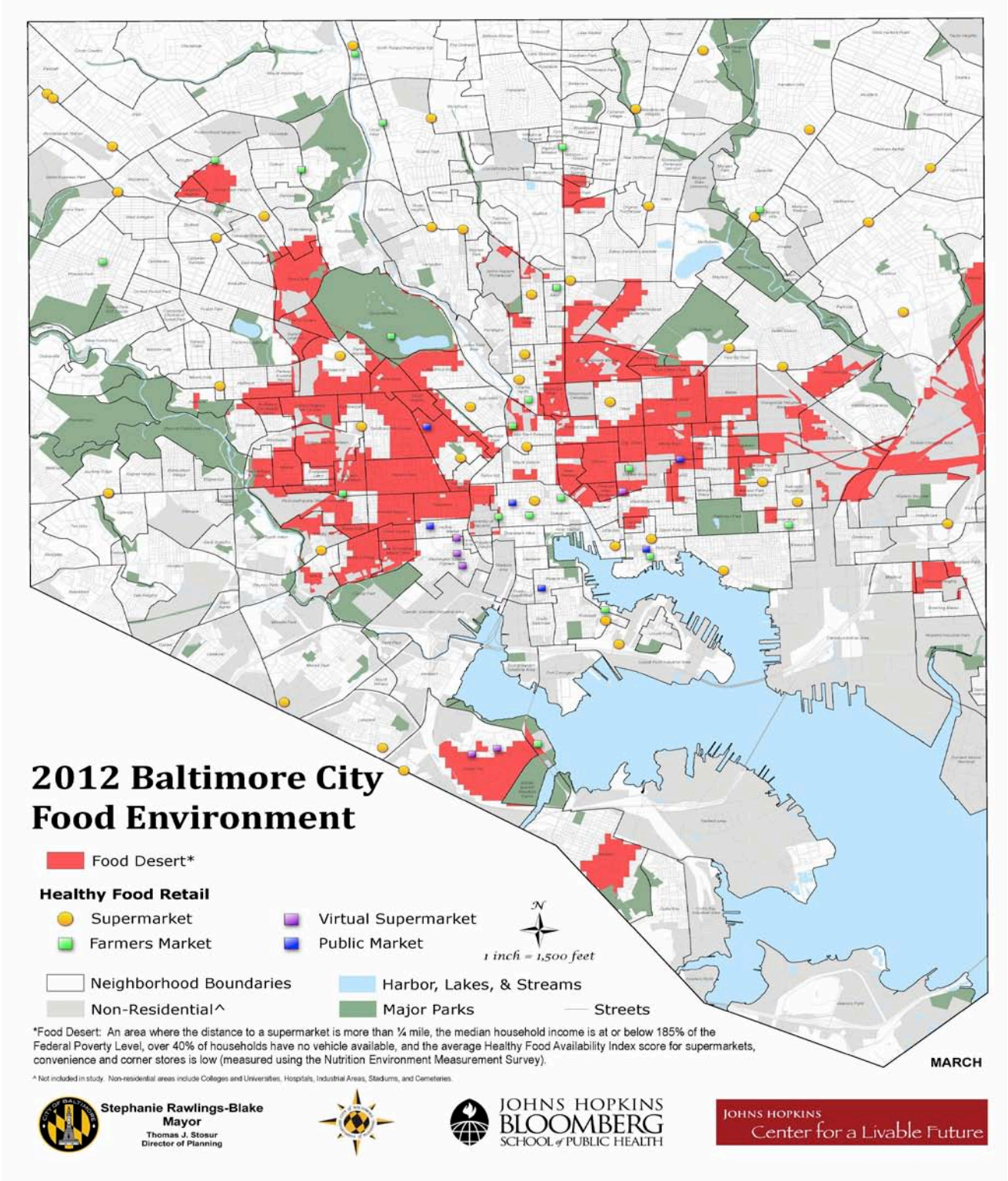
## Access to Medical Care

**Percentage of Adults Who Could Not Afford Medical Care, Baltimore City and Maryland 1997-2007**




| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002* | 2003 | 2004 | 2005 | 2006 | 2007 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Baltimore City | 14.5% | 10.0% | 12.5% | 15.1% | 9.4% | 8.6% | 16.5% | 21.5% | 13.0% | 13.3% | 13.2% |
| Maryland | 8.1% | 7.6% | 7.6% | 8.9% | 8.2% | 5.1% | 11.6% | 11.8% | 10.1% | 9.6% | 11.3% |

*Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS). See technical notes for a description of the BRFSS data and methodology (error bars represent a 95% confidence interval for the estimate). Question: "Was there a time in the past 12 months when you could not afford to see a doctor?" *2002 survey asked a slightly different question of respondents: "Was there a time in the past year when you needed medical care, but could not get it?"*


2012 Baltimore City
Food Environment
Food Desert*
Healthy Food Retail
Supermarket
Farmers Market
Virtual Supermarket
Public Market
N
1 inch = 1,500 feet
Neighborhood Boundaries
Non-Residential^
Harbor, Lakes, & Streams
Major Parks
Streets
*Food Desert: An area where the distance to a supermarket is more than ¼ mile, the median household income is at or below 185% of the Federal Poverty Level, over 40% of households have no vehicle available, and the average Healthy Food Availability Index score for supermarkets, convenience and corner stores is low (measured using the Nutrition Environment Measurement Survey).
^ Not included in study. Non-residential areas include Colleges and Universities, Hospitals, Industrial Areas, Stadiums, and Cemeteries.
MARCH
Stephanie Rawlings-Blake
Mayor
Thomas J. Stosur
Director of Planning
JOHNS HOPKINS
BLOOMBERG
SCHOOL of PUBLIC HEALTH
JOHNS HOPKINS
Center for a Livable Future

## II. Community Health Needs Assessment

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following:

(1) A description of the process used to conduct the assessment;
(2) With whom the hospital has worked;
(3) How the hospital took into account input from community members and public health experts;
(4) A description of the community served; and
(5) A description of the health needs identified through the assessment process.

