Community Benefit Narrative Report

Fiscal Year 2013

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

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 (FY13 Licensed Beds)	**800**			
Inpatient Admissions	**Total: 35,929**			
Primary Service Area Zip Codes	21201	21215	21216	21223
	21229	21217	21230	21061
	21225	21218	21207	21122
	21206	21213	21227	21060
	21228	21202	21234	21224
	21222	21244	21212	21014
	21601	21239	21157	21221
	21740	21144	21117	21001
	21040	21208	21220	21133
	21401	21009	21043	21784
	21042	21613	21015	21044
	21620	21078	21205	21214
	21136	21237		
All Other Maryland Hospitals Sharing PSA	Ann Arundel Medical Center, Baltimore Washington Medical Center, Bon Secours, Harbor, Good Samaritan, Johns Hopkins, Johns Hopkins Bayview, Maryland General, Mercy, Union Memorial, Northwest, St. Joseph, Sinai, GBMC, Franklin Square, Carroll Hospital, Howard County General, St. Agnes, Upper Chesapeake			
	County		**Uninsured**	
Percentage Uninsured Patients by County	**Grand Total**		**8.8%**	

ALLEGANY	2.6%
ANNE ARUNDEL	7.9%
BALTIMORE	7.5%
BALTIMORE CITY	10.5%
CALVERT	3.9%
CAROLINE	9.9%
CARROLL	5.8%
CECIL	8.9%
CHARLES	7.3%
DELAWARE	3.7%
DORCHESTER	8.8%
FOREIGN	25.0%
FREDERICK	5.8%
GARRETT	4.8%
HARFORD	4.9%
HOWARD	5.0%
KENT	10.2%
MONTGOMERY	16.4%
OTHER STATE	10.6%
PENNSYLVANIA	6.0%
PRINCE GEORGES	12.1%
QUEEN ANNES	11.8%
SOMERSET	10.0%
ST. MARYS	8.4%
TALBOT	5.2%
UNIDENTIFIED MD	10.1%
UNKNOWN	33.3%
VIRGINIA	11.3%
WASHINGTON	4.3%

WASHINGTON,DC	5.4%	
WEST VIRGINIA	10.2%	
WICOMICO	8.0%	

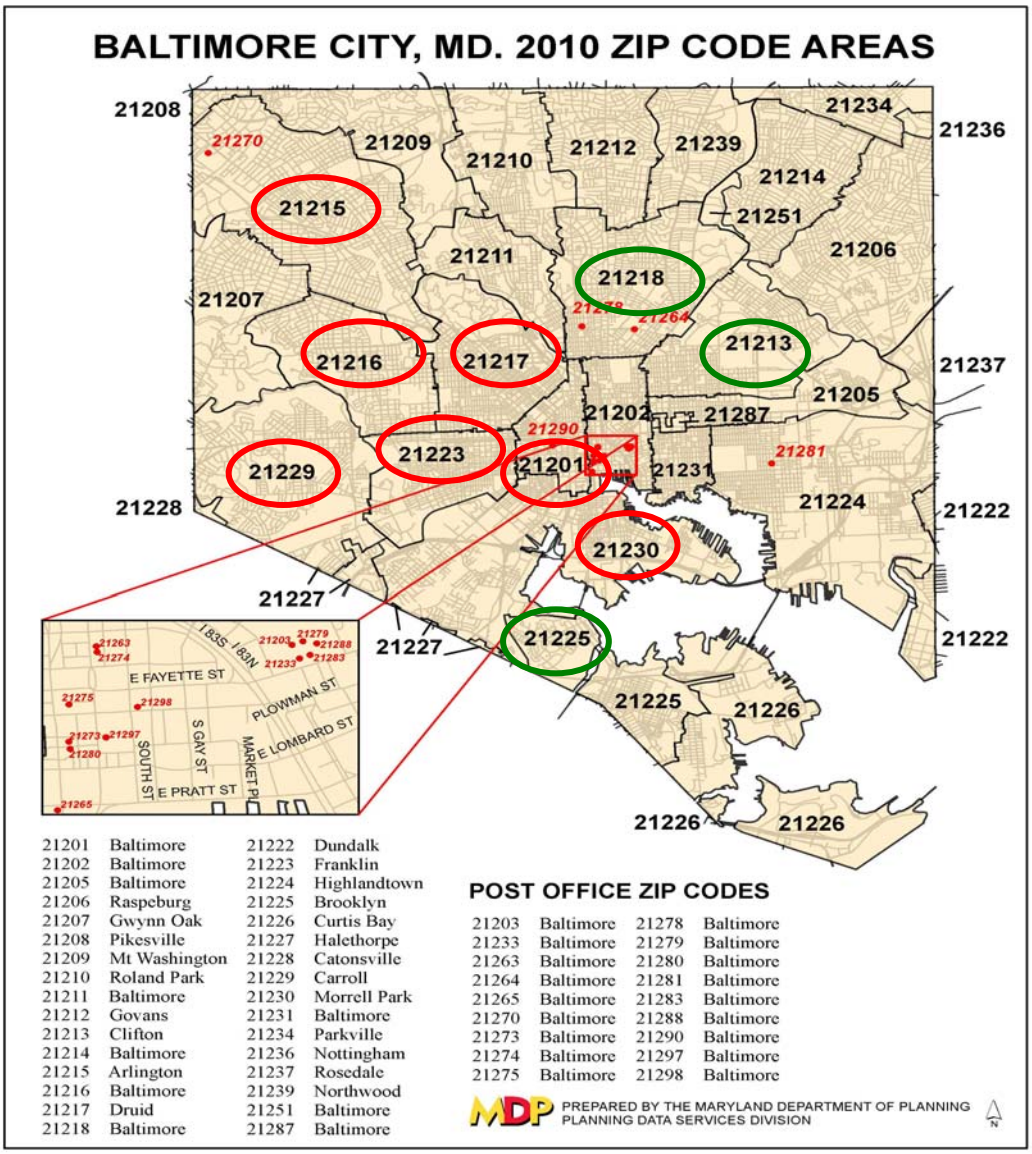
Percentage of UMMC Patients who are Medicaid by County	County	MEDICAID	MEDICAID - HMO	TOTAL
	ALLEGANY	6.0%	16.4%	22.4%
	ANNE ARUNDEL	5.2%	13.0%	18.2%
	BALTIMORE	6.4%	22.4%	28.9%
	BALTIMORE CITY (INDEPENDE	8.1%	40.5%	48.6%
	CALVERT	4.2%	16.4%	20.6%
	CAROLINE	3.9%	13.8%	17.8%
	CARROLL	3.7%	7.7%	11.4%
	CECIL	3.7%	17.5%	21.2%
	CHARLES	6.5%	17.2%	23.6%
	DELAWARE	9.3%	3.7%	13.1%
	DORCHESTER	5.3%	17.9%	23.2%
	FOREIGN	0.0%	0.0%	0.0%
	FREDERICK	7.0%	8.3%	15.2%
	GARRETT	9.5%	4.8%	14.3%
	HARFORD	4.2%	12.1%	16.3%
	HOWARD	3.2%	10.3%	13.5%
	KENT	5.1%	13.2%	18.3%
	MONTGOMERY	5.9%	10.5%	16.4%
	OTHER STATE	5.3%	1.4%	6.7%
	PENNSYLVANIA	4.4%	1.0%	5.4%
	PRINCE GEORGES	10.4%	12.9%	23.3%
	QUEEN ANNES	3.6%	9.4%	13.0%
	SOMERSET	24.3%	4.3%	28.6%
	ST. MARYS	7.5%	14.0%	21.5%
	TALBOT	4.2%	10.3%	14.5%
	UNIDENTIFIED MD	10.8%	18.9%	29.7%
	UNKNOWN	0.0%	11.1%	11.1%
	VIRGINIA	3.0%	1.2%	4.2%
	WASHINGTON	4.1%	10.3%	14.4%
	WASHINGTON,DC	23.5%	1.8%	25.3%
	WEST VIRGINIA	6.6%	0.0%	6.6%
	WICOMICO	4.5%	18.1%	22.6%
	WORCESTER	6.7%	6.2%	12.9%
	Grand Total	**6.7%**	**23.0%**	**29.7%**

