Community Benefit Narrative Report

Fiscal Year 2015

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

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

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

On January 10, 2014, the Center for Medicare and Medicaid Innovation (CMMI) announced its approval of Maryland's historic and groundbreaking proposal to modernize Maryland's all-payer hospital payment system. The model shifts from traditional fee-for-service (FFS) payment towards global budgets and ties growth in per capita hospital spending to growth in the state's overall economy. In addition to hitting aggressive quality targets, this model must save at least $330 million in Medicare spending over the next five years. The HSCRC will monitor progress overtime by measuring quality, patient experience, and cost. In addition, measures of overall population health from the State Health Improvement Process (SHIP) measures will also be monitored (see Attachment A).

To succeed, hospital organizations will need to work in collaboration with other hospital and community based organizations to increase the impact of their efforts in the communities they serve. It is essential that hospital organizations work with community partners to identify and agree upon the top priority areas, and establish common outcome measures to evaluate the impact of these collaborative initiatives. Alignment of the community benefit reporting with these larger delivery reform efforts such as the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system.

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), 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), as provided in the ACA, must include the following:

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

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. If

a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties.

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility, (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions ("LHIC's)[see: http://dhmh.maryland.gov/healthenterprisezones/Documents/Local_Population_Health Improvement_Contacts_4-26-12.pdf] schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. 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

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

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;

(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments.

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

Our CHNA is available (and has been available since 6/30/15) on the internet at:

http://www.umrehabortho.org/~/media/systemhospitals/umroi/pdfs/about/community-health-needs-assessment.pdf?la=en

The IMPLEMENTATION STRATEGY, as provided in the ACA, 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, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and
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.

All of the above items are explained in detail in the CHNA posted online at:

http://www.umrehabortho.org/~/media/systemhospitals/umroi/pdfs/about/community-health-needs-assessment-implementation-plan.pdf?la=en

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 acute care 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	141 Rehab/Chronic Beds	
Total Inpatient Discharges	2,625	
Primary Service Area (Top 60% of discharges)	**Zip Code**	**Zip Code Name**
	20707	Laurel
	20723	Laurel
	21029	Clarksville
	21042	Ellicott City

	21043	Ellicott City
	21044	Columbia
	21045	Columbia
	21046	Columbia
	21060	Glen Burnie
	21061	Glen Burnie
	21075	Elkridge
	21113	Odenton
	21117	Owings Mills
	21122	Pasadena
	21133	Randallstown
	21136	Reisterstown
	21144	Severn
	21157	Westminster
	21201	Baltimore
	21206	Baltimore
	21207	Gwynn Oak
	21213	Baltimore
	21215	Baltimore
	21216	Baltimore
	21217	Baltimore
	21218	Baltimore
	21222	Dundalk
	21223	Baltimore
	21225	Brooklyn
	21227	Halethorpe
	21228	Catonsville
	21229	Baltimore
	21230	Baltimore
	21234	Parkville
	21244	Windsor Mill
	21784	Sykesville
All Other Maryland Hospitals Sharing Primary Service Area	JOHNS HOPKINS, UNIVERSITY OF MARYLAND, MERCY MEDICAL CENTER, INC., UNION MEMORIAL, GREATER BALTIMORE MEDICAL CENTER, UM MIDTOWN, HOWARD COUNTY GENERAL, ST. AGNES, SINAI, HARBOR HOSPITAL CENTER, UM ST. JOSEPH MEDICAL ENTER, BON SECOURS, UM BWMC, NORTHWEST HOSPITAL CENTER, JOHNS HOPKINS BAYVIEW MEDICAL CENTER, ANNE ARUNDEL MEDICAL CENTER, GOOD SAMARITAN, FRANKLIN SQUARE, CARROLL HOSPITAL CENTER, LAUREL REGIONAL HOSPITAL, HOLY CROSS OF SILVER SPRING	
Percentage of UMROI Patients who are Uninsured by County	**County**	**% SELF PAY**
	ALLEGANY	0.0%
	ANNE ARUNDEL	0.0%
	BALTIMORE	0.2%
	BALTIMORE CITY	0.0%
	CALVERT	0.0%

	CAROLINE	0.0%
	CARROLL	0.0%
	CECIL	0.0%
	CHARLES	0.0%
	DELAWARE	0.0%
	DORCHESTER	0.0%
	FOREIGN	0.0%
	FREDERICK	0.0%
	GARRETT	0.0%
	HARFORD	0.0%
	HOWARD	0.3%
	KENT	0.0%
	MONTGOMERY	0.0%
	OTHER STATE	0.9%
	PENNSYLVANIA	0.0%
	PRINCE GEORGES	0.9%
	QUEEN ANNES	0.0%
	SOMERSET	0.0%
	ST. MARYS	0.0%
	TALBOT	0.0%
	UNIDENTIFIED MD	0.0%
	UNKNOWN	0.0%
	VIRGINIA	0.0%
	WASHINGTON	0.0%
	WASHINGTON,DC	0.0%
	WEST VIRGINIA	0.0%
	WICOMICO	0.0%
	WORCESTER	0.0%
	TOTAL	**0.2%**
Percentage of UMROI Patients who are Medicaid by County	**County**	**% Medicaid and Medicaid HMO**
	ALLEGANY	0.0%
	ANNE ARUNDEL	15.2%
	BALTIMORE	15.9%
	BALTIMORE CITY	35.4%
	CALVERT	12.5%
	CAROLINE	35.0%
	CARROLL	18.3%
	CECIL	25.0%
	CHARLES	40.0%
	DELAWARE	0.0%
	DORCHESTER	42.9%
	FOREIGN	0.0%
	FREDERICK	18.2%
	GARRETT	0.0%
	HARFORD	33.8%
	HOWARD	7.5%
	KENT	0.0%
	MONTGOMERY	29.4%

	OTHER STATE	7.3%
	PENNSYLVANIA	0.0%
	PRINCE GEORGES	28.4%
	QUEEN ANNES	50.0%
	SOMERSET	50.0%
	ST. MARYS	16.7%
	TALBOT	16.7%
	UNIDENTIFIED MD	36.4%
	UNKNOWN	0.0%
	VIRGINIA	0.0%
	WASHINGTON	24.0%
	WASHINGTON,DC	0.0%
	WEST VIRGINIA	0.0%
	WICOMICO	33.3%
	WORCESTER	20.0%
	TOTAL	**21.0%**

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 following information contained in this report is reflective of the recently completed FY2015 CHNA. However, Table III will reflect the community benefit initiatives that were in identified in the FY2012 CHNA for the period July 2012 through June 2015.

The University of Maryland Rehabilitation & Orthopaedic Institute (UM Rehab & Ortho) is the largest inpatient rehabilitation specialty hospital located in Maryland. Formerly known also as Kernan Orthopaedics and Rehabilitation, the hospital is Baltimore's original orthopaedic and rehabilitation specialty hospital and is a committed provider of a full array of rehabilitation programs and specialty surgery--primarily orthopaedics. A member of the University of Maryland Medical System (UMMS) and affiliated with the University of Maryland School of Medicine, the hospital has been serving patients who are residents of the State of Maryland and the surrounding Baltimore metropolitan area for over 118 years.

UM Rehab & Ortho at a Glance (FY 2015)
141 Rehabilitation, Chronic and Acute Care Beds
3,242 Admissions
479 Inpatient Surgeries
62,609 Outpatient Visits
3,432 Outpatient Surgeries

Medical Staff – 228

- 165 Physicians representing 44 specialties
  - 125 University of Maryland School of Medicine Faculty
  - 40 Community physicians
- 30 Mid-Level Providers
- 33 Dentists

557 Full and Part-Time Staff (not including PRN)

32% Nursing positions
25% Therapy positions
43% All other positions

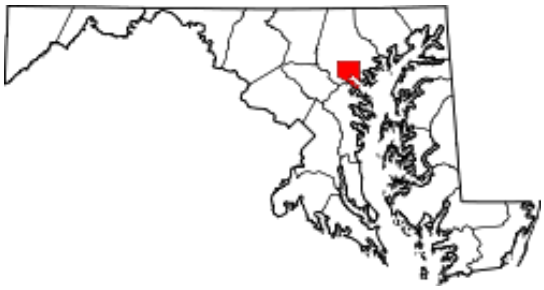
Located in the Forest Park/Gwynns Falls community in northwest Baltimore City, and the Gwynn Oak/Woodlawn area in western Baltimore County, UM Rehab & Ortho is accessible to patients residing in Baltimore City, Anne Arundel, Baltimore, and Howard counties.