Examples of sources of data available to develop a community health needs assessment include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health improvement plan (http://dhmh.maryland.gov/ship/ );
(2) Local Health Departments;
(3) County Health Rankings ( http://www.countyhealthrankings.org);
(4) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(5) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(6) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(7) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(8) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(9) For baseline information, a Community health needs assessment developed by the state or local health department, or a collaborative community health needs assessment involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(10) Survey of community residents
(11) Use of data or statistics compiled by county, state, or federal governments; and
(12) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers. .

1. **Identification of Community Health Needs:**
   Describe in detail the process(s) your hospital used for identifying the health needs in your community and the resource(s) used.

***Approach and Resources***

In fiscal year 2012 Maryland General partnered with other city-based hospitals within the University of Maryland Medical System (University of Maryland Medical Center, Kernan Orthopaedic and Rehabilitation Hospital, and Mt. Washington Pediatric Hospital), to conduct a full-scale needs assessment. The following resources were utilized to complete the assessment:

- UMMS City-Based Hospitals Community Needs Survey
- Community meetings with persons representing the broad interests of the community
- National Healthcare Disparities Report (Agency for Healthcare Research and Quality)
- Maryland State Health Improvement Process (SHIP) Plan
- Healthy Baltimore 2015 (Baltimore City Health Department)
- 2012 County Health Outcomes & Roadmaps

**2. In seeking information about community health needs, what organizations or individuals outside the hospital were consulted?**

**UMMS City-based Hospitals Community Needs Survey**

The survey was designed to obtain feedback from the community about health-related concerns. It was administered as follows:

Paper Survey

Paper surveys were administered during community events, including the UMMS- sponsored *Take a Loved One to the Doctor Day* and *Spring Into Good Health* fairs, *B'More Health Expo*, and other local community health fairs, and in MGH ambulatory care practices. The survey was also included in the Spring issue of *HealthBeat*, Maryland General Hospital's community newsletter, which is mailed to 40,000 households in our primary service area. A sample of the survey tool is an attachment to this report.

Intranet Survey

An electronic form of the survey was administered through a link that was prominently placed on websites of the participating hospitals.

**Community Meetings with Persons Representing the Broad Interests of the Community**

Representatives from Maryland General Hospital held meetings and attended community events to discuss health-related needs and priorities of our common communities and opportunities for working together. These sessions included the following:

Meetings with religious and school leaders from churches and schools in Maryland General's service area: Furman Templeton Elementary, Samuel F.B. Morse Elementary, Booker T. Washington Middle, Eutaw-Marshburn Elementary, Mt. Royal Elementary, Franklin Square Elementary/Middle
Pennsylvania Avenue AME Zion, Sharp Street United Methodist, Macedonia Baptist, Trinity Baptist, St. James Episcopal, Douglas Memorial Community, Union Baptist, Enon Baptist, Bethel AME, Madison Avenue Presbyterian, Providence Baptist

Attending the Baltimore City Health Department's *Your Community…Your Health* meetings. Representatives from city-based hospitals within the University of Maryland Medical System (University of Maryland Medical Center, Kernan, Mt. Washington Pediatric, Maryland General) attended meetings conducted in our primary service areas

**National Healthcare Disparities Report**

In 1999, Congress directed the Agency for Healthcare Research and Quality (AHRQ) to produce an annual report that tracks "prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations." Titled the *National Healthcare Disparities Report* (NHDR), this report examines disparities in health care among designated priority populations. The referenced priority populations consist of groups with unique health care needs or issues that require special focus, such as racial and ethnic minorities, low-income populations, and people with special health care needs.

**Maryland State Health Improvement Process (SHIP) Plan**

The goal of the State Health Improvement Process (SHIP) is to provide a framework for accountability, local action, and public engagement to improve the health status of Marylanders. The SHIP includes 39 measures in 6 vision areas (healthy babies, healthy social environments, safe physical environments, infectious disease, chronic disease, healthcare access) that represent what it means for Maryland to be healthy.

**Healthy Baltimore 2015**

In Spring 2009, the Baltimore City Health Department conducted a community health survey. As stated in the *Summary Results Report* released by the Department, "the main goals of the survey were to: assess health needs of city residents, identify gaps in access to health services, and to assess the use and perception of city health services." The community health survey was followed up with a report entitled *Healthy Baltimore 2015*. *Healthy Baltimore 2015* is the Baltimore City Health Department's comprehensive health policy agenda, articulating its priority

areas and indicators for action. This plan highlights where the largest impact can be made to reduce morbidity and mortality and improve the quality of life for city residents. It includes data showing significant health disparities by race, gender, education, and income, and identifies opportunities for addressing such inequities. *Healthy Baltimore 2015* sets specific goals for reducing deaths from serious illnesses such as heart disease, cancer, HIV/AIDS and diabetes. It also addresses behavioral and nutritional issues that impact health, such as smoking, alcohol abuse, drug addiction and obesity. While the focus of this report is Baltimore City health indicators, it contains useful comparisons to state-wide and national prevalence rates as well. After the report was released Dr. Oxiris Barbot, Baltimore City Commissioner of Health, met with the leaders of Baltimore City hospitals and encouraged partnering with each other and community-based organizations to develop and undertake initiatives to assist with meeting the targeted health improvement goals delineated in *Healthy Baltimore 2015.*

**2012 County Health Outcomes & Roadmaps**

*County Health Rankings* measures and compares the health of counties/cities within a state. Four types of health factors are measured and compared: health behaviors, clinical care, social and economic, and physical environment factors. Health outcomes are used to rank the overall health of each county and city.