2. For purposes of reporting on your community benefit activities, please provide the following information:

a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital's Community Benefit Service Area – "CBSA". This service area may differ from your primary service area on page 1.) This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

2. a. The University of Maryland Medical Center (UMMC) serves Baltimore City and the greater metropolitan region, including patients with in-state, out-of-state, and international referrals for tertiary and quaternary care. UMMC is a private, non-profit acute care hospital and is affiliated with the University of Maryland School of Medicine, as well as the surrounding professional schools on campus. It is the second leading provider of healthcare in Baltimore City and the state of Maryland, and has served the state's and city's populations since 1823.

Despite the larger regional patient mix, for purposes of community benefits programming and this report, the Community Benefit Service Area (CBSA) of UMMC is defined following the completion of our Community Health Needs Assessment in FY'12 using the following Baltimore City 10 zip codes: 21201, 21223, 21229, 21230, 21215, 21216, 21217, 21218, 21213, and 21225. (See Map 1). However, UMMC does respond to community health issues outside of the primary CBSA as the need arises (i.e. H1N1 preparedness, emergency & disaster preparedness for the region and state, etc.).



Red = Top 66%

Green = Top 80% cumulative with Red zips together

b. 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).

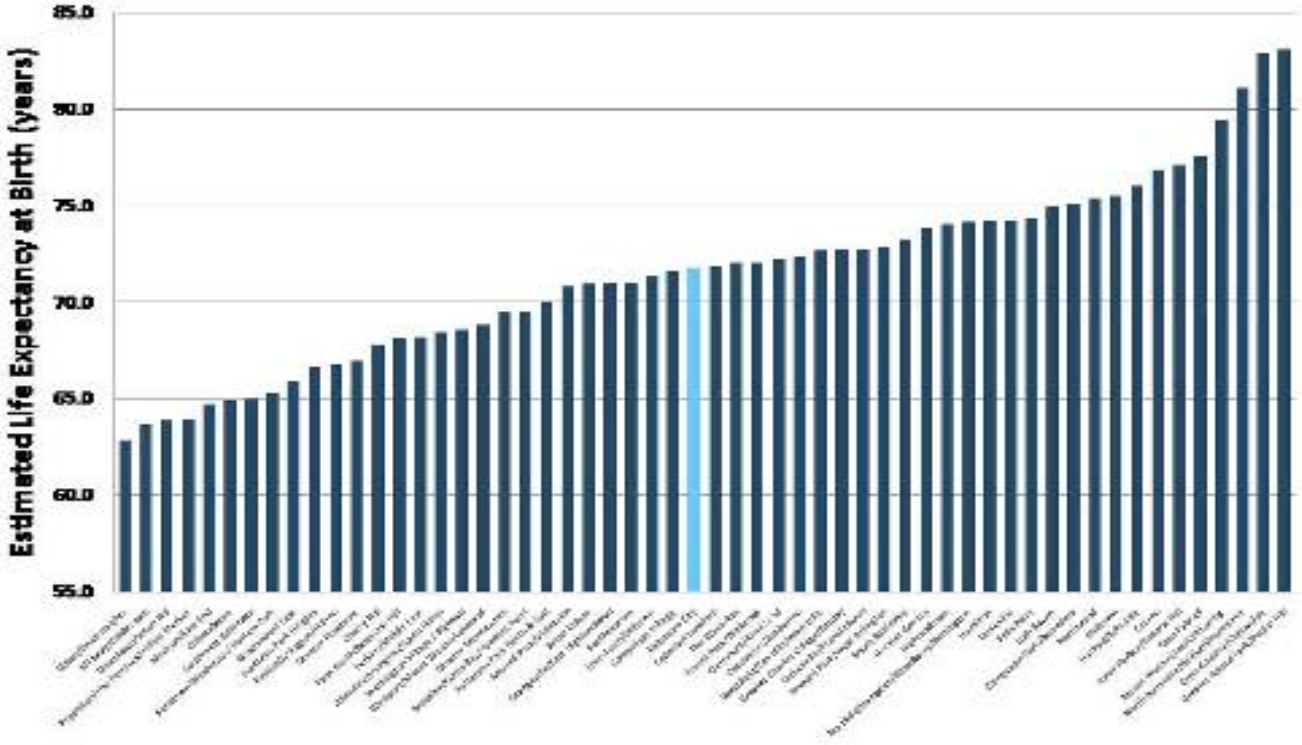
Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its County Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://vsa.maryland.gov/html/reports.cfm), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://www.dhmh.maryland.gov/mhhd/Documents/1stResource_2010.pdf), the 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, and average age)	**363,636 Total** **By Gender** **193,812 Female** **169,824 Male** **By Race** **255,523 Black/African American** **85, 268 White/Caucasian** **9,117 Asian** **1,129 American Indian/Alaska Nat** **152 Native Hawaiian/Other Pacific** **4,637 Other** **7,810 Two/More Races** **By Ethnicity** **351,794 Non-Hispanic** **11,842 Hispanic** **37.52 years – Average Age**
Median Household Income within the CBSA	**$34,675**

