FY '15 Community Benefit Report
University of Maryland St. Joseph Medical Center
7601 Osler Drive
Towson, MD 21204

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

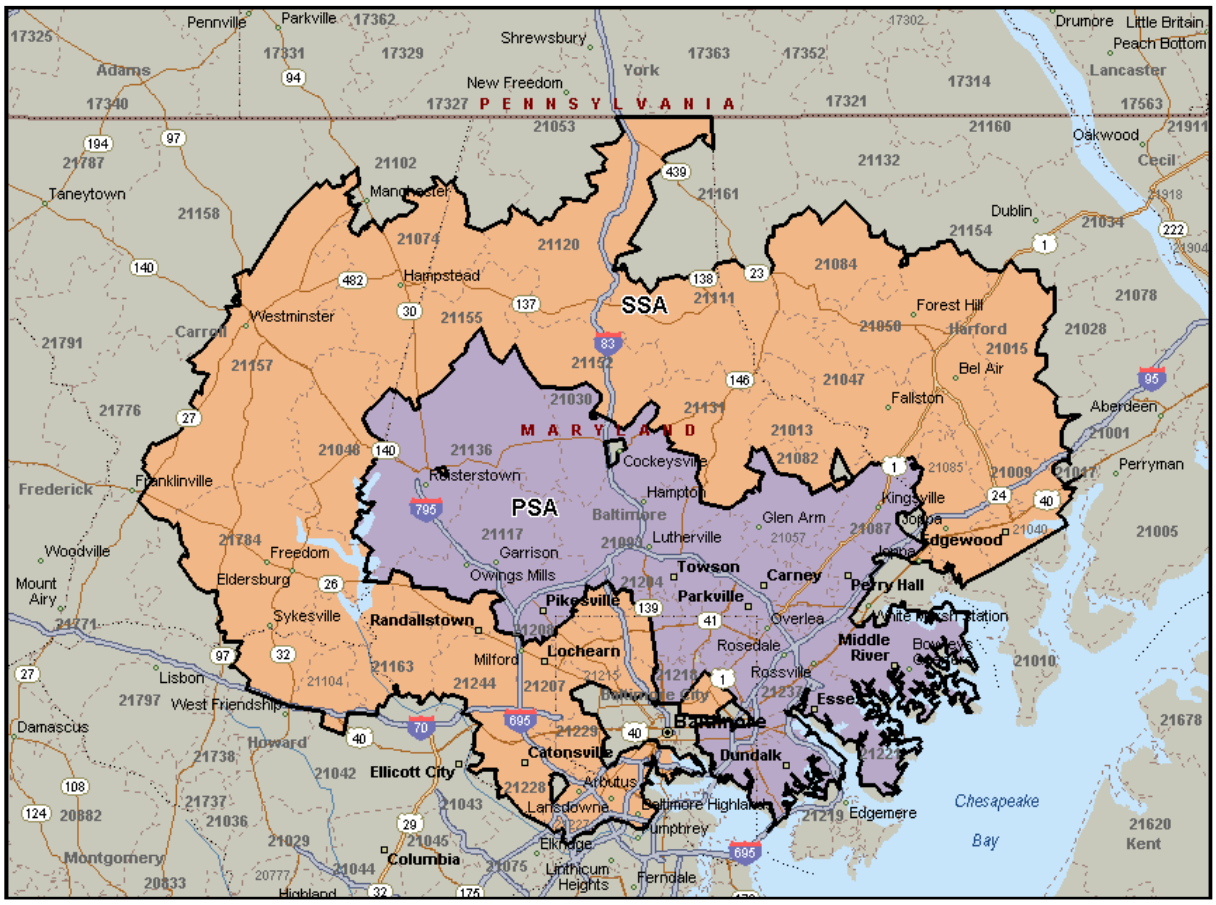
1. Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges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

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:
247 beds	18,601	21234, 21093, 21204, 21030, 21286, 21212, 21236, 21239, 21206, 21117, 21220, 21221, 21222, 21214, 21237, 21014, 21136, 21208	Greater Baltimore Medical Center, MedStar Franklin Square Hospital, MedStar Good Samaritan Hospital, Sinai Hospital	Baltimore County: 12% Maryland: 13.2%	Baltimore County: 12.5% Maryland: 15%

When the zip codes of the Primary Service Area (purple) and Secondary Service Area (orange) of UM St. Joseph Medical Center are plotted on a map, the results appear thus:

UM SJMC Primary and Secondary Service Areas



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

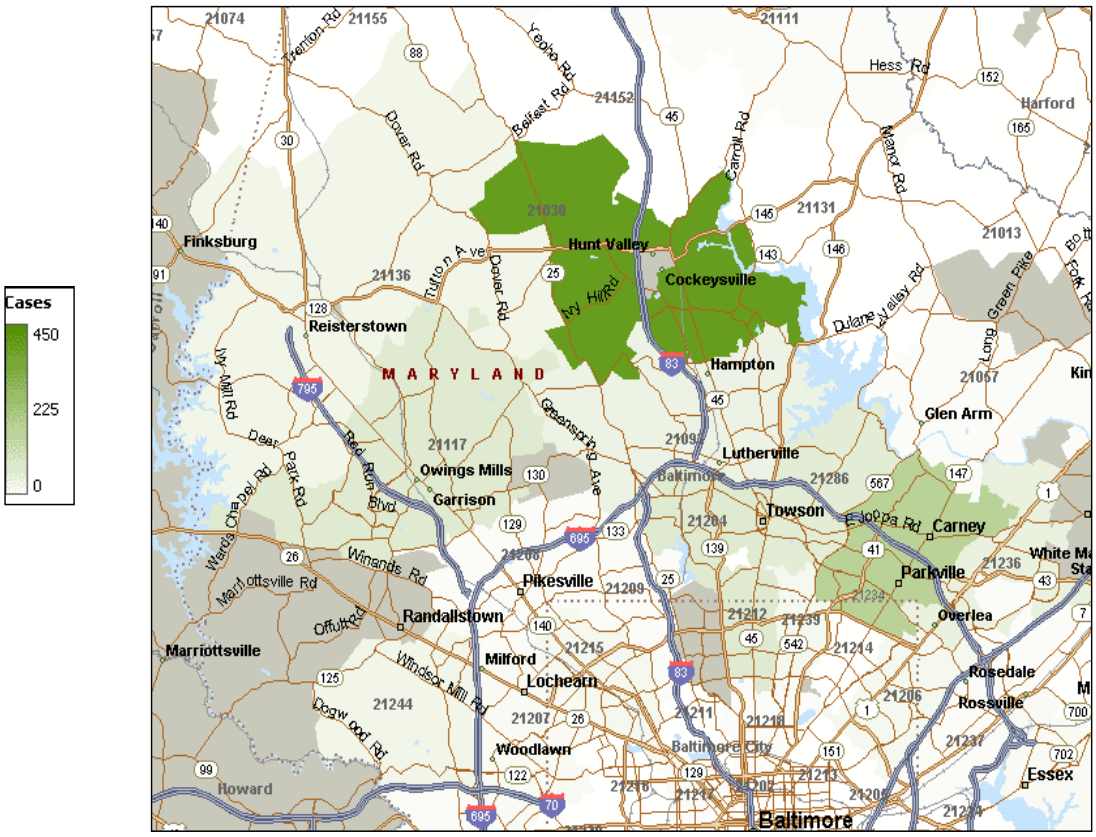
   a. Describe in detail the community or communities the organization serves. Based on findings from the CHNA, provide a list of the Community Benefit Service Area (CBSA) zip codes. These CBSA zip codes should reflect the geographic areas where the most vulnerable populations reside. Describe how the CBSA was determined, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

