Anne Arundel Medical Center

Community Benefit Report

FY2014

December 15, 2014

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. **Please <u>list</u> 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[1]:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
385 Licensed Beds for FY14[2]	26,395	21401 21403 21037 21114 20715 21012 21409 21146 21122 21113 20716 21666 21061 21032 20774	Harbor Hospital Center, Baltimore Washington Medical Center, Johns Hopkins Hospital, University of Maryland Medical Center, Prince George's Hospital Center, Holy Cross Hospital, Doctors Community Hospital, UM Rehab & Ortho Inst.	11.7% Uninsured[3] (Ages 18-64)	There were 65,323 Medicaid MCO recipients enrolled in Oct. 2014 in Anne Arundel Co.,[4] 12% of the County population. AAMC Emergency Room patients from Anne Arundel County with Medicaid totaled over 13,200 in FY14. This accounts for 23% of all AAMC *outpatient* ER visits from Anne Arundel County. Medicaid Inpatients to AAMC totaled over 1,900 in FY14 and accounted for 11% of AAMC inpatients from Anne Arundel County.[5]

[1] Maryland HSCRC
[2] Maryland Health Care Commission FY14 Licensed Bed Report dated June 2013.
[3] Anne Arundel County "Building Partnerships for a Healthier Community", Report Card of Community Health Indicators, May 2014
[4] http://www.md-medicaid.org/mco/index.cfm
[5] AAMC internal patient data

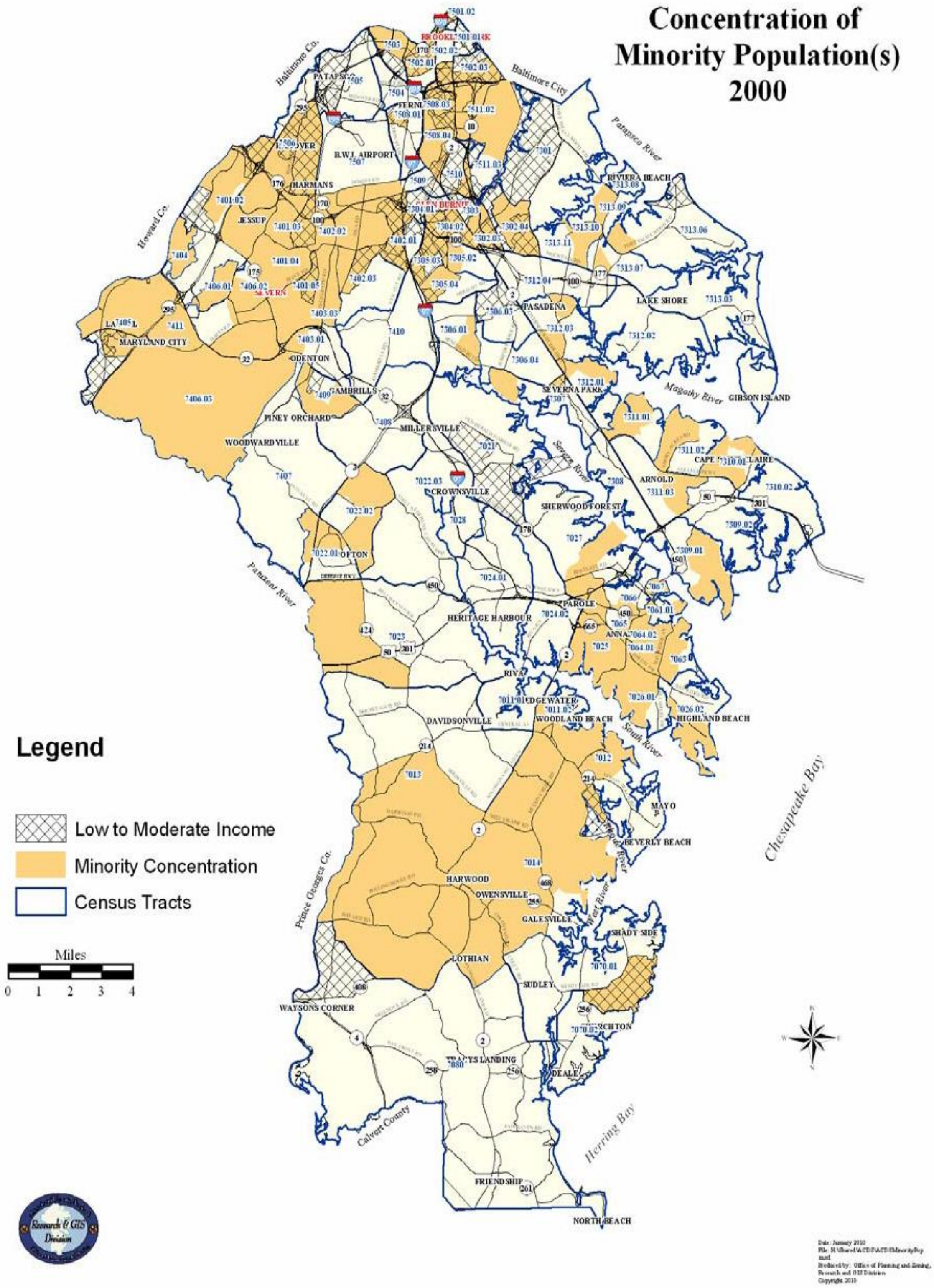
2. **For purposes of reporting on your community benefit activities, please provide the following information:**

   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.**

Anne Arundel Medical Center (AAMC) is committed to serving the Community, a value that is stated in clearly throughout our strategic initiatives. Our surrounding community has great wealth; but there are pockets of poverty in Annapolis city and parts of the surrounding county. As a result, racial health disparity is present in our community. This narrative is a description of the different communities we serve.

Although AAMC is a regional hospital serving portions of adjacent counties, Anne Arundel County ("the County") is defined as the Community Benefit Service Area since sixty-three percent of inpatient discharges (over 16,000 in FY14) come from the County. The discharged patients were comprised of 77.6% White and 22.4% non-white. The County demographics are as follows: 70% White, 16.1% Black, 7.0 % Hispanic, 3.7 % Asian, 0.3 % Native American, and 2.7 % are other races. The County is located south of Baltimore and east of Washington, D.C. and hosts some racially and ethnically diverse communities with residents living in rural, suburban, and urban settings. There are numerous factors that affect the health of the residents.

The map from Anne Arundel County below shows areas where minority populations are concentrated.



Concentration of
Minority Population(s)
2000
Legend
Low to Moderate Income
Minority Concentration
Census Tracts
Miles
0 1 2 3 4

Growing Populations

The Hispanic population has experienced the most growth among all population groups in the County. Hispanic residents increased from 3.7 percent to 6.6 percent between 2007 and the County's current Report Card 2014 (data from 2012). It is projected that the Hispanic population will continue to grow an additional 22.4% over the next 5 years. A growing immigrant population contributes to this growth. However, this exponential growth complicates access to care. Many Hispanics do not speak English and are not insured. Therefore, sliding scale programs must exist as well as increase availability of culturally sensitive, bilingual primary care providers are needed to meet the health needs of this population.

The population of the residents who are 65 and older in the County is expected to grow 24.5 percent over the next five years.[6] County patients with Medicare made up 43% of County inpatient admissions at AAMC in FY14. Because two out of every three older Americans have multiple chronic conditions[7], this age group is another priority of AAMC's community health initiative.

Geography

The southern half of the County (south of Annapolis) is primarily zoned "Residential Agricultural," per Anne Arundel County Department of Planning and Zoning[8], and it is considered a rural area. Southern Anne Arundel County accounts for only 11.5% of the County's total population.[9] This area is served by one federally-qualified health center in the Owensville/West River community. In southern Anne Arundel County, the race/ethnicity breakdown differs from the total County as the Black population decreases to 6.6 percent and the Hispanic population decreases to 4.5 percent, the White population increases to 85 percent[10] as compared to the total county. The median household income (2014) for South County is above the County and State median household income.

The northern half of the County is primarily urban and suburban as it sits adjacent to Baltimore City. The median household income (2014) for the northern half of the County is similar to the total County and above the State median household income. The race mix of this population (total over 500,000) shows a greater minority population in the northern half of the county.

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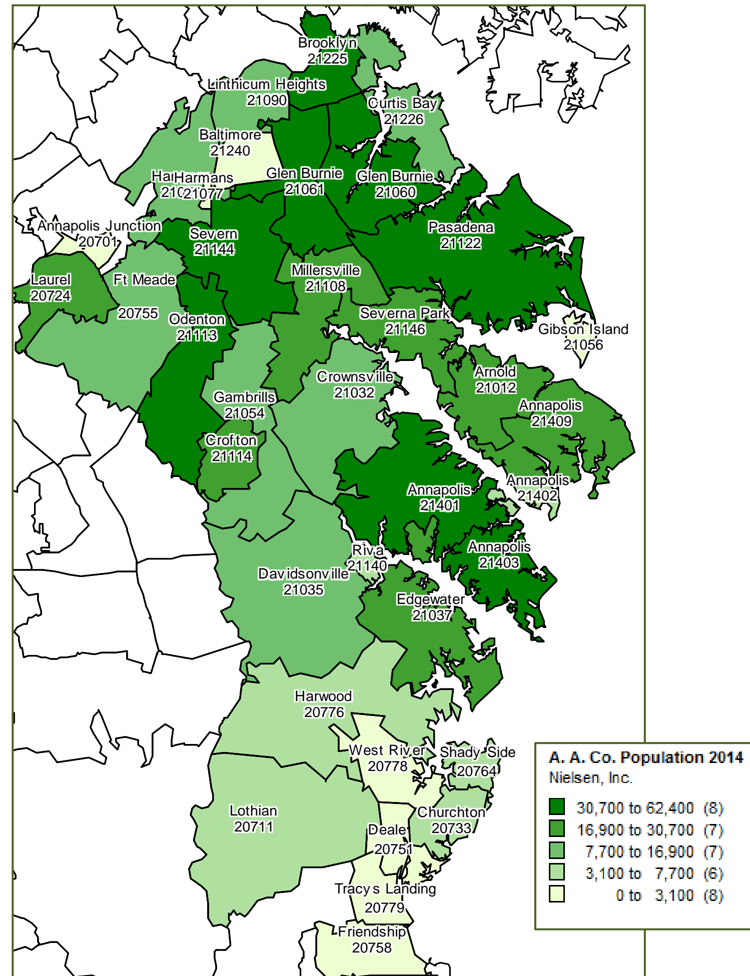
[6] Nielsen, Inc. 2014 county level demographic data
[7] http://www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf
[8] http://www.aacounty.org/PlanZone\
[9] Nielsen, Inc. 2014 population estimates
[10] Ibid.