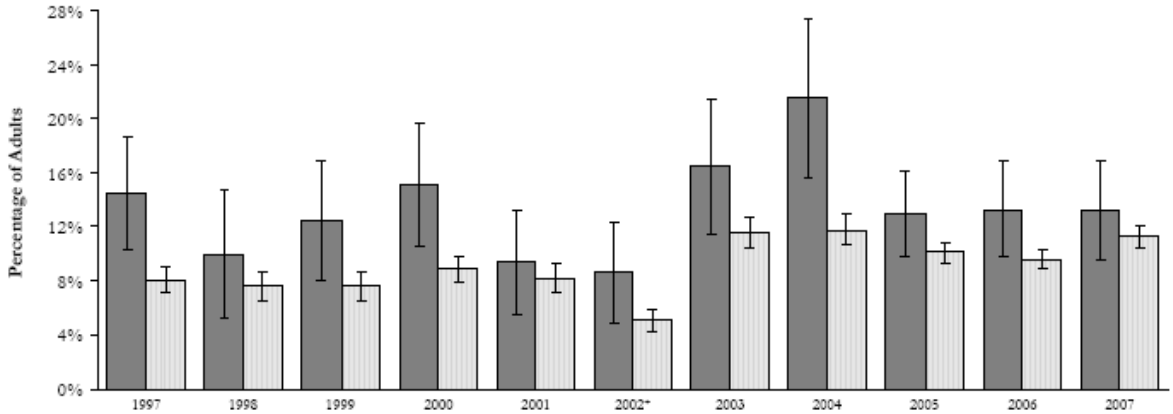
Percentage of households with incomes below the federal poverty guidelines within the CBSA	**17,054 Families for 21.41%**
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	**16.50%**
Percentage of Medicaid recipients by County within the CBSA.	**39.3%**
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.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	**73.3 years Baltimore City Overall** **71.5 yrs- Black** **76.5 yrs – White** http://eh.dhmh.md.gov/ship/SHIP_Profile_Baltimore_City.pdf
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	**7.5 Total** **8.5 White/Caucasian** **6.5 Black/African American**
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	**See Baltimore City Food Environment Map below**
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_09_5YR_B16001&prodType=table	**(See Above for Race & Ethnicity)** **Language Spoken at Home (5yrs and over)** **English 90%** **Spanish 4%** **French 1%** **All Other Combined 5%**

Estimated Life Expectancy at Birth by Neighborhood, Baltimore City, 2011



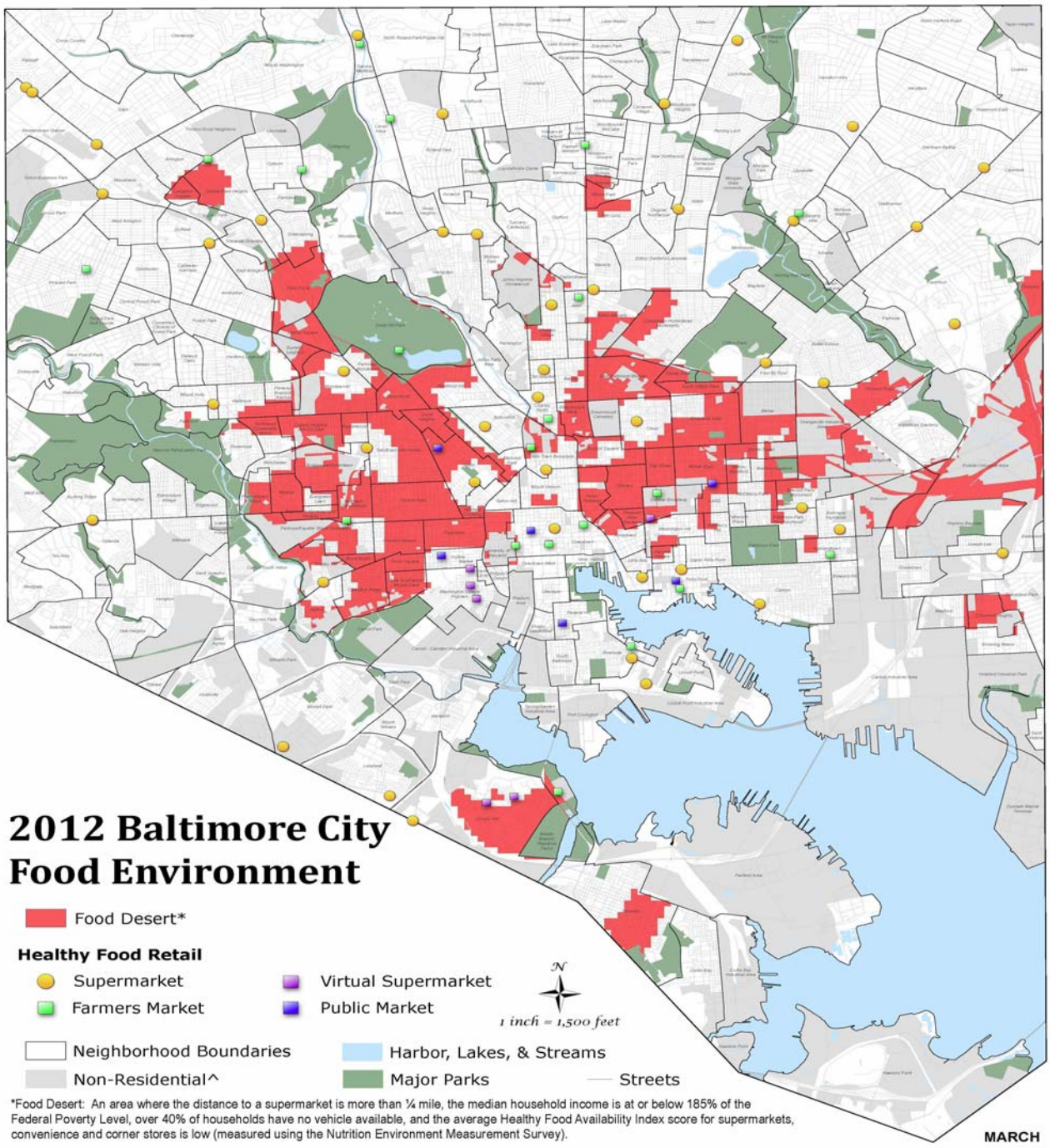
Access to Medical Care

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 (CHNA) either fiscal year 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:

> **Despite the larger regional patient mix, for purposes of community benefits programming and this report, the Community Benefit Service Area (CBSA) of UMMC is defined following the completion of our Community Health Needs Assessment in FY'12 using the following Baltimore City 10 zip codes of admissions: 21201, 21223, 21229, 21230, 21215, 21216, 21217, 21218, 21213, and 21225. (See prior Map 1). However, UMMC does respond to community health issues outside of the primary CBSA as the need arises (i.e. H1N1 preparedness, emergency & disaster preparedness for the region and state, etc.). The CBSA was identified and approved by the UMMC Community Empowerment Team (CET), then vetted through a UMB Campus panel of experts. Once it was approved at that level on 6/14/12, the priorities were presented to Senior Leadership where they were approved on 6/26/12, and in turn by the Board on 6/28/12.**

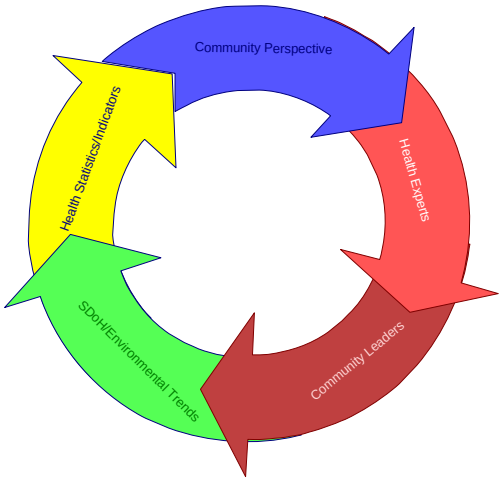
A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact 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;

> **The University of Maryland Medical Center (UMMC) completed a comprehensive community health needs assessment using the Association for Community Health Improvement's (ACHI) 6-step Community Health Assessment Process as an organizing methodology/framework. The UMMC Community Empowerment Team (CET) served as the lead team to conduct the Community Health Needs Assessment (CHNA) in Fiscal Year**

2012. The interdisciplinary UMMC CET adopted the following ACHI 6-step process (See Figure 1) to lead the assessment process and the additional 5-component assessment (See Figure 2) and engagement strategy was developed internally to lead the data collection and engagement methodology.