**(**Please see the attached table for a review of the SDoH considered for MGH's targeted zip codes from the CHNA.)

## Social Determinants of Health (SDoH) Summary

## Baltimore City 2011

| SDoH | Baltimore City | Upton/ Druid Hts | Midtown | SW Balto | Mondawmin/ Penn North | Pimlico/ Arlington/ Hilltop | Allendale/ Edmondson | Wash Vill./ Morrell Park | I. Harbor/ S. Balto | Waverlies/ Northwood |
|---|---|---|---|---|---|---|---|---|---|---|
| **Socioeconomic Characteristics** | | **(21201)** | **(21202)** | **(21223)** | **(21216 & 21217)** | **(21215)** | **(21229)** | **(21230)** | **(21230)** | **(21218)** |
| Median Income | $37,395 | $13,388 | $33,303 | $27,158 | $34,438 | $29,031 | $33,112/ 34,814 | $42,504/ 39,931 | $72,692/ 69,625 | $33,239/ $50,512 |
| Unemployment (% Unemployed) | 11.1 | 17.5 | 5.7 | 19.6 | 10.2 | 17.0 | 15.4/12.2 | 12.3/5.8 | 2.5/4.7 | 12.8/11.6 |
| Families in Poverty % | 15.7 | 48.8 | 11.2 | 26.2 | 12.2 | 21.3 | 15.1/13.3 | 20.8/11.4 | 8.8 | 23.5/6.2 |
| **Education** | | | | | | | | | | |
| Kindergarten Readiness % “Fully Ready” | 65 | 55.1 | 59.6 | 61.2 | 65.9 | 76.8 | 55.6/61.1 | 69.3/63.2 | 55.0/70.4 | 69.3/65.8 |
| Adults w/ HS Degree or less - % | 52.6 | 72.2 | 32.2 | 70.2 | 61.6 | 69.5 | 66.9/65.2 | 44.4/72.6 | 19.9/35.5 | 55.3/48 |
| **Community Built Environment** | | | | | | | | | | |
| Alcohol Store Density (#stores/10,000 people) | 4.6 | 6.2 | 8.3 | 11.2 | 5.4 | 5.9 | 4.9/1.3 | 7.3/4.4 | 4.7/3.1 | 5.1/0.6 |
| Tobacco Store Density (#stores/10,000 people) | 21.8 | 39.0 | 28.7 | 51.4 | 27.8 | 32.2 | 17.9/12.7 | 50.9/17.6 | 38.1/18.7 | 27/4.2 |
| **Community Social Environment** | | | | | | | | | | |
| Homicide Rate (#of homicides/10,000) | 20.9 | 37.9 | 11.5 | 44.2 | 31.1 | 27.9 | 22.2/19.0 | 23.6/4.4 | 6.2/0 | 21.9/8.4 |
| Domestic Violence (# of incidents/1,000) | 40.6 | 55.0 | 19.1 | 66.3 | 52.8 | 51.8 | 50.8/43.3 | 46.1/40.2 | 14.5/15.9 | 44.3/30.6 |

| Housing | Balto City | Upton/ Druid Hts | Midtown | SW Balto | Mondawmin | Pimlico/ Arlington/ Hilltop | Allendale/ Edmondson | Wash Vill./ Morrell Park | Inner Harbor/ S. Balto | Waverlies/ Northwood |
|---|---|---|---|---|---|---|---|---|---|---|
| Energy Cut-off Rate (# per 10,000/month) | 39.1 | 45.2 | 7.4 | 79.6 | 62.6 | 73.2 | 58.9/61.2 | 45.8/15.5 | 3.3/8.0 | 39.1/34.7 |
| Vacant Building Density (#of buildings/10,000 housing units) | 567.2 | 1,380.5 | 178 | 2,081.5 | 844.9 | 918.7 | 344.4/251.9 | 1,028.7/ 1,109.8 | 49.2/103.7 | 239.6/20.2 |
| **Food Environment (# of/10,000 people)** | | | | | | | | | | |
| Fast Food Density | 2.4 | 2.1 | 3.8 | 2.2 | 5.4 | 0 | 1.2/0 | 3.6/3.3 | 5.4/6.2 | 0/1.2 |
| Carryout Density | 12.7 | 16.4 | 14.7 | 24.0 | 11.8 | 18.6 | 6.8/1.3 | 20.0/12.1 | 21.0/9.4 | 12.9/4.2 |
| Corner Store Density | 9.0 | 12.3 | | 25.7 | 10.7 | 12.7 | 6.8/8.9 | 14.5/5.5 | 4.7/10.9 | |
| Supermarket Proximity (by Car in min.) | 3.7 | 1 | 2 | 2 | 3 | 2 | 3/.69 | 8/5 | 4/1 | 2/3 |
| Supermarket Proximity (by Bus in min.) | 12.3 | 1 | N/A | 8 | 11 | 8 | 8/29 | 22/11 | 11/3 | 10/7 |
| Supermarket Proximity (by Walking in min.) | 16.6 | 1 | 8 | 9 | 12 | 9 | 15/43 | 26/22 | 18/8 | 13/10 |