As the largest provider of acute spinal cord injury rehabilitation in the State of Maryland, UM Rehab & Ortho treated approximately 30 percent of all Maryland's spinal cord injury patients. Also, as the largest provider of acute traumatic brain injury rehabilitation in the State of Maryland, UM Rehab & Ortho treated 50 percent of these patients statewide.

The following information details the areas UM Rehab & Ortho serves --Baltimore City, Anne Arundel, Baltimore, and Howard counties. For purposes of this report, UM Rehab & Ortho's CBSA could be considered the following zip codes, by city and county:

Baltimore City	**Anne Arundel County**	**Howard County**	**Baltimore County**
21201	21144	21043 21207	21208
21202	21061	21044 21215	21117
21217	21122	21045 21209	21228
21216	21060	21075	21229

Baltimore City



Baltimore city consists of nine geographical regions: Northern, Northwestern, Northeastern, Western, Central, Eastern, Southern, Southwestern, and Southeastern. The West Baltimore community is nearest to UM Rehab & Ortho Institute, and consists of the Northwestern, Western, and Southwestern districts. The Northwestern district, bounded by the Baltimore County line on its northern and western boundaries, Gwynns Falls Parkway on the south and Pimlico Road on the East, is home to Pimlico Race Course, where the Preakness Stakes takes place each May, and is primarily residential.

The Western district, located west of the main commercial district downtown, is the heart of West Baltimore, bounded by Gwynns Falls Parkway, Fremont Avenue, and Baltimore Street. Coppin State University, Mondawmin Mall, and Edmondson Village, all located within this district, have been historic cultural and economic centers of the city's African American community

The Southwestern district is bounded by Baltimore County to the west, Baltimore Street to the north, and the downtown area to the east. Economic and demographic characteristics of Southwestern district vary.

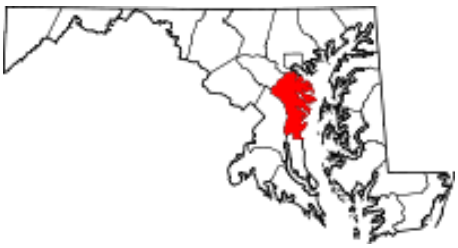
People	**Baltimore City**	**Maryland**
Population		
Population estimates, July 1, 2014, (V2014)	622793	5976407
Population estimates base, April 1, 2010, (V2014)	621121	5773785
Population, percent change - April 1, 2010 (estimates base) to July 1, 2014, (V2014)	0.3	3.5
Population, Census, April 1, 2010	620961	5773552
Age and Sex		
Persons under 5 years, percent, July 1, 2014, (V2014)	X	6.2
Persons under 5 years, percent, April 1, 2010	6.6	6.3
Persons under 18 years, percent, July 1, 2014, (V2014)	X	22.6
Persons under 18 years, percent, April 1, 2010	21.5	23.4
Persons 65 years and over, percent, July 1, 2014, (V2014)	X	13.8
Persons 65 years and over, percent, April 1, 2010	11.7	12.3
Female persons, percent, July 1, 2014, (V2014)	X	51.5
Female persons, percent, April 1, 2010	52.9	51.6
Race and Hispanic Origin		
White alone, percent, July 1, 2014, (V2014) (a)	X	60.1
White alone, percent, April 1, 2010 (a)	29.6	58.2
Black or African American alone, percent, July 1, 2014, (V2014) (a)	X	30.3
Black or African American alone, percent, April 1, 2010 (a)	63.7	29.4
American Indian and Alaska Native alone, percent, July 1, 2014, (V2014) (a)	X	0.6

American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.4	0.4
Asian alone, percent, July 1, 2014, (V2014) (a)	X	6.4
Asian alone, percent, April 1, 2010 (a)	2.3	5.5
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2014, (V2014) (a)	X	0.1
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	Z	0.1
Two or More Races, percent, July 1, 2014, (V2014)	X	2.6
Two or More Races, percent, April 1, 2010	2.1	2.9
Hispanic or Latino, percent, July 1, 2014, (V2014) (b)	X	9.3
Hispanic or Latino, percent, April 1, 2010 (b)	4.2	8.2
White alone, not Hispanic or Latino, percent, July 1, 2014, (V2014)	X	52.6
White alone, not Hispanic or Latino, percent, April 1, 2010	28.0	54.7
Population Characteristics		
Veterans, 2009-2013	35446	427068
Foreign born persons, percent, 2009-2013	7.4	14.0
Housing		
Housing units, July 1, 2014, (V2014)	X	2422194
Housing units, April 1, 2010	296685	2378814
Owner-occupied housing unit rate, 2009-2013	48.3	67.6
Median value of owner-occupied housing units, 2009-2013	157900	292700
Median selected monthly owner costs -with a mortgage, 2009-2013	1426	2037
Median selected monthly owner costs -without a mortgage, 2009-2013	501	582
Median gross rent, 2009-2013	924	1196
Building permits, 2014	X	16331
Families and Living Arrangements		
Households, 2009-2013	241455	2146240
Persons per household, 2009-2013	2.47	2.65
Living in same house 1 year ago, percent of persons age 1 year+, 2009-2013	82.6	86.7
Language other than English spoken at home, percent of persons age 5 years+, 2009-2013	8.8	16.7
Education		
High school graduate or higher, percent of persons age 25 years+, 2009-2013	80.2	88.7
Bachelor's degree or higher, percent of persons age 25 years+, 2009-2013	26.8	36.8
Health		
With a disability, under age 65 years, percent, 2009-2013	11.8	7.0
Persons without health insurance, under age 65 years, percent	14.7	8.9
Economy		
In civilian labor force, total, percent of population age 16 years+, 2009-2013	62.1	68.6
In civilian labor force, female, percent of population age 16 years+, 2009-2013	61.1	64.9
Total accommodation and food services sales, 2007 ($1,000) (c)	1434689	10758428
Total health care and social assistance receipts/revenue, 2007 ($1,000) (c)	8368892	33826636
Total manufacturers shipments, 2007 ($1,000) (c)	5730887	41456097
Total merchant wholesaler sales, 2007 ($1,000) (c)	4843424	51276797
Total retail sales, 2007 ($1,000) (c)	4348797	75664186

Total retail sales per capita, 2007 (c)	6793	13429
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2009-2013	30.1	32.0
Income and Poverty		
Median household income (in 2013 dollars), 2009-2013	41385	73538
Per capita income in past 12 months (in 2013 dollars), 2009-2013	24750	36354
Persons in poverty, percent	23.8	10.1

http://www.census.gov/quickfacts/table/PST045214/2404000,24

Anne Arundel County



Anne Arundel County is located in the state of Maryland. According to the *2010 U.S. Census*, the latest data available its population was 550,488. The county forms part of the Baltimore-Washington metropolitan area. The following information provides demographic data pertaining to Anne Arundel County.

