UNIVERSITY OF MARYLAND BALTIMORE WASHINGTON MEDICAL CENTER (UM BWMC) FY14 COMMUNITY BENEFIT REPORT

BACKGROUND

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

The Commission's response to its mandate to oversee legislation was to establish a reporting system for hospitals to report their community benefit activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, and (3) hospital community benefit administration.

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;

In addition to the five zip codes, 21061 (Glen Burnie), 21122 (Pasadena), 21060 (Glen Burnie), 21144 (Severn) and 21113 (Odenton), in which 60 percent of the hospital's patient discharges originate that define UM BWMC's Community Benefit Service Area (CBSA), UM BWMC further defines its CBSA to include the Anne Arundel County zip code 21225 (Brooklyn Park). The health and economic indicators outlined in the CHNA showed that persons residing in this zip code face significant challenges that correlate directly with increased emergency room usage, poor health outcomes such as an increased rate of low birth weight babies and an overall lower than average life expectancy. Lastly, it is important to note that approximately 69.5% of the charity care that UM BWMC provided in FY14 was provided to residents of these six zip codes.

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;

Because local action is essential to public health progress, UM Baltimore Washington Medical Center is a key stakeholder in the Healthy Anne Arundel Coalition (HAAC), a partnership of public sector agencies, health care providers and payers, community-based partners, the business community and academic institutions. The coalition was formed in December 2011 in response to a Statewide Health Improvement Process (SHIP) and is jointly led by the Anne Arundel County Department of Health, UM BWMC and Anne Arundel Medical Center (AAMC). The HAAC Steering Committee includes Vice Chair Kim Davidson, Director of Community at UM BWMC. The coalition steering committee meets every other month. Coalition subcommittees including community engagement, co-occurring disorders and obesity prevention also hold regular meetings.

To conduct the coordinated community-wide needs assessment, the Anne Arundel County Department of Health convened a workgroup from within the coalition that included UM BWMC, AAMC and social service agencies. A county-wide community health needs assessment (CHNA) was conducted between July and November 2012 by Holleran Consulting, a public health research and consulting firm with more than 20 years of experience conducting community health assessments.

To ensure that the profile of the county's health took into account various perspectives and data sources, a multi-faceted approach was used to conduct the CHNA. Comprised of three components including: 1. A secondary data profile in which data from all Anne Arundel County zip codes was included, 2. Key informant surveys and 3. Focus groups, the CHNA is a combination of quantitative health information and valuable qualitative feedback from community stakeholders. The assessment examined a variety of indicators, including social determinants of health (poverty, housing, education), mortality rates, risky behaviors (alcohol use, tobacco use) and chronic health conditions (diabetes, heart disease), to name a few. No information gaps were identified that impacted the coalition's ability to assess the health needs of the community.

The secondary data profile was gathered from existing resources, such as the United States Census Bureau and Maryland Department of Health and Mental Hygiene. The report integrated not only traditional statistics on physical health, such as cancer rates and immunization figures, but also demographic and household information. Research has shown that lower educational attainment, poverty and race/ethnicity are risk factors for certain health conditions. The profile details data covering the following areas:

- Population Statistics
- Household Statistics
- Income Statistics
- Education Statistics
- Mortality Statistics
- Birth Statistics
- Sexually Transmitted Illness Statistics
- Injury & Violence Prevention Statistics
- Communicable Disease Statistics
- Environmental Health Statistics
- Health Insurance Coverage & Health Care Utilization Statistics
- Mental Health Statistic
- Crime Statistics

The identification of the overall health status of the county's residents will contribute to community health improvement planning efforts. Implementation plans and county-wide health improvement plans have been developed to prioritize the key community wellness initiatives. Activities have been identified that will improve upon the health status of county residents. These activities will be conducted collectively, through coalition efforts, and individually, through organization-specific planning.

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 addition to an analysis of the secondary data profile, key informant surveys and focus groups were conducted. A web-based survey was conducted among Anne Arundel County "key informants." Key informants were defined as area health care professionals, social service providers, non-profit leaders, business leaders, faith-based leaders and other area authorities. Holleran staff worked closely with HAAC partners to identify prospective participants and to develop the online Key Informant Survey Tool. The questionnaire focused on gathering quantitative and qualitative feedback regarding perceptions of community needs and strengths across three primary domains: key health issues, health care access and community aspirations and capacity.

The online survey was sent via email to approximately 300 key informants, garnering 121 completed surveys between July and August 2012. The survey respondents were asked to provide feedback on the health issues that they perceived to be the most significant or concerning for Anne Arundel County. The key informants were given a list of potential response options, ranging from cancer to substance abuse to unintentional injuries. Respondents ranked the key health issues from 1 to 5, with 1 being the most significant. Additionally, survey respondents were permitted to share other health issues they deemed highly important that were not included on the list. The five issues that were most frequently selected were Obesity/Overweight, Cancer, Diabetes, Substance Abuse/Alcohol Abuse and Heart Disease. Approximately 84% of key informants ranked Obesity/Overweight as one of the top five health concerns in Anne Arundel County.

Key informants were also asked to share their perceptions on the availability of general and specialty health services and potential access barriers. The area of greatest concern with respect to accessibility and availability was the number of bilingual health care providers, followed by the number of providers who accept Medicaid or other forms of medical assistance and then lastly, access to dental care. Respondents were also asked to identify key resources or services they felt would be needed to improve access to health care for residents in Anne Arundel County. Responses included the need for increased awareness, education, prevention and outreach to inform the community about existing programs and services.

Focus group topics addressed mental and behavioral health (one session), access to health care (two sessions) and nutrition and physical activity (two sessions). Five focus groups (55 total participants) were held at various locations throughout Anne Arundel County in August and September 2012. Participants were recruited through local health and human service organizations and public news releases and came from a variety of Zip codes. The largest proportion came from 21061, 21401, 21144, 21060 and 21403. In exchange for their participation, attendees were given a gift card at the completion of the focus group. Participants in the Mental and Behavioral Health Focus Group were individuals with mental and/or

behavioral health issues or family members of individuals with mental and/or behavioral health issues. The four other focus groups included individuals from the general population in Anne Arundel County. Each session lasted approximately two hours and was facilitated by trained staff from Holleran.

Across the focus groups, several themes appeared as areas of opportunity:

- Lack of affordable medical and dental services
- Need for coordinated mental and behavioral health services
- Transportation barriers
- Lack of coordination among programs and providers
- Lack of community awareness of available programs and resources
- Need for health education and wellness programs

The analysis of local data indicated that obesity, cancer, mental health and substance abuse, dental care, sexual health, housing and the environment were all potential health improvement priorities for Anne Arundel County. After careful review of County health data, the Healthy Anne Arundel Coalition's Steering Committee prioritized the potential health improvement areas and decided to focus the Coalition's efforts on two areas: (1) Obesity Prevention and (2) Management of Mental Health and Substance Abuse as Co-occurring Disorders. The Coalition is committed to examining what evidence-based initiatives can improve the county's health in these two areas related to racial, ethnic and other demographic and geographic-related health disparities.