The Community Benefit Service Area of UM St. Joseph Medical Center is constituted by the zip codes in which patients reside who have received charity care. These zip codes are:

17361, 20011, 20724, 21001, 21014, 21030, 21050, 21057, 21078, 21082, 21093, 21094, 21111, 21117, 21120, 21136, 21161, 21202, 21204, 21206, 21207, 21209, 21211, 21212, 21214, 21215, 21216, 21217, 21218, 21221, 21222, 21227, 21228, 21229, 21234, 21236, 21237, 21239, 21244, 21286, 30062

This set of zip codes, when plotted, produces this CBSA:

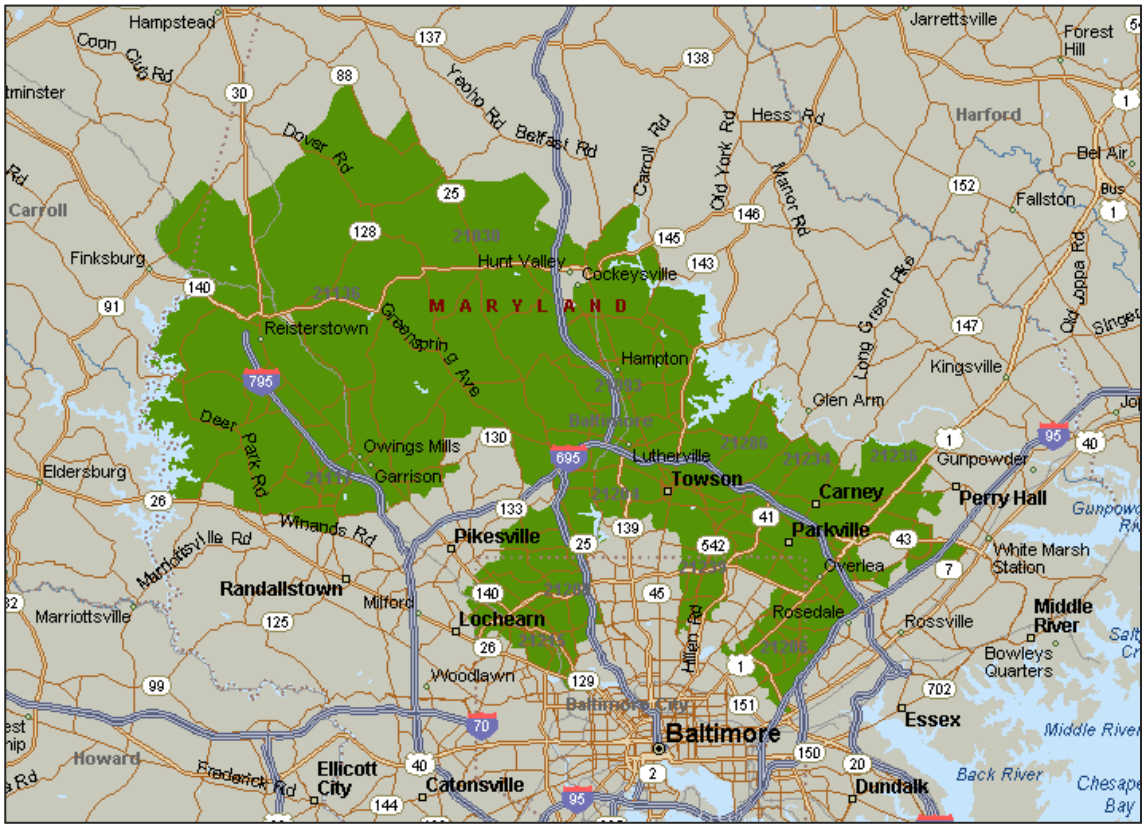
UMSJMC FY 2013 Charity Care Patient Origin



The CBSA for UM St. Joseph Medical Center (UM SJMC) has been identified by plotting the zip codes of recipients of financial assistance/charity care in FY ’15. UM St. Joseph Medical Center’s CBSA falls primarily within Baltimore County with a few outlying areas in, Harford County. When illustrated in this way, it becomes clear that a significant portion of the charity care cases for FY ’15 are concentrated in two areas, i.e., the northern segment of Baltimore County around Hunt Valley and Cockeysville, and the Eastern segment in the Carney/Parkville area. We feel this confirms several things we’ve known already: The immediate geographic area in which UM SJMC is located is predominantly a middle-class/upper middle-class population. While there are, indeed, people from the area proximate to UM SJMC who receive charity care, this is not where the greatest need for charity care exists for us. The “hidden” population receiving a significant amount of charity care is a growing Hispanic immigrant population in the Hunt Valley/Cockeysville area. This has created a pocket of financially challenged people in an area that is usually viewed as fairly affluent.

When all the recipients of charity care are plotted, no matter what the concentration of charity care received, our CBSA appears below.