Figure 1 - ACHI 6-Step Community Health Assessment Process

Figure 2 – 5-Step Assessment & Engagement Model



Using the above frameworks, data was collected from multiple sources, groups, and individuals and integrated into a comprehensive document which was utilized at a retreat of the UMMC Community Empowerment Team. During that strategic planning retreat, priorities were identified using the collected data, then the priorities were validated by a panel of UMB Campus experts.

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);

UMMC used primary and secondary sources of data as well as quantitative and qualitative data and consulted with numerous individuals and organizations during the CHNA, including other University of Maryland Medical System (UMMS) Baltimore City-based hospitals (Kernan, Maryland General, and Mt Washington Pediatric Hospitals), 70 faith leaders, community leaders, community partners, the University of Maryland Baltimore (UMB) academic community, the general public, local health experts, and the Baltimore City Health Department. As an example, the Medical Center participates in a wide variety of local coalitions including, several sponsored by the Baltimore City Health Department, including the Cancer Coalition, Tobacco Coalition, Influenza Coalition as well as partners with many community-based organizations like American Cancer Society (ACS), Susan G. Komen Foundation, Ulman Foundation, American Diabetes Association (ADA), American Heart Association (AHA), B'More Healthy Babies, Text4baby, and Safe Kids, most of whom were included in the assessment. In addition, UMB campus experts were consulted and include: Yvette Rooks, MD, and Verlyn Warrington, MD, both from University of Maryland's Dept of Family Medicine and UM School of Medicine, Dr. Pat McLaine, UM School of Nursing, Bronwyn Mayden, MSW, Assistant Dean UM School of Social Work, and Brian Sturdivant, UMB Director of Community Affairs. In addition, UMMC conducted a survey of nearly 900 Baltimore City residents during major health fairs and sponsored a focus group of nearly 30 major community partners (including the American Diabetes Association, Safe Kids Baltimore, American Cancer Society, American Heart Association, Living Legacy Foundation, March of Dimes, Trauma Survivors Network, and Ulman Foundation, to name a few). The US National Prevention Strategy, Healthy People 2020, the Maryland DHMH's State Health Improvement Plan (SHIP), Baltimore City Health Department's 2011 Neighborhood Profiles, and Healthy Baltimore 2015 were all also included to provide national and local context, prevalence date, and direction for the assessment. Additionally, UMMC participates in the UMMS Community Health Outreach and Advocacy Team to validate data and information from other UMMS hospitals and collaborate on large system-wide events and initiatives.

Social Determinants of Health (SDoH) Needs were also included in the CHNA. SDoH as defined by the World Health Organization (WHO) are the circumstances in which people live, grow, and work, which greatly determine an individual's health status (World Health Organization, 2008). At all levels of income, health and illness follow a social gradient: the lower the socioeconomic status, the lower the health status. Contributing to the major health needs of the CBSA, there are many significant SDoH which were identified (in no particular order), lack of fresh produce available (food deserts), limited transportation, unsafe housing, economic development, and literacy.

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.

Analysis of all quantitative and qualitative data described in the above sections identified these top six areas of need within Baltimore City. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths and mission. These priorities were identified and approved by the UMMC Community Empowerment Team and validated with the health experts from the UMB Campus Panel.

- **Obesity/Heart Disease/Diabetes & Cancer(Chronic Disease Prevention)**
- **Maternal & Child Health**
- **Workforce Development/Literacy**
- **Violence Prevention**
- **HIV Prevention/Influenza Prevention (Infectious Disease Prevention)**
- **Access to Care**

Based on the above assessment, findings, and priorities, the CET agreed to incorporate our identified priorities with Maryland's State Health Improvement Plan (SHIP). Using the SHIP as a framework, the following matrix was created to show the integration of our identified priorities and their alignment with the SHIP's Vision Areas (See Table 1). UMMC will also track the progress with long-term outcome objectives measured through the Maryland's Department of Health & Mental Hygiene (DHMH). Short-term programmatic objectives, including process and outcome measures will be measured annually by UMMC for each priority areas through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

In addition to the identified strategic priorities from the CHNA, UMMC employs the following prioritization framework which is stated in the UMMC Community Outreach Plan. Because the Medical Center, serves the region and state, priorities may need to be adjusted rapidly to address an urgent or emergent need in the community, (i.e. disaster response or infectious disease issue). The CHNA prioritized needs for the Sustained and

Strategic Response Categories and the Rapid and Urgent Response Categories' needs will be determined on an as-needed basis.

UMMC will provide leadership and support within the communities served at variety of response levels. Rapid and Urgent response levels will receive priority over sustained and strategic initiatives as warranted.

- **Rapid Response - Emergency response to local, national, and international disasters, i.e. Haiti disaster, weather disasters – earthquake, blizzards, terrorist attack**
- **Urgent Response - Urgent response to episodic community needs, i.e. H1N1/ Flu response**
- **Sustained Response - Ongoing response to long-term community needs, i.e. obesity and tobacco prevention education, health screenings, workforce development**
- **Strategic Response - Long-term strategic leadership at legislative and corporate levels to leverage relationships to promote health-related policy or reform and build key networks**

Table 2 - UMMC Strategic Programs and Partners

FYs '13-15

Maryland SHIP Vision Area	UMMC Priorities	UMMC Strategic Community Programs	UMMC Partners
Healthy Babies	**Maternal/Child Health**	Prenatal Education & Services	B'More Healthy Babies Stork's Nest, Text4Baby, UM Centering Program
Healthy Social Environments	**Trauma/Violence Prevention**	Violence Intervention Program (VIP)	Baltimore City Health Dept., Roberta's House
Safe Physical Environments	**Trauma Prevention** **Safe Kids**	Trauma Prevention Safe Kids Programming (Helmets, Fire Safety, Car Seats)	MIEMSS Safe Kids, Baltimore City Fire Dept, Maryland Car Seat Safety Program
Infectious Disease	**HIV Prevention/Treatment**	City Uprising	Jacques Initiative, Faith community

	Influenza	Free Fall Flu Clinics, Flu Prevention Ed	BCHD Flu Coalition
Chronic Disease	**Obesity/Heart Disease/ Diabetes**	Farmer's Market, Get Fit Maryland, Get Fit Kids Obesity Prevention Initiative (Adults & Children)	AHA, ADA, UMB Campus, UMMS City Hospitals, Baltimore City Public Schools and other various Baltimore City Agencies
	Cancer	Free Screenings - Mammograms/PAP Smears, Colorectal Smoking Cessation, Tobacco Prevention Ed	BCCP, BCHD Cancer Coalition, BCHD Tobacco Coalition ACS, Komen Foundation, Ulman Foundation, UMMS City Hospitals, Red Devils, Leukemia & Lymphoma Society
Healthcare Access	**Workforce Development**	Project Search, BACH Fellows, STRIVE Program	Balto City Public Schools, ARC Baltimore, Dress for Success

Examples of sources of data available to develop a CHNA include, 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) County Health Rankings (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 CHNA involving 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: **6/28/12** (mm/dd/yy)