Maryland's State Health Improvement Process (SHIP) provides a framework for continual progress toward a healthier Maryland. Maryland's State Heath Improvement Process (SHIP) began with national, state and local data being reviewed and analyzed by the Maryland Department of Health and Mental Hygiene (DHMH) Office of Population Health as well as by the Anne Arundel County Department of Health. It has three main components: accountability, local action and public engagement.

SHIP includes 39 measures that provide a framework to improve the health of Maryland residents. Twenty-eight of the measures have been identified as critical racial/ethnic health disparities. Each measure has a data source and a target, and where possible, can be assessed at the county level.

UM BWMC's priorities are aligned with the Maryland State Health Improvement Process vision areas and those objectives outlined by the local health improvement coalition, Healthy Anne Arundel.

UM BWMC's Priorities:

1. Chronic Diseases (Obesity, Heart Disease, Diabetes and Cancer)
2. Wellness and Access
3. Maternal/Child Health
4. Access to Healthy Food and Healthy Food Education

5. Influenza Education and Prevention
6. Violence Prevention

Several additional areas were identified through the CHNA including lack of affordable dental services, transportation barriers and environmental health concerns. The need for enhanced and improved coordination of mental health services was also a common theme throughout the assessment. While UM BWMC will focus the majority of resources on the identified priorities listed above, these areas are important to the health of the community. UM BWMC will continue to work with and provide assistance as available to other health care providers and community partners, including:

- Anne Arundel Community College
- Anne Arundel County Department of Aging and Disabilities
- Anne Arundel County Department of Detention Facilities
- Anne Arundel County Department of Health (including representatives from Women's Infants and Children (WIC) and Healthy Start
- Anne Arundel Department of Recreation and Parks
- Anne Arundel County Department of Social Services
- Anne Arundel County Mental Health Agency, Inc.
- Anne Arundel County Office of the County Executive
- Anne Arundel County Public Schools
- Anne Arundel Economic Development Corporation
- Anne Arundel Health System
- Arundel Community Development Services, Inc.
- CareFirst BlueCross BlueShield
- City of Annapolis Mayor's Office
- Community Foundation of Anne Arundel County
- Housing Authority of the City of Annapolis
- MedStar Harbor Hospital
- NAACP-Anne Arundel County Branch
- People's Community Health Centers, Inc.
- Rite Aid Corporation
- University of Maryland School of Public Health
- Wal-Mart

The unmet needs not addressed directly by UM BWMC are being addressed through the action plan of the local health improvement coalition and corresponding subcommittees on which UM BWMC is actively involved. To ensure a cohesive approach to actions and process measures that will improve the health of the community, the table below incorporates UM BWMC's priorities with outcome objectives of both Maryland's State Heath Improvement Plan (SHIP) and Healthy Anne Arundel.

Maryland SHIP Vision Area	**UM BWMC Priorities**	Healthy Anne Arundel Objectives	SHIP Outcome Objectives
Overall Goal for SHIP Outcome Objectives: 1. INCREASE LIFE EXPECTANCY			
Healthy Babies	**Reduce infant mortality (Priority #3)**	[redacted]	• Reduce infant deaths • Reduce low birth weight (LBW) & very low birth weight (VLBW) • Reduce sudden unexpected infant deaths (SUIDs) • Increase the proportion of pregnant women starting prenatal care in the first trimester
Healthy Social Environments	**Reduce infant mortality and increase violence prevention education (Priority #6)**	1. Reduce the rate of suicides rates per 100,000 2. Decrease the rate of fatal crashes where the driver had alcohol involvement	• Reduce child maltreatment • Reduce domestic violence
Safe Physical Environments	**Increase access to healthy food (Priority #4)**	[redacted]	• Increase access to healthy food
Infectious Disease	**Influenza prevention and**	[redacted]	• Increase the percentage of

Maryland SHIP Vision Area	**UM BWMC Priorities**	Healthy Anne Arundel Objectives	SHIP Outcome Objectives
Infectious Disease continued	**education (Priority #5)**	[redacted]	people vaccinated annually against seasonal influenza
Chronic Disease	**Decrease cardiovascular disease, obesity, lung cancer mortality (Priority #1)**	1. Increase the proportion of adults who are at a healthy weight 2. Reduce the proportion of young children and adolescents who are obese 3. Reduce the rate of emergency department visits related to behavioral health conditions per 100,000 population 4. Reduce the rate of drug-induced deaths per 100,000	• Reduce deaths from heart disease • Reduce the overall cancer death rate • Reduce diabetes-related emergency department visits • Reduce hypertension-related emergency department visits • Increase the proportion of adults who are at a healthy weight • Reduce the proportion of children and adolescents who are considered obese • Reduce the proportion of adults who are current smokers • Reduce the

Maryland SHIP Vision Area	**UM BWMC Priorities**	Healthy Anne Arundel Objectives	SHIP Outcome Objectives
Chronic Disease continued			proportion of youths who use any kind of tobacco product
Health Care Access	**Expand access to primary care (Priority #2)**		• Increase the proportion of adolescents who have an annual wellness checkup • Reduce the proportion of individuals who are unable to afford to see a doctor

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.

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. **Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate**

during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
310	18,632	21061 21122 21060 21144 21113	AAMC 21061 21122 21113 MedStar HH 21061 21122 UMMC 21061 21122 21060 JHH 21061 21122 21060 21144 21113 UM REHAB & ORTHO INST. 21122 21060	7% (UM BWMC patients residing in Anne Arundel County)	5% (UM BWMC patients residing in Anne Arundel County)

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.

UM BWMC Primary Community Benefit Service Area

Zip Code	City
21060	Glen Burnie
21061	Glen Burnie
21122	Pasadena
21144	Severn
21225	Brooklyn Park
21226	Curtis Bay

UM BWMC South Community Benefit Service Area

Zip Code	City
21012	Arnold
21032	Crownsville
21054	Gambrills
21108	Millersville
21114	Crofton
21401	Annapolis
21402	Annapolis
21146	Severna Park

UM BWMC West Community Benefit Service Area

Zip Code	City
21090	Linthicum
21113	Odenton
20755	Ft. Meade
21240	BWI
21227	Elkridge/Arbutus
21076	Hanover

UM Baltimore Washington Medical Center considers most of Anne Arundel County the hospital's Community Benefit Service Area (CBSA). A few southern Anne Arundel County Zip codes have been excluded (20711, 20733, 20751, 20758, 20764,

20765, 20779) and a few eastern Howard County Zip codes (20723, 20794, and 21075) are also part of the hospital's CBSA. However, for this report, the data presented is based on Anne Arundel County.

Anne Arundel County is the fifth largest jurisdiction in Maryland with over 550,000 residents. It is part of the Baltimore metropolitan area and is located on the Chesapeake Bay, encompassing a 454 square mile area. The City of Annapolis (21401), the State Capitol, is centrally located between Baltimore and Washington, D.C. The northern part of the County is suburban and urban with the southern part primarily rural and agricultural. The County has two State parks and more than 70 County parks for residents to enjoy.