UM-SJMC – CBSA



b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and *include the source of the information in each response*. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, education and environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

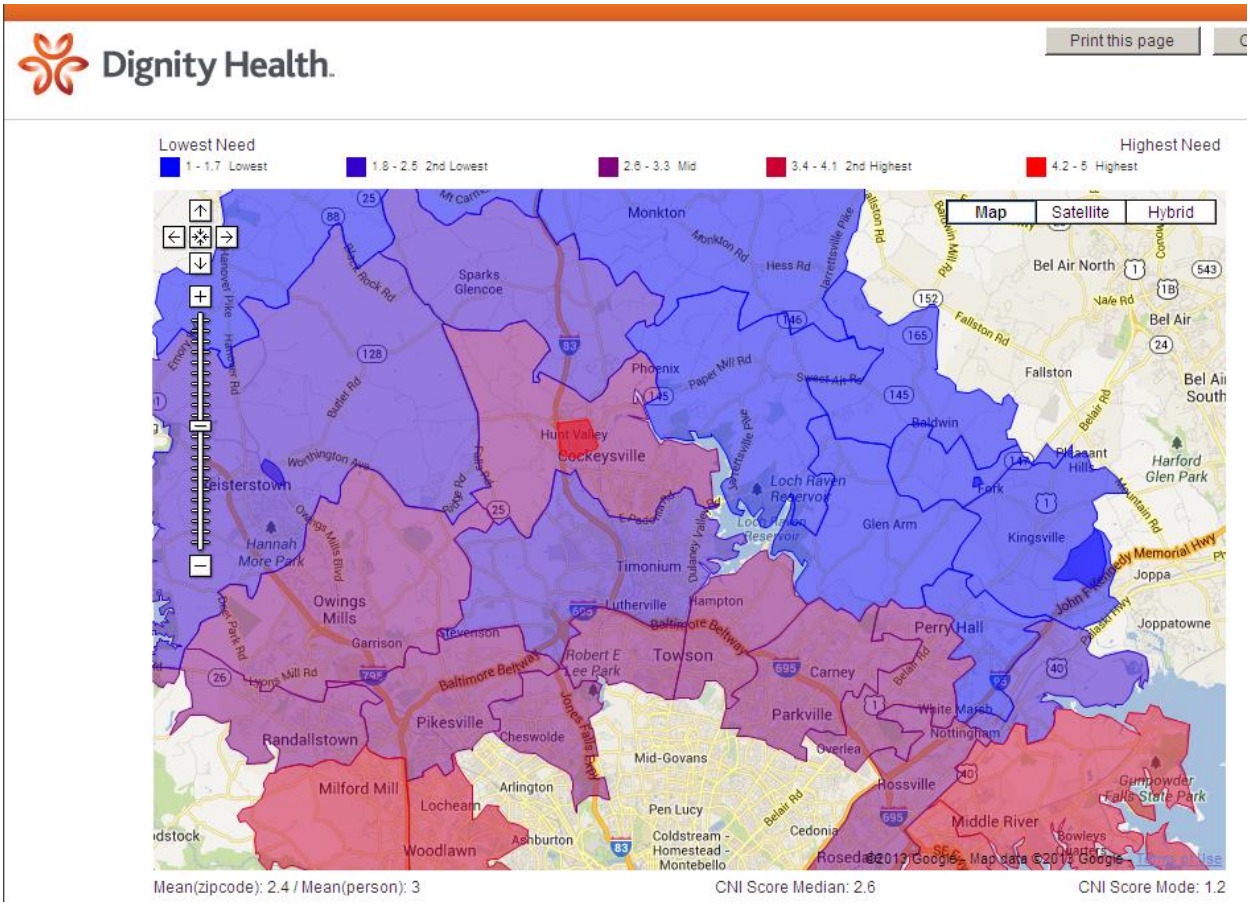
Table II

Median Household Income within the CBSA	$65,411
Percentage of households with incomes below the federal poverty guidelines within the CBSA	5.4%
Please estimate the percentage of uninsured people by County within the CBSA. This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	NH black: 17.5% Hispanic: 44.7% NH white: 10.4%
Percentage of Medicaid recipients by County within the CBSA.	107,294 recipients or 13.13%
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	General: 78.1 years Black: 75.4 years White: 78.6 years
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Heart Disease: Deaths per 100,000 people: Average: 68.3 Black: 238.6 White: 197.4 Cancer: Deaths per 100,000 people: Average: 98.5 Black: 218.8 Hispanic: 65.3 White: 191.7

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources). See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	See map below on Food Deserts
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	White: 64.8% Black/African American: 27.0% Hispanic/Latino: 4.6% Asian alone: 5.4% Two or more races: 2.2% Language other than English spoken at home: 12.6%