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

http://umm.edu/~/media/UMM/PDFs/about%20us/community%20outreach/chna%20executive%20summary.ashx

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

   _X_Yes
   ___No

   If you answered yes to this question, provide the link to the document here. **Appendix 3 at below link**

   http://umm.edu/~/media/UMM/PDFs/about%20us/community%20outreach/chna%20executive%20summary.ashx

II. 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

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

i. Senior Leadership

1. ___CEO
2. ___CFO
3. _**X**__Other (please specify) **Dana Farrakhan, MHS, FACHE, Vice President, Strategic Planning & System Program Development; Donna Jacobs, Senior Vice President, Government & Regulatory Affairs, UMMS; leading the UMMS Community Outreach & Advocacy Team**

ii. Clinical Leadership

1. **_X_**Physician (**Yvette Rooks, MD and Verlyn Warrington, MD – Family Medicine physicians and ad hoc advisors)**
2. ___Nurse
3. ___Social Worker
4. ___Other (please specify)

iii. Community Benefit Department/Team

1. _**X**__Individual (**3.0 FTEs**)
2. _**X**__Committee
   Dana Farrakhan, MHS, FACHE, VP, Strategic Planning & System Program Development
   Anne Williams, DNP, RN, Senior Manager, Community Empowerment & Health Education
   JoAnn Williams, Manager, Career Development Services
   Mariellen Synan, Community Outreach Manager
   Susan Roy, MDiv., Director of Pastoral Care
   Beth Ryan, Senior Director, UMMS Foundation
   Sharon Boston, Communications
   Dr. Yvette Rooks and Dr. Verlyn Warrington, ad hoc
   Tina Cafeo, DNP, RN ad hoc
3. ___Other (please describe)

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

Spreadsheet	__**X** _yes	_____no
Narrative	__**X** _yes	_____no

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

Spreadsheet	__**X**__yes	_____no
Narrative	__**X**__yes	_____no

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

III. 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. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting.
   Please see attached examples of how to report.

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.

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.

   Several additional topic areas were identified by the CET during the CHNA including: mental health, safe housing, transportation, and substance abuse. While the Medical Center will focus the majority of our efforts on the identified priorities outlined in the table above, 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 by other health care organizations with our assistance as available. The unmet needs not addressed by UMMC will also continue to be addressed by key Baltimore City governmental agencies and existing community-based organizations.

   The UMMC identified core priorities target the intersection of the identified community needs and the organization's key strengths and mission. The following table summarizes the major programs in use to address the identified health priorities.

Initiative 1

Obesity/CV Disease/Diabetes

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time 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? (See Instructions)
68% of Balto City adults are either overweight or obese. Heart Disease is the 1st leading cause of death, Stroke is the 3rd leading cause of death, and Diabetes is the 7th leading cause of death in Balto City. Food deserts exist in half of the targeted zips.	**Dance for Your Heart** – Event featuring dancing for seniors. Focus on keeping seniors active and moving. Health screenings, healthy lunch lecture on heart disease. **Farmer's Market** Weekly for 6 months in UM park across from UMMC featuring local, fresh produce. **Kids to Farmers Mrkt Prog**	**Primary Objective:** Provide cholesterol and BP screenings at numerous health events to increase public awareness of key health indicators - ("Know Your Numbers" campaign) **Secondary Objective:** Provide education, information, and engaging activities to the public on healthy lifestyle behaviors to minimize the risk of heart disease.	Multi-year; Ongoing through FY15	UMMC is the leading sponsor of these initiatives. UMMC partners with Verlyn Warrington, MD and Yvette Rooks, MD, UM School of Medicine, UMMC Nursing, UMB Campus, American Heart Association, American Diabetes Association, Balto City Public Schools, Balto City Parks & Rec, and other UMMS member hospitals, UM Farmer's Market vendors	Outcomes are measured in terms of volumes/ reach and using the Maryland SHIP Objectives #25, 27, 30, & 31 Launching new evaluation of **KTFM** in FY14	SHIP Objectives #30-Pending from DHMH; #25-Same (2010) #27-Decreased to 705.4 in Balto City, Trending positively #31-Decreased to 16.7 in Balto City, Trending positively **Dance for Your Heart** 325 Seniors **Farmer's Market** Added SNAP EBT service to FM in FY13; **Kids to FM Program** 54 ES students; 0ver 50% tried new produce	Initiatives are planned to continue for FY14.	$1,500 & $1,089 Salary Expense Salary Expense $1,000 &$1,000 Salary Expense

Initiative 1

Obesity/CV Disease/Diabetes

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time 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? (See Instructions)
	Get Fit Kids - Annual spring initiative targeted 3 Balto City Public Schools and provided free pedometers, walking logs, and health info to elementary school children **Take a Loved One Health Fair –** Featuring BP, Cholesterol, Vascular screenings		Multi-year; Ongoing through FY15 Multi-year; Ongoing since 2005	Calvin Rodwell ES UMMS Balto City Hospitals – UMMC, Midtown, MWPH, Kernan; Mondawmin Mall, Radio 1, Over 70 community based organizations as vendors	Outcomes are measured in terms of volumes/ reach, participant self-reported KAB and using the Maryland SHIP Objectives #25, 27, 30, & 31	**Get Fit Kids** 100 Elementary School students at Calvin Rodwell ES **TALO** 700 community members attended; Pre/post survey showed statistically significant results in knowledge of BP and Cholesterol before and after the fair. 249 BP screens & 100 Cholesterol **BP** - Z score = 3.451, $p = 0.00056$ **Chol** – Z score = 2.061, $p = 0.0394$ N = 99	Initiatives are planned to continue for FY14.	$10,000 & $16,551 Salary Expense

Initiative 2

Cancer

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time 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? (See Instructions)
Cancer is the 2nd leading cause of death in Balto City. 216.8 deaths per 100,000 in Balto City as baseline. Racial disparities in the City: White 191 and Black 236.8	Baltimore City Cancer Program (BCCP)	**Primary Objective:** Provide a variety of preventive screenings (Breast Health, Pap/Cervical, and Colon Screenings) free of charge to the public to identify people at-risk. **Secondary Objective**: Provide education, information, and engaging activities to the public on healthy lifestyle behaviors to minimize the risk of cancer.	Multi-year initiative since 2001	BCCP is funded by the Cigarette Restitution Fund, Avon, and Susan G. Komen Foundation. UMMC also partnered with the American Cancer Society, Komen's Race for the Cure, Ulman Fund, and Baltimore City's Cancer Coalition	Outcomes are measured in terms of volumes/ reach and using the Maryland SHIP Objective # 26 While many factors other than our programming affect the SHIP outcome, this is the long-term objective which is linked to this program	**Clinical Breast Exams** –777 women screened; 10 new breast cancers detected **PAP Exams** –399 women screened **Mammograms** – 842 women screened **Breast Cancer Support Group** – Meets monthly for women diagnosed with breast cancer (25 enrolled in group) **Colorectal Screenings** –162 people screened SHIP Objective #26 (updated by DHMH on 6/28/13): 217.6 cancer deaths/100,000 – Increase from 216.8 in 2011	Initiatives are planned to continue for FY14.	**Cost of the Screenings:** **CBE** = $89,999 **PAP** = $22,224 **Mammo** = $100,577 **Colorectal** = $24,475