Employment in Anne Arundel County is distributed across a wide array of industrial sectors. Based on 2012-13 employment figures, *trade, transportation and utilities, government and professional and business services* account for more than 55% of the total County employment: 21%, 18.8%, and 16.2%, respectively. Other major employment sectors include *leisure and hospitality services* (13%) and *education and health services* (11.6%) *(Source: MD Department of Labor, Licensing, and Regulation, 2013).*

Anne Arundel County has a diverse population with respect to age distribution. According to 2013 Census data, persons between the ages of 20 and 44 years old comprise the largest segment of the population at 34.1%. The next largest group is persons age 45 to 64, which makes up approximately 27.9% of the total population. Persons age 19 and under are 25.2% of the County population and those ages 65 and older comprise 13% of the population. *(Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau).*

Anne Arundel County has approximately 120 public schools, 75 private schools, 70,000 students (more than 22,000 of which are eligible for a reduced lunch program) *(Source: aacounty.org),* 5,000 teachers and three major institutions of higher education. One of the most beneficial assets to Anne Arundel County is its well-educated population. Census estimates show that approximately 91.4% of the population over age 25 has obtained a high school diploma and approximately 37.2% of Anne Arundel County's population age 25 and over has either a bachelor's degree or a graduate professional degree. *(Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau).*

While Anne Arundel County is generally considered an affluent county, it is important to recognize that more than 38,000 people (7.1%) live in poverty (*Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau).* Quality of life for this population is hindered by issues of racial disparity and limited access to affordable housing and health care.

While Anne Arundel County has not experienced the racial and ethnic transformation happening in neighboring counties, there is growth in minority numbers in all categories. Hispanics account for 6.9% of the County's population as compared to 8.7% for Maryland. Asians make-up just over 3.7% of the population *(Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau).*

Health disparities and poor health outcomes are a reality for African-Americans in Anne Arundel County. This population continues to have the highest incidence, prevalence and mortality rates from chronic diseases including cardiovascular disease, diabetes and obesity (*Source: http://www.dhmh.maryland.gov/ship).*

Preterm birth and low birth weight continues to be the leading cause of death among infants in Anne Arundel County. The health of infants (less than one year old) is reflective of the health and social system a community has in place to support families and neighborhoods. Infant mortality measures deaths during the first year of life. The health of the mother before pregnancy can have a profound impact on the health of her baby. Issues such as pre-pregnancy weight, timely initiation of prenatal care, chronic disease management and substance abuse (including tobacco, alcohol and prescription drugs) continue to affect the health of babies born in the County.

Access to health care can have a significant impact on health outcomes. According to the County Health Rankings, the patient to primary care physician ratio in Anne Arundel County (1452:1) is worse than in Maryland (1134:1) and the U.S. benchmark (1355:1) indicating that more individuals are seeking care from fewer providers.

Overall, Anne Arundel County ranks 8th (out of 24 counties including Baltimore City) in health measures such as health behaviors and social and economic factors that indicate what influences the health of the County, and 9th in health outcomes that indicate the overall health of the county (*Source:http://www.countyhealthrankings.org/maryland/anne-arundel/2014).*

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) *Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau.*	555,743 Male 49.6%; Female 50.4% White, Not Hispanic (NH) 74.1% Black, NH 16.0% Hispanic 6.9% Asian, NH 3.7% American Indian, NH 0.1% Other, NH 3.2% Median Age: 38.5
Median Household Income within the CBSA *Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau.*	$86,230
Percentage of households with incomes below the federal poverty guidelines within the CBSA *Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau*	4.7% (All Families) 7.1% (Families with related children under 18 years) 7.1% (Individuals)
Please estimate the percentage of uninsured people by County within the CBSA *Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau*	Civilian Non-institutionalized Population: 6.6% uninsured Civilian Non-institutionalized Population (under 18): 3.2% uninsured
Percentage of Medicaid recipients by County within the CBSA. *Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau*	10.7
Life Expectancy by County within the CBSA. *Source: http://www.dhmh.maryland.gov/ship (2013)*	Black: 77.3 years White: 80.1 years
Mortality Rates by County within the CBSA (Age –adjusted rates per 100,000 population). *Source: Maryland Vital Statistics Annual Reports 2012, Vital Statistics Administration, Maryland DHMH; Cigarette*	Coronary Heart Disease 171.5 All Cancer 164.1 Lung Cancer 58.7 Stroke 39.9 Diabetes 21.5

Restitution Fund Program, Cancer Report 2012, Maryland DHMH; Healthy People 2020, U.S. DHHS.	Unintentional Injuries 22.4 Female Breast Cancer 23.5 Suicide 9.3 Homicide 3.4
Access to healthy food, quality of housing, and transportation 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) Limited access to healthy food (percentage of population who are low income and do not live close to a grocery store) *Source:http://www.countyhealthrankings.org/maryland/anne-arundel/2013* Median apartment rent *Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau.* Est. median house or condo value in 2010 *Source: 2013 American Community Survey I-Year Estimates, U.S. Census Bureau.* Total Occupied Housing Units Owner-Occupied Renter-Occupied (paying rent) *Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau.*	3% $1,528 $329,300 201,695 149,129 52,566
Government Subsidized/Section 8 Housing (renter pays 30% of total adjusted income) *Source: http: www.hcaac.org/ and www.aacounty.org/Aging*	1,026 available units Currently waiting list for placement is a minimum of one year. Available but preferential consideration is given to those with one or more of the following mitigating factors: 1. 62 years or older 2. Anne Arundel County resident 3. Disabled 4. Rent burdened (paying more than half of income for rent) In addition, factors such as

	homelessness, displacement, substandard residence, and physical victimization may be considered.
Transportation Vehicles available (based on total housing units) No vehicles available *Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau.* Anne Arundel County is served by a variety of public and specialized transportation, providing both local service and regional connections. The transit providers serving the County include (but not limited to): Maryland Transit Administration • MARC Commuter Rail service on the Penn line with stops in Odenton and BWI Airport rail stations. • Light rail service linking downtown Baltimore to Patapsco, Baltimore Highlands, Nursery Road, North Linthicum, Linthicum, BWI Business Park, BWI Airport, Ferndale and Cromwell stations in the County. MTA local bus services • Route 14 between Annapolis, Patapsco light rail station, and downtown Baltimore • Route 17 between Parkway Center, BWI Airport, and Patapsco light rail station Central Maryland Regional Transportation/Connect-A-Ride services in West Anne Arundel County: • Route 501: Laurel Mall to Maryland City • Route 201: Laurel Mall/Arundel Mills Mall /Cromwell Light Rail \Station/Glen Burnie/Freetown • Route 202: Arundel Mills Mall/Severn/Meade	193,250 8,445