The map below shows the population density of the County by zip code boundary.



The County is considered a high risk area for terrorism as it is home to the National Security Agency, the U.S. Naval Academy, Baltimore-Washington Thurgood Marshall International Airport, Fort Meade, and its proximity to Washington, D. C. The U. S. Army Base Realignment and Closure's (BRAC) 2007-2015 implementation caused the Fort Meade region (Odenton area) to expand to 56,800[11] military, government service civilians, contractor employees, and their families. The Fort Meade region is the epicenter of the Cyberspace and Information Assurance Industries, part of the DOD's Defense Information Systems Agency (DISA) and headquarters of Cyber Command. This has increased the demand for healthcare services in West County. As a result, AAMC developed a medical office building in Odenton in partnership with Johns Hopkins Medicine offering Primary Care, Specialty Care, and Urgent Care.

Transportation

An inadequate public transportation system in the County is a barrier for employment and healthcare. The County is situated along the western shore of the Chesapeake Bay and consists of a series of peninsulas which makes a comprehensive public transportation system too expensive to maintain.[12] As a result, there are not adequate local bus lines to service many areas of the County. South County has only

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[11] http://www.aacounty.org/BRAC/Resources/20111018_BRAC_Beyond.pdf, Slide 4
[12] Anne Arundel County Local Health Plan 2011

three bus stops in the Edgewater area which leaves a great portion of southern Anne Arundel County without public transportation. Public transportation is in need of additional routes. Anne Arundel County's Transportation Division concluded its study: *Corridor Growth Management Plan* in July of 2012 with plans to provide more frequent bus transit service. These projects will depend on future funding and they do not expand far into county neighborhoods.[13] As a result, only 3.3 percent of Anne Arundel County residents utilize public transportation to get to work.[14] "The City of Annapolis does operate a growing transit system but it stops at the borders of the city with few linkages to expanding workforce sites such as the Video Lottery Casino at Arundel Mills, and the Fort Meade area where the workforce has increased due to BRAC." The lack of public transportation is a significant issue throughout Anne Arundel County, especially related to "its impact on potential self-sufficiency for families through adequate employment".[15]

Social Determinants of Health

While the County ranks overall favorably as compared to the State with regard to income, housing, and health insurance coverage, there are apparent inequities. Specifically, the 2014 median household income (HHI) in the County is $88,602 and by race: White HHI $94,204, Black HHI $70,474, and Hispanic HHI $66,831.[16] The County Report Card (2012 data) indicates that 4.0 percent of families/5.9 percent of individuals are living below the poverty level. The average unemployment rate for the civilian labor force for the County, 2014 to date is 6.2 percent.[17] The U. S. Bureau of Labor statistics shows that unemployment for the Black population is twice as much as unemployment for the White population. Furthermore, 12 percent of Black county residents and 15.3 percent of Hispanic/Latino residents live in poverty. This is compared to 4.6 percent among the County's White residents.[18]

There are approximately 211,400 households in the County with few (6.9 percent) vacant housing units. This compares favorably to the number of vacant housing units throughout Maryland (11.4 percent) and the U.S. (10.5 percent). [19]

The *Anne Arundel County Report Card of Community Health Indicators* (May 2014) noted that health insurance coverage is also a consideration in the County: "Lack of health insurance varies not only by age and geography, but also by gender, race and ethnicity. More men lack insurance than women (9.2% versus 6.8%). The White, non-Hispanic population has the highest health insurance coverage, with only 5.5 percent lacking insurance. Ten percent (9.9%) of the Black population, 12.7 percent of the Asian population and 31.7 percent of the Hispanic population (any race) are estimated to lack insurance." The County uninsured rate for 18 – 64 year olds is 11.7 percent.[20] In Maryland, the uninsured rates for the nonelderly by race/ethnicity for 2013 are: White 9 percent, Black 11 percent, and Hispanic 33 percent[21].

Disparity

The Hospital is located in the 21401 Annapolis community which has been identified by the State as a designated "Health Enterprise Zone" (HEZ).[22] The Annapolis zip codes of 21401 and 21403 have distinct

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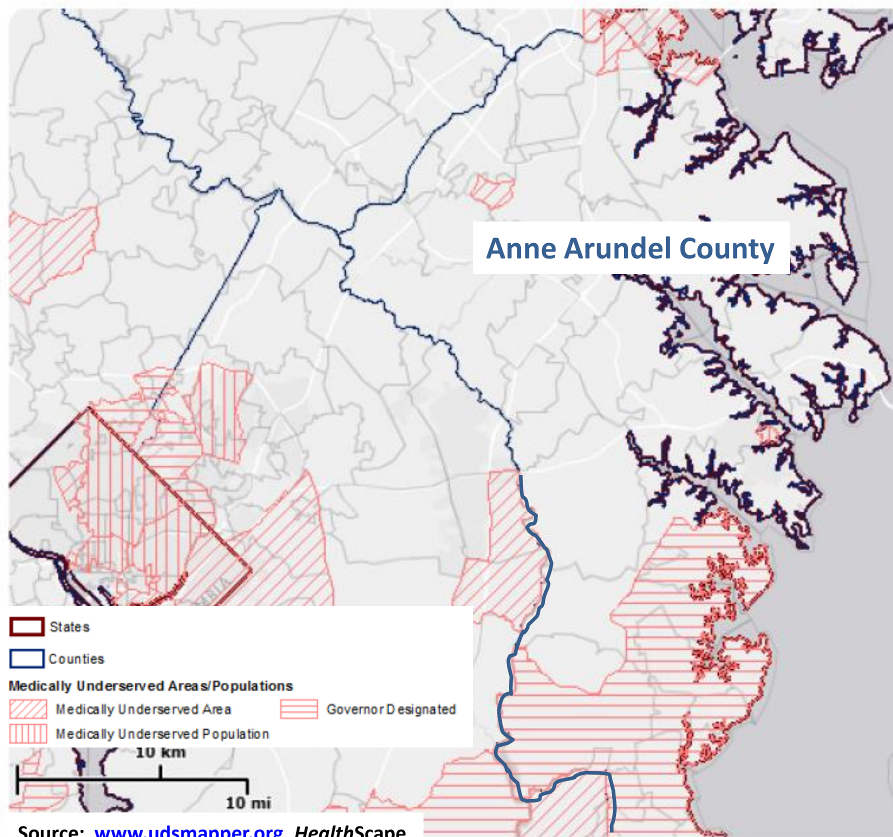
[13] http://www.aacounty.org/planzone/transportation/transit.cfm.
[14] Nielsen, Inc. 2014 county level demographic data
[15] http://www.aacounty.org/Partnership/Resources/2012_AA_County_Needs_Assessment.pdf
[16] Nielsen, Inc. 2014 county level demographic data
[17] http://www.dllr.state.md.us/lmi/laus/annearundel.shtml
[18] 2012 Community Health Needs Assessment Final Report – Anne Arundel County Department of Health
[19] Ibid.
[20] "Building Partnerships for a Healthier Community", Report Card of Community Health Indicators, May 2014
[21] http://kff.org/uninsured/state-indicator/rate-by-raceethnicity/
[22] http://eh.dhmh.md.gov/hez/index.html

areas where residents suffer significant health disparities that are compounded by common social determinants of health to include: reduced access to health care, high rates of poverty, limited transportation, low literacy levels, and high rates of crime. Approximately 33 percent of Annapolis rental units are public housing or receive a public subsidy to provide housing to low and moderate income households, as defined by HUD.[23]

In addition, the rate of Medicaid (130.7/1000 residents) in this area is higher than the rate for the State. A section of this zip code also is home to the very poor with a census tract median household income of $14,375 for the Hispanic population and $24,514 for the African American population.[24] In 21401 zip code, low-birth weight infant deliveries (6.4%) and the rate of Medicaid recipients qualified this area as a Maryland Health Enterprise Zone (HEZ).
(http://dhmh.maryland.gov/healthenterprisezones/SitePages/Updates.aspx)

Medically underserved areas as designated by the governor are noted on the map below. The census tract that is the designated HEZ is shown in Annapolis and the southern part of the County is shown where, generally, there lacks sufficient primary care physicians per population density.