Initiative 2

Cancer

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time 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? (See Instructions)
24.7% of Balto City adults smoke which is a higher rate than the 15.2% rate in Maryland. Racial disparities in the City: 19.7% Whites smoke and 28.2% of Blacks smoke	**Kick the Habit Classes** **Kick the Habit Website**	**Primary Objective:** Provide education and information to individuals who are interested smoking cessation. Classes include information on behavioral triggers, health hazards of smoking, pharmaceuticals options, nutrition and smoking, health benefits of quitting, secondhand smoke information, and support resources. **Secondary Objective**: Provide information on secondhand smoke hazards, information on smoking cessation	Multi-year initiative since 2004	UMMC partners with BCCP, UM Midtown, Susan G. Komen Foundation, American Cancer Society, Komen's Race for the Cure, Ulman Fund, and Baltimore City's Tobacco Coalition	Outcomes are measured in terms of volume/ reach and using Maryland SHIP Objective #32	There were no participants who completed the smoking cessation classes in FY13. Parking, transportation, and location were listed as potential barriers for the class. Based on this, UMMC began referring individuals to our UM Midtown location for their smoking cessation classes. Smoking cessation and secondhand smoke information was distributed to over 2,560 people at various health fairs. DHMH did not report on Objective #32 for this fiscal year.	Initiatives are planned to continue for FY14. – Phasing smoking cessation classes over to UM Midtown Campus in FY14.	$1,000 & $1,000 Salary Expense

Initiative 3

Maternal Child Health

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time 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? (See Instructions)
Infant Mortality (per 1,000 live births) is 12.1 in Balto City with higher mortality in 6/10 targeted zips. % of Prenatal Care in 1st Trimester avg is 77.3% in Balto City with lower avgs in 4/10 targeted zips. % of Births to Mothers who Smoke avg is 8.8% in Balto City with higher prevalence rates in 6/10 targeted zips. Racial disparities in the City: Whites 85.2%/Blacks 72%	**Stork's Nest** Prenatal education for pregnant, lower SES income women. Classes run for 8 weeks. **Centering Pregnancy** National, evidence-based model of group prenatal care integrating health assessment, education, & support	**Primary Objective**: Provide access to evidence-based prenatal care and support to promote healthy pregnancies and healthy babies. **Secondary Objective**: Provide education and information to families on healthy pregnancies, breastfeeding, early infant care, and accident avoidance/prevention through engaging programs and initiatives.	Multi-year initiative since 2005 Multi-year initiative started in late 2011	UMMC partners with Zeta Phi Beta Sorority, B'More Healthy Babies, Centering Institute, and March of Dimes Centering Program, March of Dimes	Outcomes are measured in terms of volume/ reach and using Maryland SHIP Objectives #3, 4, 6	**Stork's Nest** - 183 women in FY13 **Centering Pregnancy** - 108 women with 100 births to date. Preliminary data: Pre-term birth rate = 4%; Breastfeeding initiation rate = 70% DHMH did not report update on Objectives #3, 4, or 6 for this fiscal year.	Initiatives are planned to continue for FY14.	$1,000 & $16,947 in Salary Expense Salary Expense

Rate of pediatric asthma emergency room visits in Balto City is 138.4 which is twice as high as the Maryland rate of 59.1	**Breathmobile** Mobile van serving Baltimore City and focusing on pediatric asthma prevention & treatment.	**Primary Objective**: Provide access to evidence-based pediatric asthma care. **Secondary Objective**: Provide education and information to children and families on asthma triggers, prevention, and care		Kohl's, UM Dept of Pediatrics, BCPSS	Outcomes are measured in terms of volume/ reach and using Maryland SHIP Objective #17	**Breathmobile** Served 512 patients with 951 visits in FY'13. SHIP Objective #17 – Last updated in 2011, Trending positively		$18,841 & Salary Expense

Initiative 4

Infectious Disease Prevention (HIV and Influenza)

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time 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? (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	**City Uprising Campaign (State campaign which is supported by UMMC) -** Provided free HIV testing and counseling	**Primary Objective**: Provide access to free HIV screening services and counseling to the targeted West Baltimore zip codes. **Secondary Objective:** Educate the community on the importance of HIV prevention, screening, and early treatment	Multi-year Initiative since 2008	UMMC supported the City Uprising Campaign with the Institute of Human Virology, JACQUES Initiative, and the Faith Community	Outcomes are measured in terms of volume/ reach and using Maryland SHIP Objective #20	Provided free HIV screenings to the public at three major health fairs. Screened nearly 300 Provided in-kind staff support to annual City Uprising HIV Screening event	Initiatives are planned to continue for FY14	Salary Expense
37.4% of Balto City adults had a flu shot in last year. Racial disparities in the City: 46.1% Whites/ 32.6% Blacks had a flu shot	**Influenza Campaign**	**Primary Objective**: Provide access to free flu vaccines in the targeted West Baltimore zip codes. **Secondary Objective:** Educate the community on the importance of receiving annual flu vaccines		Balto City Health Dept Influenza Coalition, DHMH	Maryland SHIP Objective #24	957 people were vaccinated for influenza through UMMC-sponsored flu immunization clinics. DHMH did not report update on Objectives #20 or 24 for this fiscal year.		$3,737 for supplies and vaccine & $1,387 Salary Expense

Initiative 5

Injury Prevention

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time 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? (See Instructions)
Homicide is the 6th leading cause of death in Balto City. Homicide rate is higher in 5/10 of the targeted zips and at same rate in 1 zip. Alcohol/ substance use & distractions impairs driving & lead to preventable accidents. Rate of pedestrian injuries in Balto City is 122.4 which is more than 3 times the Maryland baseline	**Violence Intervention Program (VIP)** **Injury Prevention** **Trauma Prevention Program** **Safe Kids Baltimore, Safe Kids Buckle Up, & Safe Kids Inspector Detector**	**Primary Objective:** Provide access to evidence-based intervention programs **Secondary Objective:** Educate community on the importance of violence prevention, distracted driving, pedestrian safety, and helmet/seat buckle use.	Multi-year Initiative, since 1998 Multi-year Initiative, since 2005	UMMC partners with Baltimore City Police Commissioner, Baltimore City Health Dept., HSCRC, local Fire Depts., and DPSC Secretary Balto City Fire Dept., Balto City Police Dept. BCPSS	Outcomes are measured in terms of volume/ reach and using Maryland SHIP Objectives #9, 15	**VIP Program** 119 participants **Injury Prevention** 17,667 educated **TPP** 335 At-risk youth DHMH did not report update on Objectives #9 or 15 for this fiscal year. **SK Baltimore** 1,100 children **SK Buckle Up** 195 children **SK Inspector Detector** 3,757 homes/families	Initiatives are planned to continue for FY14	**VIP** $1,808 & Salary Expense **Injury Prevention** $29,156 & Salary Expense **TPP** $6,819 & Salary Expense **Safe Kids** $14,954 & $40,789 in Salary Expense