**Source: Baltimore City Health Department (2011). 2011 Neighborhood Health Profile Report. www.baltimorehealth.org**

## Health Outcomes Summary
## Baltimore City 2011

| Health Outcomes | Baltimore City | Upton/ Druid Hts (21201) | Midtown (21202) | SW Balto (21223) | Mondawmin Penn North (21216 & 21217) | Pimlico/ Arlington (21215) | Allendale/ Edmondson (21229) | Wash Vill./ Morrell Park (21230) | I.Harbor/ S. Balto (21230) | Waverlies/ Northwood (21218) |
|---|---|---|---|---|---|---|---|---|---|---|
| Life Expectancy at Birth (in years) | 71.8 | 62.9 | 75.5 | 65 | 69.6 | 66.8 | 68.5/71.6 | 68.6/70.8 | 77.1/73.3 | 72.1/75.4 |
| Causes of Death (% of Total Deaths) | | | | | | | | | | |
| 1 – Heart Disease | 25.8 | 26.5 | 30.2 | 26.4 | 24.9 | 26.8 | 28.9/27.4 | 26.6/26.1 | 27.5 | 20/22.5 |
| 2 – Cancer | 20.8 | 17.5 | 20.8 | 20.2 | 19.5 | 18.9 | 20.3/22.6 | 21.8/19.8 | 20.0/26.3 | 23.3/24.4 |
| Lung | 6.3 | 5.5 | 6.5 | 7.0 | 4.3 | 5.5 | 6.2//7.1 | 8.9/5.7 | 6.7/9.7 | 6.7/5.2 |
| Colon | 2.1 | 1.8 | 1.6 | 1.6 | 2.1 | 3.2 | 2.1/3.3 | 1.7/2.5 | 1.8/2.9 | 2.5/2.5 |
| Breast | 3.2 | 1.5 | 5.3 | 2.7 | 4.6 | 2.6 | 3.1/3.3 | 1.8/2.6 | 1.3/2.8 | 5/5 |
| Prostate | 2.5 | 2.8 | 2.4 | 2.2 | 3.0 | 3.2 | 2.3/2.2 | 1.4 | 1.8/3.0 | 3.0/4.0 |
| 3 – Stroke | 4.7 | 3.6 | 4.5 | 3.6 | 6.8 | 4.8 | 5.2/4.8 | 4.9/4.0 | 3.8/2.2 | 5.9/4.8 |
| 4 – HIV/AIDS | 3.5 | 7.4 | 6.5 | 4.0 | 3.8 | 4.8 | 2.8/3.7 | 3.7/2.6 | 1.6/0.7 | 6.7/2.7 |
| 5 – Chronic Lower Respiratory Disease | 3.5 | 1.4 | 2.2 | 2.6 | 2.4 | 2.1 | 2.8/3.7 | 5.5/7.4 | 8.9/6.5 | 3.5/1.9 |
| 6 - Homicide | 3.4 | 5.0 | 1.3 | 4.3 | 4.3 | 3.4 | 3.8/2.9 | 3.1/0.7 | 0.4/0 | 4/3.4 |
| 7 – Diabetes | 3.2 | 4.4 | 4.0 | 3.3 | 3.5 | 3.1 | 2.8/3.1 | 3.4/2.0 | 3.3/2.9 | 4.5/2.1 |
| 8 – Septicemia | 3.1 | 3.6 | 1.5 | 3.1 | 2.9 | 4.3 | 2.7/2.5 | 4.1/2.9 | 3.3/1.8 | 2.7/3.3 |
| 9 – Drug Induced Death | 2.8 | 4.1 | 1.6 | 5.0 | 3.3 | 2.5 | 2.7/2.1 | 2.7/3.8 | 1.6/2.9 | 3/1.8 |
| 10 - Injury | 2.5 | 2.3 | 2.1 | 2.9 | 2.4 | 2.0 | 3.1/1.5 | 3.4/2.3 | 2.4/1.1 | 2.2/2.2 |
| **Maternal & Child Health** | | | | | | | | | | |
| Infant Mortality (per 1,000 live births) | 12.1 | 15.0 | 11.5 | 13.6 | 18.5 | 14.9 | 15.0/10.0 | 12.6/6.2 | 5.1/8.8 | 11.1/12 |
| Low Birthweight % (LBW < 5 lbs, 8 oz) | 12.8 | 14.1 | 11.1 | 13.8 | 18.0 | 14.4 | 16.4/15.2 | 14.4/10.5 | 6.5/5.1 | 13.8/12.7 |
| %Prenatal Care 1st Tri. | 77.3 | 71.4 | 83.8 | 71.6 | 68.4 | 72.2 | 79.4/77.7 | 84.4/81.9 | 91.6 | 67.9/76.5 |
| % Births to Mothers Who Smoke | 8.8 | 10.4 | 5.1 | 17.0 | 11.3 | 10.0 | 6.3/6.3 | 20.0/14.3 | 0.6/3.4 | 6.4/3.6 |

**Source: Baltimore City Health Department (2011). 2011 Neighborhood Health Profile Report. www.baltimorehealth.org**

3. **When was the most recent needs identification process or community health needs assessment completed?**
   **Provide date here: 6/2012 (mm/dd/yy)**

4. **Although not required by federal law until 2013, has your hospital conducted a community health needs assessment that conforms to the definition on the previous page within the past three fiscal years?**
   _X__Yes
   http://www.marylandgeneral.org/pdfs/MGH%20Community%20Needs%20Assessment%20Report%206_12%20FINAL.pdf
   ___ No

   If you answered yes to this question, please provide a link to the document or attach a PDF of the document with your electronic submission.

## III. Community Benefit Administration

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

   a. Does your hospital have a CB strategic plan?

      _X_Yes
      __No

   b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

      i. Senior Leadership

         1. _X_CEO (Sylvia Smith Johnson)
         2. ___CFO
            _X_ Other (Donald Ray, VP, Operations; Director of Marketing; 3 Board Members)

      ii. Clinical Leadership

         1. _X_ Physician
         2. ___Nurse
         3. ___Social Worker
         4. ___Other (please specify)

      iii. Community Benefit Department/Team

1. __Individual
2. _X_Committee (CB Committee of the Board)
3. __Other (MGH participates with the UMMS Community Outreach & Advocacy and Benefits Teams, both led by Donna Jacobs, UMMS Senior Vice President)

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

| | | |
|---|---|---|
| Spreadsheet | __X_yes | ____no |
| Narrative | __X _ yes | ____no |

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

| | | |
|---|---|---|
| Spreadsheet | __X__yes | ____no |
| Narrative | __X__yes | ____no |

## IV. Hospital Community Benefit Program and Initiatives
## Major Health Needs

The following tables covers the strategic priorities relevant to the health needs as identified through the needs assessment presented earlier and presents the initiatives completed in FY'12. The community strategic priorities focus on:

- Promote Access to Quality Care
- Decrease Smoking and Drug/Alcohol Use
- Decrease the Spread of HIV and Other Sexually Transmitted Diseases
- Diabetes Management and Prevention

2. Unmet Community Needs

Maryland General Hospital identified core community outreach priorities target the intersection of the identified community needs and the organization's key strengths and mission. Several additional topic areas were identified during the CHNA process including:

| | |
|---|---|
| Obesity/CVD | Cancer |
| Mental Health | Asthma/Lung disease |
| Dental Health | SIDS |
| Injuries | |

Maryland General will focus the majority of our efforts on the identified priorities outlined in the 4 priorities above, and we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through other health care organizations with our assistance as available. The unmet needs not addressed by MGH will be addressed by key Baltimore City governmental agencies, other local healthcare providers and organizations, and existing community-based organizations with whom we partner with regularly.