Medically Underserved Population

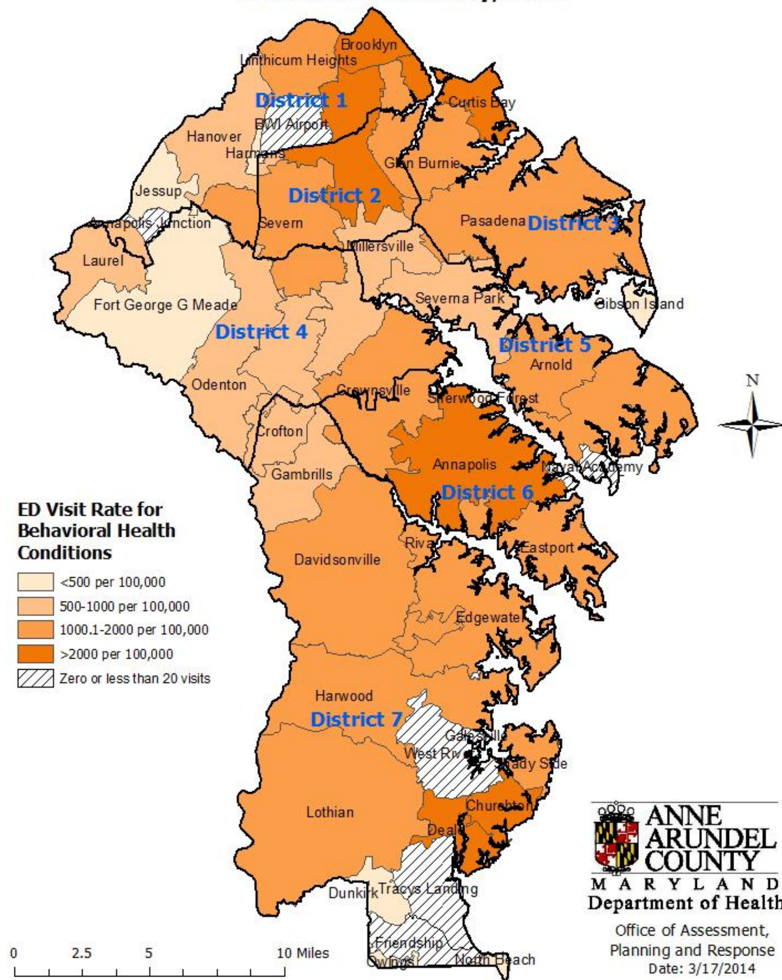


Community Health Needs
The FY2013 Community Health Needs Assessment (CHNA) identified the health needs of County residents. The percentage of obese and overweight adults is nearly 68 percent. This is higher than the

[23] http://www.mdp.state.md.us/PDF/OurWork/CompPlans/AnneArundel/Annapolis/09_CMP_Annapolis.pdf
[24] Nielsen, Inc. 2014 demographic data, census tract 24003706101

rates for Maryland and the United States (64.4% percent and 63.3 percent respectively). The CHNA rated weight problems as the number one health issue for the County. The connection with chronic disease prevention and management (diabetes, heart disease) was noted as were the barriers to eating well and integrating healthy lifestyle options into daily routines. Specifically, the availability of healthy food options and recreational opportunities are often limited to those with financial means.

Co-occurring disorders have been identified as the second ranked health problem in the County. There were more than 2,200 hospitalizations for mental health disorders in FY14 among Anne Arundel County residents.[25] The suicide rate in the County is 9.8 per 100,000, which is above the State rate of 8.8.[26]



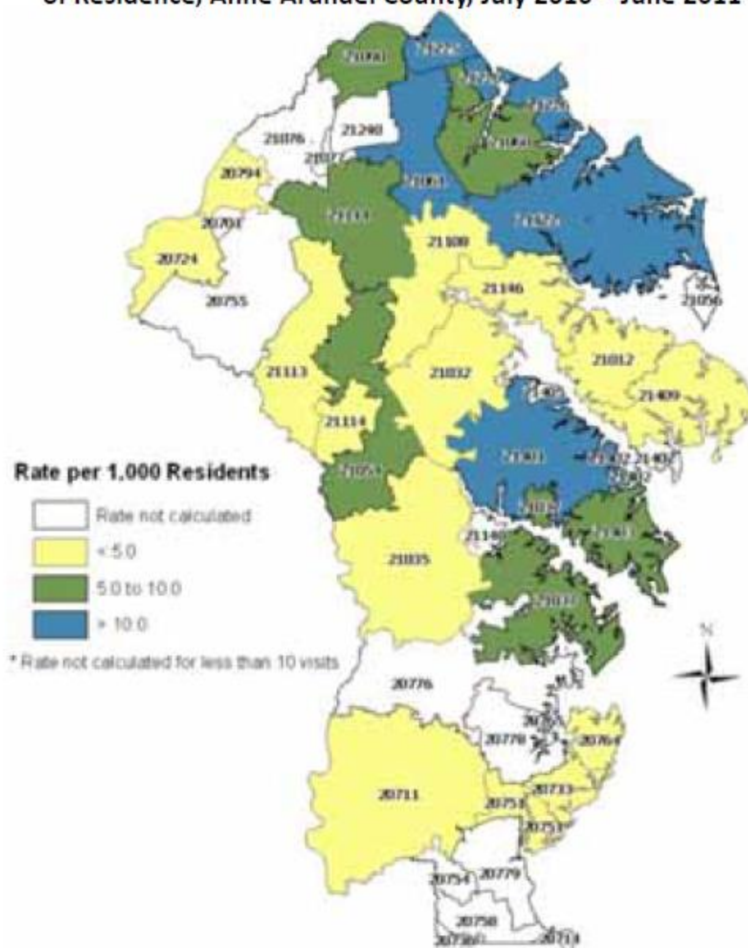
[25] HSCRC data sets ending June 30, 2014 by APR-DRGs:740,750,751,752,753,754,755,756,757,758,759,760,770,772, 773,774,775,776

[26] http://dhmh.maryland.gov/vsa/Documents/12annual.pdf

Substance Abuse remains a chronic problem as well. The County's 2013 Substance Abuse Consumption and Perception Survey of 12 to 20 year olds stated that prescription opioid drug overdoses are the third highest state-wide (http://aahealth.org/pdf/ConsumptionSurvey9_13.pdf). There were 17 prescription opioid overdose deaths in 2011 and 11 prescription opioid deaths in 2012 and reported in our local newspaper in February 2014: "Between 2011 and 2013, the number of heroin-related deaths in Maryland increased 87.8 percent […], according to statistics from the Maryland Department of Health and Mental Hygiene".

The percentage of adults in the County who consume alcohol on a regular basis and who binge drink (17.7 percent), exceeds the state and national rates (14.2 percent and 16.8percent respectively). Adults in the County who report 10 or more days in a typical month where alcohol is consumed are also more likely to report 10 or more days of poor mental health in the month compared to those who do not drink (17.7 percent versus 11.6 percent), according to the 2012 Mental Health Needs Assessment (MHNA) for Anne Arundel County, conducted by Holleran Consulting, LLC. Residents living with mental illness and/or addiction are more likely to be obese, have diabetes, have had a heart attack, or have coronary artery disease. As noted in the MHNA, there is increasing frustration with navigating the system of care in the County; there are barriers to receiving the treatment, particularly for the under- and uninsured; and, there is a stigma attached the diagnosis.

Rate of Emergency Department Visits for Substance Use* by ZIP Code of Residence, Anne Arundel County, July 2010 – June 2011



*Includes alcohol, illegal drugs and nonmedical use of prescription drugs.
Data Source: Rates calculated based on 2010 U.S. Census; MD Health Services Cost Review Commission.

The CHNA also stated that cancer and chronic disease (heart disease and diabetes) are the third and fourth health needs in the County. The overall, age-adjusted mortality rates for heart disease and cancer have dropped in the County and they are below the state averages. This is also true for Emergency Room visits for hypertension. But, there is disparity in the County between Whites and Blacks for Emergency Room visits for hypertension (Whites are 139.4/100,000 and Blacks are 432./100,000), according to the 2013 Maryland SHIP website updates. Therefore, community health initiatives will continue to focus on the prevention and management of these chronic diseases among the aged as well as those conditions that are disproportionately affecting the growing minority populations.[27]

However, the rapid growth in the percentage of individuals with diabetes as well as the proportion of those undiagnosed with diabetes and other risk factors (high blood pressure, high cholesterol, etc.) is alarming to county providers. While diabetes rates in the County continue to track lower than the state averages for diabetes, there remains a disparity between Whites and Blacks in the County. The rate for diabetes in the County is 9.3 [28] which is lower than the state rate of 10.0. The Maryland SHIP website shows the rate of Emergency Room visits for diabetes (2013 update) in the County as 169.3/100,000

[27] Anne Arundel County Local Health Plan 2011
[28] http://www.marylandbrfss.org/

population as compared to the state rate of 205.0/100,000. Blacks have a significantly higher rate of ER visits for diabetes as compared to Whites in the County (368.9 visits for Blacks and 169.3 visits for Whites).

In summary, secondary data for the County reveals higher socio-economic groups with higher income, education level and housing as compared to the State. The majority of residents also have health insurance. Higher rates of mortality for heart disease, diabetes, and cancer exist as a whole. Obesity and co-occurring disorders are higher in the County as compared to state and national figures. In addition, there are health inequities across some groups, particularly in Annapolis. The FY2013 CHNA identified seven issues that affect county residents: obesity, co-occurring disorders, cancer incidence and mortality (lung and melanoma cancers), chronic disease (heart disease and diabetes), health care services for the under- and uninsured, health inequities that vary by race, and awareness of existing services. AAMC will focus on all seven initiatives, primarily providing community benefit programs within the 21401 (HEZ) and 21403 zip codes. In addition, AAMC has also recognized the data that demonstrates the County's population is aging and there will be a need to manage the healthcare needs of the elderly and chronic conditions.