Village/Pioneer City/Seven Oaks/Odenton MARC/Odenton • Route 203: A peak hour circulator route providing service between the Piney Orchard Community and the Odenton MARC Station *Source: http://www.aacounty.org/PlanZone/Transportation/Transit.cfm.*	
CBSA Adult Obesity (Percentage of adults that report BMI >=30) *Source: http://www.countyhealthrankings.org/maryland/anne-arundel/2014*	28%
Annual Average CBSA Unemployment Rate *Source: Maryland Department of Labor, Licensing & Regulation, 2014.*	5.4%
Access to Quality Health Care Hospitals Federally Qualified Health Centers (FQHCs) *Source: http://www.dhmh.state.md/us/gethealthcare/FQHC.pdf*	UM Baltimore Washington Medical Center Anne Arundel Medical Center Peoples Community Health Center, Inc.** 2 centers: (1) 21226 and (1) 21144 (**PCHC closed both locations in June 2014)
Health Disparities (selected) Infant Mortality Rate (per 1,000 births) Percentage of births that are Low Birth Weight (LBW) Rate of ED visits for asthma per 10,000 population Rate of ED visits for diabetes per 100,000 population Rate of ED visits for hypertension per 100,000 population *Source: http://www.dhmh.maryland.gov/ship (2013)*	 White/Non-Hispanic: 4.4 Black: 10.5 White/Non-Hispanic: 6.3% Black: 12.2% White/Non-Hispanic: 25.9 Black: 130.9 White/Non-Hispanic: 132.3 Black: 368.9 White/Non-Hispanic: 139.4 Black: 432.9

Primary Language (spoken; five years of age and older) *Source: 2013 American Community Survey 1-Year Estimates, U.S. Census Bureau.*	English: 89.2% Other than English: 10.8% (47% of which is Spanish)

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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. Conducted August 2012-February 2013; Published May 2013

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

   http://www.mybwmc.org/community-benefit-0

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.

   http://www.mybwmc.org/community-benefit-0

III. COMMUNITY BENEFIT ADMINISTRATION

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

   a. Is Community Benefits planning part of your hospital's strategic plan?

      _x_Yes
      Community Outreach activities associated with Community benefit are included in UM BWMC's annual operating plan that is derived from UM BWMC's 5-year strategic plan that was completed in 2010 and updated in FY14.

      ___No

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

process and provide additional information if necessary):

i. Senior Leadership

1. _x_ CEO
2. _x_ CFO
3. _x_ Other (please specify)
   – COO/Senior Vice-President
   – Board of Directors

ii. Clinical Leadership

1. _x_ Physician
   - Director, Community Vascular Screening Program
   - Chairman, Thoracic Surgery
2. _x_ Nurse
   - Inpatient Team Certified Registered Nurse Practitioner (CRNP)
   - Director, Emergency Department (ED) Nursing
   - Director, Women's and Children Services
3. ___ Social Worker
4. ___ Other (please specify)

iii. Community Benefit Department/Team

1. _x_ Individual (please specify FTE)
   - Director, Community Outreach (1.0 FTE)
2. _x_ Committee (please list members)
   - Board of Director's Community Benefit Committee Members include:
   - Lou Zagarino - Chairman, UM BWMC Board of Directors
   - Michael Caruthers – UM BWMC Board of Directors and Chairman, UM BWMC Community Benefit Committee
   - Paul Gable – UM BWMC Board of Directors
   - Penny Cantwell – UM BWMC Foundation Board of Directors
   - Donna Jacobs - Senior Vice President
     Government and Regulatory Affairs
     University of Maryland Medical System
   - Karen Olscamp- President and Chief Executive Officer, UM BWMC
   - Al Pietsch – Senior Vice President and Chief Financial Officer, UM BWMC

- Kathleen McCollum – Chief Operating Officer and Senior Vice President, Clinical Integration, UM BWMC
- Ed DeGrange - Manager, Community Development and Business Relations, UM BWMC
- Dr. Dawn Lindsay – President, Anne Arundel Community College

3. _x_ Other (please describe)
   - Director, Decision Support, UM BWMC (1.0 FTE)

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 FY13 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.

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

Lack of affordable dental services, transportation barriers and environmental health concerns are community health needs identified through the CHNA not directly being addressed by UM BWMC due to a lack of available resources. The need for enhanced and improved coordination of mental health services was also a common theme throughout the assessment. While UM BWMC will focus the majority of resources on the identified priorities outlined in Section II. of this narrative, these areas are important to the health of the community. The unmet needs not addressed directly by UM BWMC are being addressed through the action plan of the local health improvement coalition and corresponding subcommittees on which UM BWMC is actively involved. UM BWMC will continue to work with other health care providers and community partners, proving assistance as available.

Table III A. Initiative I- Stork's Nest

Identified Need	Infant Mortality (Note of measureable disparity: Cause specific infant mortality rates continue to be higher for black infants than white infants for nearly all leading causes of death)
Hospital Initiative	Stork's Nest
Primary Objective	The primary objectives of Stork's Nest include: • preventing premature births • low birth weight babies • sudden infant death syndrome (SIDS), the leading causes of infant mortality. Prenatal care is essential to increasing chances of positive pregnancy outcomes. UM BWMC's Stork's Nest is an incentive-based prenatal education program designed to encourage pregnant women to have a healthy pregnancy, giving their babies the best opportunity for a healthy beginning. Educational topics include: • healthy eating for two • exercise • managing stress • breastfeeding • safe sleeping for baby. Any pregnant Anne Arundel County resident is eligible to participate, however, the program targets pregnant women at the greatest risk for having poor pregnancy outcomes, specifically African-American women, teenagers, women of low socioeconomic status, and women with previous poor pregnancy outcomes. Each year, approximately 20 eight-week, hour-long education classes are held. English, Spanish (Esperando Bebe) and classes specifically for teenagers are offered. Metrics used to evaluate program results and effectiveness include: • indices directly linked to reducing infant mortality • percentage of the babies born at healthy birth weight • babies taken to the pediatrician regularly for wellness visits and immunizations • percentage of breastfed babies • percentage of babies provided a safe sleep environment.
Single or Multi-Year Initiative Time Period	Multi-year initiative beginning in 2006.
Key Partners in Development and/or Implementation	UM BWMC is the lead sponsor of this initiative. Additional supporting sponsors include the Anne Arundel County Department of Health, March of Dimes (Maryland Chapter) and Zeta Phi Beta Sorority.