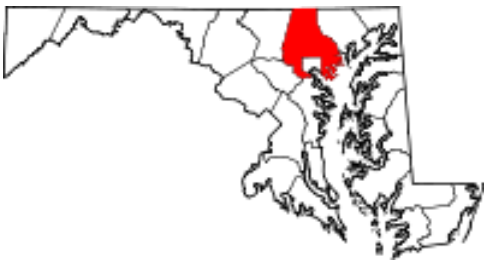
People	**Anne Arundel County**	**Maryland**
Population		
Population estimates, July 1, 2014, (V2014)	560133	5976407
Population estimates base, April 1, 2010, (V2014)	537656	5773785
Population, percent change - April 1, 2010 (estimates base) to July 1, 2014, (V2014)	4.2	3.5
Population, Census, April 1, 2010	537656	5773552
Age and Sex		
Persons under 5 years, percent, July 1, 2014, (V2014)	6.3	6.2
Persons under 5 years, percent, April 1, 2010	6.4	6.3
Persons under 18 years, percent, July 1, 2014, (V2014)	22.6	22.6
Persons under 18 years, percent, April 1, 2010	23.3	23.4
Persons 65 years and over, percent, July 1, 2014, (V2014)	13.4	13.8
Persons 65 years and over, percent, April 1, 2010	11.8	12.3
Female persons, percent, July 1, 2014, (V2014)	50.5	51.5
Female persons, percent, April 1, 2010	50.6	51.6
Race and Hispanic Origin		
White alone, percent, July 1, 2014, (V2014) (a)	76.1	60.1
White alone, percent, April 1, 2010 (a)	75.4	58.2
Black or African American alone, percent, July 1, 2014, (V2014) (a)	16.6	30.3
Black or African American alone, percent, April 1, 2010 (a)	15.5	29.4
American Indian and Alaska Native alone, percent, July 1, 2014, (V2014) (a)	0.4	0.6
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.3	0.4
Asian alone, percent, July 1, 2014, (V2014) (a)	3.9	6.4
Asian alone, percent, April 1, 2010 (a)	3.4	5.5
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2014, (V2014) (a)	0.1	0.1
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	0.1	0.1
Two or More Races, percent, July 1, 2014, (V2014)	2.9	2.6
Two or More Races, percent, April 1, 2010	2.9	2.9

Hispanic or Latino, percent, July 1, 2014, (V2014) (b)	7.2	9.3
Hispanic or Latino, percent, April 1, 2010 (b)	6.1	8.2
White alone, not Hispanic or Latino, percent, July 1, 2014, (V2014)	70.2	52.6
White alone, not Hispanic or Latino, percent, April 1, 2010	72.4	54.7
Population Characteristics		
Veterans, 2009-2013	54387	427068
Foreign born persons, percent, 2009-2013	8.1	14.0
Housing		
Housing units, July 1, 2014, (V2014)	218903	2422194
Housing units, April 1, 2010	212562	2378814
Owner-occupied housing unit rate, 2009-2013	74.2	67.6
Median value of owner-occupied housing units, 2009-2013	340000	292700
Median selected monthly owner costs -with a mortgage, 2009-2013	2134	2037
Median selected monthly owner costs -without a mortgage, 2009-2013	581	582
Median gross rent, 2009-2013	1454	1196
Building permits, 2014	2441	16331
Families and Living Arrangements		
Households, 2009-2013	199904	2146240
Persons per household, 2009-2013	2.65	2.65
Living in same house 1 year ago, percent of persons age 1 year+, 2009-2013	86.9	86.7
Language other than English spoken at home, percent of persons age 5 years+, 2009-2013	10.6	16.7
Education		
High school graduate or higher, percent of persons age 25 years+, 2009-2013	90.7	88.7
Bachelor's degree or higher, percent of persons age 25 years+, 2009-2013	37.1	36.8
Health		
With a disability, under age 65 years, percent, 2009-2013	6.5	7.0
Persons without health insurance, under age 65 years, percent	8.6	8.9
Economy		
In civilian labor force, total, percent of population age 16 years+, 2009-2013	68.4	68.6
In civilian labor force, female, percent of population age 16 years+, 2009-2013	65.0	64.9
Total accommodation and food services sales, 2007 ($1,000) (c)	1288086	10758428
Total health care and social assistance receipts/revenue, 2007 ($1,000) (c)	2092866	33826636
Total manufacturers shipments, 2007 ($1,000) (c)	3610107	41456097
Total merchant wholesaler sales, 2007 ($1,000) (c)	6922158	51276797
Total retail sales, 2007 ($1,000) (c)	9464955	75664186
Total retail sales per capita, 2007 (c)	18491	13429
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2009-2013	29.8	32.0
Income and Poverty		
Median household income (in 2013 dollars), 2009-2013	87430	73538

Per capita income in past 12 months (in 2013 dollars), 2009-2013	40415	36354
Persons in poverty, percent	7.3	10.1

Retrieved from US Census Bureau Quick Facts 2015,
http://www.census.gov/quickfacts/table/PST045214/24003,24

Baltimore County



A part of the Baltimore-Washington Metropolitan area, Baltimore County is located in the northern part of the state of Maryland. In 2010, the county's population was 805,029. Comprised of approximately 598 square miles, Baltimore County does not have any incorporated cities or towns and is divided into council districts. UM Rehab & Ortho is located on the southwestern border of district 4 (Randallstown/Woodlawn/Security) of the county and Baltimore City.

People	**Baltimore County**	**Maryland**
Population		
Population estimates, July 1, 2014, (V2014)	826925	5976407
Population estimates base, April 1, 2010, (V2014)	804973	5773785
Population, percent change - April 1, 2010 (estimates base) to July 1, 2014, (V2014)	2.7	3.5
Population, Census, April 1, 2010	805029	5773552
Age and Sex		
Persons under 5 years, percent, July 1, 2014, (V2014)	6.0	6.2
Persons under 5 years, percent, April 1, 2010	6.0	6.3
Persons under 18 years, percent, July 1, 2014, (V2014)	21.6	22.6
Persons under 18 years, percent, April 1, 2010	22.0	23.4
Persons 65 years and over, percent, July 1, 2014, (V2014)	15.8	13.8
Persons 65 years and over, percent, April 1, 2010	14.6	12.3
Female persons, percent, July 1, 2014, (V2014)	52.7	51.5
Female persons, percent, April 1, 2010	52.7	51.6
Race and Hispanic Origin		
White alone, percent, July 1, 2014, (V2014) (a)	63.5	60.1
White alone, percent, April 1, 2010 (a)	64.6	58.2
Black or African American alone, percent, July 1, 2014, (V2014) (a)	27.8	30.3
Black or African American alone, percent, April 1, 2010 (a)	26.1	29.4
American Indian and Alaska Native alone, percent, July 1, 2014, (V2014) (a)	0.4	0.6
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.3	0.4
Asian alone, percent, July 1, 2014, (V2014) (a)	5.9	6.4
Asian alone, percent, April 1, 2010 (a)	5.0	5.5
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2014, (V2014) (a)	0.1	0.1
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	Z	0.1
Two or More Races, percent, July 1, 2014, (V2014)	2.3	2.6
Two or More Races, percent, April 1, 2010	2.4	2.9

Hispanic or Latino, percent, July 1, 2014, (V2014) (b)	5.0	9.3
Hispanic or Latino, percent, April 1, 2010 (b)	4.2	8.2
White alone, not Hispanic or Latino, percent, July 1, 2014, (V2014)	59.6	52.6
White alone, not Hispanic or Latino, percent, April 1, 2010	62.7	54.7
Population Characteristics		
Veterans, 2009-2013	58028	427068
Foreign born persons, percent, 2009-2013	11.1	14.0
Housing		
Housing units, July 1, 2014, (V2014)	336992	2422194
Housing units, April 1, 2010	335622	2378814
Owner-occupied housing unit rate, 2009-2013	66.5	67.6
Median value of owner-occupied housing units, 2009-2013	253300	292700
Median selected monthly owner costs -with a mortgage, 2009-2013	1793	2037
Median selected monthly owner costs -without a mortgage, 2009-2013	537	582
Median gross rent, 2009-2013	1139	1196
Building permits, 2014	1004	16331
Families and Living Arrangements		
Households, 2009-2013	313912	2146240
Persons per household, 2009-2013	2.52	2.65
Living in same house 1 year ago, percent of persons age 1 year+, 2009-2013	88.0	86.7
Language other than English spoken at home, percent of persons age 5 years+, 2009-2013	13.1	16.7
Education		
High school graduate or higher, percent of persons age 25 years+, 2009-2013	89.9	88.7
Bachelor's degree or higher, percent of persons age 25 years+, 2009-2013	35.7	36.8
Health		
With a disability, under age 65 years, percent, 2009-2013	7.2	7.0
Persons without health insurance, under age 65 years, percent	11.5	8.9
Economy		
In civilian labor force, total, percent of population age 16 years+, 2009-2013	67.4	68.6
In civilian labor force, female, percent of population age 16 years+, 2009-2013	63.2	64.9
Total accommodation and food services sales, 2007 ($1,000) (c)	1414111	10758428
Total health care and social assistance receipts/revenue, 2007 ($1,000) (c)	5767627	33826636
Total manufacturers shipments, 2007 ($1,000) (c)	9247191	41456097
Total merchant wholesaler sales, 2007 ($1,000) (c)	5609327	51276797
Total retail sales, 2007 ($1,000) (c)	12074866	75664186
Total retail sales per capita, 2007 (c)	15341	13429
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2009-2013	28.8	32.0
Income and Poverty		
Median household income (in 2013 dollars), 2009-2013	66486	73538
Per capita income in past 12 months (in 2013 dollars), 2009-2013	34374	36354
Persons in poverty, percent	9.5	10.1

http://www.census.gov/quickfacts/table/PST045214/24005,24

Howard County

Howard County is located in the central part of the Maryland, between Baltimore and Washington, D.C. It is considered part of the Baltimore-Washington Metropolitan Area.