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).

Table II

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, ethnicity, and median age)	**Total Population:** 558,700 Male: 49.4% Female: 50.6% **Race** (NH = non-Hispanic) White, NH: 70.1% Black, NH: 16.1% Hispanic: 7.3% Asian, NH: 3.7% American Indian, NH: 0.3% Other, NH: 2.7% **Average Age[29]:** 38.8 Years **Percent of Total Population by Age:** 0 – 4 Years: 6.2% 5 – 17 Years: 16.5%

[29] Nielsen, Inc. 2014, population and demographics

	18 – 64 Years: 63.9% 65+ Years: 13.4%
Median Household Income within the CBSA	$ 88,602[30]
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Families Below Poverty Level[31] 4.0%, a 0.3% increase from last year Individuals Below Poverty Level 5.9%, a 0.4% increase from last year.
Please estimate the percentage of uninsured people by County within the CBSA	11.7% Uninsured (Ages 18 to 64)[32]
Percentage of Medicaid recipients by County within the CBSA. Source: http://www.md-medicaid.org/mco/index.cfm	FY14 Average Medicaid Eligible population is 58,892 residents or 10.5%.
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	79.8yrs with race disparities[33] White 80.1 yrs Black 77.3 yrs
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/vsa/Documents/12annual.pdf	Mortality Rate (all races): 714.2/100,000 (age-adjusted) White 758.9 Black 567.9 Hispanic 110.5 Mortality Rates of Chronic Lower Respiratory Disease: 38.9 (Other disease mortality rates listed in each section below).
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 http://mdfoodsystemmap.org/wp-content/uploads/2014/01/Anne-Arundel-County1.pdf	59% of all restaurants in the County are Fast Food restaurants (no update). Ship Objective #18: In the County, the number of residents living in Designated Limited Supermarket Access Areas is 12.69% and 12.88% are living in a USDA Food Desert. Percent of residents in poor or fair health is 11%. Physical inactivity is at 23%. Excessive drinking is at 19%. 17% of the County population is lacking adequate social support. 16%

[30] Nielsen, Inc. 2014 county level demographic estimates
[31] A. A. County Report Card of Community Health Indicators, May 2014
[32] Ibid.
[33] Md. Vital Statistics Annual Report 2012, http://dhmh.maryland.gov/vsa/Documents/12annual.pdf

	of County ninth graders will not graduate high school. [34]
Tobacco Use – SHIP Objective #32 http://dhmh.maryland.gov/ship/SitePages/Home.aspx http://www.marylandbrfss.org/	Ship Objective #33, The percentage of adolescents who used any tobacco product in the last 30 days is 17.7% (2013). From DHMH: Adults currently smoke 19.7% From BRFSS, adults: White 19% Black 10.6% Other Race 19.2% Multi-Race 7.9% Hispanic 2.2%
Premature death (Years of Potential Life Lost-YPLL) http://www.countyhealthrankings.org/app/#/maryland/2013/anne-arundel/county/outcomes/overall/	Ranked 8th best in MD for years of potential life lost before age 75.
Education http://quickfacts.census.gov/qfd/states/24/24003.html	Pop. 25+ without H.S. Diploma 9.4% Pop. 25+ Bachelor's or above 36.8%
Obesity: Body Mass Index (BMI) of 30 or more Overweight: BMI of 25 to 29.9 http://www.marylandbrfss.org/ http://www.aahealth.org/pdf/aahealth-report-card-2013.pdf	Total Adults: Overweight by BMI 32.9% Obese by BMI 30.6% White: Overweight 35.6%, Obese 31% Black: Overweight 25.8%, Obese 36.6% Children: Obesity and Overweight 30.2%
Asthma – SHIP Objective #17 http://dhmh.maryland.gov/ship/SitePages/Home.aspx	Rate of ED visits for asthma per 10,000 population, 44.6 with disparities: White 25.9 Black 130.9 Hispanic 26.1
Heart Disease – SHIP Objective #25 http://dhmh.maryland.gov/vsa/Documents/12annual.pdf Hypertension – SHIP Objective #28	<u>Mortality Rate:</u> 171.5/100,000 (age-adjusted) White 172.7 Black 200.8 Rate of ED visits for hypertension: 181.9/100,000 with disparities:

[34] http://www.countyhealthrankings.org/app/home#/maryland/2013/anne-arundel/county/outcomes/overall/snapshot/by-rank

http://dhmh.maryland.gov/ship/SitePages/Home.aspx http://www.marylandbrfss.org/	White 139.4 Black 432.9 Total County: 4.4% told by a doctor they had an MI White 4.2% Black 3.9% Other Race 10.1% Multi-Race 7.9%
Cancer – SHIP Objective #26 http://phpa.dhmh.maryland.gov/cancer/SiteAssets/SitePages/surv_data-reports/2013%20Cancer%20Data%20Final.pdf	Mortality Rate: 165.5/100,000 which is well above the State rate of 170.9/100,000 White 162.64 Black 197.1 Age-Adjusted Cancer Incidence Rates All Cancers: Total Rate: 466.7 (Male 536.8/Fem 412.1) Whites 449.0 Blacks 451.5 Hispanics 352.9 Lung & Bronchus Incidence Rates: Total Rate: 58.8 (Male 71.9/Fem 48.4) Whites 61.1 Blacks 50.5 Mortality rate: 46.4 (Male 52.7/Fem 41.8) Whites 47.2 Blacks 44.1 Melanoma Incidence Rates: Total Rate: 34.5 (Male 42.9/Fem 27.5)
Diabetes – SHIP Objective #27 http://dhmh.maryland.gov/vsa/Documents/12annual.pdf http://dhmh.maryland.gov/ship/SitePages/Home.aspx http://www.marylandbrfss.org/	Mortality Rate: 21.5/100,000 Rate of ED visits for diabetes per 100,000 population Total: 169.3 with great disparities: White-132.3 Black-368.9 Hispanic-62.6 9.0% of County have a Diabetes diagnosis (excludes pregnancy) White 8.2% Black 11.9%

Co-occurring disorders http://dhmh.maryland.gov/ship/SitePages/Home.aspx SHIP Objectives #29 & 34 http://www.marylandbrfss.org/	Incidence Rate of drug induced deaths = 14/100,000; Incidence Rate of suicide = 9.8/100,000 White: 10.6/100,000 Black: 8.0/100,000; Incidence Rate of ED visits for a mental health condition 3,899/100,000 population (2013); Alcohol: Binge Drinkers 17.7% above the State rate of 14.2% White 19.8% Black 17.7%
Infant Mortality/ Low Birth Weight – SHIP Objective #2 & #3 http://dhmh.maryland.gov/ship/SitePages/Home.aspx	Infant Mortality Rate/1,000 live births: Total 5.4 White-4.0 Black-11.0 Hispanic 7.7 (no update) Low Birth Weight: Total 8.0% White- 6.7% Black- 12.9% Asian- 9.0% Hispanic-7.7%
Access to primary care physicians	AAMC estimates that 23.7% of visits to the Emergency Department are for primary care conditions.[35] The estimated gap of Primary Care Physician (PCP) FTE's in Anne Arundel County (2014) is 46.3 FTE's (Family Practice and Internal Medicine) based on 1,800/1 PCP FTE[36].

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.

[35] AAMC Internal data – EPIC ER Bill Level Report
[36] http://www.mass.gov/eohhs/docs/dph/com-health/primary-care/shortage-designations-benefits.pdf

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.

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. 1/23/2013 **(mm/dd/yy)**
The Community Health Needs Assessment was conducted between July, 2012 and December, 2013. Results were finalized and released in January, 2013. The CHNA was a collaboration and conducted under the leadership of representatives from AAMC, Baltimore Washington Medical Center (BWMC), the Anne Arundel County Department of Health, the Partnership for Children, Youth and Families, and the Mental Health Alliance. This group provides the leadership to the local health improvement coalition, Healthy Anne Arundel Coalition (HAAC). HAAC is a large partnership within the County and includes representation from public sector agencies, health care providers and payers, community-based partners, the business community and academic institutions. The purpose of this collaboration of the leadership of HAAC was to define the scope of the CHNA process, what goals needed to be fulfilled (each organization requires a needs assessment for various reporting reasons) and to define the participants. Anne Arundel County was defined as the scope of work and its residents were the participants. The process is defined as follows.

The group contracted with Holleran Consulting, LLC to conduct a countywide community health needs assessment (CHNA) in order to gather information about the health needs and health behaviors of Anne Arundel County residents. The assessment examined a variety of indicators, including social determinants of health (poverty, housing, education), mortality rates, high risk behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease). Holleran Consulting, LLC was also directed to collect the information through secondary data sources, focus groups and key informant surveys and they provided the written report.

The CHNA was comprised of several research components, combining quantitative health information and valuable qualitative feedback from community stakeholders. This multi-faceted approach ensured a

profile of the county's health that takes into account various perspectives and data sources. The following list outlines the three research components. Each component is further detailed throughout the document.

1. Secondary Data Profile
2. Key Informant Surveys
3. Focus Groups

Secondary data sources were collected from a variety of existing reports such as the county Health Report Card, vital statistics, data and statistics from the Centers for Disease Control, county health rankings, crime statistics from the FBI, state and county health facts from the Kaiser Foundation, DHMH, surveillance data from the National cancer Institute. These are just some examples of the reports that generated data. It should be noted that in some cases, local-level data was limited or dated. This is an inherent limitation with secondary data. The most recent data was used when possible. When available, state and national comparisons were also provided as benchmarks for the Anne Arundel County statistics. In some cases, Healthy People 2020 goals and County Health Rankings national benchmarks were included with relevant data points. Secondary data was used to develop questions for the key informant interviews and focus groups.