How were the outcomes evaluated?	The program coordinator contacts program participants at three months and 12 months postpartum to conduct a thorough follow-up to determine health of the mother and baby. At three months, each participant is asked a variety of questions regarding the baby's birth weight, whether the baby is taken to the pediatrician regularly, the emotional health of the mother and whether or not the baby is breast fed and provided a safe sleep environment. At 12 months, participants are questioned about continuing to take their infant to the pediatrician for wellness visits/immunizations.	
Outcomes (Include process and impact measures)	219 Anne Arundel County residents participated in Stork's Nest in FY14. FY14 outcomes (for participants with due dates on or before 6/30/14) directly linked to reducing infant mortality in Anne Arundel County (where overall infant mortality rates are lower than both the U.S. and Maryland) include: • Babies born >= 37 weeks gestation: 87% • Babies born >5 lbs. at birth: 90% • Babies put to sleep on their back: 97.2% • Babies taken to wellness visits: 100% • Participants breastfeeding for at least three months: 52% Anne Arundel County average infant mortality rates have been reduced by 26.1% since 2004: **2004-2008:** 7.2 per 1000 live births **2009-2013:** 5.3 per 1000 live births	
Continuation of Initiative	Yes.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $74,767 (includes staff salaries)	B. Direct offsetting revenue from Restricted Grants $1,468 (including monetary and in-kind program donations)

Table III A. Initiative II- Heartbeat for Health

Identified Need	Cardiovascular Disease, Obesity
Hospital Initiative	Heartbeat for Health
Primary Objective	The primary objectives of Heartbeat for Health include: • increasing education and awareness, • encouraging community members to make healthy lifestyle choices to reduce the incidence of obesity and corresponding conditions including heart disease, high cholesterol and high blood pressure. Heartbeat for Health celebrates the benefits of dance and exercise in the prevention of heart disease. Held annually in February to coincide with National Heart Month, participants have the opportunity to try various dance styles, enjoy dance and exercise demonstrations and participate in free health screenings such as cholesterol, blood pressure and body mass index. Educational information on heart disease, cancer, making healthy food choices and diabetes is also available. Metrics used to evaluate program results include: • indices directly linked to reducing heart disease including implementing lifestyle changes to increase physical activity and lowering cholesterol.
Single or Multi-Year Initiative Time Period	Multi-year initiative.
Key Partners in Development and/or Implementation	UM BWMC is the leading sponsor of this initiative. Community partners include Advanced Radiology, Maryland Primary Care Physicians and a variety of dance schools and exercise instructors.
How were the outcomes evaluated?	Not applicable for FY14. Event was cancelled due to inclement weather.
Outcomes (Include process and impact measures)	Not applicable for FY14. Event was cancelled due to inclement weather.
Continuation of Initiative	Yes. Heartbeat for Health is scheduled for Saturday, February 21, 2015.

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative Not applicable for 2014 due to cancellation of event.	B. Direct offsetting revenue from Restricted Grants None.

Table III A. Initiative III- Vascular Screenings

Identified Need	Cardiovascular Disease, Obesity
Hospital Initiative	Vascular Screenings
Primary Objective	The primary objective of offering potentially life-saving vascular screenings is to educate the community about the importance of screening as a tool in the early detection of carotid artery disease (linked to stroke), abdominal aortic aneurysms and peripheral arterial disease. Screenings are offered to community members age 50 or older who have one of the following risk factors: hypertension, diabetes, family history of vascular disease, high cholesterol or history of smoking (target audience). Metrics used to evaluate program results include: • increasing disease detection • reducing stroke mortality.
Single or Multi-Year Initiative Time Period	Multi-year initiative.
Key Partners in Development and/or Implementation	UM BWMC is the sponsor of the vascular screening initiative. UM BWMC partners with community organizations such as senior centers and churches to host the screenings.
How were the outcomes evaluated?	Vascular screening results are evaluated by a UM BWMC clinician at the time of screening and immediately provided to the participant. Participants are counseled as to their risk for vascular disease/stroke and provided a recommendation for the frequency of future screenings and lifestyle changes if indicated. For abnormal results where follow-up is indicated, a clinician from The Vascular Center at UM BWMC calls the participant's primary physician to discuss the findings.
Outcomes (Include process and impact measures)	208 area residents participated in the vascular screenings offered at UM BWMC and at various locations in UM BWMC's CBSA. Of those screened, 16 abnormal results (7.7% abnormal rate) were determined.
Continuation of Initiative	Yes. Screenings are offered on an on-going basis.

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $75,608 (includes all associated screening costs)	B. Direct offsetting revenue from Restricted Grants None.

Table III A. Initiative IV- The Weight of the Nation (WOTN)

Identified Need	Cardiovascular Disease, Obesity
Hospital Initiative	The Weight of the Nation (WOTN)
Primary Objective	A presentation of HBO and the Institute of Medicine (IOM), in association with the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), and in partnership with the Michael & Susan Dell Foundation and Kaiser Permanente, the objectives of the four-part The Weight of the Nation series offered by UM BWMC include educating adults on weight, weight loss and the obesity epidemic and giving participants the tools to make positive changes in their lifestyle, empowering them to educate their peers and children to do the same. Participants were given 'homework' each week and were encouraged to consider how they could incorporate the information presented each week into their everyday lives, resulting in healthy changes for themselves and their family. Metrics used to evaluate the program include: • Attendance • # of participants willing to make lifestyle change
Single or Multi-Year Initiative Time Period	Multi-year.
Key Partners in Development and/or Implementation	UM BWMC is the sponsor for this initiative but contracts with Anne Arundel Community College to provide program facilitator. A local caterer was used to provide a healthy dinner for participants as well as to provide instruction regarding food preparation and nutritional content.
How were the outcomes evaluated?	Outcomes were evaluated through the use of an in-take survey that asked participants to evaluate their current behaviors related to diet and exercise. After each of the four sessions, participants were asked to complete a survey about if and how content presented resonated with them and how likely they were to change their current behavior.
Outcomes (Include process and impact measures)	Nineteen area residents participated in WOTN (11 attended all four sessions). Fourteen out of 19 participants considered themselves overweight and needing to make significant changes to their diet and exercise routines as indicated on the in-take survey administered at the beginning of program on week #1. At the end of week #4, 19 participants completed an exit survey. 100% of participants indicated having made at least one lifestyle change related to diet and/or exercise based on the information presented in the WOTN series or by the program facilitator. Participants learned that while obesity is a complex problem, there are many things within their control that they can change to help themselves and their families pursue and achieve healthier lives.