Initiative 6

Workforce Development

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time 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? (See Instructions)
11% Unemploy-ment rate in Balto City with 6/10 targeted zips with much higher rates (up to 19.6%)	Project Search, PCT Training, Youth Works, BACH Fellows, Building Steps, NAHSE, and Healthcare Career Alliance Programs	**Primary Objective**: Provide employment opportunities for the unemployed and underemployed within our targeted community **Secondary Objective**: Create career advancement and skill enhancement opportunities for UMMC employees **Tertiary Objective**: Introduce minority youth to careers in health care	Multi-year initiative, since 2003	UMMC partners with University of Maryland, Baltimore, The ARC of Baltimore, Baltimore City Public Schools, Division of Rehabilitation Services, Building STEPS	Outcomes are measured in terms of volumes/ reach and Maryland SHIP Objective #36 While many factors other than our programming affect the SHIP outcome, this is the long-term objective which is linked to this program	Volume/reach: **PCT Training** – Hired 24/24 participants **Student Internships** Hired 45/45 participants **BACH Fellows** – Hired 10/10 participants **Out of School Youth Internships** – Hired 15/15 participants **Surgical Tech Training** – Hired 1/1 participant SHIP Objective #36 (updated by DHMH on 6/28/13): 84.3% - Increase from 83.6% in 2011	Initiatives are planned to continue for FY14	$90,300 & $53,560 in Salary Expense

IV. 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.

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

IV. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):
    a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's FAP. (label appendix I)

    For ***example***, state whether the hospital:

    - Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
        - in a culturally sensitive manner,
        - at a reading comprehension level appropriate to the CBSA's population, and
        - in non-English languages that are prevalent in the CBSA.
    - posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
    - provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
    - provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
    - includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
    - discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

    b. Include a copy of your hospital's FAP (label appendix II).
    c. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).

2. Attach the hospital's mission, vision, and value statement(s) (label appendix IV).

Appendix 1

Financial Assistance Policy Description

University of Maryland Medical Center's Financial Clearance Program 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.

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

- Signage in main admitting areas and emergency rooms of the hospital
- Patient Handbook distributed to all patients
- Brochures explaining financial assistance are made available in all patient care areas
- Patient Information Sheets (available in English & Spanish) – See attached in Appendix 3
- Appearing in print media through local newspapers (Baltimore City Papers, May/June 2013)

POLICY

This policy applies to The University of Maryland Medical System (UMMS) following entities:

- University of Maryland Medical Center (UMMC)
- James L. Kernan Hospital (JLK)
- University Specialty Hospital (USH)

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

It is the policy of the UMMS Entities to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications.

UMMS Entities will publish the availability of Financial Assistance on a yearly basis in their 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 to patient with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency and may apply only to those accounts on which a judgment has not been granted.

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

PROGRAM ELIGIBILITY

Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UMMC, JLK, and USH hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

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

1. Services provided by healthcare providers not affiliated with UMMS hospitals (e.g., durable medical equipment, home health services)

2. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, or Workers Compensation), are not eligible for the Financial Clearance Program.
   a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.
3. Unpaid balances resulting from cosmetic or other non-medically necessary services
4. Patient convenience items
5. Patient meals and lodging

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

1. Refusal to provide requested documentation or provide incomplete information.
2. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Medical Center due to insurance plan restrictions/limits.
3. Failure to pay co-payments as required by the Financial Assistance Program.
4. Failure to keep current on existing payment arrangements with UMMS.
5. Failure to make appropriate arrangements on past payment obligations owed to UMMS (including those patients who were referred to an outside collection agency for a previous debt).
6. Refusal to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.
7. Refusal to divulge information pertaining to a pending legal liability claim

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.

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 Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

Coverage amounts will be calculated based upon 200-300% of income as defined by federal poverty guidelines and follows the sliding scale included in *Attachment A* for a Reduced Cost of Care.

Presumptive Financial Assistance

Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage
b. QMB coverage/ SLMB coverage
c. PAC coverage
d. Homelessness
e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
f. Medical Assistance spend down amounts
g. Eligibility for other state or local assistance programs
h. Patient is deceased with no known estate
i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
j. Non-US Citizens deemed non-compliant

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

a. Purely elective procedures (example – Cosmetic) are not covered under the program.
b. 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.

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.
2. 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.
   a. Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income (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.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.
   d. Upon receipt of the patient's application, they will have twenty (20) days to submit the required documentation to be considered for eligibility. If no data is received within the 20 days, a denial letter will be sent notifying that the case is now closed for inactivity and the account will be 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.

3. There will be one application process for UMMC, JLK, and USH. The patient is required to provide a completed Financial Assistance Application. In addition, the following may be required:
   a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...
   b. A copy of their most recent pay stubs (if employed) or other evidence of income.
   c. A Medical Assistance Notice of Determination (if applicable).
   d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.
4. 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, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.
   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.
      i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
      ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
         (1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.
5. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
6. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination, up to 3 years prior, and up to six (6) calendar months in to the future. However, there are no limitations on the Financial Assistance eligibility period. Each eligibility period will be determined on a case-by-case basis. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department.
7. If a 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.
8. A letter of final determination will be submitted to each patient who has formally submitted an application.
9. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds may be issued back to the patient for credit balances, due to patient payments, resulted from approved financial assistance on considered balance(s).
10. Patients who have access to other medical care (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.

11. The Financial Assistance Program will accept the University Physicians, Inc.'s (UPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting UPI's application requirements.
12. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.
13. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.
    a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
    b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

Financial Hardship

The amount of uninsured medical costs incurred at either UMMC, JLK, or USH will be considered in determining a patient's eligibility for the Financial Assistance Program. The following guidelines are outlined as a separate, supplemental determination of Financial Assistance, known as Financial Hardship. Financial Hardship will be offered to all patients who apply for Financial Assistance.

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

1) Their medical debt incurred at our either UMMC, JLK, or USH exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship; and
2) who meet the income standards for this level of Assistance.

For the patients who are eligible for both, the Reduced Cost Care under the primary Financial Assistance criteria and also under the Financial Hardship Assistance criteria, UMMC, JLK, and USH will grant the reduction in charges that are most favorable to the patient.

Financial Hardship is defined as facility charges incurred here at either UMMC, JLK, or USH for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.

Medical Debt is defined as out of pocket expenses for the facility charges incurred here at UMMC, JLK, or USH for medically necessary treatment.

Once a patient is approved for Financial Hardship Assistance, coverage will be effective starting the month of the first qualifying date of service and up to the following twelve (12) calendar months from the application evaluation completion date. Each patient will be evaluated on a case-by-case basis for the eligibility time frame according to their spell of illness/episode of care. It will cover the patient and the immediate family members living in the household for the approved reduced cost and eligibility period for medically necessary treatment. Coverage shall not apply to elective or cosmetic procedures. However, the patient or guarantor must notify the hospital of their eligibility at the time of registration or admission. In order to continue in the program after the expiration of each eligibility approval period, each patient must reapply to be reconsidered. In addition, patients who have been approved for the program must inform the hospitals of any changes in income, assets, expenses, or family (household) status within 30 days of such change(s).

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

Asset Consideration

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 situations, such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are considered in the evaluation process.

1. Under the current legislation, the following assets are exempt from consideration:
    a. The first $10,000.00 of monetary assets for individuals, and the first $25,000.00 of monetary assets for household families.
    b. Up to $150,000.00 in primary residence equity.
    c. 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.