Key Informant interviews were conducted between July and August, 2012. The interviews were computer based questionnaires and were targeted to County residents with computer access. Holleran Consulting, LLC provided the listing of key categories of coverage and HAAC leadership was responsible for providing accurate e-mail addresses and any other contact information of key informants to Holleran Consulting, LLC. One hundred twenty one online questionnaires were collected from representatives throughout a variety of sectors including public health and medical services, non-profit and social organizations, children and youth agencies, faith-based organizations, and the business community. It is important to note that the number of completed surveys and limitations to the sampling method yield results that were directional in nature. Results reflect the perceptions of some community leaders, but may not necessarily represent all community leaders within Anne Arundel County.

Five focus groups were held at various locations throughout Anne Arundel County in August and September 2012. Focus groups topics addressed Mental & Behavioral Health, Access to Health Care, and Nutrition & Physical Activity. Topics were determined based on findings from the Secondary Data research. Each session lasted approximately two hours and was facilitated by trained staff from Holleran Consulting, LLC. In total, 55 people participated in the focus groups. Participants were recruited through local health and human service organizations and public news releases. In exchange for their participation, attendees were given a $50 gift card at the completion of the focus group. Participants came from a variety of ZIP Codes throughout Anne Arundel County. It is important to note that the results reflect the perceptions of some community members, but may not necessarily represent all community members in Anne Arundel County, MD. In general, the proportion of females and Blacks/African Americans was higher in the focus groups than the overall population in Anne Arundel County.

Themes emerged throughout the process. Nearly 68 percent of the County's adult population is considered overweight and obese. Co-occurring disorders affect a large percentage of the adult and adolescent population (MHNA) and there are not adequate facilities and programs to address the need. The CHNA leadership group ranked obesity and co-occurring disorders based on the overwhelming need demonstrated through the data collection process. Other priorities were ranked based on findings as well. HAAC spent FY13 developing and submitting action plans to the state to address the obesity epidemic and the rising problems with co-occurring disorders. Sub-committees were established to address these two needs and workplans were distributed to members. Work is on-going to this day to develop

programs, increase awareness and access about programs. Individual organizations are implementing programs and plans to address the other health needs – cancer, chronic disease, access to programs, and health disparity. Individual organizations/ facilities who are involved include: Anne Arundel County Department of health, AAMC, BWMC, Arundel Lodge, Partnership for Children & Youth, Anne Arundel County Department of Aging, Anne Arundel County Department of Recreation and parks, City of Annapolis Department of Recreation and Parks. This list is not exhaustive and members continue to join the process to improve health for County residents.

The identification of the overall health status of the county's residents will contribute to community health improvement planning efforts. AAMC's Board of Directors adopted the CHNA developed in partnership with HAAC, in its entirety in April, 2013. AAMC developed an Implementation plan to address the health needs that were outlined in the CHNA. It was adopted by the Board of Directors in October, 2013.

If you answered yes to this question, provide a link to the document here.
http://www.aahs.org/community/

NOTE: This is the AAMC link to our Community Benefits webpage. There are links to our CHNA and Implementation Plan.

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.

Link to AAMC's implementation strategy: http://www.aahs.org/community/pdfs/Plan2013-2015.pdf

AAMC's Board of Directors adopted an Implementation Plan in October, 2013 that addressed the seven health concerns outlined in the County's CHNA. All health concerns have been addressed, a plan has been implemented for each.

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

   AAMC is included on our Annual Operating Plan and it is also measured and reported through our metrics reporting process.

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

i. Senior Leadership

1. **_X__CEO**
2. **_X__CFO**
3. **_X__Other (please specify)**

Chief Medical Officer, Chief Nursing Officer/Chief Operating Officer, Chief Strategy Officer, Vice President of Physician Services, Chair of Clinical Integration, Vice President of Quality & Patient Safety, Vice President of Clinical & Support Services

ii. Clinical Leadership

1. **_X__Physician**
2. **_X__Nurse** (Emergency Department Clinical Director, Senior Clinical Nursing Director – Acute Care, and Executive Director of Oncology)
3. **___Social Worker**
4. **_ X __Other (please specify)** (Executive Director of Women's & Children's Services, Executive Director of Pathways Alcohol & Drug Program)

iii. Community Benefit Department/Team

1. **_X__Individual (please specify FTE)** 0.75 FTE's
2. **_X__Committee (please list members)**

AAMC's Strategic Planning Sub-Committee to the Board of Directors develops, reviews, and approves the Community Benefit Report and Strategic Plan. AAMC's CBR Team includes the Executive Director of Marketing, Communications and Wellness, the Manager of Health Promotion, community outreach nurses (askAAMC), community outreach dieticians, representatives from the hospital's clinical education team (including mother/baby, oncology, surgical, joint, spine, and drug and alcohol program).

3. **_X__Other (please describe)**

The CBR Initiative is supported by the Director of Reimbursement, Director of Finance, Reimbursement Financial Analyst, the Strategic Planning and Decision Support Dept., the Manager of the Annapolis Outreach Center & Community Health Center, several analysts, and staff of the Marketing and Communications Department.

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.

Page 26, FY2013 Community Health Needs Assessment – Anne Arundel County Maryland
http://www.aahealth.org/pdf/chna-final-report.pdf

Overall CHNA Findings & Conclusions

1. *Obesity/Overweight*
2. *Cancer*
3. *Mental Health & Substance Abuse*
4. *Chronic Illness (Heart Disease, Diabetes)*
5. *Services for Uninsured and Under-Insured*
6. *Awareness of Services*
7. *Health Inequities by Race/Ethnicity*

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.

The CHNA did describe other determinants of health such as transportation and health care affordability. The need to improve dental health was also mentioned in the CHNA. Public transportation is not in the scope of services that AAMC can provide as a hospital. AAMC is currently looking for grant and donor funding to support a full time dental clinic in the Annapolis Stanton Center to expand low cost and affordable dental care. In FY14, a local dentist expanded hours to care for underserved patients. Free and low cost dental care was provided to residents who do not have access to dental care. The wait list for preventive dental care has decreased, but it still remains a concern. AAMC has expanded the low cost primary care clinics to three different locations in Annapolis to better coordinate care and offer affordable primary care.

While the CHNA mentioned these determinants, it did not include them in the final analysis and conclusions. In FY14, AAMC had initiatives underway to address cancer, substance abuse, chronic disease, services for under- and uninsured and healthcare disparities. The FY14-15 Implementation Plan does include programs to address all health needs indicated in the CHNA.

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.

Population changes and the implementation of the Affordable Care Act (ACA) are projected to create demand for 52,000 additional U.S. primary care physicians (PCP) by 2025, according to a study in the Annals of Family Medicine. The Association of American Medical Colleges estimates that the U.S. will face a shortage of 90,000 doctors by 2020 and more than 130,000 by 2025.

Locally, there is a significant shortage of primary care physicians in the region. There is a shortage of 46.3 primary care physicians in Anne Arundel County, based on calculations using the guidelines of the Federal Health Professional Shortage Areas. Data analysis demonstrates that 58% of the population in all Anne Arundel County zip codes needs at least 1 additional primary care physician FTE. There is an increased utilization of primary care services due to the implementation of the Affordable Care Act mandating health insurance coverage for all and Medicaid expansion.

This shortage results in seriously limited access to primary care in parts of our Community Benefit Service Area. Building primary care access is essential to the Hospital's strategic plan, Vision 2020. Increased accessibility and coordinating health care increased the focus on prevention and improving the population health of our CBSA.

AAMC continues to promote physician recruitment with regard to primary care physicians in the county. Four additional primary care physicians joined the AAMC's team in early FY14. A primary care walk-in clinic is planned for opening in FY15 in an Annapolis grocery store to expand access to care. Physician recruitment, particularly primary care recruitment, continues to be a major initiative for the organization.

The most significant effort put forth in FY2014 was to continue to focus on the underserved population. Resources were allocated to the continued operations of the Community Health Center on Forest Drive in Annapolis and of the Morris Blum Community Health Center within the state-designated Health Enterprise Zone (HEZ) in Annapolis on Glenwood Street. Included in the HEZ effort is the Annapolis Community Health Partnership, which consists of Anne Arundel Medical Center, the Housing Authority of the City of Annapolis, the City of Annapolis, the Anne Arundel County Department of Health and the Anne Arundel County Department of Aging and Disabilities.

The Annapolis Community Health Partnership is focusing on a currently medically underserved neighborhood with high rates of emergency room utilization, hospital admissions and readmissions, and a large volume of medical 911 calls. Through funding provided by the HEZ designation, the partnership established a new patient-centered medical home at the Morris H. Blum Senior Apartments Building. This medical office, nestled in the community it is meant to serve, is easily accessible by foot or public transportation. The primary care medical home personnel treat infants, children and adults in the surrounding community who are uninsured, under-insured or have public coverage. By having a regular doctor in a regular site, patient-physician relationships strengthen and care improves.

Health outcomes are being monitored and demonstrated by measuring patient satisfaction, improving management of chronic disease and decreasing preventable medical 911 calls, emergency room visits and hospital admissions.