Continuation of Initiative	Yes. Weight of the Nation will be offered again in April 2015.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $9,361	B. Direct offsetting revenue from Restricted Grants $5,120 (from Anne Arundel County Local Development Council)

Table III A. Initiative V- Reduced-Dose Lung Cancer CT Screening

Identified Need	Lung Cancer Mortality
Hospital Initiative	Reduced-Dose Lung Cancer CT Screening
Primary Objective	The primary objective for the reduced-dose lung CT screening program is to educate the community about the importance of screening as a tool in the early detection of lung cancer and to screen those at risk. Cancer is a leading cause of death in Anne Arundel County with incidence and mortality rates of lung cancer above the state average. With provider consent, current and former smokers who meet the established screening criteria (target audience) remain in the program for three years, receiving an annual reduced-dose lung CT screening. Metrics used to evaluate program results include indices directly linked to reducing lung cancer incidence and mortality.
Single or Multi-Year Initiative Time Period	Multi-year initiative beginning in 2012.
Key Partners in Development and/or Implementation	UM BWMC and Advanced Radiology sponsor the reduced dose lung cancer CT screening program.
How were the outcomes evaluated?	The established guidelines for the reduced-dose lung cancer CT screening program recommend participants be screened annually for a total of three years, provided the CT screening is negative. All results are reviewed by a multidisciplinary team with results and recommendations sent to the participants prescribing provider.
Outcomes (Include process and impact measures)	Since launching the program in November 2012, 112 area residents have participated in the reduced-dose lung CT screening program at UM BWMC- 50 in FY13 and 62 in FY14. In FY14, seven (7) patients were referred to a UM BWMC thoracic surgeon for consultation and follow-up. Two (2) of these referrals resulted in confirmed cases of lung cancer; one stage 1 cancer and one stage 3 cancer. The UM BWMC lung program clinical coordinator contacts all patients annually from the date of screening for two subsequent years to remind them to schedule the repeat reduced-dose CT scan.
Continuation of Initiative	Yes. Screenings are offered on an on-going basis.

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative Participants are charged $100 per low-dose CT. However, UM BWMC will offer the screening to eligible participants regardless of their ability to pay.	B. Direct offsetting revenue from Restricted Grants None.

Table III A. Initiative VI- Smoking Cessation

Identified Need	Lung Cancer Mortality
Hospital Initiative	Smoking Cessation Classes
Primary Objective	The primary objective of the smoking cessation program is to educate participants on the health risks associated with tobacco use and provide the mechanisms (medication, counseling, etc.) to discontinue its usage. Made possible by a grant from the Anne Arundel County Department of Health, UM BWMC offers smoking cessation classes for those who live or work in Anne Arundel County who want to make the healthy lifestyle choice to quit smoking. Metrics used to evaluate program results include increasing the number of people who attend smoking cessation classes, thereby reducing the percentage of adults who smoke and reducing lung cancer incidence and mortality (Evidence-based National Cancer Institute Lung Screening Trial; published in the New England Journal of Medicine on June 29, 2011).
Single or Multi-Year Initiative Time Period	Multi-year initiative.
Key Partners in Development and/or Implementation	UM BWMC sponsors and administers smoking cessation classes with a grant from the Anne Arundel County Department of Health.
How were the outcomes evaluated?	Participants are contacted at three, six and 12 months after completing the program to find out if they continue to be smoke-free. It is important to note that it is typically very difficult for the coordinator to reach participants for follow-up (phone number out of service, multiple messages not returned, etc.)
Outcomes (Include process and impact measures)	In FY14, 21 people living or working in A.A. County participated in UM BWMC's smoking cessation program. Fifteen of these participants completed the program (71%); 12 of which quit smoking at the end of their session (80%). Three of the 12 participants (25%) were smoke-free when contacted by the program coordinator at three months post program. While the program saw fewer participants in FY14 as compared to FY13, a greater number of participants completed the program and were smoke free at three months post program. As compared to FY13: 41 participants 22 completed the program (54%) 20 quit smoking at the end of their session (91%) 4 participants were smoke-free at three month post-program (20%)

	While many factors play a role in lung cancer incidence and mortality, both continue trending downward in Anne Arundel County: **<u>2005-2009</u>** Lung cancer incidence (Male & female): 72.5 per 100,000 Lung cancer mortality (male & female): 61.9 per 100,000 **<u>2006-2010:</u>** Lung cancer incidence (Male & female): 70.5 per 100,000 Lung cancer mortality (male & female): 58.7 per 100,000 Because approximately one out of five Anne Arundel County residents use tobacco, UM BWMC continues to look for additional opportunities to effectively educate the community on the risk associated with tobacco use. 2010: 15.3% 2011: 22.9% 2012: 18.1%	
Continuation of Initiative	Yes.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $5,869	B. Direct offsetting revenue from Restricted Grants $5,869

Table III A. Initiative VII- Farmer's Markets

Identified Need	Access to Healthy Food/Obesity
Hospital Initiative	Farmers' Markets
Primary Objective	The primary objective of UM BWMC's Farmers' Markets includes providing convenient access to healthy, fresh, local produce, meat and dairy products. Area residents are able to speak directly with the farmers who produce the food, learn more about how it is grown and how to prepare it, enabling them to make educated food choices. Markets are offered every Saturday from 9 a.m. to 1 p.m. on UM BWMC's Glen Burnie campus and every Thursday from 4 to 7 p.m. at Van Bokkelen Elementary School in Severn (market opened in June 2014), June through October 2013 and then again June through October 2014. Electronic Benefit Transfer (EBT), WIC Fruit & Vegetable Checks (FVC) and Farmers' Market Nutrition Program (FMNP) are accepted. Metrics used to evaluate program results include indices directly linked to increasing access to healthy food and reducing obesity rates.
Single or Multi-Year Initiative Time Period	Multi-year initiative.
Key Partners in Development and/or Implementation	UM BWMC partners with Healthy Markets, Benefit LLC.
How were the outcomes evaluated?	While it is difficult to directly measure the impact of this type of initiative, increasing weekly market attendance and increasing use of Electronic Benefit Transfer (EBT) (implemented June 2013) by food stamp beneficiaries, UM BWMC's farmers' markets increases access to affordable sources of fresh produce, directly contributing and positively impacting the percentage of overweight adults in Anne Arundel County.
Outcomes (Include process and impact measures)	Approximately 100 people attended each farmers' market in Glen Burnie and approximately 15 people attended each farmers' market in Severn. Many people attend the market multiple times each month. It is estimated that approximately 800 area residents visited at least one UM BWMC Farmers' Market each season (June through October). <u>Glen Burnie Market</u> June 2013 Electronic Benefit Transactions (EBT): 2 July 2013 (EBT): 5 August 2013 (EBT): 5 September 2013 (EBT): 8 October 2013 (EBT): 9

	June 2014 (WIC checks): 7 <u>Severn Market</u> June 2014 (EBT or WIC checks): None While many factors play a role in weight, including lifestyle and genetics, the percent of overweight adults (18 years and older) in Anne Arundel County remains constant but is overall trending downward since 2009: **2009:** 40.9% **2010:** 38.3% **2011:** 36.2% **2012:** 36.7%	
Continuation of Initiative	Yes. Market locations are subject to change to maximize community engagement and benefit.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $1,840	B. Direct offsetting revenue from Restricted Grants None.