According to the *2010 U.S. Census*, the latest data available, its population was 299,430. Its county seat is Ellicott City. The center of population of Maryland is located on the county line between Howard County and Anne Arundel County, in the unincorporated town of Jessup.

Due to the proximity of Howard County's population centers to Baltimore, the county has traditionally been considered a part of the Baltimore Metropolitan Area. Recent development in the south of the county has led to some realignment towards the Washington, D.C. media and employment markets. The county is also home to Columbia, a major planned community of 100,000 founded by developer James Rouse in 1967.

Howard County is frequently cited for its affluence, quality of life, and excellent schools. For 2011, it was ranked the fifth wealthiest county by median household income in the United States by the U.S. Census Bureau. Many of the most affluent communities in the Baltimore-Washington Metropolitan Area, such as Clarksville, Glenelg, Glenwood and West Friendship, are located along the Route 32 corridor in Howard County. The main population center of Columbia/Ellicott City was named 2nd among *Money* magazine's 2010 survey of "America's Best Places to Live." Howard County's schools frequently rank first in Maryland as measured by standardized test scores and graduation rates.

People	**Howard County**	**Maryland**
Population		
Population estimates, July 1, 2014, (V2014)	309284	5976407
Population estimates base, April 1, 2010, (V2014)	287085	5773785
Population, percent change - April 1, 2010 (estimates base) to July 1, 2014, (V2014)	7.7	3.5
Population, Census, April 1, 2010	287085	5773552
Age and Sex		
Persons under 5 years, percent, July 1, 2014, (V2014)	6.0	6.2
Persons under 5 years, percent, April 1, 2010	6.0	6.3
Persons under 18 years, percent, July 1, 2014, (V2014)	24.6	22.6
Persons under 18 years, percent, April 1, 2010	26.0	23.4
Persons 65 years and over, percent, July 1, 2014, (V2014)	12.2	13.8
Persons 65 years and over, percent, April 1, 2010	10.1	12.3
Female persons, percent, July 1, 2014, (V2014)	51.0	51.5
Female persons, percent, April 1, 2010	51.0	51.6
Race and Hispanic Origin		
White alone, percent, July 1, 2014, (V2014) (a)	60.4	60.1

White alone, percent, April 1, 2010 (a)	62.2	58.2
Black or African American alone, percent, July 1, 2014, (V2014) (a)	18.6	30.3
Black or African American alone, percent, April 1, 2010 (a)	17.5	29.4
American Indian and Alaska Native alone, percent, July 1, 2014, (V2014) (a)	0.4	0.6
American Indian and Alaska Native alone, percent, April 1, 2010 (a)	0.3	0.4
Asian alone, percent, July 1, 2014, (V2014) (a)	16.9	6.4
Asian alone, percent, April 1, 2010 (a)	14.4	5.5
Native Hawaiian and Other Pacific Islander alone, percent, July 1, 2014, (V2014) (a)	0.1	0.1
Native Hawaiian and Other Pacific Islander alone, percent, April 1, 2010 (a)	Z	0.1
Two or More Races, percent, July 1, 2014, (V2014)	3.6	2.6
Two or More Races, percent, April 1, 2010	3.6	2.9
Hispanic or Latino, percent, July 1, 2014, (V2014) (b)	6.4	9.3
Hispanic or Latino, percent, April 1, 2010 (b)	5.8	8.2
White alone, not Hispanic or Latino, percent, July 1, 2014, (V2014)	55.4	52.6
White alone, not Hispanic or Latino, percent, April 1, 2010	59.2	54.7
Population Characteristics		
Veterans, 2009-2013	18971	427068
Foreign born persons, percent, 2009-2013	18.2	14.0
Housing		
Housing units, July 1, 2014, (V2014)	115311	2422194
Housing units, April 1, 2010	109282	2378814
Owner-occupied housing unit rate, 2009-2013	73.9	67.6
Median value of owner-occupied housing units, 2009-2013	428100	292700
Median selected monthly owner costs -with a mortgage, 2009-2013	2553	2037
Median selected monthly owner costs -without a mortgage, 2009-2013	761	582
Median gross rent, 2009-2013	1489	1196
Building permits, 2014	1446	16331
Families and Living Arrangements		
Households, 2009-2013	106142	2146240
Persons per household, 2009-2013	2.74	2.65
Living in same house 1 year ago, percent of persons age 1 year+, 2009-2013	88.9	86.7
Language other than English spoken at home, percent of persons age 5 years+, 2009-2013	22.5	16.7
Education		
High school graduate or higher, percent of persons age 25 years+, 2009-2013	94.9	88.7
Bachelor's degree or higher, percent of persons age 25 years+, 2009-2013	60.0	36.8
Health		
With a disability, under age 65 years, percent, 2009-2013	4.5	7.0
Persons without health insurance, under age 65 years, percent	7.7	8.9
Economy		
In civilian labor force, total, percent of population age 16 years+, 2009-2013	72.9	68.6
In civilian labor force, female, percent of population age 16 years+, 2009-2013	67.5	64.9
Total accommodation and food services sales, 2007 ($1,000) (c)	565685	10758428

Total health care and social assistance receipts/revenue, 2007 ($1,000) (c)	1130964	33826636
Total manufacturers shipments, 2007 ($1,000) (c)	2368343	41456097
Total merchant wholesaler sales, 2007 ($1,000) (c)	7170808	51276797
Total retail sales, 2007 ($1,000) (c)	4554990	75664186
Total retail sales per capita, 2007 (c)	16622	13429
Transportation		
Mean travel time to work (minutes), workers age 16 years+, 2009-2013	30.6	32.0
Income and Poverty		
Median household income (in 2013 dollars), 2009-2013	109865	73538
Per capita income in past 12 months (in 2013 dollars), 2009-2013	48172	36354
Persons in poverty, percent	5.3	10.1

http://www.census.gov/quickfacts/table/PST045214/24027,24

3b. In Table II, describe the population within the CBSA, including 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, transportation, education and healthy 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 Area Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf), The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

