COMMUNITY BENEFIT NARRATIVE REPORT

FY2013

MedStar Franklin Square Medica

BACKGROUND

The Health Services Cost Review Commission's (HSCRC or Commission) 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's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. 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 regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. 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) hospital community benefit programs.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes	All Other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:

347 MedStar Franklin Square Planning Office, 9-6-13	24,370 MSFSMC, 6-30-13	21221 21220 21222 21237 21234 21236 21027 (HSCRC http://www.hscrc.state.md.us/init_cb.cfm PSA for FY 2013 CB Report accessed 9-1-13)	MedStar Good Samaritan Hospital, MedStar Union Memorial Hospital, John Hopkins Bayview Medical Center; University of Maryland; Saint Joseph; Mercy; Johns Hopkins; GBMC http://www.hscrc.state.md.us/init_cb.cfm PSA for FY 2013 CB Report (accessed 9-1-13)	9.0% (Baltimore County) MD Dept. of Planning http://planning.maryland.gov/msdc/American_Community_Survey/2011ACS.shtml, accessed 9-1-13)	13.0% (Baltimore County) http://www.md-medicaid.org/mco/index.cfm MD Medicaid E health stats. (Avg. FY13/BCo. Pop).

2. For purposes of reporting on your community benefit activities, please provide the following information:
   a. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, education and environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary). Some statistics may be accessed from:
      - The Maryland State Health Improvement Process. http://dhmh.maryland.gov/ship/
      - The County Health Profiles 2013 http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx
      - The Maryland Vital Statistics Administration. http://vsa.maryland.gov/html/reports.cfm

- The Maryland Plan to Eliminate Minority Health Disparities (2010-2014). http://www.dhmh.maryland.gov/mhhd/Documents/1stResource_2010.pdf
- Maryland ChartBook of Minority Health and Minority Health Disparities 2nd Edition http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, ethnicity, and average age)	Baltimore County Population 789,814 Sex47.6% male 52.4% female Race White67.1% Black25.1% Asian4.1% Asian Indian1.1% Other 2.6% Hispanic/Latino (of any race) 3.3% Median age 38.8 CBSA Population 193,790 Race White 72.4% African-American 19.6% Hispanic 4.5% Asian/Pacific Islander 2.7% American Indian/Alaska Native 0.6% Age Median, Baltimore County 38.8 Gender Male 47.6% Female 52.4% Sources: 2009 American Community Survey 1-Year Estimates Community Needs Assessment for Baltimore County's Southeast Area, June 2013
Median Household Income within the CBSA	Average weighted household income for Southeast Area - $47,421 21206 $47,472* 21219 $59,759* 21220 $58,533* 21221 $50,459* 21222 $46,421* 21224 $51,508* 21237 $61,027* *With relatively high margins of error due to smaller size compared to Baltimore County Baltimore County – $65,411

	Sources: MedStar Franklin Square Medical Center Community Health Assessment 2012 Community Needs Assessment for Baltimore County's Southeast Area, June 2013
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Percentage of people whose income in the past 12 months is below the federal poverty guidelines (Baltimore County): All people 9.6% People Under 18 12.5% Sources: US Census Bureau 2010 http://www.census.gov/did/www/saipe/data/interactive/#view=StateAndCounty, accessed 9-6-13.
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links:http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Baltimore County 9.0% Maryland 10.4% Sources: (MD Dept. of Planning http://planning.maryland.gov/msdc/American_Community_Survey/2011ACS.shtml, accessed 9-6-13)
Percentage of Medicaid recipients by County within the CBSA.	Baltimore County 13% Sources: http://www.md-medicaid.org/mco/index.cfm MD Medicaid E health stats. (Avg. FY13/BCo. Pop)
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).See SHIP website: http://dhmh.maryland.gov/ship/SitePages/objective1.aspxand county profiles:http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Baltimore County 78.8 White 79.3 Black 76.7 Sources: Maryland Vital Statistics Annual Report 2011 http://dhmh.maryland.gov/vsa/Documents/11annual.pdf, accessed 9-6-13
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Maryland 7.5 per 1,000 White 8.5 Black 6.5 Sources: Maryland Vital Statistics Annual Report 2011 http://dhmh.maryland.gov/vsa/Documents/11annual.pdf, accessed 9-6-13
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health statusby County within the CBSA. (to the extent information is available from localor county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county	Population, low access to store (%), 2010 Baltimore County – 20.27% Percentage of children who enter kindergarten ready to learn (MSDE 2010-2011) Baltimore County 85.0% MD Target 2014 85.0%

profiles for primary service area information:http://dhmh.maryland.gov/ship/SitePages/measures.aspx	Percentage of students who graduate high school four years after entering 9th grade (Using lever Rate) (MSDE 2011) Baltimore County 83.06% MD87.01% Housing Occupancy Owner occupied 67% Renter occupied33 % Number of days per year the Air Quality Index exceeded 100 (not all counties are measured for AQI) (EPA 2008) Baltimore County 15 MD Target 2014 8.8 Sources: http://www.ers.usda.gov/data-products/food-environment-atlas/go-to-the-atlas.aspx, accessed 9-6-13 Community Needs Assessment for Baltimore County's Southeast Area, June 2013 U.S. Census, 2010 http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1&prodType=table accessed 9-6-13 MD SHIP Baltimore County http://eh.dhmh.md.gov/ship/SHIP_Profile_Baltimore.pdf, accessed 9-6-13
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions.	Population, Baltimore County Race White64.6% African American26.1% Asian/Pacific Islander5.58% Hispanic 4.20% American Indian/Alaska Native 0.35% Median age 39.1 Language spoken in home, Baltimore County: English 87.6% Spanish 3.1% Indo-European 4.9% Asian/Pacific Islander 2.8% Other 1.6% Sources: Community Needs Assessment for Baltimore County's Southeast Area, June 2013 2010 Demographic Profile http://factfinder2.census.gov/faces/nav/jsf/pages/community_facts.xhtml, accessed 9-6-13 2009 American Survey