Table III A. Initiative VIII- Influenza Prevention and Education

Identified Need	Influenza Prevention and Education
Hospital Initiative	Free influenza clinics(s)
Primary Objective	The primary objective of UM BWMC's community flu clinic(s) is to provide free influenza vaccine and prevention education to underinsured, underserved and at-risk area residents (6 months and older) to reduce the incidence of influenza cases annually. Seasonal influenza is a serious disease that causes illness, hospitalizations and deaths every year. Metrics used to evaluate program results include increasing the percentage of people vaccinated for influenza each year.
Single or Multi-Year Initiative Time Period	Multi-year initiative.
Key Partners in Development and/or Implementation	UM BWMC is the sponsor of this initiative. UM BWMC partners with community organizations to host the screenings.
How were the outcomes evaluated?	Because Anne Arundel County and the State of Maryland are not required to report individual seasonal flu cases or deaths of people older than 18 years of age to the Centers of Disease Control (CDC), it is difficult to measure the impact of this type of initiative on the community. The CDC recommends annual influenza vaccination for all people aged six months and older to lower the annual incidence of flu in the community.
Outcomes (Include process and impact measures)	In FY14, UM BWMC vaccinated 275 area residents (6 months and older) and utilized mybwmc.org and social media (Facebook, Twitter, etc.) to raise awareness about the importance of flu vaccination to the community at large.
Continuation of Initiative	Yes.

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $4,923 (including vaccines, supplies and expenses related to 12 staff hours)	B. Direct offsetting revenue from Restricted Grants None.

Table III A. Initiative IX- Expand Access to Primary Care

Identified Need	Access to Primary Care
Hospital Initiative	Expand access to primary care
Primary Objective	The primary objective is to increase access to primary care whereby increasing the proportion of area residents who are seen for an annual wellness check-up. By increasing access to primary and preventative care, the goal is to lower overall health care costs by improving the health status among individuals and communities.
Single or Multi-Year Initiative Time Period	Multi-year initiative.
Key Partners in Development and/or Implementation	UM BWMC Physician Enterprise
How were the outcomes evaluated?	Outcomes are evaluated based on the number of new patients accessing UM BWMC primary care practitioners.
Outcomes (Include process and impact measures)	In FY14, UM BWMC Physician Enterprise acquired one physician practice, located an internal medicine physician in a busy primary care office in one of UM BWMC's primary community benefit service area (21122) to expand capacity and recruited three physicians (MDs) and 4 advanced practice providers (APPs). As a result of this additional staffing, visits to UM BWMC primary care clinicians increased 22% (approximately 3000 visits) in FY14.
Continuation of Initiative	Yes. UM BWMC will continue to seek opportunities to expand access to primary care where appropriate.

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $1.09M (gross)	B. Direct offsetting revenue from Restricted Grants None.

V. PHYSICIANS

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

There are no gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured at UM Baltimore Washington Medical Center.

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.**

(1) Hospital-based physicians with whom UM BWMC has an exclusive contract-
(a) Hospital-based laborists and UM Baltimore Washington Women's Health Associates (UM BWWHA) physicians - Obstetrics and gynecologic services are provided. Without the availability of these practitioners, patients would have to be transferred to another facility for care. A negative margin is generated ($2,585,246).
(b) Psychiatrists - Psychiatric services are provided in both inpatient and outpatient settings at UM BWMC, allowing patients access to the scarcely available mental health services in Anne Arundel County. A negative margin is generated ($446,805).

(2) Non-resident house staff - These physicians ensure the continuum of primary care for inpatients. A negative margin is generated ($632,453).

(3) Emergency Department Call – UM BWMC pays to provide the availability of on call physician specialists for the emergency department. These specialists would otherwise not provide services and patents would have to be transferred to another facility for care. A negative margin is generated ($1,220,348).

VI. 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

University of Maryland Baltimore Washington Medical Center's Financial Assistance Policy (FAP) is established to assist patients in obtaining financial aid when it is beyond their ability to pay for services rendered.

A patient's inability to obtain financial assistance does not, in any way, preclude the patient's right to receive and have access to medical treatment at UM Baltimore Washington Medical Center.

UM Baltimore Washington Medical Center 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 financial assistance policy in the following manner:

- UM BWMC prepares its FAP in a culturally sensitive manner, at a reading level appropriate to the CBSA's population and in Spanish.
- UM BWMC posts its FAP and financial assistance contact information in all admission areas, the emergency room and all other outpatient areas throughout the facility.
- A copy of UM BWMC's FAP is included in the patient handbook that is provided to each patient upon admission.
- A copy of UM BWMC's FAP and financial assistance contact information is provided to each patient upon discharge.
- A copy of UM BWMC's FAP and financial assistance contact information is provided in patient bills; and/or
- UM BWMC discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and employs dedicated staff on-site to assist patients with qualification for such programs.
- An abbreviated statement referencing UM BWMC's financial assistance policy, including a phone number to call for more information, is run annually in the local newspapers (*Maryland Gazette, Capital and Baltimore Sun*).

Appendix 2: Financial Assistance Policy (FAP)

	UM BALTIMORE WASHINGTON MEDICAL CENTER **Subject:** Financial Assistance Policy – Administrative Policy Manual	Policy Number: M.8 [ ] New [X]Revised 10/14 [ ] Reviewed	
	Originator: Director, Patient Financial Services	Effective Date	10/14
		Next Review Date	10/17
Senior VP/COO: _____	Date:	Page	
		Supersedes	4/10

1. POLICY

a. This policy applies to Baltimore Washington Medical Center ("BWMC"). BWMC is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

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

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

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

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

2. *PROGRAM ELIGIBILITY*

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, BWMC strives to ensure that the

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

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

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

ii) Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, Workers Compensation, or Medicaid), are not eligible for the Financial Assistance Program.
   (1) Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made considering medical and programmatic implications.

iii) Unpaid balances resulting from cosmetic or other non-medically necessary services.
iv) Patient convenience items
v) Patient meals and lodging
vi) Physician charges related to the date of service are excluded from BWMC's financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.

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

i) Refusal to provide requested documentation or providing incomplete information.
ii) Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to BWMC due to insurance plan restrictions/limits.
iii) Failure to pay co-payments as required by the Financial Assistance Program.
iv) Failure to keep current on existing payment arrangements with BWMC.
v) Failure to make appropriate arrangements on past payment obligations owed to BWMC (including those patients who were referred to an outside collection agency for a previous debt).
vi) Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.

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

e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance (See Section 3 below) eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

f. Coverage amounts will be calculated based upon 200-300% of income as defined by the Maryland DHMH Medicaid Income Eligibility Limits and follow the sliding scale included in ***Attachment B.***

g. *Net receipts from self-employment (receipts from a person's own incorporated business, professional enterprise, or partnership, after deductions for business expenses) will be used to compute the income amount used in determining eligibility for financial assistance.*

3. PRESUMPTIVE FINANCIAL ASSISTANCE

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

i) Active Medical Assistance pharmacy coverage
ii) Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums)
iii) Primary Adult Care (“PAC”) coverage
iv) Homelessness
v) Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
vi) Maryland Public Health System Emergency Petition patients

vii) Participation in Women, Infants and Children Programs ("WIC")
viii) Food Stamp eligibility
ix) Eligibility for other state or local assistance programs
x) Patient is deceased with no known estate
xi) Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
xii) *Patients that have filed bankruptcy are granted protection under bankruptcy laws.*

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

i) Reside in primary service area (address has been verified)
ii) Lacking health insurance coverage
iii) Not enrolled in Medical Assistance for date of service
iv) Indicate an inability to pay for their care
v) Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

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

i) Purely elective procedures (e.g., Cosmetic procedures) are not covered under the program.
ii) Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive Financial Assistance program until the Maryland Medicaid Psych program has been billed.
iii) Qualifying Non-U.S. citizens are to be processed for reimbursement through the Federal program for Undocumented Alien Funding for Emergency Care (a.k.a. Section 1011) prior to financial assistance consideration.