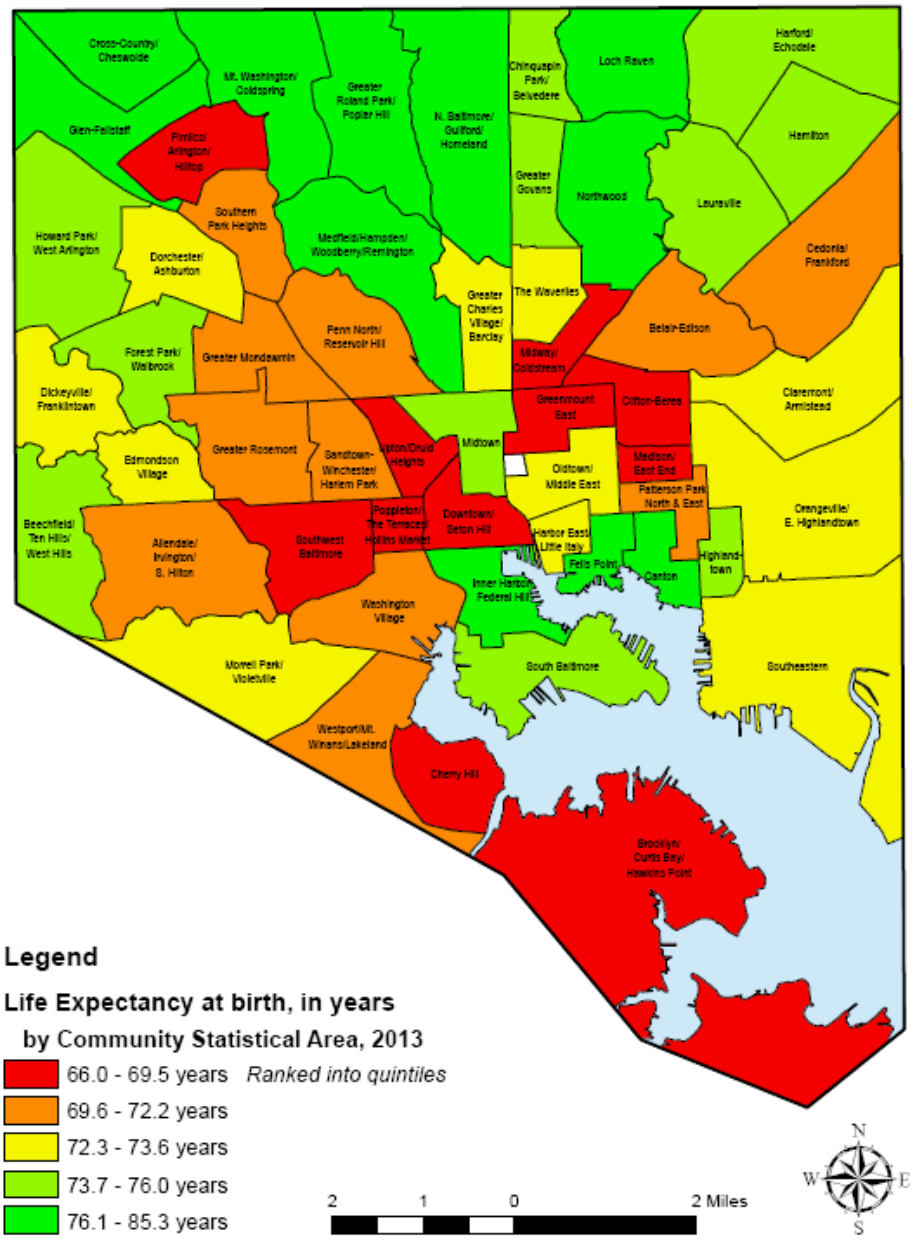
Table II

CBSA Population Total	Balto City & 3 Counties: 744,272
Median Household Income within the CBSA	Baltimore City: $42,266 Anne Arundel County: $86,230 Baltimore County: $64,795 Howard County: $109,476 http://planning.maryland.gov/msdc/American_Community_Survey/2013/Income/MedHHIncome_1999_2013_WithUS.pdf
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Baltimore City: 22.7% Anne Arundel County: 7.3% Baltimore County: 9.5% Howard County: 5.3% http://planning.maryland.gov/msdc/poverty/poverty.shtml
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Baltimore City: 14% Anne Arundel County: 9% Baltimore County: 11% Howard County: 8% http://www.countyhealthrankings.org/app/maryland/2014/measure/factors/85/data
Percentage of Medicaid recipients by County within the CBSA.	Baltimore City: 30.9% Anne Arundel County: 10.5% Baltimore County: 14% Howard County: 7.9%
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	Baltimore City All Races: 73.9 Years White/Caucasian: 76.5 Years Black/African American: 72.2 Years Anne Arundel County All Races: 79.8 Years White/Caucasian: 79.9 Years Black/African American: 77.8 Years Baltimore County All Races: 79.4 Years White/Caucasian: 79.6 Years Black/African American: 78.1 Years Howard County All Races: 82.6 Years White/Caucasian: 82.3 Years Black/African American: 81.4 Years

	http://dhmh.maryland.gov/vsa/Documents/13annual.pdf
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Crude Death Rates (per 100,000 population) All Races – 1,028.1 White/Caucasian – 1,001.2 Black/African American – 1,084.2 http://dhmh.maryland.gov/vsa/Documents/13annual.pdf
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	Baltimore City Percentage of HS graduates: 66% Unemployment: 8.1% (higher in AA men) No Vehicle Available: 15.3% Severe Housing Problems: 24% Anne Arundel County Percentage of HS graduates: 84% Unemployment: 6.1% No Vehicle Available: 2.4% Severe Housing Problems: 14% Baltimore County Percentage of HS graduates: 82% Unemployment: 7.3% No Vehicle Available: 2.9% Severe Housing Problems: 15% Howard County Percentage of HS graduates: 91% Unemployment: 5% No Vehicle Available: 1.5% Severe Housing Problems: 12% http://www.countyhealthrankings.org/app/maryland/2015/rankings/baltimore-city/county/outcomes/overall/additional
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	Gender Male – 350,426 Female – 393,846 Median Age Baltimore City: 34.6 Years Anne Arundel County: 38.5 Years Baltimore County: 39.1 Years Howard County: 38.4 Years Race – all areas White/Caucasian: 346,632

	Black/African American: 317,462 Amer Indian/Alaska Native: 1,941 Asian: 45,149 Native Hawaiian/Other Pacific: 501 Other: 12,096 Two or More Races: 20,491 <u>Ethnicity – all areas</u> Hispanic: 36,228 Non-Hispanic: 708,044 http://factfinder.census.gov
Other	

Baltimore City Life Expectancy Map



Prepared by the Baltimore City Health Department.
2013 Life Expectancy data provided by DHMH's Vital Statistics Administration.

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**. 6/30/15** (mm/dd/yy)

If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

http://www.umrehabortho.org/~/media/systemhospitals/umroi/pdfs/about/community-health-needs-assessment.pdf?la=en

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

_**X**__Yes **6/30/15** (mm/dd/yy) Enter date approved by governing body here:
___No

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

http://www.umrehabortho.org/~/media/systemhospitals/umroi/pdfs/about/community-health-needs-assessment-implementation-plan.pdf?la=en

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? (Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b,)**

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

_**X**__Yes – Strategic Planning process underway currently. Community benefits and community health needs assessment findings being added to the new Strategic Plan.
___No

If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

Elements of the CHNA and community benefits are being integrated into the Strategic Plan currently within this current fiscal year. Prior Strategic Plan did not include community benefits, but with the process underway currently, this is now being included into the Plan.

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. _X_CEO
2. ___CFO
3. _**X**__Other (please specify) CNO, CMO, Director of Therapy, Director of Patient Experience & Volunteers, Director of Outreach, Sr. Director of Strategic Planning & Business Development

Describe the role of Senior Leadership.

- Provides strategic oversight and leadership for community health improvement
- Translates connections to population health initiatives
- Provides contacts to external partners and academic organizations
- Advises Director and team on strategic direction and planning
- Executive sponsor/link to the Board of Directors

ii. Clinical Leadership

1. **_X**__Physician CMO, Medical Director of Sports Medicine
2. **_X**__Nurse
3. ___Social Worker
4. _X_Other (please specify) As a rehabilitation hospital, numerous rehab staff, ie physical therapists, occupational therapists, etc participate

Describe the role of Clinical Leadership

- Provides clinical knowledge/context for needs assessment and programming
- Develops/approves protocols for health screenings
- Provides oversight to health screenings & outreach programs

iii. Community Benefit Operations

1. **_X**_Individual (please specify FTE – (**2.5 FTEs)**
2. _X_Committee (please list members)
   Susan Kirby, Director of Service Excellence and Volunteer Services,
   John Bielawski, Director of Outreach
   Cindy Kelleher, Sr. Director Strategic Planning & Business Development
3. ___Department (please list staff)
4. ___Task Force (please list members)
5. ___Other (please describe)

Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.

Susan Kirby – Coordinates the reporting for the community benefit report and volunteer activities

John Bielawski – Leads the athletic training program and assists with community benefits tracking

Lori Patria – Leads the adaptive sports program and assists with community benefits tracking

Cindy Kelleher – Leads overall effort in both the development and reporting of community benefits

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

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

After completion, the Narrative is reviewed by the UMMS Director, Community Health Improvement, and UM Rehab CEO. After their approval, it is then reviewed by the UMMS SVP for Government & Regulatory Affairs. After completion, the Spreadsheet is reviewed by the UMMS Director, Community Health Improvement, UM Rehab CEO and UMMS SVP for Government & Regulatory Affairs, and the UMMS Vice President of Reimbursement & Revenue. A high level overview of both reports are reviewed and approved at the UM Rehab of the Board meeting in late November.