Initiative 1

**Promote Access to Quality Health Care**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi-Year Initiative Time Period | Key Partners and/or Hospitals in initiative development and/or implementation | Evaluation dates | Outcome (Include process and impact measures) | Continuation of Initiative | Cost of initiative for current FY? (See Instructions) |
|---|---|---|---|---|---|---|---|---|
| Many residents of the targeted zip codes use the ED or are hospitalized for conditions such as diabetes and hypertension due to poor access to primary care services. Early diagnosis and treatment in an ambulatory care setting would lead to better health outcomes. | **Offer free screening services** (blood pressure, glucose, cholesterol, pregnancy, and prostate). | **Primary Objective:** Facilitate early diagnosis and treatment of diabetes, hypertension, and other health conditions. | Multi-year, ongoing | Union Baptist Church; Mt. Zion Baptist Church; Brown's Memorial Baptist Church; Druid Heights CDC; UMMC; Waxter Center; DHMH; ADA | Quarterly and annually | Community Health & Education staff participated in 33 community events. 14,117 free screenings provided to 5,745 individuals. | Initiative will continue through FY 13. | $179,977 |
| | **Improve access to health information** | **Primary Objective:** Send subject matter experts into the community to provide specialized health information and education. | Multi-year, Ongoing | MGH Medical Staff; Sodexo; Center for Diabetes and Endocrinology | Quarterly and annually | Subject matter experts from the following services participated: Mammography, Food & Nutrition, Diabetes & Endocrinology, Rehab Medicine, Ophthalmology | Initiative will continue through FY 13. | $6,560 |
| | **Assist patients in need of transportation for hospital services** | **Primary Objective:** Increase patient compliance with clinic appointments. | Multi-year, Ongoing | | Annually | 3,962 free trips to using hospital van services. Also provided taxi reimbursement and tokens. | Initiative will continue through FY 13. | $379,836 |

**Initiative 2**
**Decrease Smoking and Drug/Alcohol Abuse**

| Identified Need | Hospital Initiative (Major Initiatives) | Primary Objective of the Initiative | Single or Multi-Year Initiative Time Period | Key Partners and/or Hospitals in initiative development and/or implementation | Evaluation dates | Outcome (Include process and impact measures) | Continuation of Initiative | Cost of initiative for current FY? (See Instructions) |
|---|---|---|---|---|---|---|---|---|
| According to the 2009 Community Health Survey and Healthy Baltimore 2015, approximately 28% of the adult population of Baltimore are smokers.<br><br>In 2010, 1,930 adults were discharged from city emergency departments for alcohol and drug related conditions. | **Offer Smoking Cessation course on MGH campus** | **Primary Objective:** Help smokers plan a successful quit attempt by providing essential information, skills for coping with cravings, and group support. | Multi-year, ongoing | American Cancer Society | Quarterly and annually | Trained 6 hospital staff members as volunteer Freshstart facilitators. 12 participants started program, and 5 successfully completed it. | Initiative will continue through FY 13. | $2,688 |
| | **Partnership with the Baltimore City Police Department D.A.R.E. Program** | **Primary Objective:** Educate middle-school age children on the adverse health consequences of using illegal drugs and abusing alcohol. | Multi-year, Ongoing | Officer Charles Lee, Baltimore City Police Department; Eutaw Marshburn Middle School; Furman Templeton Middle School | Quarterly and annually | Completed educational sessions at two Baltimore City Middle Schools. | Initiative will continue through FY 13. | $1,025 |

Initiative 3

**HIV Infection and Sexually Transmitted Diseases**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi-Year Initiative Time Period | Key Partners and/or Hospitals in initiative development and/or implementation | Evaluation dates | Outcome (Include process and impact measures) | Continuation of Initiative | Cost of initiative for current FY? (See Instructions) |
|---|---|---|---|---|---|---|---|---|
| HIV infection is the 4th leading cause of death in Balto City with 6/10 targeted zips with higher prevalence of mortality than city-wide average | **Expand free HIV testing sites and access to prevention information on the MGH campus** | **Primary Objective:** Enhance access to free HIV screening services and counseling by providing services through the Community Health Center (in addition to the IHV Clinic)<br><br>**Secondary Objective:** Provide education on the importance of HIV prevention, testing, and early treatment | Multi-year, ongoing | Baltimore City Health Department | Quarterly and annually | Over 40 persons received free rapid HIV testing in the IHV service. Application completed and submitted to expand testing to CHEC. Awaiting certification from BCHD. Free condoms and HIV information offered at multiple sites (CHEC, IHV Clinic, Bolton Hill, Women's Health, MICA) | Initiative will continue through FY 13. | $2,420 |

Initiative 4

**Diabetes Management & Prevention**

| Identified Need | Hospital Initiative | Primary Objective of the Initiative | Single or Multi-Year Initiative Time Period | Key Partners and/or Hospitals in initiative development and/or implementation | Evaluation dates | Outcome (Include process and impact measures) | Continuation of Initiative | Cost of initiative for current FY? (See Instructions) |
|---|---|---|---|---|---|---|---|---|
| In Baltimore, 11.7% of adults have been diagnosed with diabetes and the death rate due to diabetes is 56% higher than the national average. Diabetes was identified as a major concern of the respondents to the Community Health Assessment, ranking between 1st and 5th in importance in zip codes within Maryland General's primary service area. | Reduce the prevalence of diabetes and the resulting adverse health outcomes | **Primary Objective:** Increase awareness of diabetes management and prevention | Multi-year, ongoing | American Diabetes Association; Center for Diabetes and Endocrinology | | Sponsored MGH Team for ADA's "Step Out" Walk for Diabetes (Approx. 25 MGH staff participants). Bronze sponsor for American Diabetes Assn's "Rally to Stop Diabetes " | Initiative will continue through FY '13. | $5,000 |

## V. Physicians

1. Maryland General Hospital is committed to serving the health needs of residents of Baltimore City. Because of our partnership with the University of Maryland Medical System, there are no gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for within the community.

2. Maryland General Hospital does not list Physician Subsidy information in Category C of the Community Benefit Inventory Spreadsheet.