While the uninsured and underserved population can access care through the clinics, specialty care remains a challenge. Therefore, AAMC financially subsidizes specialists who take on the care of the underserved/uninsured from the clinics. This incentive allows for additional care for the underserved. Since healthcare system navigation is a challenge, a care manager in the clinics was hired in FY14 to assist with placing these patients in appropriate specialty care. AAMC continues to monitor and address the problems associated with care for the uninsured and underserved.

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.**

- The hospital maintains 24/7 inpatient coverage with the Hospitalist Program and physician coverage for Palliative Care Program, Neurology Stroke Program, Women's Pelvic Health, Thoracic Surgery Program, Neonatal Ophthalmology, Gyn Oncology Program, Surgical Oncology Program, Hematology/Medical Oncology Program, Annapolis Oncology Center & Breast Center, $10,581,654 (Line C92).
  - This coverage provides round the clock access for patients to needed specialties. It guarantees patient access to needed services.

- Emergency Department On-Call Physician(s), $433,484.86 (Line C91). AAMC provides funding for comprehensive Emergency Department medical staff coverage (24/7/365).
    - This coverage ensures there is always appropriate level of care in the ED in order to maintain quality patient care.
- The hospital contributed $62,000 (Line C10) in FY14, working in collaboration with the Anne Arundel County Health Department to provide physician(s) and mid-wives for patients that participate in the Anne Arundel County Department of Health Pre-natal Maternity Clinic, which provides care for uninsured Latina women whose infants would be Medicaid-eligible.
    - This coverage provided free pre-natal care to more than 180 women and their children.
- The hospital contributed $50,000 in FY14 (Line C40), working in collaboration with Johns Hopkins Physicians to treat uninsured patients that present at the Kent Island Urgent Care Center.
    - This program provided care to patients in their own community.

V. 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)**
    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).**

    Please see the attached Appendices I, II, and III.

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

    Please see the attached Appendix IV.

Table III – FOR HOSPITAL COMPLETION
FY14

Initiative 1								
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?
Obesity ranked number one health concern in A. A. Co. with 63.5% obese or overweight	Develop, implement and support initiatives to increase access to healthier food and exercise options, and expand educational resources related to a healthy lifestyle.	Support the Healthy Anne Arundel Coalition in their efforts to increase awareness among county residents that obesity is a health risk. 1. Participate actively in the workgroups of the Healthy Anne Arundel Coalition including the Steering Committee and the Obesity Reduction Committee. *(No. meeting, events))* Increase access to appropriate nutrition education and treatment for residents with diverse racial and financial backgrounds. *1.* Expand AAMC dietitian consults to low-income families	Multi-year	Anne Arundel County Department of Health and the Healthy Anne Arundel Coalition, area churches, City of Annapolis, County Executive's office, Annapolis City and AA County Departments of Recreation and Parks, Low Income Housing, Anne Arundel County Public Schools, BWMC, NAACP, Anne Arundel Community College,& Glen Burnie Chamber of Commerce	This is a multi-year initiative in which planning began in the Spring, 2013. Decreased from 66% to 63.5%	Increase the proportion of adults who are at a healthy weight (from 34% to 35.2% FY15) Reduce the number of adults who engage in no leisure-time activity. *These are also metrics to evaluate outcomes* Obesity prevention Sub committee meetings – 6 meetings annually. 60 hours allocated to self pay/ indigent	Ongoing through FY2015	150 staff hours ($13,812) committed to Healthy Anne Arundel by Christine Crabbs $1,000 cost (time and room rental) Dietitian cost for 60 hours = $5,700

Metrics are in parenthesis and italicized text

		and individuals. Low cost/ free nutrition counseling is not available locally. *(No. hours and encounters)* 2. Develop and implement yearly education seminars in each of the low-income housing neighborhoods and the Housing Authority of the City of Annapolis to educate residents about health risks associated with obesity. *(No. programs/ seminars provided)* Support county programs that strive to improve the availability of fruits and vegetables throughout the county. *1.* Provide a farmer's market on the AAMC campus annually between June and October. *(no. markets provided)* *2.* Increase access to fruits and vegetables at AAMC by adopting Healthy Anne Arundel's healthy meeting/ fellowship meal policies. *(adoption of policy at AAMC)* Disseminate information about available exercise programs, including low-cost and free services and program. 1. Partner with Westfield Mall to promote walking paths within the mall. *(no. of registration*				patients 60 encounters 2. 10 programs in low income housing neighborhoods 1. # markets = 16 2. Yes, policy was adopted 564 mall walkers registered		Hours – 50 Cost - $2,000 Farmers Market Cost (staff hours) $6,720 N/A $2,264 for pedometers to Mall Walkers

Metrics are in parenthesis and italicized text

Table III – FOR HOSPITAL COMPLETION
FY14

Initiative 2								
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	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY?
Cancer Lung Cancer (mortality rate is 46.4/100,000 compared to MD 46.0/100,000 Melanoma (4.6/100,000 as compared to MD 2.4/100,000) (continued)	Smoking Cessation Initiative (Smoking rate for Blacks is 10.6% vs White 19.0%) Lung cancer program	Reduce smoking rate for Adults and adolescents through prevention, education and treatment. . *(no. encounters and classes)* 1. A Smoking cessation program is made available for free to the Anne Arundel County adults and adolescents. Individual counseling is available for adults who are in-patients and out-patients. Classes are available for adolescents. Support groups to maintain cessation is available for adults. NOTE: Emphasis on working with African American churches and low income housing. *(no of classes, support groups, encounters, smoking/tobacco use rate changes))* Early diagnosis of lung cancer to reduce mortality 1.Provide low cost/ sliding scale fee CT scans for low income residents (*no of CT Scans provided at reduced rate or free)* 2. Access to Rapid Access Chest and Lung Assessment program for early diagnosis (no of patients enrolled)	Multi-year initiative; on-going	AAMC, Healthy Anne Arundel Coalition, American Cancer Society, Anne Arundel County Schools, Physician groups, faith-based community(African American Churches) and the Housing Authority of City of Annapolis	Yearly Objectives are measured via metrics and changes towards healthy behaviors. Outcomes describe evaluation metrics.	Smoking rate for adults 19.7% Tobacco use adolescents – 17.7% Counseling encounters = 2,674 Outpatient individual Counseling = 428 encounters Adult classes encounters = 388 Support group to maintain cessation = 44 encounters Adolescent prevention classes in schools = 50 encounters Adolescent prevention classes at Pathways (substance abuse treatment facility) = 16 encounters # CT scans= 116 157 county residents accessed the Rapid Access program	The current activities will continue; increased outreach and education will focus on adolescent outreach since the smoking rates for teens continues to be high	$105,357 Healthy Lung Screening Charity: $76,676

Metrics are in parenthesis and italicized text

Table III – FOR HOSPITAL COMPLETION
FY14

Initiative 2 (Cont)

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 Lung Cancer (mortality rate is 46.4/100,000 compared to MD 46.0/100,000 Melanoma (4.6/100,000 as compared to MD 2.4/100,000)	Provide education to county residents (adolescents) about the dangers of tanning beds Improve access to treatment for melanoma patients	Reduce the number of residents and adolescents who use tanning beds. 1. Develop and implement educational program on the risks of sun exposure *(no. of educational sessions, no of participants)* 2. Implement skin cancer screenings with local dermatologists (*no of screenings, no of participants)* 3. Support county/ state efforts to limit tanning exposure to minors (*no. policy initiatives introduced and passed)* Implement two additional clinical trials to further treatment options for melanoma patients *(no of trial opened and no of participants enrolled)*	Multi-year initiative; on-going	AAMC, Healthy Anne Arundel, American Cancer Society, Anne Arundel County Schools, Physician groups, faith-based community	Yearly. The program will be evaluated using metrics described and changes towards healthy behaviors (reduction in tanning bed use, long term monitoring of melanoma rates)	Reduce the number of residents who will use tanning beds through education and policy changes. 8 education events; 850 participants 1 skin cancer screening; 30 screened Supported (passed) 1tanning bed legislation Opened E1697: Phase III Randomized Study of Four Weeks High Dose IFN-α2b in Stage T2b No, T3a-b, T4a-b No, and T1-4, N1a, 2a, 3 (microscopic) Melanoma 1 Pt enrolled in trial	The current activities will continue	$2,550 $1,000 n/a Total cost of research program that supports all clinical trials $805,218

Metrics are in parenthesis and italicized text

Table III – FOR HOSPITAL COMPLETION
FY14

Initiative 3								
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)
Mental health and substance abuse (9.8/100,000 suicide rate in the County as compared to 9.5/100,000 in Maryland) (17.7% binge drinking in the County as compared to 14.2% in the state	Access to substance abuse treatment	Decrease the rate of drug-induced admissions and deaths Decrease the rate of binge drinking. Access to care is critical for all individuals. Provide low and no cost treatment options *(no and amount of charity care)*	Multi Year Initiative	AAMC, AA County Public Schools, Department of Juvenile Justice, AA County Courts, AA County Department of Health	Yearly – using metrics included in this documen t and changes in suicide rate, hospitaliz ations etc.	No cost treatment beds for detox patients = 10 patients. $43,369 in charity care Support groups for patients in recovery -3,648 encounters Rate of drug induced deaths = 14/100,000 Alcohol: Binge Drinkers 17.7% above the State rate of 14.2%	AAMC has focused on substance abuse disorders' initiatives.	Pathways Net Community Benefit= $152,669 AAMC In-Kind Donations: $19,500
	Access to co-occurring disorder treatment	Expand Pathways to treat co-occurring disorders not only substance abuse. • Hire and train appropriate staff Psychiatrists will be added to the ER on-call system • Implementation of a mental health unit within the ER to address mental health ER visits and admissions					Rate of suicide 9.8/100,000 Rate of ED visits for behavioral health condition is 3,899/100,000 population which is above the Ship Objective #34 State 2014 target of 2,652.6 /100,000.	$655,749