Other	Heart Disease, Hypertension Rate of heart disease deaths per 100,000 population (age adjusted) Baltimore County 198.1 Maryland 182.0 MD Target 2014 173.4 White197.4 Black238.6 Asian68.3 Rate of ED visits for hypertension per 100,000 population Baltimore County226.2 Maryland 222.2 MD Target 2014 202.4 NH black--490.3 NH white--143.5 Sources: VSA 2008-2010 HSCRC 2010 Asthma Rate of ED visits for asthma per 10,000 population Baltimore County 66.1 Maryland 59.1 MD Target 2014 49.5 NH Asian--9.3 NH black--141.4 Hispanic--36.5 NH white--38.9 Source: HSCRC 2011 Tobacco Use, Cancer Percentage of adults who currently smoke Baltimore County 15.4% Maryland 14.9% MD Target 2014 13.5% White/NH15.2% Black16.0% Asian1.9% Hispanic12.8% Rate of cancer deaths per 100,000 population (age adjusted) Baltimore County 191.2 Maryland 170.9 MD Target 2014 169.2 API--98.5 Black--218.8 Hispanic--65.3 White--191.7 Sources: BRFSS 2008-2010 VSA 2007-2009

b. Please use the space provided to complete the description of your CBSA. Provide any detail that is not already stated in Table II (you may copy and paste the information directly from your CHNA).

Located in the Rosedale section of Eastern Baltimore County, Maryland, MedStar Franklin Square Medical Center's (MedStar Franklin Square) Community Benefit Service Area (CBSA) includes neighborhoods in southeastern Baltimore County and adjacent to the Chesapeake Bay including Overlea (21206), Edgemere (21219), Middle River (21220), Essex (21221), Dundalk (21222, 21224), Rosedale (21237), Nottingham (21236) and Perry Hall (21128).

This region was selected due to MedStar Franklin Square's pre-existing partnership with the Baltimore County Southeast Area Network (Network) – a volunteer community organization that monitors and works to improve the health of residents in the southeastern portion of Baltimore County. The 2013 Community Needs Assessment for Baltimore County's Southeast Area, done in collaboration with the Network, demonstrated higher than County/State levels of infant mortality, low birth weight, births to teens and births to mothers who never finished high school, juvenile arrest, public assistance recipients, property crime, violent crimes, domestic violence, child abuse/neglect, and school absenteeism. The largest County shelter for homeless families, which serves more than 150 people each night, is located in this area.

The majority (72.4 percent) of the southeast area's population is white, compared to 74.4 percent in Baltimore County overall and 64.0 percent in Maryland. African-Americans account for 19.6 percent of the southeast area's population, as opposed to 19.9 percent of Baltimore County's population and 27.7 percent of Maryland's population. The remaining racial/ethnic breakdown is: 4.5 percent Hispanic, 2.7 percent Asian/Pacific Islanders and 0.6 percent American Indians/Alaskan Natives.

In the southeast area population, the estimated percentage of all people whose income was below the federal poverty level is 11.4 percent, compared to 8.2 percent in Baltimore County. (American Community Survey, 2007-2011). Four of the ZIP codes – 21206, 21221, 21222, and 21224 - have poverty rates that are considerably higher (11.0-19.2 percent) than the county average.

Based on results from MedStar Franklin Square's FY12 Community Health Assessment, pediatric asthma, awareness of resources concerning alcohol and substance abuse and heart health have been identified as the community health priorities. The rate of ED visits for asthma per 10,000 population for Baltimore County (66.1) is greater than the state average (MD SHIP, 2011) and the MD SHIP 2014 target (59.1 and 49.5, respectively). Baltimore County's heart disease death rate (198.4 per 100,000 people) is higher than the national average of 185.2. The heart disease death rate percentage in the southeast area (25.9 percent) is also higher than the national average (24.6 percent).

Smoking contributes to asthma, heart disease and cancer. Cancer is the second leading cause of death in the United States and Maryland. The southeast area has a higher cancer death rate as a percentage of all deaths (24.5) than either Baltimore County (23.3) or Maryland (23.7). The percentage of adults who currently smoke in

Baltimore County (15.4%) is above the 2014 MD SHIP target (13.5%).