## VI. Appendices

1. Financial Assistance Policy Description (See Appendix 1)
2. Financial Assistance Policy (See Appendix 2)
3. Patient Information Sheet (See Appendix 3)
4. Mission, Vision, Values (See Appendix 4)

Appendix 1

1. Financial Assistance Policy Description

Maryland General Hospital's Financial Assistance Policy is a clear, comprehensive policy established to assess the needs of particular patients that have indicated a possible financial hardship in obtaining aid when it is beyond their financial ability to pay for services rendered.

Maryland General Hospital makes every effort to make financial assistance information available to our patients including, but not limited to:

- Signage in main admitting areas of the hospital
- Patient Handbook distributed to all patients
- Brochures explaining financial assistance are made available in all patient care areas

Appendix 2

## ***POLICY***

a. This policy applies to Maryland General Hospital ("MGH"). MGH 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 medically necessary care based on their individual financial situation.

b. It is the policy of MGH 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.

c. MGH will publish the availability of Financial Assistance on a yearly basis in the local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients on patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided to patients receiving inpatient services with their Summary Bill and made available to all patients upon request.

d. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

e. MGH 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 services, applications to the Financial Assistance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

## ***2. PROGRAM ELIGIBILITY***

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, MGH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further MGH commitment to our mission to provide healthcare to those residing in the neighborhoods surrounding our hospital, MGH reserves the right to grant Financial Assistance without formal application being made by our patients. The zip codes for the MGH primary service area are included in ***Attachment A***. Additionally, patients residing outside of our primary service area may receive Financial Assistance on a one-time basis for a specific episode of care.

b. Specific exclusions to coverage under the Financial Assistance program include the following:

   i) Services provided by healthcare providers not affiliated with MGH (e.g., home health services)

   ii) Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, Workers Compensation, or Medicaid), are not eligible for the Financial Assistance Program.

      (1) 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 considering medical and programmatic implications.

   iii) Unpaid balances resulting from cosmetic or other non-medically necessary services

   iv) Patient convenience items

   v) Patient meals and lodging

vi) Physician charges related to the date of service are excluded from MGH's financial assistance policy. Patient's who wish to pursue financial assistance for physician-related bills must contact the physician directly.

c. Patients may become ineligible for Financial Assistance for the following reasons:

i) Refusal to provide requested documentation or providing incomplete information.

ii) Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to MGH due to insurance plan restrictions/limits.

iii) Failure to pay co-payments as required by the Financial Assistance Program.

iv) Failure to keep current on existing payment arrangements with MGH.

v) Failure to make appropriate arrangements on past payment obligations owed to MGH (including those patients who were referred to an outside collection agency for a previous debt).

vi) Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.

d. 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.

e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance (See Section 3 below) eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel 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.

f. Coverage amounts will be calculated based upon 200-300% of income as defined by federal poverty guidelines and follow the sliding scale included in ***Attachment B***.

## *3. PRESUMPTIVE FINANCIAL ASSISTANCE*

a. 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 and/or supporting documentation on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with Financial Assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, MGH 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:

i) Active Medical Assistance pharmacy coverage

ii) Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums)

iii) Primary Adult Care ("PAC") coverage

iv) Homelessness

v) Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs

vi) Maryland Public Health System Emergency Petition patients

vii) Participation in Women, Infants and Children Programs ("WIC")

viii) Food Stamp eligibility

ix) Eligibility for other state or local assistance programs

x) Patient is deceased with no known estate

xi) Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program

b. Patients who present to the Outpatient Emergency Department but are not admitted as inpatients and who reside in the hospitals' primary service area may not need to complete a Financial Assistance Application but may be granted presumptive Financial Assistance based upon the following criteria:

i) Reside in primary service area (address has been verified)

ii) Lacking health insurance coverage

iii) Not enrolled in Medical Assistance for date of service

iv) Indicate an inability to pay for their care

v) Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

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

i) Purely elective procedures (e.g., Cosmetic procedures) are not covered under the program.

ii) 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.

iii) Qualifying Non-U.S. citizens are to be processed for reimbursement through the Federal program for Undocumented Alien Funding for Emergency Care (a.k.a. Section 1011) prior to financial assistance consideration.

## *4. MEDICAL HARDSHIP*

a. Patients falling outside of conventional income or presumptive Financial Assistance criteria are potentially eligible for bill reduction through the Medical Hardship program.

i) Uninsured Medical Hardship criteria is State defined:

(1) Combined household income less than 500% of federal poverty guidelines

(2) Having incurred collective family hospital medical debt at MGH exceeding 25% of the combined household income during a 12 month period. The 12 month period begins with the date the Medical Hardship application was submitted.

(3) The medical debt excludes co-payments, co-insurance and deductibles

b. Patient balance after insurance

i) MGH applies the State established income, medical debt and time frame criteria to patient balance after insurance applications

c. Coverage amounts will be calculated based upon 0 - 500% of income as defined by federal poverty guidelines and follow the sliding scale included in **Attachment B.**

d. If determined eligible, patients and their immediate family are certified for a 12 month period effective with the date on which the reduced cost medically necessary care was initially received

e. Individual patient situation consideration:

   i) MGH reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.

   ii) The eligibility duration and discount amount is patient-situation specific.

   iii) Patient balance after insurance accounts may be eligible for consideration.

   iv) Cases falling into this category require management level review and approval.

f. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance programs, MGH is to apply the greater of the two discounts.

g. Patient is required to notify MGH of their potential eligibility for this component of the financial assistance program.

## *5. ASSET CONSIDERATION*

a. Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient responsibility without causing undue hardship. Individual patient financial situation such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are reviewed.

b. Under current legislation, the following assets are exempt from consideration:

   i) The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.

   ii) Up to $150,000 in primary residence equity.

   iii) Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

## *6. APPEALS*

a. Patients whose financial assistance applications are denied have the option to appeal the decision.

b. Appeals can be initiated verbally or written.

c. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

d. 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.

e. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration

f. The escalation can progress up to the Chief Financial Officer who will render a final decision.

g. A letter of final determination will be submitted to each patient who has formally submitted an appeal.

## *7. PATIENT REFUND*

a. Patients applying for Financial Assistance up to 2 years after the service date who have made account payment(s) greater than $25 are eligible for refund consideration

b. Collector notes, and any other relevant information, are deliberated as part of the final refund decision. In general, refunds are issued based on when the patient was determined unable to pay compared to when the payments were made.

c. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for refund.