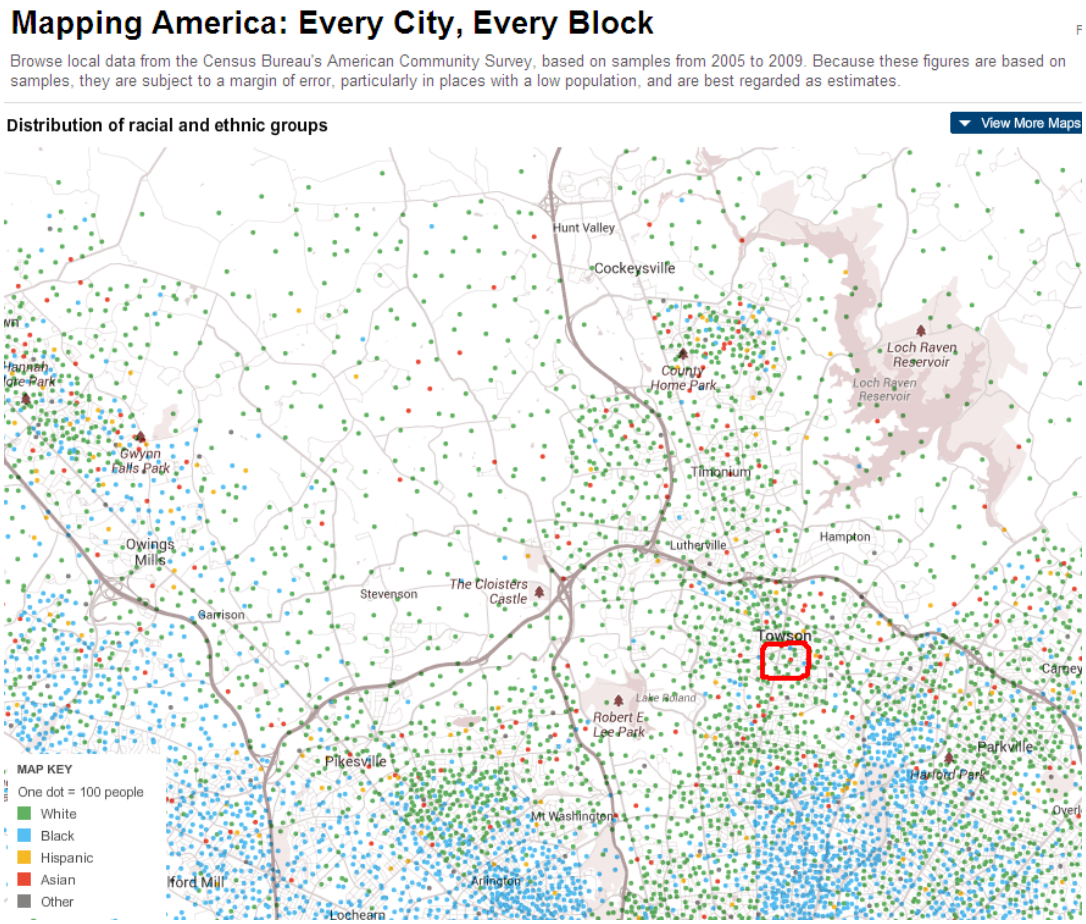
The UM St. Joseph Medical Center is located in a northern suburb of Baltimore County, and as shown on the map detailing our Primary and Secondary Service areas, draws patients from Franklinville, Westminster in the West, Aberdeen and Eastern Shore to the East, to the Pennsylvania line up the I-81 corridor including and Hanover, PA and as far south as Landsdowne. This is an area distinctive in the very broad range of populations it contains in terms of economic, ethnic/racial, and urban/rural considerations.

The map below also illustrates that our CBSA overlaps with some areas of significant unmet health needs in Baltimore County. On this map, blue indicates an area where health needs are well met, while the more red an area is colored the more it contains unmet health needs. Surprisingly, the red dot in the middle of the Hunt Valley area is a pocket of severely unmet health needs that corresponds with the presence of the Hispanic population in that same area. This is an area from which many patients of our St. Clare Medical Outreach clinic (a free clinic for those who have no health insurance at all) come from.



Map from Dignity Health interactive website: http://cni.chw-interactive.org

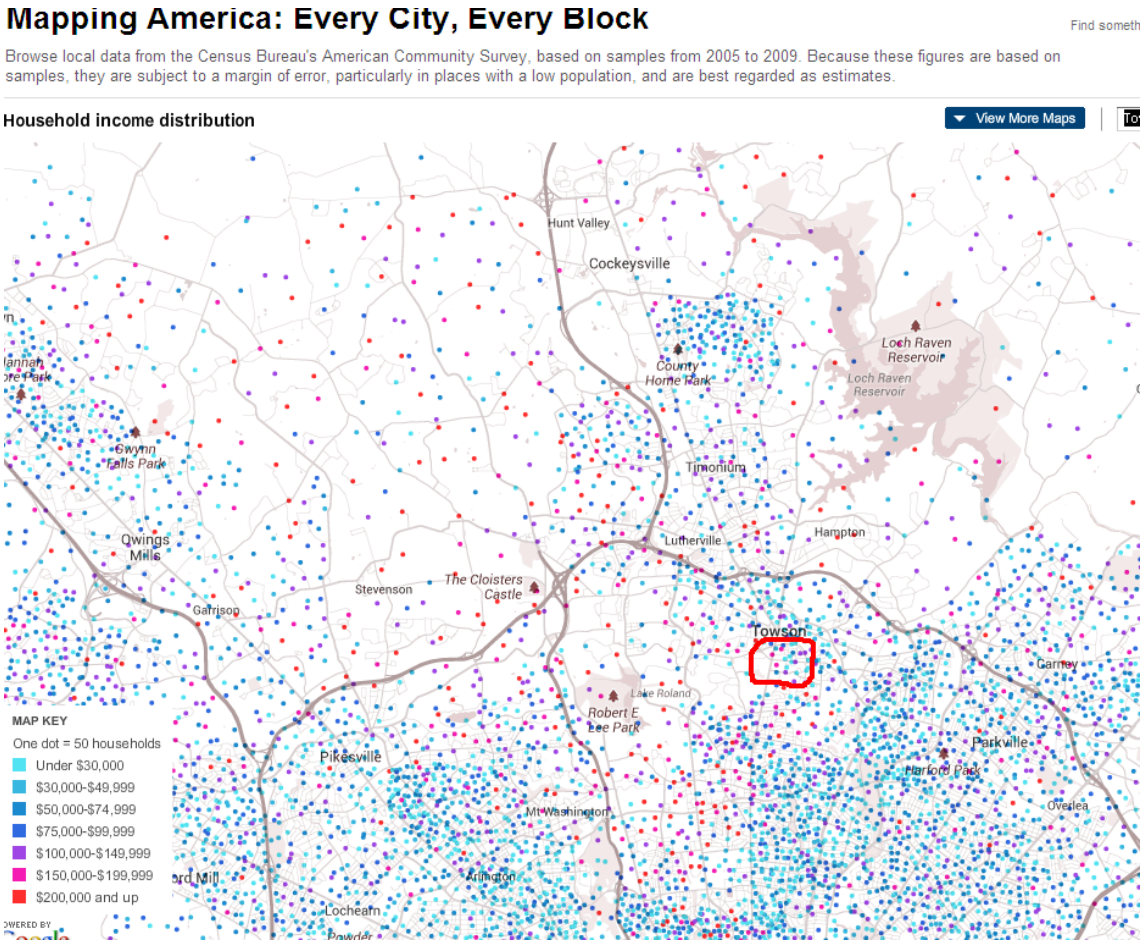
The ethnic/racial characteristics of our primary and secondary service areas, which include our CBSA, are illustrated in the map below. The red circle indicates the location of UM St. Joseph Medical Center:



Map: http://projects.nytimes.com/census/2010/explorer

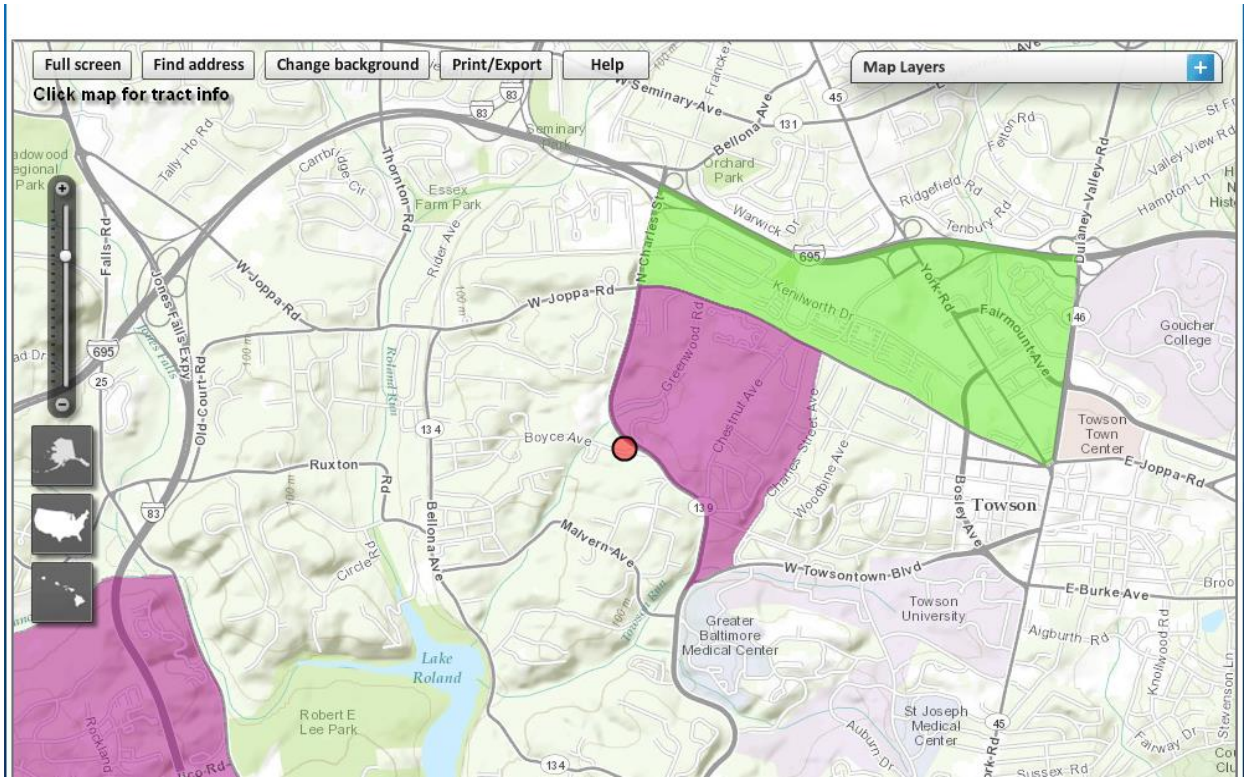
This map and the legend in the lower left-hand corner confirm the data from the DHHS and Maryland Bureau of Vital Statics which indicates that our primary and secondary service area is largely white, with a lesser presence of a black population in that area. Just south and east of Cockeysville, the gold dots indicate the presence of the Hispanic population in the area.

Finally, the map below illustrates the income range in our PSSA/SSA and our CBSA. It is useful to note the presence of lighter blue dots in the southeastern Cockeysville area and in the area just north of Towson. These three maps illustrate the complex demographic mix of our PSSA/SSA and CBSA which include households with comfortable economic means alongside households where economic realities are difficult. The red circle indicates the location of UM St. Joseph Medical Center.



As was the case last year, within our CBSA the USDA Economic Research Service provides tools to identify food deserts in our CBSA. On the map below, the red dot in the center of the image locates UM St. Joseph Medical Center. Just to our north and east is a low vehicle access area which creates significant hardships for residents to access supermarkets easily. The green area highlighted to the north of that area indicates both a low vehicle access area and low income area, compounding the problem of access to supermarkets and nutritious food.

Food Deserts



The CHNA that was completed and published by UM SJMC in June, 2013, provided the following information on health needs in our CBSA obtained through interviews with key stakeholders and residents of the CBSA.

Ranking of key health issues

Rank	Health Issue	% Respondents who selected this issue	% Respondents who selected this as most significant issue
1	Access to health care	72%	33%
2	Overweight/Obesity	56%	22%
3	Mental Health/Suicide	44%	22%
4.	Diabetes	33%	6%
5	Substance Abuse/Alcohol Abuse	22%	6%
6	Heart Disease	17%	0%
7	Maternal/Infant Health	17%	6%
8	Aging/Chronic Disease Disability	17%	0%
9	Cancer	11%	6%
10	Tobacco	11%	0%

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?

   XX Yes
   ___ No

   Provide date here. _6_/_15_ /_13_– Date published

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

http://www.stjosephtowson.com/Community-Health-Needs-Assessment.aspx

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

   XX Yes
   ___ No

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

http://www.stjosephtowson.com/Community-Health-Needs-Assessment.aspx

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?

      XX Yes
      ___ No

   b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and describe the role each plays in the planning process (additional positions may be added as necessary):

      i. Senior Leadership

         1. XX CEO
         2. XX CFO

3. XX Other (please specify)
    - Vice President, Mission Integration
    - Senior Director, Marketing and Community Health

Our CEO provides the value orientation of all leadership and management to our community benefit activities. Our CFO instructs our local financial team to provide assistance in compiling financial data for the annual CBR. Our Vice President for Mission Integration is tasked with educating the entire medical center community about community benefit-eligible activity and educating staff in the use of CBISA, and is also responsible for compiling the annual CBR. Our Director of Marketing and Community Health provides leadership to the community health outreach team.

ii. Clinical Leadership

1. XX Physician – Chief Medical Officer
2. XX Nurse – Chief Nursing Officer
3. XX Social Worker – Supervisor of Case Management
4. ___ Other (please specify)