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act ("ACA"), hospitals must perform a Community Health Needs Assessment (CHNA) either fiscalyear 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and perform an assessment at least every three years. 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, the IRS defines a CHNA as a:

> Written document developed for a hospital facility that includes a description of the community served by the hospital facility: the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

The written document (CHNA) must include the following:

A description of the community served by the hospital and how it was determined;

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. If a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties;

A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility, including a description of when and how the hospital consulted with these persons

(whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and

A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

Examples of sources of data available to develop a CHNAinclude, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP) (http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) The Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) Local Health Departments (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);

(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) 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;
(12) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNAinvolving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(13) Survey of community residents; and
(14) Use of data or statistics compiled by county, state, or federal governments.

In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the Public and adopt an implementation strategy to meet the health needs identified by the CHNA by the end of the same taxable year.

The IMPLEMENTATION STRATEGY must:

a. Be approved by an authorized governing body of the hospital organization;
b. Describe how the hospital facility plans to meet the health need; or
c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

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

X Yes
_ No

Provide date here.6/30/2012

If no, please provide an explanation

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

http://medstarhealth.thehcn.net/javascript/htmleditor/uploads/MFSMC_Full_Report_CHA_2012_20120717103704.pdf

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

X Yes
_ No

If no, please provide an explanation

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

http://medstarhealth.thehcn.net/javascript/htmleditor/uploads/MFSMC_Narrative_and_Implementation_Strategy_CHA_2012_20120717103726.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?
    a. Is Community Benefits planning part of your hospital's strategic plan?

    X Yes
    _ No

    If no, please provide an explanation

    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 processand provide additional information if necessary):
        i. Senior Leadership
            1.X CEO
            2.X CFO
            3.X Other (Please Specify)
            Director Community Medicine Service Line
        ii. Clinical Leadership
            1.X Physician

2.X Nurse

3.X Social Worker

4._ Other (Please Specify)

iii.Community Benefit Department/Team

1.X Individual (please specify FTE)

Director, Community Medicine Service line (1.0), Community Outreach Manager (1.0), Health Education Specialist (2.0) ,Health Educator (1.0) ,Fitness Coordinator (0.25) ,Administrative Coordinator (1.0) ,Data Entry Clerk (.20)

2.X Committee (please list members)

Community Outreach Committee: Community Outreach Manager, Health Education Specialist, Health Educator, Medical Librarian, Women's Services Representative, Women's Services Navigator, Oncology Program Manager, Director of Food Services, Director of Volunteers, Media Relations Manager, Physical Therapy Clinical Specialist, Patient Advocacy Senior Director, Director of Pharmacy, Ambulatory Care Practice Manager, Financial Services

3.X Other (Please Specify)

Community Health Improvement Board Committee: Chair (Board member), Community Service line Director, Community Outreach Manager, Board members, Physicians, Baltimore County Government representative, Non board member community business representatives, Hospital Representatives for Chamber Boards, Finance Representative, Vice President of the Foundation

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

Spreadsheet X Yes _ No

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

Narrative X Yes _ No

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

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

Spreadsheet X Yes _ No

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

Narrative X Yes _ No

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

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each initiative and how the results will be measured, time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Please be sure these initiatives occurred in the FY in which you are reporting.

For example for each principal initiative, provide the following:

a Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.

b. Name of Initiative: insert name of initiative.

c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics

that will be used to evaluate the results (Use several pages if necessary)

d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

e. Key Partners in Development/Implementation: Name the partners(community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.

f. How were the outcomes of the initiative evaluated?

g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?

h. Continuation of Initiative: Will the initiative be continued based on the outcome?

i Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.

Initiative 1

Identified Need	Asthma Care At 21.9%, the proportion of children diagnosed with asthma is higher than any surrounding county and higher than the state percentage (16.4%). This statistic translates into missed days of school, limitations on daily activities, visits to the emergency department for treatment of asthma symptoms, and hospitalizations. MedStar Franklin Square Medical Center CY2011 Asthma Statistics: - Pediatric ED visits: 449 - Admissions: 143 - Transferred to PICU: 13 Baltimore County Public Schools (BCPS) 2010-11 (total enrollment 104,000 students): - 13,344 students with asthma diagnosis - 4,831 students had asthma medication orders at school BCPS school nurses report increased nurse visits and 911 transfers of students from school to emergency room due to asthma Resource access (spacers, management plans) is limited in this area due to economic status Rate of ED visits for asthma per 10,000 population: MD SHIP target-49.5 Baltimore County-66.1 NH Asian--9.3 NH black--141.4 Hispanic--36.5 NH white--38.9 (HSCRC 2011) Number of days the air quality index (AQI) exceeded 100 MD SHIP Target- 8.8 Baltimore County- 15.0 (EPA 2011)
Hospital Initiative	Asthma Care Facilitate the use of a standardized, accessible management plan form for each elementary school child experiencing asthma Increase the availability of spacers for use in schools Continue collaboration with BCPS and area school nurses through the Community Asthma Team.
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Improve the quality of asthma care for children in the fifty-one BCPS schools in the Community Benefit Service Area (CBSA) through standardized asthma management plans and spacer availability. •Convene monthly meetings to identify