## *8. JUDGEMENTS*

a. If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained or the debt submitted to a credit reporting agency, MGH shall seek to vacate the judgment and/or strike the adverse credit information.

## *9. PROCEDURES*

a. Each Service Access area will designate a trained person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Customer Service, etc.

b. Every 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.

   i) Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.

   ii) Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.

   iii) MGH will not require documentation beyond that necessary to validate the information on the Maryland State Uniform Financial Assistance Application.

   iv) 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.

   v) Patients will have thirty (30) days to submit required documentation to be considered for eligibility. If no data is received within 20 days, a reminder letter will be sent notifying that the case will be closed for inactivity and the account referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.

c. In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:

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

   ii. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.

   iii. Proof of social security income (if applicable)

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

   v. Proof of U.S. citizenship or lawful permanent residence status (green card).

vi. Reasonable proof of other declared expenses.

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

d. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on MGH guidelines.

i. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.

(1) If the patient does qualify for financial clearance, appropriate personnel will notify the treating department who may then schedule the patient for the appropriate service.

(2) If the patient does not qualify for financial clearance, appropriate personnel will notify the clinical staff of the determination and the non-emergent/urgent services will not be scheduled.

(a) A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.

e. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.

f. The following may result in the reconsideration of Financial Assistance approval:

i. Post approval discovery of an ability to pay

ii. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to MGH

g. MGH will track patients with 6 or 12 month certification periods utilizing either eligibility coverage cards and/or a unique insurance plan code(s). However, it is ultimately the responsibility of the patient or guarantor to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

h. If patient is determined to be ineligible, 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.

**DEVELOPER**
Patient Financial Services Department, MGH
**Reviewed/Revised**: 09-28-2010

**ATTACHMENT A**

The following zip codes represent the coverage areas for MGH:
21225, 21201, 21202, 21205, 21206, 21207, 21211, 21212, 21213, 21215, 21216, 21217, 21218, 21223, 21224, 21228, 21229, 21230, 21239

| MARYLAND GENERAL HOSPITAL<br>UNIVERSITY OF MARYLAND MEDICAL SYSTEM | Maryland General Hospital<br>Policy & Procedure | *Policy #:* | TBD |
|---|---|---|---|
| | | *Effective Date:* | 07-01-2011 |
| | ***Subject:***<br>**FINANCIAL ASSISTANCE** | *Page #:* | 31 of 35 |
| | | *Supersedes:* | 07-31-2010 |

**ATTACHMENT B**

**Sliding Scale**

| | | % of Federal Poverty Level Income | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 200% | 210% | 220% | 230% | 240% | 250% | 260% | 270% | 280-290% | 300% - 499% | |
| Size of Family Unit | FPL Income | Approved % of Financial Assistance | | | | | | | | | | |
| | | 100% | 90% | 80% | 70% | 60% | 50% | 40% | 30% | 20% | 25% of Income | |
| 1 | $10,830 | $21,660 | $22,743 | $23,826 | $24,909 | $25,992 | $27,075 | $28,158 | $29,241 | $30,324 | $32,490 | $54,150 |
| 2 | $14,570 | $29,140 | $30,597 | $32,054 | $33,511 | $34,968 | $36,425 | $37,882 | $39,339 | $40,796 | $43,710 | $72,850 |
| 3 | $18,310 | $36,620 | $38,451 | $40,282 | $42,113 | $43,944 | $45,775 | $47,606 | $49,437 | $51,268 | $54,930 | $91,550 |
| 4 | $22,050 | $44,100 | $46,305 | $48,510 | $50,715 | $52,920 | $55,125 | $57,330 | $59,535 | $61,740 | $66,150 | $110,250 |
| 5 | $25,790 | $51,580 | $54,159 | $56,738 | $59,317 | $61,896 | $64,475 | $67,054 | $69,633 | $72,212 | $77,370 | $128,950 |
| 6 | $29,530 | $59,060 | $62,013 | $64,966 | $67,919 | $70,872 | $73,825 | $76,778 | $79,731 | $82,684 | $88,590 | $147,650 |
| 7 | $33,270 | $66,540 | $69,867 | $73,194 | $76,521 | $79,848 | $83,175 | $86,502 | $89,829 | $93,156 | $99,810 | $166,350 |
| 8 | $37,010 | $74,020 | $77,721 | $81,422 | $85,123 | $88,824 | $92,525 | $96,226 | $99,927 | $103,628 | $111,030 | $185,050 |

*Patient Income and Eligibility Examples:*

| Example #1 | Example #2 | Example #3 |
|---|---|---|
| - Patient earns $53,000 per year<br>- There are 5 people in the patient's family<br>- The % of potential Financial Assistance coverage would equal 90% (they earn more than $51,580 but less than $54,159) | - Patient earns $37,000 per year<br>- There are 2 people in the patient's family<br>- The % of potential Financial Assistance coverage would equal 40% (they earn more than $36,425 but less than $37,882) | - Patient earns $54,000 per year<br>- There is 1 person in the family<br>- The balance owed is $20,000<br>- This patient qualifies for Hardship coverage, owed 25% of $54,000 ($13,500) |

***Notes:*** FPL = Federal Poverty Levels

MARYLAND GENERAL HOSPITAL
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

**PATIENT INFORMATION SHEET** **Appendix 3**

**Hospital Financial Assistance Policy**

Maryland General Hospital is committed to ensuring that uninsured patients within its service area who lack financial resources have access to medically necessary hospital services. If you are unable to pay for medical care, you may qualify for Financial Assistance or Reduced Cost Medically Necessary Care if you have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability. Financial Assistance eligibility is based upon family income, in relation to the federal poverty guidelines. Maryland General Hospital meets or exceeds the legal requirements by providing financial assistance to those individuals in households below 200% of the federal poverty level and reduced cost-care up to 400% of the federal poverty level.

**Patients' Rights**

Maryland General Hospital will work with their uninsured patients to gain an understanding of each patient's financial resources.