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

Spreadsheet __**X**___yes _____no
Narrative __**X**___yes _____no

If 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:

__**X**__ Other hospital organizations
__**X**__ Local Health Department
N/A_ Local health improvement coalitions (LHICs) – **There is no active LHIC in Baltimore City**

__**X**__ Schools
_____ Behavioral health organizations
__**X**_ 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
University of Maryland Medical Center	Anne Williams	Director, Community Health Improvement	Consultant to process
University of Maryland Medical System	Donna Jacobs	Senior Vice President	Hosted community partner focus group
BARS	Pam Lenhart	Director	Key informant on identifying needs of disabled community
Dept of Rehabilitation Services	Darice Bunch Polly Huston	Supervisor Director	Key informant on identifying needs of disabled community
Mayor's Office on Disabilities	Dr. Nollie Wood	Executive Director	Understand key elements of ADA, assisting City with accessibility issues
Mount de Sales Academy	Annie McDonald	Athletic Director	Key informants on needs of private schools sports programs
Howard County Public Schools	Kerrie Wagaman John Davis	Coordinator of Health Services Coordinator of Athletics	Key informants on needs of public schools sports programs

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 _____no **N/A – No active LHIC in Baltimore City**

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 _____no **N/A – No active LHIC in Baltimore City**

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 evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), 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 example of how to report.**

   (See attached Table III)

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.

- What were the measurable results of the initiative?
- 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?

2. Were there any primary community health needs 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.

- No health insurance
- Too expensive
- No transportation
- Local MDs not part of the plan
- Couldn't get appointment with MD

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)

The Population Health Strategy and Implementation Plan is currently being finalized. This plan will cover both the University of Maryland Medical Center and Midtown Campuses with some integration with UM Rehab & Ortho Institute. The Community Health Needs Assessments and Community Benefits Reports are integrated into the Plan to provide a context of the community for planning purposes. There are six workgroups which will be tasked with specific elements of the overall strategy. The Social Determinants of Health (SDoH)/Community Partnership Workgroup will be led by the Director of Community Health Improvement with Executive Oversight by two Senior Vice Presidents along with the Director of Population Health. Initiatives will be further developed which will address the SDoH which are barriers in the targeted West Baltimore population. UM Rehab & Ortho Institute will be part of the West Baltimore Transformation Grant along with the University of Maryland Medical Center and Midtown Campuses. Additionally, UM Rehab has 2 Patient Navigators who are dedicated for population health initiatives. To support the population health initiatives with chronic high utilizers, UM Rehab & Ortho Institute has begun to offer the Living Well/Chronic Disease Management Program to patients and the community.

3. 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

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.

The UM Rehab & Ortho is a specialty hospital that offers total joint surgery, non-operative management of back pain, the latest minimally invasive techniques for shoulder surgery, integrative medicine, and leadership in sports medicine and pediatric orthopaedics. The hospital's expert staff treats a full range of rehabilitative issues resulting from stroke, spinal cord injuries, traumatic brain injuries and neurological disorders in both the inpatient and outpatient setting.

As an orthopaedic and rehabilitation specialty hospital, UM Rehab & Ortho does not have an emergency department. It is classified as a Level IV emergency service facility. There is 24/7 staffing by an internal medicine physician (hospitalist). Appropriate referral to an acute care facility capable of providing continued emergency services are made if necessary Visitors and outpatients who suffer cardiopulmonary arrest will have emergent care initiated by the code blue team and then will be transported to an emergency room via 911.

All inpatients requiring treatment by the code blue team or rapid response team will be evaluated by the hospitalist and or attending physician to determine the appropriate level of care. This may include continued care on the rehab unit, admission to the med surg unit, elective transfer to tertiary care facilities via transfer agreements, or transport to the nearest emergency department via 911.

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

meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

Not Applicable

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).
    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).
Attachment A

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) SLECTED POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers
- Reduce the % of youth using any kind of tobacco product
- Increase the % vaccinated annually for seasonal influenza
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- Reduce hospital ED visits from asthma
- Reduce hospital ED visits related to behavioral health
- Reduce Fall-related death rate

Table III – Chronic Disease: Obesity in Adults

A. 1. Identify Need 2. Was this identified through the CHNA process?	1. Increase the proportion of adults who are at a healthy weight and reduce death from heart disease. Decrease risk of stroke, diabetes; reduce death from heart disease. Obesity rates among disabled adults are nearly 58% higher than adults without disabilities. (2012 Behavioral Risk Factor Surveillance System, CDC) 2. Yes, this was identified through the CHNA process in FY12
B. Hospital Initiative	Adapted Sports Festival With a desire to help improve the quality of life for its patient population, UM Rehab & Ortho organized and hosted its sixth annual Adapted Sports Festival September 6, 2014. All-day event that occurs 10 a.m. – 4 p.m.
C. Total Number of People Within the Target Population	Estimates of Maryland adults vary. Approximately 120,000 people, or 2.4% of the state's population, experience difficulties with performing activities of daily living such as bathing, dressing, or moving around inside of their homes. http://www.disabled-world.com/news/america/maryland/#stats
D. Total Number of People Reached by the Initiative Within the Target Population	125
E. Primary Objective of the Initiative	To encourage disabled community members to participate in sports and to keep as physically fit as possible, in order to reduce obesity and other health risk factors. Opportunities to participate in hand cycling, bocce ball, wheelchair basketball, a wheelchair slalom course, scuba diving, adapted golf and quad rugby.
F. Single or Multi-Year Initiative – Time Period	Multi-year since 2009.
G. Key Collaborators in Delivery of Initiative	Baltimore Adaptive Recreation and Sports (BARS), Forest Park Golf Course, Brain Injury Association
H. Impact/Outcome of Hospital Initiative	Approximately 125 community members participated in the adapted sports events. Evaluations by participants (via survey) indicated that UM Rehab & Ortho should continue providing opportunities for sports/activities for people with disabilities.
I.Evaluation Outcomes:	According to the Maryland SHIP website, the following data trends are:

	(Source: http://dhmh.maryland.gov/ship/SitePages/Home.aspx) % of Adults at Healthy Weight – Baltimore City: 2011 = 34.5%, 2012 =39.7%, 2013 = 35% Obesity rates among disabled adults are nearly 58% higher than adults without disabilities. (2012 Behavioral Risk Factor Surveillance System, CDC) Sufficient evidence now exists to recommend that adults with disabilities should also get regular physical activity.	
J. Continuation of Initiative?	Yes, This event marked the sixth year of the initiative. Will continue indefinitely due to the identified need for disabled adults in the community.	
K. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Offsetting Revenue	A. Total Cost of Initiative $ 20,302	B. Direct Off-setting Revenue from Restricted Grants $ 5,000

Table III – Chronic Disease: Childhood Obesity

A. 1. Identify Need 2. Was this identified through the CHNA process?	1. **Chronic Disease: Obesity –** Many high school students in the Baltimore and Howard County communities do not have a primary care physician and some do not have the resources to see a doctor to obtain a physical in order to participate in sports. The athletic trainers at UM Rehab & Ortho, as well as many of the sports medicine physicians, donate their time each summer to provide an opportunity for students to see a physician at their school and obtain a free physical in order to participate in athletics—an opportunity for many of these students to remain active in order to reduce obesity. Additionally, the physicians and /or residents in the sports medicine program donate their time to attend athletic contests as team physicians for various schools. 2. Yes, this was identified through the CHNA process in FY12
B. Hospital Initiative	Promoting Physical Activity in High Schools Through Sports
C. Total Number of People Within the Target Population	30,342 High School Students in Baltimore County 5,541 High School Students in the targeted Howard County Schools
D. Total Number of People Reached by the Initiative Within the Target Population	149 Event occurs over several Saturdays during the early summer – June/July
E. Primary Objective of the Initiative	Reduce the proportion of children and adolescents who are considered obese by providing sports physicals and care to high school students who participate in sports activities. Studies show that keeping active in sports enables many students to ward off obesity and to set a course for a life time of physical fitness.
F. Single or Multi-Year Initiative – Time Period	Multi-Year
G. Key Collaborators in Delivery of Initiative	Baltimore County Private School: Mt. de Sales Howard County Schools: Howard High School, Mt. Hebron High School, Glenelg High School, Atholton High School
H. Impact/Outcome of Hospital Initiative?	149 students screened Feedback from the High School Athletic Director annually re: Program
I. Evaluation Outcomes:	According to the Maryland SHIP website, the following data trends are:

	(Source: http://dhmh.maryland.gov/ship/SitePages/Home.aspx % of Children/Adolescents Who are Obese – Baltimore County: 12% Maryland 2017 Goal = 10.7%	
J. Continuation of Initiative?	Yes, Continuing – While trends for childhood obesity are stable or improving slightly, they are still not at the Maryland goal and warrant continued focus.	
K. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Offsetting Revenue	C. Total Cost of Initiative $ X # of dollars $12,571	D. Direct Offsetting Revenue from Restricted Grants $4,455

Table III – Healthcare Access

A. 1. Identify Need 2. Was this identified through the CHNA process?	*1.* **Healthcare Access** - Reduce the proportion of individuals who are unable to afford to see a doctor 2. Yes, this was identified through the CHNA process in FY12
B. Hospital Initiative	Support Groups: UM Rehab & Ortho provides education, serves as an advocate and supports the disability populations within its continuum of care. During FY 2015, UM Rehab & Ortho provided and facilitated monthly support groups for brain injury, stroke, spinal cord injury, amputee, caregivers', total joint, and trauma survivors' programs. Additionally, clients with multiple sclerosis were served by participating in UM Rehab & Ortho MS (Multiple Sclerosis) Day Program. These groups and classes are free and open to all. Each group meets monthly or bi-monthly, depending upon needs of the group. Length of meeting varies from 1 – 2 hours. In addition to monthly groups UM Rehab & Ortho held an Amputee Walking Clinic.
C. Total Number of People Within the Target Population	Estimates of Maryland adults vary. Approximately 120,000 people, or 2.4% of the state's population, experience difficulties with performing activities of daily living such as bathing, dressing, or moving around inside of their homes. http://www.disabled-world.com/news/america/maryland/#stats
D. Total Number of People Reached by the Initiative Within the Target Population	1,002
E. Primary Objective of the Initiative	To help those experiencing a life-changing event, and/or their loved ones to be able to adapt to their new experience with the aid of support groups.
F. Single or Multi-Year Initiative – Time Period	Multi-Year
G. Key Collaborators in Delivery of Initiative	UMMS and other hospitals within the community: UM Shock Trauma Center, UMMC, UMMC Midtown, BWMC, St. Agnes, Howard County General BARS (Baltimore Adapted Recreation and Sports) WEAN (Women Embracing Abilities Now)
H. Impact/Outcome of Hospital Initiative?	A total of 1,002 visit the support groups.

	A total of 85 attendees came to the Walking Clinic Feedback from patients and families on topics as well as monitor attendance ongoing	
I. Evaluation Outcomes:	According to the Maryland SHIP website, the following data trends are: (Source: http://dhmh.maryland.gov/ship/SitePages/Home.aspx	
J. Continuation of Initiative?	Yes, Based on the unique needs of the disabled community in Maryland, this warrants continued focus. As a specialty hospital, UM Rehab & Ortho provides care to patients who have unique health care needs. In partnership with treating those who have been patients in the stroke, multi-trauma, spinal cord, or traumatic brain injury units, a series of classes and support groups are offered that are open to patients, caregivers and the community. These free classes focus on prevention and wellness, while support groups are specifically tailored to the specialized needs of patients who have undergone a life changing event and rehabilitation process, and would not have access to appropriate providers and caregivers. Physicians, nurses and other caregivers are frequent guest speakers.	
K. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Offsetting Revenue	A.Total Cost of Initiative $ X # of dollars $39,347	B. Direct Offsetting Revenue from Restricted Grants $200

Table III – Dental Care

A. 1. Identify Need 2. Was this identified through the CHNA process?	1. Increase the proportion of children and adolescents in need who receive dental care. 2. Yes, this was identified through the CHNA process in FY12
B. Hospital Initiative	Dental Education Provide education at neighboring elementary/middle schools each year.
C. Total Number of People Within the Target Population	744,272 in entire targeted population
D. Total Number of People Reached by the Initiative Within the Target Population	290
E. Primary Objective of the Initiative	To provide education to children and adults who have limited access to oral health care. Staff visits area schools to instruct students on oral care, as well as participate in community health fairs. The dental clinic staff has formed relationships with dental practices throughout Maryland so that all patients have resources to dental care they need available to them prior to arriving for an appointment.
F. Single or Multi-Year Initiative – Time Period	Multi-year program since the 1980s
G. Key Collaborators in Delivery of Initiative	Area Schools, hospitals, primary care and dental practices throughout the State of Maryland that cannot treat special needs children and adults. MCHP program University of Maryland School of Dentistry
H. Impact/Outcome of Hospital Initiative?	9,362 clinic visits of patients including disabled and /or low income adults and children in FY15 290 individuals received education on dental care
I. Evaluation Outcomes:	According to the Maryland SHIP website, the following data trends are: (Source: http://dhmh.maryland.gov/ship/SitePages/Home.aspx

	ED Visit Rate for Dental Care – Baltimore City: 2010 – 2014 Maryland 2017 Goal: 792.8 Baltimore City | 2071.7 | 2138.1 | 2361.5 | 2371.0 | 2315.	
J. Continuation of Initiative?	Yes. Visits to area schools and community groups confirm that many area children do not see a dentist regularly and are uninformed regarding oral care. City-wide indicators are not improving and warrant continued focus.	
K. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Offsetting Revenue	A. Total Cost of Initiative $ X # of dollars $2,555	B. Direct Offsetting Revenue from Restricted Grants $0

Appendix 1

Financial Assistance Policy Description

University of Maryland Rehabilitation & Orthopedic Institute 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 Financial Clearance Program Policy is a clear, comprehensive policy established to assess the needs of particular patients that have indicated a possible financial hardship in obtaining aid when it is beyond their financial ability to pay for services rendered.

UM Rehabilitation and Orthopedic Institute makes every effort to make financial assistance information available to our patients including, but not limited to:

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

Appendix 2

Financial Assistance Policy Changes since ACA Description

UM Rehabilitation and Orthopedic Institute's Financial Assistance Policy utilizes a sliding scale model (as seen in Attachment B of our Financial Assistance Policy in Appendix 3) and is now based on the Maryland Medicaid Income Limits which are approximately 30% higher than the Federal Poverty Guidelines. This change allows greater numbers of our patients to qualify for financial assistance.

Appendix 3

University of Maryland Medical Center University of Maryland Medical Center Midtown Campus University of Maryland Rehabilitation & Orthopaedic Institute University of Maryland St. Joseph Medical Center	**The University of Maryland Medical System** **Central Business Office** **Policy & Procedure**	*Policy #:*	TBD
		Effective Date:	01/01/2015
	Subject: **FINANCIAL ASSISTANCE**	*Page #:*	1 of 8
		Supersedes:	07-01-2012

POLICY

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

- University of Maryland Medical Center (UMMC)
- University of Maryland Medical Center Midtown Campus (MTC)
- University of Maryland Rehabilitation & Orthopaedic Institute (UMROI)
- 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.

University of Maryland St. Joseph Medical Center (UMSJMC) adopted this policy effective June 1, 2013.

University of Maryland Medical Center Midtown Campus (MTC) adopted this policy effective September 22, 2014.

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, MTC, UMROI, and UMSJMC 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 Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits 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% write-off 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. 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)
m. Bankruptcy, by law, as mandated by the federal courts
n. St. Clare Outreach Program eligible patients
o. UMSJMC Maternity Program eligible patients
p. UMSJMC Hernia Program eligible patients

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. 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 lack of the required documentation. 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, MTC, UMROI, 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 Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI'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, MTC, UMROI, and 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, MTC, UMROI, and 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, MTC, UMROI, 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 either UMMC, MTC, UMROI, 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, MTC, UMROI, and 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.