	challenges, opportunities and resources. •Identify, implement and promote the use of a standardized form •Identify and eliminate barriers and mitigate obstacles to spacer access •Identify funding source(s) for spacers •Obtain and distribute spacers to schools
Single or Multi-Year InitiativeTime Period	July 2012- December 2014
Key Partners and/or Hospitals in initiative development and/or implementation	Baltimore County Public Schools Health Services School RNs MedStar Franklin Square Community Asthma Team MedStar Grant Development Team MedStar Franklin Square Outpatient Pharmacy
How were the outcomes evaluated?	The number of completed asthma action plans in targeted schools by November 2012 Number of spacers provided to each of the fifty-one BCPS schools in the CBSA by November 2014 Decrease 911 calls by 10% from the fifty-one BCPS schools in the (CBSA)
Outcome (Include process and impact measures)	Unable to assess # completed asthma action plans due to Family Educational Rights and Privacy Act (FERPA) confidentiality concerns. #Spacers provided Deep Creek Elementary School – 50 Golden Ring Middle School – 50 Kenwood High School – 50 Unable to assess 911 calls from BCPS due to Family Educational Rights and Privacy Act (FERPA) confidentiality concerns.
Continuation of Initiative	Action Plans:This outcome will not be measured in the future. BCPS Health Services will be using the new State Asthma Management Plan form and requested redirection of initiative. Spacers: For sustainability, access to current resources, e.g., insurance coverage will be explored. Supportive funding sources will also be investigated. 911 calls: Investigating Hospital and other data sources to continue evaluation of initiative. Redirection: BCPS Health Services identified a need for improvement in communication between BCPS RNs and healthcare providers, especially during the school day. In response, plans include: •Surveys of BCPS RNs to evaluate

	communication with area providers •Introducing a point of contact for all providers at the MedStar Franklin Square's Family Health Center; •Continued monthly community asthma group meeting with school nurses and the parents of our patients; •A yearly school nurse asthma symposium; and •Asthma self-management education for school children, e.g. American Lung Association Open Airways
Cost of initiative for current FY?	$18,025

Initiative 2

Identified Need	Senior Cardiovascular Health Heart disease is the leading cause of death in Maryland, accounting for 25% of all deaths (MD SHIP) 36.2% of people in Baltimore County report high cholesterol (MD BRFSS, 2009) 33.8% of people in Baltimore County report high blood pressure (MD BRFSS, 2009) Heart disease accounts for 26.5% of all deaths in Southeast Baltimore County Deaths due to heart disease per 100,000 population in Baltimore County 198.1 Pacific I--68.3 Black--238.6 White--197.4 (VSA 2008-2010) Deaths due to heart disease per 100,000 population in Baltimore County 239.0 (HSCRC, 2010) Rate of ED visits for hypertension per 100,000 population Baltimore County 226.2 NH black--490.3 NH white--143.5 (HSCRC 2010)(HSCRC 2011) 81.8% (n=243) of Community Input Survey respondents rated heart disease to be "critical" or "very critical" 73.4% (n=243) of Community Input Survey respondents rated stroke to be "critical" or "very critical" The heart disease death rate percentage in the southeast area (25.9%) is higher than the national average (24.6%). (Community Needs Assessment for Baltimore County's Southeast Area, June 2013)
Hospital Initiative	Heart Smart Seniors

	Implement Heart Smart Seniors in each targeted Senior Center: Ateaze, Edgemere, Essex, Fleming, Overlea-Fullerton, Rosedale and Victory Villa
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Improve the quality of cardiovascular health for seniors attending the seven Baltimore County Department of Aging (BCDA) Senior Centers in the Community Benefit Service Area. •Recruit 10 participants at each senior center •Assess each participant for baseline heart health indicators •Collect pertinent heart health medical information from each participant •Hold monthly meetings (Oct –May) to discuss hearth health topics •Reassess heart health indicators and BRFSS questions at end of program
Single or Multi-Year InitiativeTime Period	July 2012-December 2013
Key Partners and/or Hospitals in initiative development and/or implementation	Baltimore County Department of Aging Senior Centers Fitness Centers CountyRide University of Maryland, Baltimore and Notre Dame of Baltimore Pharmacy students MedStar Franklin Square Community Health Education Food and Nutrition Consumer Health Library Pharmacy Fitness Coordinator Family Medicine Residency MedStar Health Cardiovascular Services Nurse American Heart Association Million Hearts Initiative
How were the outcomes evaluated?	Number of Blood pressures in therapeutic range among program participants Number of hospital/ED visits for hypertension by program participants. Participants were screened for the following indicators at the first and last sessions of the program: •Height/weight (BMI) •Waist circumference •Blood pressure •Glucose •Cholesterol •Number of hospital/ED visits for HTN-related issues
Outcome (Include process and impact measures)	73 total registrants The only statistically significant biometric change was decreased cholesterol level.