Table III – FOR HOSPITAL COMPLETION
FY14

Initiative 4								
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	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Chronic disease High mortality rate from Heart Disease (171.5/100,000 compared to MD 194/100,000) and diabetes (21.5/100,000 compared to MD 20.8/100,000) Blacks have 368.9/100,000 ED visit rate compared to Whites at 132.3/100,000 11.9% of Blacks have diabetes vs 8.2% Whites	Smoking Cessation Initiative Obesity Initiative Blood Pressure Screening and Monitoring Program Education for prevention and early detection for heart disease Dare to C.A.R.E. Increase access to diabetes Education for residents	See cancer for details See Initiative 1 for details Provide blood pressure screenings in the community for high risk individuals *(no of clinics, no of participants)* • In local African American churches • Low income neighborhoods • Lighthouse Homeless Shelter Expand Early Heart Attack Care campaign and Million hearts campaign as educational platforms in the community. *(number of participants)* Increase access to vascular screenings in the community *(no of screenings and number of participants)* Develop a plan for community based diabetes education program that includes a population health focus. The plan will include prevention, treatment, and research components. *(plan development)*	Multi-year initiative; on-going	AAMC, Healthy Anne Arundel Coalition, County parks and Recreation, American Heart Association, American Cancer Society, Anne Arundel County Schools, Physician groups, faith based community MedStar Health System	Yearly – using stated metrics and evaluating changes in rates of heart disease and diabetes	Blood Pressure Screenings: 1,421 Participants Dare To C.A.R.E. Vascular Screenings: 1,262 Participants	The current activities will continue	$18,346 n/a Dare to C.A.R.E Charity: $457,878 AAMC Cash Donations to Dare to C.A.R.E: $60,000 Plan is developed; recruiting Medical Director

Metrics are in parenthesis and italicized text

Table III – FOR HOSPITAL COMPLETION
FY14

Initiative 5								
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	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Services for uninsured and Under-insured population 12.7% [1]of residents in the HEZ area 21401 are uninsured – compared to Maryland average of 10.2%	Provide access to primary care services for under and uninsured residents	To provide access to quality, affordable healthcare to the uninsured and underinsured. (number of encounters) Reduce emergency room visits by providing medical services with an emphasis on early intervention and prevention of disease. *(23.7% of ED visits for primary care)* There are three clinics operating in Annapolis in low income areas with populations of minority individuals. This is also to address health disparity. The three clinics are: • AAMC Community Health Center • Arundel Lodge • Morris Blum Health Clinic	Multi year	AAMC Department of Social Services AA County Department of Health Center for Hope (Centro de Ayuda) MCHRC City of Annapolis	Quarterly using stated metrics in this document	Patient encounters at AAMC CHC 7,873 Arundel Lodge – 216 encounters Annapolis Outreach Clinic – 922 Morris Blum Clinic – 1,443 encounters Improve population health: Mortality Rate : 14.2/100,000 Rate of ED visits for asthma per 10,000 (ten thousand) population 44.6 Rate of ED visits for hypertension: 181.9/100,000, Rate of ED visits for diabetes per 100,000 population 169.3	Morris Blum Health Clinic opened in FY2014	Community Health Center: $536,246 AADI provided $405,187 in services to 1,503 CHC patients Outreach Clinic: $1,851 Morris Blum Clinic $235,010

[1] Source: U.S. Census Bureau, 2008-2012 American Community Survey
Metrics are in parenthesis and italicized text

Table III – FOR HOSPITAL COMPLETION
FY14

Initiative 6								
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	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Health Disparity	Improve networks and collaborations to reduce the health disparity in community	Throughout this workplan, AAMC has proposed to target low income individuals that face health disparity. The biggest areas of disparity related to the CHNA are: • Hypertension • Diabetes • Access to Primary care • See other initiatives for plans to work with low income neighborhoods and African American churches	Multi year	Housing Authority of Annapolis, churches, Healthy Anne Arundel, AAMC, other Social services organizations	Evaluation of metrics included throughout the document; changes in Health disparities rates	Increased number of participants in programs	Continuation	Rolled into other initiatives

Table III – FOR HOSPITAL COMPLETION
FY14

Initiative 7								
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	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Managing the Health Needs of the Elderly (two out of every three older Americans have multiple chronic conditions)	AAMC Collaborative Care Network Acute Care for the Elderly Unit	ACO share with Medicare any savings generated from lowering the growth in health care costs, while meeting standards for quality of care by improving care coordination and providing care that is appropriate, safe, and timely.	Multi year	CMS, AAMC	Quarterly	ACO enrollees – 9,360 Uncontrolled Diabetes – .11/1000 COPD/Asthma – 5/9/1000 CHF – 7.84/1000 Pneumonia – 6.44/1000 30 day readmission – 6.6%	New FY13– on-going	$45,000
	Palliative Care Program	The Palliative Care team of physicians, nurses, social workers work with patients suffering from serious and chronic illnesses such as cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD), Alzheimer's, dementia, effects of stroke and other serious conditions. The team establishes, with input from family and their primary care physician, to create an individual care plan.		Hospice of the Chesapeake; Chesapeake Palliative Medicine	Monthly 893 referrals to program	39% - same day consult 52% - 2 day consultation from admission 33% referred to hospice	New FY13– on-going	$268,507
	Hackerman Patz House	Hackerman-Patz House is a low cost hotel option for patients, families and community on AAMC campus. It operates on a sliding scale fee so no one is turned away. Patients have access to the care they need.		Community referrals		Patients –726 visits	New FY13– on-going	$844,999

Metrics are in parenthesis and italicized text

Appendix I

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)**

Hospital Financial Assistance Communications

- The Financial Assistance Signage is conspicuously displayed in English & Spanish in the Emergency Department, Cashiering & Financial Counseling.
- Financial Assistance Policy as well as a printable Uniform Financial Assistance application is posted on the AAMC website.
- English/Spanish table top tents display this information at every patient entry point and it is included in each patient guide located in the inpatient rooms.
- Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.
- The financial assistance application is available at all registration points – but in particular the Emergency Department.
- A brochure "What you need to know About Paying for Your Health Services" is available at every patient access point. The brochure was developed by Patient Financial Services with guidance from Public Relations. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish. Also, it is posted on AAMC's website.
- It is mandatory that all inpatients receive the "What you need to know about paying for your health services" brochure as part of the admission packet.
- Informational "business cards" are available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital Financial Counseling office for assistance.
- Hospital Patient Financial Service staff receive extensive training on the revenue cycle and are incentivized to obtain AAHAM Technical (CPAT) certifications to demonstrate their expertise in billing and revenue cycle requirements.

<table>
<tr><td> </td><td colspan="2">Patient Financial Services – Hospital Financial Assistance, Charity Care, Billing & Collection Policy</td></tr>
<tr><td colspan="2">Dates Previously Reviewed/Revised:
Newly Reviewed By:
Effective Date: December 1, 1997
Review Date: August 15, 2012
F&A Committee Approval: September 21, 2012
Board of Trustees Approval: September 27, 2012</td><td>Owner: Director of Patient Financial Services

Reviewed (date & initials): ________</td></tr>
<tr><td colspan="3">Approver Title: Chief Financial Officer

____
Approval Signature</td></tr>
</table>

Scope: Anne Arundel Medical Center

Policy Statement:
To promote access to all for medically necessary services regardless of an individual's ability to pay, to provide a method of documenting uncompensated care and to ensure fair treatment of all applicants and applications

Purpose:

- To assure the hospital communicates patient responsibility amounts in a fair and consistent manner.
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices, effective June 1, 2009
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To define the hospital's decision making process for referral for collection or legal action.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices, effective June 1, 2009

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Charity Care

- Determination of Probable Eligibility: Within two business days following a patient’s request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.
- AAMC provides 100% charity to individuals with household income at or below 200% of the US Poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.
- AAMC provides 100% charity to individuals enrolled in the Medicaid Primary Adult Care program and other means tested State & Local programs.
- AAMC provides a sliding fee scale for individuals with household income at or below 330% of the US poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.
- AAMC provides financial assistance not only to the uninsured but to patients with a demonstrated inability to pay their deductibles, copayments and balance after insurance.
- The hospital excludes assets such as the patient’s primary home, method of transportation and cash assets less than $15,000.
- For all income levels, AAMC will take into account special circumstances such as the amount of the bill compared to income and cumulative impact of all medical bills.
- AAMC developed an initiative with the A.A. County Department of Health to help provide free prenatal diagnostic testing for uninsured unregistered immigrants. These individuals are not eligible for any Medicaid program.
- AAMC participates with an Anne Arundel County specific program (REACH) administered through the AA County Department of Health to provide free care to low income uninsured or under-insured individuals (below 200% of the US Poverty Guideline). These individuals come to AAMC on an elective basis and are prescreened by the local Department of Social Services.
- Diagnostic and Treatment services are provide free of charge to referrals from the AAMC Outreach Free Clinic initiative located in downtown Annapolis.
- Payment plans, Interest Free

Billing

Patient Statement of Charges:

- A Summary Bill of charges, formally referred to as the Uniform Summary Bill is mailed to every inpatient within 15 days of discharge from the hospital. This contains information on the insurance company billed as well as how to contact the Patient Financial Services office for questions or assistance.
- Uninsured patients receive this Summary as well
- Each bill for outpatient services includes detail charge information on the first request for payment.
- At any time, the patient may request a copy of their detailed itemized bill.
- The HSCRC required Patient Billing Information sheet data is printed on the Uniform Summary Bill and the back of all patient billing statements.
- A representative list of services and charges is available to the public on the hospital's website and in written form. The website will be updated quarterly with the most recent average charge per case for each of the services.
- Requests and inquires for current charges for specific procedures/services will be directed to the ACP Financial Coordinator or if applicable the specific department Financial Coordinator. The Coordinator will communicate with the patient and the patient's provider of care to provide the best possible estimate of charges. Using the CPT code, service description and/or other supply/hospitalization time charge estimates are based on, a) review of the charge master for the CPT code/service description, and/or b) review of cost of similar surgical procedures/treatments/hospital stays. The patient will be informed cost quotes are estimates and could vary based on the actual procedure(s) performed, supplies used, hospital stay/OR time & changes in HSCRC rates. If the Coordinator requires guidance or additional information to provide the estimate he/she will contact the Reimbursement Department. Every effort will be made to respond to the request for charges within 2 business days depending on information needed to fulfill the patient's request.