- They will provide assistance with enrollment in publicly-funded entitlement programs (e.g. Medicaid) or other considerations of funding that may be available from other charitable organizations.
- If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.
- If you believe you have wrongfully referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

**Patients' Obligations**

Maryland General Hospital believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

- Cooperate at all times by providing complete and accurate insurance & financial information.
- Provide requested data to complete Medicaid applications in a timely manner.
- Maintain compliance with established payment plan terms.
- Notify us timely at the number listed below of any changes in circumstances.

**Contacts:**

Call (443-552-2987) or (410-225-8895) with questions concerning:

- How to apply for Financial Assistance or to request a Financial Assistance application. You can also download the uniform financial assistance application from the following link: http://www.hscrc.state.md.us/consumers_iniform.cfm
- Your rights and obligations with regards to your hospital bill
- How to apply for Maryland Medicaid
- Questions concerning your hospital bill, please call the billing department at 410-225-8814.

**For information about Maryland Medical Assistance**

Contact your local department of Social Services
1-800-332-6347 TTY 1-800-925-4434
Or visit: www.dhr.state.md.us

**Physician charges are not included in hospitals bills and are billed separately.**

**HOJA PACIENTE DE LA INFORMACIÓN**

**Política de la ayuda financiera del hospital**

General de Maryland Hospital está confiado a asegurarse de que los pacientes sin seguro dentro de su área de servicio que carecen recursos financieros tienen acceso a los servicios médicamente necesarios del hospital. Si usted no puede pagar asistencia médica, usted puede calificar para la ayuda financiera o el cuidado médicamente necesario reducido del coste si usted no tiene ningunas otras opciones del seguro o fuente del pago incluyendo ayuda médica, el pleito o la responsabilidad de tercera persona.

La elegibilidad de la ayuda financiera se basa sobre renta de la familia, en lo referente a las pautas federales de la pobreza. El hospital general de Maryland resuelve o excede los requisitos legales proporcionando ayuda financiera a esos individuos en casas debajo de 200% del nivel de pobreza federal y del coste-cuidado reducido hasta el 400% del nivel de pobreza federal.

**Derechas de los pacientes las'**

General de Maryland Hospital trabajará con sus pacientes sin seguro para ganar una comprensión de los recursos financieros de cada paciente.

- Proveerán de ayuda la inscripción en programas público-financiados del derecho (e.g. Medicaid) u otras consideraciones del financiamiento que pueden estar disponibles de otras organizaciones caritativas.
- Si usted no califica para la ayuda médica, o la ayuda financiera, usted puede ser elegible para un plan extendido del pago para sus cuentas médicas del hospital.
- Si usted cree usted ilícito ha referido a una agencia de colección, usted tiene la derecha de entrar en contacto con el hospital para solicitar ayuda. (Véase la información del contacto abajo).

**Obligaciones de los pacientes'**

General de Maryland Hospital cree que sus pacientes tienen responsabilidades personales relacionadas con los aspectos financieros de sus necesidades del healthcare. Nuestros pacientes esperan:

- Coopere siempre proporcionando seguro completo y exacto y información financiera.
- Proporcione los datos solicitados para terminar los usos de Medicaid de una manera oportuna.
- Mantenga la conformidad con términos establecidos del plan del pago.
- Notifiqúenos oportunos en el número enumerado abajo de cualquier cambio en circunstancias.

**Contactos:**

Llame (443-552-2987) o (410-225-8895) con preguntas respecto a:

- Cómo solicitar ayuda financiera o a la petición a Uso de la ayuda financiera. Usted puede también descargue el uso uniforme de la ayuda financiera del acoplamiento siguiente: http://www.hscrc.state.md.us/consumers_iniform.cfm
- Las sus derechas y obligaciones con respeto a su cuenta del hospital
- Cómo solicitar Maryland Medicaid
- Preguntas respecto a su cuenta del hospital, llame por favor el departamento de facturación en 410-225-8814.

**Para la información sobre la ayuda médica de Maryland**

Entre en contacto con su departamento local de servicios sociales

1-800-332-6347 Equipo teleescritor 1-800-925-4434

O visita: www.dhr.state.md.us

**Las cargas del médico no se incluyen en cuentas de los hospitales y son cuenta por separado.**

MARYLAND GENERAL HOSPITAL
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

# Mission, Goals, Values

## Our Mission

To improve the health of our community through superior, compassionate care and medical education in partnership with our physicians and employees.

## Our Goals

### Quality

Provide the highest quality of patient care to achieve positive patient outcomes.

### Growth

Provide increased access and expanded services to more patients. Grow market share through increased volume, physician recruitment and facility planning maintenance.

### Service

Exceed patients' expectations for the services provided. Provide excellence in patient care and support services to meet or exceed physician needs and expectations.

### Stewardship

Achieve positive financial performance to reinvest in enhanced clinical programs and improved facilities for our patients as well as competitive salaries and benefits for our staff.

### People

Maximize our human resources through recruitment, retention, training and development, resulting in the provision of excellent clinical care and support services to our patients.

### Community

Improve the image of MGH with staff and care providers as well as with our external constituents. Continue our efforts in community outreach to better meet the health and wellness needs of those we serve as well as those we hope to serve.

# Our Core Values


**R**espect, **I**ntegrity, **T**eamwork, **E**xcellence.

## Respect

We seek to understand and address the individual needs and concerns of our patients and provide for their comfort while treating them with honor and dignity. We show respect for our patients' privacy and confidentiality in all that we do. We embrace the diversity and individual perspectives of our team while working together to achieve our common mission to improve the health status of the community we serve.

## Integrity

We are honest and ethical in all of our interactions, starting with how we treat each other. Our personal conduct ensures that we are always worthy of trust. Our reputation for providing high quality care is maintained by living our values.

## Teamwork

We work together to ensure that our patients experience exceptional care. We are committed to creating an environment of mutual respect where open, honest communication is our cornerstone. We listen carefully in order to understand each other and communicate frequently and effectively.

## Excellence

We strive to exceed expectations by providing services to our patients and co-workers in a timely and efficient manner and through continuous performance improvement. It is our commitment to ensure that every patient receives excellent care, service, and support at all times and at every point of service.