	There was no statistical change in knowledge or risk behavior.
Continuation of Initiative	Heart Smart Seniors, under IRB supervision, is complete and data have been reviewed. Implications are being assessed. To continue addressing senior cardiovascular health, MedStar Franklin Square will implement Active Living Every Day, an evidence-based program to decrease sedentary lifestyle, will be facilitated at the area BCDA Senior Centers.
Cost of initiative for current FY?	$17,806 BCDA contract $8,000

Initiative 3

Identified Need	Tobacco Use and Substance Abuse Prevention and Cessation Tobacco use contributes to cancer, heart disease, and respiratory diseases (including emphysema, bronchitis, and chronic airway obstruction), premature birth, low birth weight, stillbirth, and infant death. Registration for free tobacco cessation programs at MedStar Franklin Square is frequently so low that programs are cancelled The current adult smoking rate in Maryland is 15.2% (MD BRFSS) The current adult smoking rate in Baltimore County is 15.6% (MD BRFSS) 70.3% (n=243) of Community Input Survey respondents think tobacco use is a “critical” or “very critical” issue 27.3 (n=243) of Community Input Survey respondents “don’t know” that smoking cessation, prevention, education and support programs are available in Southeast Baltimore County 28.3 (n=243) of Community Input Survey respondents “don’t know” that substance abuse prevention, education and support programs are available in Southeast Baltimore County Only 41.4% (n=243) of Community Input Survey respondents “agreed” or “strongly agreed” that smoking cessation, prevention, education and support programs are available; 27.3% did not know; another 6.6% did not respond Only 38.5% (n=243) of Community Input Survey respondents “agreed” or “strongly agreed” that substance abuse, prevention, education and support programs are available; 28.3% did not know; another 8.2% did not respond
Hospital Initiative	Resource awareness program Identify obstacles to resource awareness Increase publicity about tobacco and other substance abuse resources. Re-execution of the Holleran community input survey at all the previous sites
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Increase the awareness of the public, providers and policy makers in the CBSA about available tobacco and other substance abuse prevention, education and support programs resources. Hold three community input sessions with the Southeast Network, other healthcare providers, and community members

	Utilize MedStar Franklin Square marketing opportunities to publicize smoking and substance abuse cessation prevention, education and support programs in the CBSA Collaborate with Baltimore County and area resource providers in related publicity campaigns Send brochure electronically to BCDH and SEN to be distributed to all providers and clients
Single or Multi-Year InitiativeTime Period	July 2012- December 2014
Key Partners and/or Hospitals in initiative development and/or implementation	Baltimore County Department of Health Tobacco Coalition Baltimore County Department of Aging Baltimore County Office of Planning Baltimore County Public Schools Southeast Area Network
How were the outcomes evaluated?	Number of Stop Smoking Today participants
Outcome (Include process and impact measures)	# Participants registered FY12 30 FY13 65 # Participants attended FY12 16 FY13 32 # Participants completed FY12 8 FY13 16 # Participants quit smoking FY12 5 FY13 7 Quit rate FY12 62.5% FY13 43.8% Tobacco Use Prevention and Cessation Activities #events FY12 19 FY13 35 #encounters FY12 1091 FY13 2160 Publicity of Stop Smoking Today increased by electronic distribution of information and registration materials to all Southeast Network providers, Parish Nurses, Clergy, and Hospital clinicians. Collaboration with Baltimore County, One

	Voice Dundalk, and other area resource providers in community resource events such as DunFest and Race to Recovery.
Continuation of Initiative	Continue publicity by electronic distribution. Continue collaboration with Baltimore County, and other area resource providers in community resource events Working with Transitional Care Nurses to provide brief interventions and referrals to COPD patients. Working with Clinical Informatics to hardwire brief interventions and referrals through electronic medical records.
Cost of initiative for current FY?	$11,172

Initiative 4

Identified Need	
Hospital Initiative	
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	
Single or Multi-Year InitiativeTime Period	
Key Partners and/or Hospitals in initiative development and/or implementation	
How were the outcomes evaluated?	
Outcome (Include process and impact measures)	
Continuation of Initiative	
Cost of initiative for current FY?	

Initiative 5

Identified Need	
Hospital Initiative	
Primary Objective of the Initiative/Metrics that will be used to evaluate the results	
Single or Multi-Year InitiativeTime Period	
Key Partners and/or Hospitals in initiative development and/or implementation	
How were the outcomes evaluated?	
Outcome (Include process and impact measures)	
Continuation of Initiative	
Cost of initiative for current FY?	

2. Were there any primary community health needs that were identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

See attachment.

V. PHYSICIANS

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

MedStar Franklin Square is in a HRSA-designated medically underserved area. In response to the recognized need for services to the county's homeless population, MedStar Franklin Square Medical Center collaborated with Healthcare for the Homeless and the Baltimore County Health Department under a HRSA grant to offer a new point of access for primary care. Needs for specialty care are addressed on an individual basis. Many of these needs, as well as similar needs of the larger uninsured or underinsured population, are addressed by our financial assistance policy.

Both Pediatric and OB/GYN outpatient practices are operated at a loss due to the community need for these services.

- Timely placement of patients in need of inpatient psychiatry services
- Limited availability of outpatient psychiatry services
- Limited availability of inpatient and outpatient substance abuse treatment

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

MedStar Franklin Square's 2013 Community Benefit Report includes subsidies for losses from physician services stemming from serving patients who are uninsured or underinsured, including the Medicaid population.
The amount in Primary Care Physician, Hospitalist, and OB/GYN subsidies provides community services and ensures adequate primary care coverage for our community. The amount in Emergency/Trauma ensures that the hospital maintains adequate surgical call coverage for the emergency department. These subsidies make up for the shortfall in payments related to the cost of providing 24/7 coverage.