4. MEDICAL HARDSHIP

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

i) Uninsured Medical Hardship criteria is State defined:

(1) Combined household income less than 500% of federal poverty guidelines
(2) Having incurred collective family hospital medical debt at BWMC exceeding 25% of the combined household income during a 12 month period. The 12 month period begins with the date the Medical Hardship application was submitted.
(3) The medical debt excludes co-payments, co-insurance and deductibles

b. Patient balance after insurance

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

c. Coverage amounts will be calculated based upon 0 - 500% of income as defined by the Maryland DHMH Medicaid Income Eligibility Limits and follow the sliding scale included in **Attachment B.**

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

e. Individual patient situation consideration:

i) BWMC reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.
ii) The eligibility duration and discount amount is patient-situation specific.
iii) Patient balance after insurance accounts may be eligible for consideration.
iv) Cases falling into this category require management level review and approval.

f. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance programs, BWMC is to apply the greater of the two discounts.
g. Patient is required to notify BWMC of their potential eligibility for this component of the financial assistance program.

5. ASSET CONSIDERATION

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

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

i) The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.
ii) Up to $150,000 in primary residence equity.
iii) Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

6. APPEALS

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

b. Appeals can be initiated verbally or written.

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

d. Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.

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

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

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

7. *PATIENT REFUND*

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

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

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

8. JUDGEMENTS

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

9. PROCEDURES

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

b. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

   i) Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.
   ii) Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   iii) BWMC will not require documentation beyond that necessary to validate the information on the Maryland State Uniform Financial Assistance Application.
   iv) Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.
   v) Patients will have thirty (30) days to submit required documentation to be considered for eligibility. If no data is received within 20 days, a reminder letter will be sent notifying that the case will be closed for inactivity and the account referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.

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

   i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable).
   ii. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.
   iii. Proof of social security income (if applicable)
   iv. A Medical Assistance Notice of Determination (if applicable).
   v. Proof of U.S. citizenship or lawful permanent residence status (green card).
   vi. Reasonable proof of other declared expenses.
   vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

d. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the

required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on BWMC guidelines.

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

(1) If the patient does qualify for financial clearance, appropriate personnel will notify the treating department who may then schedule the patient for the appropriate service.
(2) If the patient does not qualify for financial clearance, appropriate personnel may notify the clinical staff of the determination and the non-emergent/urgent services may not be scheduled.

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

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

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

i. Post approval discovery of an ability to pay
ii. Changes to the patient's income, assets, expenses or family status which are expected·to be communicated to BWMC

g. BWMC will track patients with 6 or 12 month certification periods utilizing either eligibility coverage cards and/or a unique insurance plan code(s). However, it is ultimately the responsibility of the patient or guarantor to advise of their eligibility status for the program at the time of registration or upon receiving a statement.
h. If patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

ORIGINATOR:

Director, Patient Financial Services

REVIEW CYCLE:

3-year

APPROVAL:

Senior VP/COO

ATTACHMENT A

The following zip codes represent the coverage areas for the respective entities:

BWMC: All Maryland zip codes

ATTACHMENT B

Current updated income levels are on a separate spreadsheet (page 54)

ATTACHMENT B

Sliding Scale Reduction Amount 2014

Note: Based on the 2014 Maryland State DHMH Medicaid Income Eligibility Limits

Size of Family Unit	100% FPL	Discount%	100%	90%	80%	70%	60%	50%
1	16,105.00		32,210.00	33,820.50	35,431.00	37,041.50	38,652.00	40,262.50
2	21,707.00		43,414.00	45,584.70	47,755.40	49,926.10	52,096.80	54,267.50
3	27,310.00		54,620.00	57,351.00	60,082.00	62,813.00	65,544.00	68,275.00
4	32,913.00		65,826.00	69,117.30	72,408.60	75,699.90	78,991.20	82,282.50
5	38,516.00		77,032.00	80,883.60	84,735.20	88,586.80	92,438.40	96,290.00
6	44,119.00		88,238.00	92,649.90	97,061.80	101,473.70	105,885.60	110,297.50
7	49,721.00		99,442.00	104,414.10	109,386.20	114,358.30	119,330.40	124,302.50
8	55,324.00		110,648.00	116,180.40	121,712.80	127,245.20	132,777.60	138,310.00

Size of Family Unit	100% FPL	Discount%	40%	30%	20%	10%	0%
1	16,105.00		41,873.00	43,483.50	45,094.00	46,704.50	48,315.00
2	21,707.00		56,438.20	58,608.90	60,779.60	62,950.30	65,121.00
3	27,310.00		71,006.00	73,737.00	76,468.00	79,199.00	81,930.00
4	32,913.00		85,573.80	88,865.10	92,156.40	95,447.70	98,739.00
5	27,910.00		100,141.60	103,993.20	107,844.80	111,696.40	115,548.00
6	44,119.00		114,709.40	119,121.30	123,533.20	127,945.10	132,357.00
7	49,721.00		129,274.60	134,246.70	139,218.80	144,190.90	149,163.00
8	55,324.00		143,842.40	149,374.80	154,907.20	160,439.60	165,972.00

http://aspe.hhs.gov/povertv/14poverty.cfm

Source: http://marylandhealthconnection.gov/assets/mhc_income_eligibilitv.pdf

LD-34
ATTACHMENT 3

Appendix III

BALTIMORE WASHINGTON MEDICAL CENTER
PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy

Baltimore Washington Medical Center (BWMC) is committed to ensuring that uninsured patients within its service area who lack financial resources have access to medically necessary hospital services. If you are unable to pay for medical care, you may qualify for Free or Reduced Cost for Medically Necessary Care if you have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability.

BWMC 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 of care up to 400% of the federal poverty level.

Patients' Rights

BWMC works with their uninsured patients to gain an understanding of each patient's financial resources.

- We 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 are wrongfully referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below.)

Patients' Obligations

BWMC believes that patients have specific responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

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

Contacts:

Call 410-787-4440 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

Appendix III continued

Or visit: www.dhr.state.md.us

Physician charges are not included in hospital bills and are billed separately.

I have read and understand the Patient Financial Policy and agree to follow its guidelines.

_____

Signature of Patient or Responsible Party **Date**

Appendix IV: Mission and Vision Statements

VISION STATEMENT

To be the preferred regional medical center through nationally recognized quality, personalized service and outstanding people.

MISSION STATEMENT

The mission of UM Baltimore Washington Medical Center is to provide the highest quality healthcare services to the communities we serve.