Our Chief Medical Officer helps educate all the physicians regarding the importance of uncompensated care as part of the services they provide. Our Chief Nursing Officer encourages all the nurse managers to become familiar with what constitutes community benefit-eligible activity. Our Supervisor of Case Management has social workers working quickly with patients and families who are identified as having financial difficulties.

iii. Community Benefit Department/Team

1. .3 FTE Individual (please specify FTE)
2. ____ Committee (please list members)
3. 4.8 FTE Other (please describe)
    - Oncology Outreach Program Coordinator (.8 FTE)
    - Community Health Specialist (3 X 1. FTE)
    - Nurse Manager of our free clinic (1. FTE)
    - Director of Revenue Cycle/Managed Care
    - Decision Support Analyst
    - Diabetes educator

The .3 FTE Individual refers to our Vice President for Mission Integration, whose role is already described above. Our oncology center has a part-time employee who serves as Oncology Outreach Program Coordinator. We have three full-time Community Health Specialists who coordinate work in the community to provide preventive care such as flu shots and bone density screenings at no cost to participants. We also have a Nurse Manager of our St. Clare Medical Outreach Clinic, a free clinic for those who have no health insurance whatsoever.

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

Spreadsheet	XX	yes	____	no
Narrative	____	yes	XX	no

If yes, describe the details of the audit/review process (Who does the review? Who signs off on the review?)

Our Chief Financial Officer oversees a team of internal and external financial analysts who prepare the hospital's annual audit. This same team then provides the financial spreadsheet for the CBR. This is ultimately approved by our CFO. There is no narrative accompanying our audit of the CBR.

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

Spreadsheet	XX	yes	____	no
Narrative	XX	yes	____	no

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

External collaborations are highly structured and effective partnerships with relevant community stakeholders aimed at collectively solving the complex health and social problems that result in health inequities. Maryland hospital organizations should demonstrate that they are engaging partners to move toward specific and rigorous processes aimed at generating improved population health. Collaborations of this nature have specific conditions that together lead to meaningful results, including: a common agenda that addresses shared priorities, a shared defined target population, shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

a. Does the hospital organization engage in external collaboration with the following partners?

_____ Other hospital organizations
_____ Local Health Department
XX Local health improvement coalitions (LHICs)
_____ Schools
_____ Behavioral health organizations
XX Faith based community organizations
_____ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete).

Organization	Name of Key Collaborator	Title	Collaboration Description
Baltimore County Cancer Program	Constance A. Notaro, R.N.	Public Health Nurse Administrator of Cancer Programs	Helps with our monthly screening program for cervical and/or colorectal cancer
Hoffberger Foundation	Ladan Nabet	Program Associate	Awarded St. Clare Medical Outreach with $59,000 for diabetes test strips
Baltimore Gas and Electric	Lynn Hrdlick David L. Vosvick II	Principal Corporate Social Responsibility Specialist Vice President, Human Resources	Awarded St. Clare Medical Outreach with $25,000 for education materials
Nueva Vida Inc.	Sandra Villa de Leon	Program Coordinator	Provides support network for Latinas with cancer

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars?

____ yes XX no

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?

____ yes XX no

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. Please use Table III 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. 1. 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. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.
2. Please indicate whether the need was identified through the most recent CHNA process.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following link: http://www.thecommunityguide.org/)
(Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

c. Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?

d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?

e. 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.

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

g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.

h. Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.

i. What were the measurable results of the initiative?

ii. For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.

j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:
A. 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.
B. Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

TABLE III – Initiative 1 – Early Cancer Detection – Screening

a. 1. Identified Need 2. Was this identified through the CHNA process?	Cancer prevention and early detection through cancer screenings. No	
b. Hospital Initiative	*One Voice*	
c. Total Number of People Within the Target Population	Unavailable	
d. Total Number of People Reached by the Initiative Within the Target Population	210	
e. Primary Objective of the Initiative	To provide early mammogram screening for patients who had not had screenings before due to financial issues.	
f. Single or Multi-Year Initiative – Time Period	Multi-year	
g. Key Collaborators in Delivery of the Initiative	Baltimore County Cancer Program Advanced Radiology	
h. Impact/Outcome of Hospital Initiative?	210 routine screening mammograms and clinical breast exams 1 diagnosis of cancer with follow-up treatment	
i. Evaluation of Outcomes:	Modestly successful	
j. Continuation of Initiative?	Unknown (dependent on funding and collaboration)	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $10,386	B. Direct Offsetting Revenue from Restricted Grants None

TABLE III – Initiative 2 – Cancer Prevention and Early Detection

a. 1. Identified Need 2. Was this identified through the CHNA process?	Cancer prevention and early detection through cancer screenings. Yes, in addition, needs were identified through Nueva Vida, a community cancer support program for Latinas and Baltimore County Cancer Program.	
b. Hospital Initiative	*One Voice*	
c. Total Number of People Within the Target Population	Unavailable	
d. Total Number of People Reached by the Initiative Within the Target Population	63 uninsured women were educated and provided CBE and Mammograms through the Cancer Institute *One Voice* Program, a monthly Breast Cancer Education and Screening Program. 40 Diagnostic follow-up procedures were provided to women in the *One Voice* Program.	
e. Primary Objective of the Initiative	To educate uninsured/underserved women about cancer prevention and provide early detection of breast cancer through screening program and patient navigation.	
f. Single or Multi-Year Initiative – Time Period	Multi-year	
g. Key Collaborators in Delivery of the Initiative	Nueva Vida, a Community Cancer Support and Advocacy Group for Hispanic women, Cancer Institute Breast Center who provides the CBE and follow-up for women with positive findings and Advanced Radiology who provided 100 free screening mammograms for the program. UM SJMC works with Baltimore County Cancer Program (BCCP) to enroll women in need of a biopsy and/or treatment into the Breast and Cervical Cancer Diagnosis and Treatment Program.	
h. Impact/Outcome of Hospital Initiative?	Through our collaborative partners, the *One Voice* Breast Screening Program has been able to be sustained since 2012 and has expanded to include diagnostics and a seamless referral process for cervical and colorectal screenings for uninsured women.	
i. Evaluation of Outcomes:	Metrics include the following: ▪ # women screened (unavailable) ▪ Feedback provided from women served by the program, Nueva Vida, Breast Center and Advanced Radiology. ▪ Two quality measures were added to the monthly breast screening program based on evaluation: Diagnostics were included in the Screening Program to provide continuity of care for the women and a Referral Process was developed with BCCP for women in need of Cervical and/or Colon cancer screening.	
j. Continuation of Initiative?	Yes	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $1129	B. Direct Offsetting Revenue from Restricted Grants None