Appendix I - Describe FAP

Appendix I

MedStar Franklin Square's FAP and financial assistance contact information is:

- available in both English and Spanish
- posted in all admissions areas, the emergency room, and other areas of facilities in which eligible patients are likely to present
- provided with financial assistance contact information to patients or their families as part of the intake process
- provided to patients with discharge materials
- included in patient bills

Patient Financial Advocates visit all private pay patients and are available to all patients and families to discuss the availability of various government benefits, such as Medicaid or state programs, and assist patients with qualification for such programs, where applicable.

Appendix II - Hospital FAP

MedStar Health

Corporate Policies

Title:	**Hospital Financial Assistance Policy**	**Section:**	
Purpose:	To ensure uniform management of the MedStar Helath Corporate Financial Assistance Program within all MedStar Health Hospitals.	**Number:**	
Forms:		**Effective Date:**	07/01/2011

Policy

1. As one of the region's leading not-for-profit healthcare systems, MedStar Health is committed to ensuring that uninsured patients within the communities we serve who lack financial resources have access to necessary hospital services. MedStar Health and its healthcare facilities will:

   1.1 Treat all patients equitably, with dignity, with respect and with compassion.
   1.2 Serve the emergency health care needs of everyone who presents at our facilities regardless of a patient's ability to pay for care.
   1.3 Assist those patients who are admitted through our admissions process for non-urgent, medically necessary care who cannot pay for the care they receive.
   1.4 Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep its hospitals' doors open for all who may need care in the community.

Scope

1. In meeting its commitments, MedStar Health's facilities will work with their uninsured patients to gain an understanding of each patient's financial resources prior to admission (for scheduled services) or prior to billing (for emergency services). Based on this information and patient eligibility, MedStar Health's facilities will assist uninsured patients who reside within the communities we serve in one or more of the following ways:

   1.1 Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
   1.2 Assist with consideration of funding that may be available from other charitable organizations.
   1.3 Provide charity care and financial assistance according to applicable guidelines.
   1.4 Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
   1.5 Offer periodic payment plans to assist patients with financing their healthcare services.

Definitions

1. **Free Care**

   Financial assistance for medically necessary care provided to uninsured patients in households between 0% and 200% of the FPL.

2. **Reduced Cost-Care**

   Financial assistance for medically necessary care provided to uninsured patients in households between 200% and 400% of the FPL.

3. **Medical Hardship**

Medical debt, incurred by a household over a 12-month period, at the same hospital that exceeds 25% of the family household income.

4. **Maryland State Uniform Financial Assistance Application**

   A uniform data collection document developed through the joint efforts of Maryland hospitals and the Maryland Hospital Association.

5. **Maryland Patient Information Sheet / MedStar Patient Information Sheet (Non-Maryland Hospitals)**

   A patient education document that provides information about MedStar's Financial Assistance policy, and patient's rights and obligations related to seeking and qualifying for free or reduced cost medically necessary care.

Responsibilities

1. Each facility will post the policy, including a description of the applicable communities it serves, in each major patient registration area and in any other areas required by applicable regulations, will communicate the information to patients as required by this policy and applicable regulations and will make a copy of the policy available to all patients. Additionally, the Maryland Patient Information Sheet / MedStar's Patient Information Sheet will be provided to inpatients on admission and at time of final account billing.

2. MedStar Health believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. The charity care, financial assistance, and periodic payment plans available under this policy will not be available to those patients who fail to fulfill their responsibilities. For purposes of this policy, patient responsibilities include:

   2.1 Completing financial disclosure forms necessary to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.

   2.2 Working with the facility's financial counselors and other financial services staff to ensure there is a complete understanding of the patient's financial situation and constraints.

   2. 3Completing appropriate applications for publicly-funded healthcare programs. This responsibility includes responding in a timely fashion to requests for documentation to support eligibility.

   2. 4 Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.

   2 .5 Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

   2.6 It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

3. Uninsured patients of MedStar Health's facilities may be eligible for charity care or sliding-scale financial assistance under this policy. The financial counselors and financial services staff will determine eligibility for charity care and sliding-scale financial assistance based on review of income for the patient and their family (household), other financial resources available to the patient's family, family size, and the extent of the medical costs to be incurred by the patient.

4. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

4.1 Federal Poverty Guidelines. Based on family income and family size, the percentage of the then-current Federal Poverty Level (FPL) for the patient will be calculated.

4.1.1 Free Care: Free Care will be available to uninsured patients in households between 0% and 200% of the FPL.

4.1.2 Reduced Cost-Care: Reduced Cost-Care will be available to uninsured patients in households between 200% and 400% of the FPL. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

4.1.3 Ineligibility. If this percentage exceeds 400% of the FPL, the patient will not be eligible for Free Care or Reduced-Cost Care assistance (unless determined eligible based on Medical Hardship criteria, as defined below).

4.2 Basis for Calculating Amounts Charged to Patients: Free Care or Reduced-Cost Care Sliding Scale Levels:

	Financial Assistance Level Free / Reduced-Cost Care	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Facilities and non-HSCRC Regulated Services**
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

4.3 **MedStar Health Hospitals** will comply with IRS 501(r) requirements on limiting the amounts charged to uninsured patients seeking emergency and medically necessary care.

4.3.1 Amounts billed patients who qualify for financial assistance will be an average of the three best negotiated commercial rates.