Patient Balance Billing:

- From the point in which it is known that the patient has a balance for which they are responsible the hospital begins billing the patient to request payment.
- Each patient receives a minimum of 3 requests for payment over a 90 day period.
- Each patient bill includes contact information for financial assistance and states where to call to request a payment plan.
- Each bill informs the patient they may receive bills from physicians or other professionals.
- Short and Long term interest free payment plans are available. The hospital takes into account the balance of the bill and the patient's financial circumstances in determining the appropriate agreement.
- Should the patient contact Patient Financial Services Customer Service unit regarding inability to pay – financial assistance is offered and the financial assistance screening process begins.

Collection Agency process:

- If there is no indication from the patient or a representative that they cannot pay and no attempt at payment or reasonable payment arrangements is made, the account is referred to a collection agency.

- The collection agency referral would typically occur between 90 – 110 days from the first request to the patient to pay assuming the patient made no attempt to work out payment arrangements or indicated financial need.
- The final statement to the patient communicates the account will be referred to an external agency if the balance is not satisfied.

Collections

- The Director of Patient Financial Services oversees the hospital's business relationship with the Collection Agency.
- AAMC does not utilize a credit reporting bureau.
- AAMC does not charge interest to patients
- The collection agency performs a financial checkpoint before taking the next step to legal action.
- AAMC staff reviews each case before being referred for legal action
- The collection agency is educated on how to make referrals to AAMC's financial counseling department for individuals indicating they have an inability to pay.
- The collection agency will establish payment arrangements in compliance with AAMC's interest free commitment.
- As a last resort, AAMC will file suit for collection of debts.
- If the court makes judgment in the hospitals favor – a formal legal credit mark referred to as a "judgment" is placed on an individual's credit and remains intact for 10 years. Once the full payment is made the patient may request that the judgment reflects as satisfied on the credit rating.
- AAMC will file suit against estates and in some cases, when appropriate, trust funds.
- AAMC does actively enforce a lien against an individual's primary home.

Approved by CFO
Bob Reilly

Patient Billing Information Q&A

included in my hospital bill?
ll from Anne Arundel Medical Center is for
you receive from nurses, social workers,
ns, therapists and other staff. It also includes
for your room, meals, linens, supplies,
tions, diagnostic tests and supervised
onal services, such as those of respiratory and
l therapists.

not included in my hospital bill?
be billed separately by your physicians,
ing physicians, and surgeons for services they
to you. These services are NOT included in
spital bill. Each physician who cares for you
d you a separate bill for services they provided.
cludes physicians who may have treated you
Emergency Department; those you may never
luding physicians who interpret diagnostic
such as X-rays, EKGs, and certain laboratory
ens; and anesthesiologists, staff pediatricians
nal medicine physicians who may have treated
ing your stay.

es health insurance billing work?
ou receive services at Anne Arundel Medical
we will bill your health insurance provider on
half. To do this, and to assure the hospital is
services provided to you, we need a copy of
urance card. We must supply complete and
e information to your health plan, including
l name, address, phone number, date of birth,
ial Security number. Incomplete or incorrect
ation could mean a denial from your insurance
r. You could be held responsible for the
of the invoice when an insurance provider
denies, or makes partial payment. Your
ce company may also require that you make
-payment at the time of service.

annot or will not provide complete insurance
scriber information Anne Arundel Medical
cannot submit your bill to your insurance
y. If that is the case, you will be a "self pay"
and we will ask you for a deposit for services

All cosmetic services and services not deemed medically necessary by your insurance company must be paid in full and in advance of the service.

What if I Have a Managed Care or HMO Plan?
If you have a managed care or HMO plan and you are admitted to our emergency room, your plan may require you to contact your local office to obtain authorization for your admission within 24 hours of an emergency admission. Your health insurance card should provide you with your plan's telephone number. Anne Arundel Medical Center staff will attempt to contact your insurance plan with notification of your inpatient admission. Most HMO plans require you to obtain a referral or authorization for certain non-emergency services. Anne Arundel Medical Center will help you obtain the authorization.

Many HMOs require you to receive diagnostic services such as laboratory tests and X-rays at a designated provider, not at the hospital's outpatient department.

What if my visit involves worker's compensation?
If we do not receive worker's compensation information from you or your employer you will be responsible for your bill. It is important that you provide your medical insurance benefit information as well, so any required authorizations or other steps to ensure coverage are followed. This will assist in protecting you and the hospital financially should worker's compensation deny payment. We need a copy of the denial in order to bill your insurance.

What if my visit is due to a motor vehicle accident?
Anne Arundel Medical Center does not bill auto insurance providers. MVA patients are responsible for payment of services provided. It is important that you provide your medical insurance benefit information as well, so any required authorizations or other steps to ensure coverage are followed. This will assist in protecting you and the hospital financially should the auto insurance deny payment. We need a copy of the denial in order to bill your insurance.

What does Medicare Cover?
"Medical Necessity" is a term used by Medicare to describe the services Medicare feels are "reasonable and necessary" for the treatment or diagnosis of an illness or injury. In most cases Medicare provides payment for "medically necessary" services. If your physician prescribes a service that may not be covered by Medicare you will be asked to sign an Advance Beneficiary Notice before service is provided stating that Medicare is not likely to pay for the service. By signing this form you agree to be responsible for payment.

What are my options under Medicare?
If you have an Advance Beneficiary Notice you can sign it and agree to pay for the services yourself or you can refuse the service or treatment. If you refuse the service or treatment, we encourage you to talk with your physician about options that would be covered under Medicare. You have the right to appeal a Medicare decision of non-coverage. If you would like to file an appeal or have other Medicare-related questions, please call the Medicare Beneficiary Hotline at 1-800-633-4227.

What if I can't pay on time?
We understand that certain circumstances may make it difficult for you to pay your bill on time. However, if your account becomes past due, Anne Arundel Medical Center will take action to recover the amount owed. Please call 443-481-6500 between the hours of 8:30 a.m. – 4:00 p.m., Monday through Friday, to discuss your circumstances. We want to help you protect your credit.

What if I am unable to pay any portion of my bill?
If you are unable to pay your bill we can help you apply for state and federal programs that may pay all or a portion of your bill. Please call 443-481-1401 for assistance. Anne Arundel Medical Center offers financial assistance for those who do not qualify for state or federal programs but meet certain federal poverty guidelines. Also, you may be eligible for a partial reduction on the amount you owe.

For more information about patient financial services resources and telephone numbers, see the back of this brochure.

ou for choosing Anne Arundel
Center for your health care needs.
erstand this can be a challenging
our patients, and we know that the
aspect of hospitalization sometimes
onfusing.

he confusion out of the payment
our Patient Financial Services Team
le to help you understand your
bill. We also can help you with
options, including whether you
le for financial assistance through
nd state programs. We can answer
uestions about the manner in
ur insurance company processed

prepared this brochure to help
e most commonly asked questions
ling. If your specific question is
here, please contact 443-481-6500
- Friday between 8:30 a.m. and

Patient Financial Services Resources

Our Financial Counseling team is located at the Medical Park Campus, 2001 Medical Parkway, Annapolis, Maryland.

You may make an appointment to meet with a financial coordinator by calling:

Financial Assistance 443-481-1401

Medical Assistance application 443-481-1401

Payment Arrangements 443-481-1401

If you have received a bill and have questions or wish to discuss payment arrangements you may call:

Questions about your bill 443-481-6500

Payment Arrangements............ 443-481-6500

Anne Arundel Health System

Patient Billing Information Q&A

Appendix IV

Our Mission and Vision

Mission: To enhance the health of the people we serve
Vision 2020: Living Healthier Together

Our Corporate Values

COMPASSION
It happens in a hundred different ways every day. An encouraging word for a patient. Empathizing with a family. Making a co-worker's day a little smoother. Compassion is at the heart of our mission.

TRUST
This is the foundation of our culture -- patients and families putting their trust in us.

DEDICATION
Caring for patients requires selflessness and teamwork. We are thousands of people in jobs of every description all committed to the same goals.

QUALITY
Quality means meeting the high standards of excellence we expect of each other and that our patients deserve. Together we achieve better outcomes and experiences.

INNOVATION
Since our founding in 1902, we have been at the forefront of advancements in technology and patient care to benefit the people of our communities.

DIVERSITY
We benefit and draw strength from our differences. Diversity is our daily experience, a journey – not a destination.

COLLABORATION
In partnership with many, we work together toward our vision: *living healthier together*.