TABLE III – Initiative 3 – Cancer Coalition Building

a. 1. Identified Need 2. Was this identified through the CHNA process?	Coalition building and advocacy are vital to a strong outreach program focused on cancer education, prevention, early detection and survivorship, with particular attention to culturally sensitive approaches. Yes, with addition of collaborative partnerships.	
b. Hospital Initiative	Cancer Coalition Building and Advocacy	
c. Total Number of People Within the Target Population	Unavailable	
d. Total Number of People Reached by the Initiative Within the Target Population	1,768	
e. Primary Objective of the Initiative	To enhance the effectiveness of each participating organization/agency in cancer education/prevention by collaborating in initiatives to educate and screen persons, especially those in minority and traditionally underserved/marginal communities.	
f. Single or Multi-Year Initiative – Time Period	Multi-year	
g. Key Collaborators in Delivery of the Initiative	Nueva Vida, UMSJMC Community Health, UMMS Community Outreach Downtown, MD State Cancer Collaborative, MD State Cancer Control Steering Committee, Baltimore County Cancer Coalition	
h. Impact/Outcome of Hospital Initiative?	Total # of collaborative education/prevention activities = 36	
i. Evaluation of Outcomes:	Metrics include the following: # people reached (unavailable) # people screened (unavailable) # evaluations at individual events (unavailable) # of collaborative activities (unavailable)	
j. Continuation of Initiative?	Yes	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $705	B. Direct Offsetting Revenue from Restricted Grants None

TABLE III – Initiative 4 – St. Clare Medical Outreach

a. 1. Identified Need 2. Was this identified through the CHNA process?	Primary care services for persons with no insurance whatsoever (no Medicare, no Medicaid, not eligible for any health insurance under the ACA) or an easily accessible bus route. Yes, access to health care was identified as one of the primary unmet health care needs.
b. Hospital Initiative	St. Clare Medical Outreach
c. Total Number of People Within the Target Population	Number of Hispanics in Baltimore City 2010 Census – 29,960 Number of Hispanics in Baltimore County 2010 Census – 33,735 Total – 63,695
d. Total Number of People Reached by the Initiative Within the Target Population	St. Clare has 900 individual patients.
e. Primary Objective of the Initiative	Primary health care service for those with no health insurance, particularly the Hispanic community (also immigrant).
f. Single or Multi-Year Initiative – Time Period	Multi-year
g. Key Collaborators in Delivery of the Initiative	• UM SJMC – provides no cost lab and out-patient services • Charity in-patient services for patients referred from St. Clare Medical Outreach, including surgery and cancer treatment • Service of employed physicians • Service of non-employed specialists who accept St. Clare patients as pro bono patients • Baltimore County Cancer Prevention Program • Baltimore City Cancer Prevention Program – Med Star • Esperanza Center • House of Ruth/Adelente Familia • Nueva Vida • Provision – JHH Wilmer Eye Institute – Diabetic Retinopathy • University of MD Dental School • Baltimore County Health Department for Women's Health • Baltimore City FQHC for Women's Health Care • Baltimore City Health Dept. – STD clinics • Medicine and International Health JHU SOM Center for TB Research
h. Impact/Outcome of Hospital Initiative?	St. Clare sees approximately 2200 patients/year
i. Evaluation of Outcomes:	• Number of patients able to be seen with limited health care providers in the practice • Decrease in AIC markers indicating better control of diabetes (diabetes is one of the most prevalent and chronic conditions of St. Clare patients) • Decrease number of patients seen in the Emergency Room at SJMC.
j. Continuation of Initiative?	Yes. UM St. Joseph Medical Center is committed to underwriting the expenses of St. Clare Medical Outreach including rent, salaries, pharmaceuticals, etc.

k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $735,527	B. Direct Offsetting Revenue from Restricted Grants None

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.

   A priority identified in the Key Informant interviews in the CHNA that UM SJMC has not pursued is dental health since we do not have dental resources at UM SJMC. We have not developed a response to the Baltimore County Health Coalition priority of obesity in children and adolescents because we have a very small pediatric service at UM SJMC and no on-going relationships with pediatricians in the area which is the appropriate entry point for addressing this priority. We have not developed a response to the Maryland SHIP priority concerning infectious diseases, i.e., HIV/AIDS, tuberculosis and Hepatitis A and B, because after consultation with our Senior Infection Prevention Coordinator, these infectious diseases are not felt to be present in the populations we serve to the degree that would make a concerted effort addressing them an appropriate use of our resources.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

   STATE INNOVATION MODEL (SIM)
   http://hsia.dhmh.maryland.gov/SitePages/sim.aspx
   MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
   http://dhmh.maryland.gov/ship/SitePages/Home.aspx
   HEALTH CARE INNOVATIONS IN MARYLAND
   http://www.dhmh.maryland.gov/innovations/SitePages/Home.aspx
   MARYLAND ALL-PAYER MODEL http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/
   COMMUNITY HEALTH RESOURCES COMMISSION
   http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

   UM SJMC's Community Benefit activities contribute to the first of the Maryland State measures of increasing life expectancy by helping patients to have access to quality health care including cancer care. The second of the State of Maryland's measures – reduce infant deaths – is addressed through the referral of pregnant women, who are seen at St. Clare Medical Outreach, to our team of high-risk pregnancy physicians, which also addresses measure three – reduce the percent of low birth weight babies. Women's gynecological health is also provided by our staff of physicians and nurse midwives at Women's Health Associates, who treat women of all ages. In our last CHNA, access to

health care was identified as one of the unmet health needs in the participants, and the presence of St. Clare Medical Outreach directly addresses that unmet needs, as does our Cancer Institute's collaboration with local cancer-focused support groups.

VI. 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.

   UM SJMC is fortunate to be an affiliate hospital of the University of Maryland Medical System. When UM SJMC is treating a patient who requires care of specialist we do not have quickly available locally, we are able to refer them to the University Medical Center, which typically has a physician of that specialty available. Two areas in particular of gap in specialist providers for St. Clare Medical Outreach are those of neurology and endocrinology. These are chronic gaps in specialist care, and these patients are often referred to UMMS for their specialized care.