4.3.2 MedStar Health will calculate the average of the three best negotiated commercial rates annually.

4.3.3 Maryland hospitals are prohibited from contacting with commercial payor. Charges are regulated by the Health Services Cost Review Commission (HSCRC) and will define the limits of the amount charged to all patients including the uninsured.

5. **FINANCIAL ASSISTANCE: ADDITIONAL FACTORS USED TO DETERMINE ELIGIBILITY FOR MEDICAL ASSISTANCE: MEDICAL HARDSHIP.**

5.1 MedStar Health will evaluate patients for Medical Hardship Financial Assistance if they exceed the 400% of the FPL and are deemed ineligible for Free Care or Reduced-Cost Care.

5.2 Medical Hardship is defined as medical debt, incurred by a household over a 12-month period, at the same hospital that exceeds 25% of the family household income.

5.3 MedStar Health will provide Reduced-Cost Care to patients with income below 500% of the FPL that, over a 12 month period, has incurred medical debt at the same hospital in excess of 25% of the patient's household income. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

5.4 A patient receiving reduced-cost care for medical hardship and the patient's immediate family members shall receive/remain eligible for Reduced-Cost medically necessary care when seeking subsequent care for 12 months beginning on the date which the reduced-care was received. It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

5.5 If a patient is eligible for both Free Care / Reduced-Cost Care, and Medical Hardship, the hospital will employ the more generous policy to the patient.

5.6 Medical Hardship Reduced-Care Sliding Scale Levels:

	Financial Assistance Level – Medical Hardship	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Facilities and non-HSCRC Regulated Services**
Less than 500%	**Not to Exceed 25% of Household Income**	**Not to Exceed 25% of Household Income**

6. **METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE: INCOME AND ASSET DETERMINATION.**

6.1 Patients may obtain an application for Financial Assistance Application:
- 6.1.1 On Hospital websites
- 6.1.2 From Hospital Patient Financial Counselor Advocates
- 6.1.3 By calling Patient Financial Services Customer Service

6.2 MedStar Health will evaluate the patient's financial resources **EXCLUDING**:

- 6.2.1 The first $250,000 in equity in the patient's principle residence
- 6.2.2 Funds invested in qualified pension and retirement plans where the IRS has granted preferential treatment
- 6.2.3 The first $10,000 in monetary assets e.g., bank account, stocks, CD, etc

6.3 MedStar Health will use the Maryland State Uniform Financial Assistance Application as the standard application for all MedStar Health Hospitals. MedStar Health will require the patient to supply all documents necessary to validate information to make eligibility determinations.

6.4 Financial assistance applications and support documentation will be applicable for determining program eligibility one (1) year from the application date. Additionally, MedStar will consider for eligibility all accounts (including bad debts) 6 months prior to the application date.

7. PRESUMPTIVE ELIGIBILTY

7.1 Patients already enrolled in certain means-tested programs are deemed eligible for free care on a presumptive basis. Programs eligible under the MedStar Health financial assistance program include, but may not be limited to:

- 7.1.1 Maryland Primary Adult Care Program (PAC)
- 7.1.2 Maryland Supplemental Nutritional Assistance Program (SNAP)
- 7.1.3 Maryland Temporary Cash Assistance (TCA)
- 7.1.4 Maryland State and Pharmacy Only Eligibility Recipients
- 7.1.5 DC Healthcare Alliance or other Non-Par Programs

7.2 Additional presumptively eligible categories will include with minimal documentation:

- 7.2.1 Homeless patients
- 7.2.2 Deceased patients with no known estate
- 7.2.3 Members of a recognized religious organization who have taken a vow of poverty
- 7.2.4 All patients based on other means test scoring campaigns
- 7.2.5 All secondary balances after primary Medicare insurance where patients meet income and asset eligibility tests
- 7.2.6 All spend-down amounts for eligible Medicaid patients.

8 MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS

8.1 In the event a patient is denied financial assistance, the patient will be provided the opportunity to appeal the MedStar Health denial determination.

8.2 Patients are required to submit a written appeal letter to the Director of Patient Financial Services with additional supportive documentation.

8.3 Appeal letters must be received within 30 days of the financial assistance denial determination.

8.4 Financial assistance appeals will be reviewed by a MedStar Health Appeals Team. Team members will include the Director of Patient Financial Services, Assistance Vice President of Patient Financial Services, and the hospital's Chief Financial Officer.

8.5 Denial reconsideration decisions will be communicated, in writing, within 30 business days from receipt of the appeal letter.

8.6 If the MedStar Health Appeals Panel upholds the original denial determination, the patient will be offered a payment plan to the patient.

9. PAYMENT PLANS

9.1 MedStar Health will make available payment plans to uninsured patients with income between 200% and 500% of the FPL.

9.2 Patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to meet

these continuing responsibilities, the patient will become financially responsible for the original amount owed, less any payments made to date.

10 **BAD DEBT RECONSIDERATIONS AND REFUNDS**

10.1 In the event a patient who, within a two (2) year period after the date of service was found to be eligible for free care on that date of service, MedStar will initiate a review of the account(s) to determine the appropriateness for a patient refund for amounts collected exceeding $25.

10.2 It is the patient's responsibility to request an account review and provide the necessary supportive documentation to determine free care financial assistance eligibility.