Appeals

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

Judgments

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, UMMC, JLK, or USH shall seek to vacate the judgment and/or strike the adverse credit information.

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

HHS 2011 Poverty Guidelines		Poverty Level Up to 200% Pt Resp 0% 100% Charity Max	S L I D I N G S C A L E	Poverty Level Pt Resp 10% 90% Charity Max	Poverty Level Pt Resp 20% 80% Charity Max	Poverty Level Pt Resp 30% 70% Charity Max	Poverty Level Pt Resp 40% 60% Charity Max	Poverty Level Pt Resp 50% 50% Charity Max	Poverty Level Pt Resp 60% 40% Charity Max	Poverty Level Pt Resp 70% 30% Charity Max	Poverty Level Pt Resp 80% 20% Charity Max	Poverty Level Pt Resp 90% 10% Charity Max
HH Size	100% FPL Max											
1	10,890.00	**21,780.00**		22,869.00	23,958.00	25,047.00	26,136.00	27,225.00	28,314.00	29,403.00	30,492.00	32,669.00
2	14,710.00	**29,420.00**		30,891.00	32,362.00	33,833.00	35,304.00	36,775.00	38,246.00	39,717.00	41,188.00	44,129.00
3	18,530.00	**37,060.00**		38,913.00	40,766.00	42,619.00	44,472.00	46,325.00	48,178.00	50,031.00	51,884.00	55,589.00
4	22,350.00	**44,700.00**		46,935.00	49,170.00	51,405.00	53,640.00	55,875.00	58,110.00	60,345.00	62,580.00	67,049.00
5	26,170.00	**52,340.00**		54,957.00	57,574.00	60,191.00	62,808.00	65,425.00	68,042.00	70,659.00	73,276.00	78,509.00
6	29,990.00	**59,980.00**		62,979.00	65,978.00	68,977.00	71,976.00	74,975.00	77,974.00	80,973.00	83,972.00	89,969.00
7	33,810.00	**67,620.00**		71,001.00	74,382.00	77,763.00	81,144.00	84,525.00	87,906.00	91,287.00	94,668.00	101,429.00
8	37,630.00	**75,260.00**		79,023.00	82,786.00	86,549.00	90,312.00	94,075.00	97,838.00	101,601.00	105,364.00	112,889.00

Appendix 3

UNIVERSITY of MARYLAND MEDICAL CENTER

Maryland Hospital Patient Information Sheet

Hospital Financial Assistance Policy

The University of Maryland Medical Center provides healthcare services to those in need regardless of an individual's ability to pay. Care may be provided without charge, or at a reduced charge to those who do not have insurance, Medicare/Medical Assistance coverage, and are without the means to pay. An individual's eligibility to receive care without charge or to pay for their care over time is determined on a case by case basis. If you are unable to pay for medical care, you may qualify for Free 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.

University of Maryland 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 300% of the federal poverty level.

Patient's Rights

University of Maryland 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)

Patient's Obligations

University of Maryland Medical Center believes that its patient's 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 application ins 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 410-821-4140or toll free 1-877-632-4909 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 hospital bills and are billed separately.

HOJA DE INFORMACION PARA PACIENTES DEL HOSPITAL DE MARYLAND

Potitica de Ayuda Financiera del Hospital

El Centro Medico de la Universidad de Maryland proporciona atencion de salud a quienes la necesitan sin importar la capacidad de pago del individuo. Se puede brindar atenci6n sin cargo, 0 a menor costo, a las personas que no tienen seguro medico, ni cobertura de Medicare/ Asistencia Medica 0 no disponen de medios de pago. La elegibilidad de un individuo para recibir atenci6n sin cargo, a menor costo 0 para pagar por su atencion a 10 largo de un perlodo de tiempo se determinara segun el caso. En caso de no poder pagar por su atencion medica, podria calificar para recibir Atencion Medicamente Necesaria Gratis 0 a Menor Costo, si no tiene ninguna otra opci6n de seguro medico ni otras fuentes de pago, incluyendo Asistencia Medica, litigio ° responsabilidad civiL

EI Centro Medico de la Universidad de Maryland satisface ° excede los requisitos legales proporciooando ayuda financiera a individuos cuyos hogares estan 200% par debajo del nivel de pobreza federal y atencion a costa reducido hasta 300% del nivel de pobreza federal.

Derechos de los Pacieotes

El Centro Medico de la Universidad de Maryland trabajara con sus pacientes no asegurados para llegar a comprender los recurs os financieros con que cuenta cada paciente.

• Brindara ayuda para la inscripcion en programas de beneficios con fondos publicos (por ejemplo, Medicaid) u otras consideraciones de financiamiento que podrfan estar disponibles mediante otras instituciones de beneficencia.

• Si usted no califica para Asistencia Medica oi ayuda financiera, puede que sea elegible para un plan de pagos a largo plazo que le ayude a pagar sus cuentas medicas del hospital.

• Si usted cree que su caso ha sido enviado por error a una agencia de cobranzas, tiene derecho a contactar al hospital para solicitar ayuda. (Vea la informacion para contactarnos que aparece mas abajo.)

Obligaciones de los Pacientes

EI Centro Medico de la Universidad de Maryland cree que sus pacientes tienen responsabilidades personales con respecto a 105 aspectos financieros de sus necesidades de atencion medica. Se espera que nuestros pacientes:

• Cooperen en todo momento dando Informacion completa y exacta sobre su seguro y sus flnanzas.

• Proporcionen Ios datos requerldos para completar las solicitudes de Medicaid en forma oportuna.

• Cumplan con los terminos de 10s planes de pago establecidos.

• Notifiquen oportunarnente al telefono abajo mencionado sobre cualquier cambia en sus circunstancias.

Telefonos para contactarnos:

Llame aI410-821-4140 0 gratis all-877-632-4909 si tiene preguntas sobre:

• Su cuenta del hospital

• Sus derechos y obligaciones con respecto a su cuenta del hospital

• Como solicitar Medicaid de Maryland

• C6mo solicitar atenci6n gratis 0 a menor costo

Para mayor informacion sobre Asistencia Medica de Maryland:

Contacte al Departamento de Servicios Sociales de su localidad al
1-800-332-6347 TTY 1-800-925-4434

O vi site www.dlu·.state.md.us

Los cargos de Ios medicos no estan Incluldos en Ias cuentas de! hospital y se facturan por separado.

UNIVERSITY of MARYLAND MEDICAL CENTER

Our Mission: The University of Maryland Medical Center (UMMC) exists to serve the state and region as a tertiary/quaternary care center, to serve the local community with a full range of care options, to educate and train the next generation to health care providers, and to be a site for world-class clinical research.

Our Vision: UMMC will serve as a health care resource for Maryland and the region, earning a national profile in patient care, education and research, strengthened by our partnership with the Schools of Medicine and Nursing.

Our Values: Excellence in Service, Respect for the Individual, Quality in Education and Research, Cost Effectiveness

Commitment to Excellence – Five Pillars Leading Organizational Transformation:

Innovation, People, Safety & Quality, Service, Stewardship

C2X UMMC
COMMITMENT TO EXCELLENCE