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

   The following physician subsidies are paid by UM-SJMC to insure that these services are available to all patients who come to the hospital, regardless of their ability to pay for the services received or whether they have any insurance. Without these subsidies, these services would not be available to our patients on a 24/7 basis:

   > Anesthesia, Specialty Care (including NICU (On Call), MSICU (On Call), Radiology (On Call), Clinical Surgical Support, Pediatric House Staff, OB/GYN, Cardiac Surgery Support), Emergency Department, Mental Health, Primary Care and Women's Health Associates (noted above) for a total physician subsidy of $9,087,021.

VII. 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. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II) (There has been no change in our Financial Assistance Policy since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014).
c. Include a copy of your hospital's FAP (label appendix III).
d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

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

Appendix I – Description of Financial Assistance Policy

Our financial assistance policy and the communication about our financial assistance policy is regularly reviewed to make sure it is available to our patients in a variety of formats and that it is available in culturally/linguistically sensitive manner and at a reading comprehensive level appropriate to the population of our CBSA.

The availability of financial assistance for patients who would otherwise be billed for services about their eligibility for assistance under federal, state or local government programs is communicated to patients in multiple ways:

At all our points of registration in the hospital (general registration, Emergency Department) and in our specialized service areas (Perinatal Center, Cancer Institute, etc.) large signs are posted informing the patient that if they face problems in paying for their care, they may apply for financial assistance. The phone number is posted for them to contact one of our financial counselors.

When patients are registering in the hospital for inpatient treatment or outpatient treatment, they are given the Patient Financial Information Sheet (Appendix III) that is printed on two sides in English and Spanish. This Patient Financial Information Sheet is available at every point of entrance to the hospital and every point of service delivery. It is also included in the patient information packet given to each patient.

When patients are inpatients and do not have any health insurance, one of our financial counselors visits them in their room and discusses with them availability of various government benefits such as Medicaid or state programs offering health care assistance and assists the patients with appropriate qualifications to apply.

When patients receive outpatient services and do not have any health insurance, the financial counselor sends them information about their potential eligibility for various government benefits such as Medicaid or state programs offering health care assistance, and invites them to call (Spanish and English-speaking financial counselors are available) to discuss applying for these programs.

When a patient applies for financial assistance, our bilingual financial assistance counselor works with the patient to gather appropriate documents and submit their application for financial assistance.

Appendix III – Financial Assistance Policy

UNIVERSITY of MARYLAND MEDICAL SYSTEM	**The University of Maryland Medical System Policy & Procedure**	*Policy #:*	TBD
		Effective Date:	02-01-2013
	Subject:	*Page #:*	25 of 33
	FINANCIAL ASSISTANCE	*Supersedes:*	07-01-2012

POLICY

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

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

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

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

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

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

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

PROGRAM ELIGIBILITY

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

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

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

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

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

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

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

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

Presumptive Financial Assistance

Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive

circumstances, the only financial assistance that can be granted is a 100% writeoff of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

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

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

a. Purely elective procedures (example – Cosmetic) are not covered under the program.
b. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.
2. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.
   d. Upon receipt of the patient's application, they will have twenty (20) days to submit the required documentation to be considered for eligibility. If no data is received within the 20 days, a denial letter will be sent notifying that the case is now closed for inactivity and the account will be

referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.

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

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

Financial Hardship

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

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

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

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

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

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

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

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

Asset Consideration

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

1. Under the current legislation, the following assets are exempt from consideration:
    a. The first $10,000.00 of monetary assets for individuals, and the first $25,000.00 of monetary assets for household families.
    b. Up to $150,000.00 in primary residence equity.
    c. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement, account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.

Appeals

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

Judgments

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

Appendix IV – Patient Financial Information Sheet

UNIVERSITY of MARYLAND
ST. JOSEPH MEDICAL CENTER

FACTS ABOUT

FINANCIAL ASSISTANCE POLICY

St. Joseph Medical Center has a financial assistance policy and under Maryland law must inform you that you may be entitled to receive financial assistance with the cost of medically necessary hospital services if you have a low income, do not have insurance, or your insurance does not cover your medically-necessary hospital care and you are low-income.

Patients' Rights

- If you meet the policy criteria you may receive financial assistance from the hospital.
- If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance.
- You may be eligible for Maryland Medical Assistance. This is a joint state and Federal program that pays the full cost of health coverage for low-income individuals who meet certain criteria.

Patients' Obligations

- Those able to pay for their bill, will do so in a timely manner.
- It is your responsibility to provide correct insurance information.
- If you do not have health coverage or cannot afford to pay the bill in full, you should contact the business office promptly, to discuss payment.
- You must provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office.

Contacts

- You can download the uniform financial assistance application from the following link: http://hscrc.state.md.us/consumers_uniform.cfm
- For information on Maryland Medical Assistance contact your local Department of Social Services by phone 1-800-332-6347; TTY 1-800-925-4434; or www.dhr.state.md.us.

Physician Services

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement.

Business Office

410-821-4140

Financial Assistance Office

410-337-3902

Appendix V – Mission, Vision and Core Values

Mission Statement:

As a proud member of the University of Maryland Medical System, the University of Maryland St. Joseph Medical Center provides the highest quality health care service for our community's medical needs. In close collaboration, our physicians and staff provide a continuum of loving service and compassionate care for all who come to us. As a Catholic hospital observing the *Ethical and Religious Directives,* we are committed to

- Growing our services to become the preferred health partner for patients and providers.
- Serving and advocating for those who are poor and marginalized
- Partnering with others to improve the quality of life in our community.

Vision Statement:

As a partner hospital within the University of Maryland Medical System, the University of Maryland St. Joseph Medical Center aspires to serve the highest ideals of our Catholic health care tradition, our role as an innovative community hospital, and our unique clinical relationship with UMMC and the University School of Medicine. Through loving service and compassionate care, and an enduring focus on quality and integrity, we will exceed expectations to become the health system of choice for providers and patients.

Core Values:

- **R**everence – respect for all people as God's loved children
- **I**ntegrity – Coherence between what we say and what we do/how we do it
- **C**ompassion – Ability to enter into another's joy and sorrow. Com-passion = to feel with
- **E**xcellence – *Always* putting forth our personal and professional best efforts