10.3 If the patient failed to comply with requests for documentation, MedStar Health will document the patient's non-compliance. The patient will forfeit any claims to a patient refund or free care assistance.

10.4 If MedStar Health obtains a judgement or reported adverse information to a credit reporting agency for a patient that was later to be found eligible for free care, MedStar Health will seek to vacate the judgement or strike the adverse information.

Exceptions

1 **PROGRAM EXCLUSION**

MedStar Health's financial assistance program excludes the following:

1.1 Insured patients who may be "underinsured" (e.g. patient with high deductibles/coinsurance)

1.2 Patient seeking non-medically necessary services, including cosmetic procedures

1.3 Non-US Citizens,

1.3.1 Excluding individuals with permanent resident /resident alien status as defined by the Bureau of Citizenship and Immigration Services has issued a green card. MedStar will consider non-US citizens who can provide proof of residency within the defined service area.

1.4 Patients residing outside a hospital's defined zip code service area

1.4.1 Excluding patient referral between MedStar Health Network System

1.4.2 Excluding patients arriving for emergency treatment via land or air ambulance transport

1.4.3 Specialty services specific to each MedStar Health hospital and approved as a program exclusion

1.4.3.a Union Memorial Hospital – Cardiac Service, Hand Center, and Renal Patients
1.4.3.b Georgetown University Hospital – Transplant, and Cyber Knife Patients
1.4.3.c Washington Hospital Center – Cardiac Service Patients
1.4.3.d Good Samaritan Hospital – Renal Patients
1.4.3.e Franklin Square Hospital – Cyber Knife Patients

1.5 Patients that are non-compliant with enrollment processes for publicly –funded healthcare programs, charity care programs, and other forms of financial assistance

As stated above, patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to

meet these continuing responsibilities, the patient will become financially responsible for the original amount owed, less any payments made to date.

What Constitutes Non-Compliance

Actions or conduct by MedStar Health employee or contract employee in violate of this Policy.

Consequences of Non-Compliance

Violations of this Policy by any MedStar Health employee or contract employee may require the employee to undergo additional training and may subject the employee to disciplinary action, including, but not limited to, suspension, probation or termination of employment, as applicable.

Explanation And Details/Examples

N/A

Requirements And Guidelines For Implementing The Policy

N/A

Related Policies

N/A

Procedures Related To Policy

Admission and Registration
Financial Self Pay Screening
Billing and Collections
Bad Debt

Legal Reporting Requirements

HSCRC Reporting as required – Maryland Hospitals Only
Year End Financial Audit Reporting
IRS Reporting

Reference To Laws Or Regulations Of Outside Bodies

Maryland Senate Bill 328 Chapter 60 – Maryland Hospitals Only
COMAR 10.37.10 Rate Application and Approval Procedures – Maryland Hospitals Only
IRS Regulations Section 501(r)

Right To Change Or Terminate Policy

Any change to this Policy requires review and approval by the Legal Services Department.
Proposed changes to this Policy will be discussed with all affected parties at both the Business Unit and Corporate levels of the Organization.
The Corporation's policies are the purview of the Chief Executive Officer (CEO) and the CEO's management team

Reference:	
Approved By:	 Michael J. Curran, Executive Vice President and CFO
Additional Signature Information:	

Appendix III - Patient Information Sheet

Appendix III

MedStar Health

MARYLAND HOSPITAL PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy

MedStar Franklin Square Medical Center 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, have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability, you may qualify for **Free or Reduced Cost Medically Necessary Care**.

MedStar Franklin Square Medical Center 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

Medstar Franklin Square Medical Center 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 been wrongfully referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

Patients' Obligations

MedStar Franklin Square Medical Center 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 and 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 (410-933-2424) or toll free (1-800-280-9006) with questions concerning:

- Your hospital bill
- Your rights and obligations with regards to your hospital bill
- How to apply for Maryland Medicaid
- How to apply for free or reduced care

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.

(This sheet is also available in Spanish.)

Appendix VI - Mission, Vision, Value Statement

Appendix IV – Mission, Vision, and Values

Mission

MedStar Franklin Square Medical Center, a member of MedStar Health, provides safe, high quality care, excellent service, and education to improve the health of our community.

Vision

The trusted leader in caring for people and advancing health.

Values

Service: We strive to anticipate and meet the needs of our patients, physicians and co-workers.

Patient First: We strive to deliver the best to every patient every day. The patient is the first priority in everything we do.

Integrity: We communicate openly and honestly, build trust and conduct ourselves according to the highest ethical standards.

Respect: We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.

Innovation: We embrace change and work to improve all we do in a fiscally responsible manner.

Teamwork: System effectiveness is built on collective strength and cultural diversity of everyone, working with open communication and mutual respect.

Section IV Attachments

MedStar Franklin Square Medical Center
Section IV, Question 2

Condition / Issue	Classification	Source	Explanation
Transportation	Access to Care	42.1% (n=243) of Community Input Survey respondents found the quality of transportation to be "fair," "poor" or "very poor"	MedStar Franklin Square does not have the expertise or infrastructure to serve as a lead around this area of need
Housing	Quality of Life	53.1% (n=243) of Community Input Survey respondents found the quality of housing to be "fair," "poor" or "very poor"	MedStar Franklin Square does not have the expertise or infrastructure to serve as a lead around this area of need