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, MTC, UMROI, and UMSJMC shall seek to vacate the judgment and/or strike the adverse credit information.

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

MD DHMH 2014 Income Elig Limit Guidelines		Income Level Up to 200% Pt Resp 0%	S L I D I N G S C A L E	Income Level Pt Resp 10%	Income Level Pt Resp 20%	Income Level Pt Resp 30%	Income Level Pt Resp 40%	Income Level Pt Resp 50%	Income Level Pt Resp 60%	Income Level Pt Resp 70%	Income Level Pt Resp 80%	Income Level Pt Resp 90%
HH Size	100% MD DHMH Max	100% Charity Max		90% Charity Max	80% Charity Max	70% Charity Max	60% Charity Max	50% Charity Max	40% Charity Max	30% Charity Max	20% Charity Max	10% Charity Max
1	**16,105.00**	**32,210.00**		33,820.50	35,431.00	37,041.50	38,652.00	40,262.50	41,873.00	43,483.50	45,094.00	48,314.00
2	**21,707.00**	**43,414.00**		45,584.70	47,755.40	49,926.10	52,096.80	54,267.50	56,438.20	58,608.90	60,779.60	65,120.00
3	**27,310.00**	**54,620.00**		57,351.00	60,082.00	62,813.00	65,544.00	68,275.00	71,006.00	73,737.00	76,468.00	81,929.00
4	**32,913.00**	**65,826.00**		69,117.30	72,408.60	75,699.90	78,991.20	82,282.50	85,573.80	88,865.10	92,156.40	98,738.00
5	**38,516.00**	**77,032.00**		80,883.60	84,735.20	88,586.80	92,438.40	96,290.00	100,141.60	103,993.20	107,844.80	115,547.00
6	**44,119.00**	**88,238.00**		92,649.90	97,061.80	101,473.70	105,885.60	110,297.50	114,709.40	119,121.30	123,533.20	132,356.00
7	**49,721.00**	**99,442.00**		104,414.10	109,386.20	114,358.30	119,330.40	124,302.50	129,274.60	134,246.70	139,218.80	149,162.00
8	**55,324.00**	**110,648.00**		116,180.40	121,712.80	127,245.20	132,777.60	138,310.00	143,842.40	149,374.80	154,907.20	165,971.00

* Income eligibility levels for children and pregnant women are higher
Effective 7/1/14

UNIVERSITY of MARYLAND
REHABILITATION &
ORTHOPAEDIC INSTITUTE

MARYLAND HOSPITAL PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy

University of Maryland Rehabilitation and Orthopaedic Institute provides healthcare services to those in need regardless of an individual's ability to pay. Care may be provided without charge, or at a reduced charge to those who do not have insurance, Medicare/Medical Assistance coverage, and are without the means to pay. Eligibility to receive care without charge, at a reduced charge, or to pay for their care over time is determined on a case by case basis. If you are unable to pay for medical care, you may qualify for Free or Reduced Cost Medically Necessary Care if you have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability.

University of Maryland Rehabilitation and Orthopaedic Institute meets or exceeds the legal requirements by providing financial assistance to those individuals in households below 200% of the federal poverty level and reduced cost-care up to 300% of the federal poverty level.

Patients' Rights

University of Maryland Rehabilitation and Orthopaedic Institute will work with their uninsured patients to gain an understanding of each patient's financial resources.

- They will provide assistance with enrollment in publicly-funded entitlement programs (e.g. Medical Assistance) or other considerations of funding that may be available from other charitable organizations.
- If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.
- If you believe you have wrongfully referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

Patients' Obligations

University of Maryland Rehabilitation and Orthopaedic Institute believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

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

Contacts:

Call 410-821-4140 or toll free 1-877-632-4909 with questions concerning:

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

For information about Maryland Medical Assistance

Contact your local department of Social Services
1-800-332-6347 TTY 1-800-925-4434
Or visit: www.dhr.state.md.us

Physician charges are not included in hospitals bills and are billed separately

UNIVERSITY of MARYLAND
REHABILITATION &
ORTHOPAEDIC INSTITUTE

HOJA DE INFORMACIÓN PARA EL PACIENTE DE MARYLAND HOSPITAL

Política de asistencia financiera del hospital
El Instituto de Rehabilitación y Ortopedia de University of Maryland proporciona servicios de cuidado de la salud a aquellos que lo necesitan independientemente de la capacidad de pago de la persona. Se puede proporcionar cuidado sin cargo o a un cargo reducido a aquellos que no cuenten con seguro, cobertura de Asistencia médica/Medicare y no cuenten con los medios para pagar. La elegibilidad para recibir cuidado sin cargo, a un cargo reducido o pagar por su cuidado con el tiempo se determina dependiendo del caso. Si no puede pagar por el cuidado de la salud, puede calificar por Cuidado médicamente necesario a costo reducido o gratuito si no tiene opciones de seguro o fuentes de pago incluso Asistencia médica, litigación o responsabilidad de terceros.

El Instituto de Rehabilitación y Ortopedia de University of Maryland cumple o supera los requisitos legales al proporcionar asistencia financiera a aquellas personas en hogares por debajo del 200% del nivel federal de pobreza y de cuidado a costo reducido a 300% del nivel federal de pobreza.

Derechos del paciente
El Instituto de Rehabilitación y Ortopedia de University of Maryland trabajará con sus pacientes no asegurados para comprender los recursos financieros de cada paciente.

- Proporcionarán asistencia con la inscripción en los programas de derechos financiados de forma publicitaria (por ejemplo, Asistencia médica) u otras consideraciones de financiamiento que pueden estar disponibles de otras organizaciones caritativas.
- Si no califica para la Asistencia médica o asistencia financiera, puede ser elegible para un plan de pago extendido para sus facturas médicas de hospital.
- Si cree que se le ha referido de forma incorrecta a una agencia de cobro, tiene el derecho de comunicarse con el hospital para solicitar asistencia. (Vea la Información de contacto a continuación).

Obligaciones del paciente
El Instituto de Rehabilitación y Ortopedia de University of Maryland cree que sus pacientes tienen responsabilidades personales relacionadas con los aspectos financieros de sus necesidades de cuidado de la salud. Se espera que nuestros pacientes:

- Cooperen todo el tiempo al proporcionar información financiera y de seguro completa y precisa.
- Proporcionen datos solicitados para completar las solicitudes de Asistencia médica en una manera oportuna.
- Sigan cumpliendo con los términos del plan de pago establecidos.
- Nos notifiquen de una manera oportuna al número que se indica a continuación sobre cualquier cambio en las circunstancias.

Contactos:
Llame al 410-821-4140 o llame sin costo al 1-877-632-4909 con preguntas relacionadas con:

- Su factura del hospital
- Sus derechos y obligaciones con relación a su factura del hospital
- Cómo solicitar Asistencia médica de Maryland
- Cómo solicitar atención de costo reducida o gratis

Para obtener información sobre la Asistencia médica de Maryland

Comuníquese con su departamento local de Servicios sociales
1-800-332-6347 TTY 1-800-925-4434
O visite: www.dhr.state.md.us

Los cargos médicos no se incluyen en las facturas del hospital y se facturan por separado

Mission
University of Maryland Rehabilitation & Orthopaedic Institute delivers innovative, high-quality, and cost effective rehabilitation and surgical services to the community and region. We provide:

- An interdisciplinary continuum of care including inpatient and outpatient surgery, rehabilitation and additional services as required.
- A proactive environment for patient safety, implementing improvements as patient safety risks are identified.
- A site for public and professional health care education and research.

Vision
UM Rehabilitation & Orthopaedic Institute's vision is to become widely recognized as an integral component of the University of Maryland Medical System in its role as:

- A regional hospital specializing in the provision of acute, chronic and outpatient rehabilitation services;
- A regional hospital specializing in the provision of a full array of orthopaedic services for adults and children;
- A high quality provider of specialized medical/surgical programs.

Values
Quality and Compassionate Care
Excellence in Service
Respect for the Individual
Patient Safety
Quality in Research and Education
Cost Effectiveness