HSCRC Community Benefit Reporting Narrative

I. General Hospital Demographics and Characteristics:

1. Table I: Primary Service Area Description:

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
115	7610 (Includes Adult and Newborn admissions)	20602 20646 20603 20601 20640 20695	Medstar Southern Maryland Hospital Center (20602)	Charles County: 7.4%*	Charles County: 15.4%**

**US Census Bureau, 2009 – 2013 American Community Survey 5-year Estimates*
*** Fiscal Year 2014 Maryland Medicaid e-Health Statistics*

2. Describe the community the hospital serves:

a. Description of Community Benefit Service Area:

The Community Benefit Service Area for the University of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the six zip codes identified as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county.

<u>Geography</u>

Charles County is located 23 miles south of Washington, D.C. It is one of five Maryland counties, which are part of the Washington, DC-MD-VA metropolitan area. At 458 square miles, Charles County is the eighth largest of Maryland's twenty-four counties and accounts for about 5 percent of Maryland's total landmass. The northern part of the county is the "development district" where commercial, residential, and business growth is focused. The major communities of Charles County are La Plata (the county seat), Port Tobacco, Indian Head, and St Charles, and the main commercial cluster of Hughesville-Waldorf-White Plains. Approximately 60 percent of the county's residents live in the greater Waldorf-La Plata area. By contrast, the southern (Cobb Neck area) and western (Nanjemoy, Indian Head, Marbury) areas of the region still remain very rural with smaller populations.

Population

Charles County has experienced rapid growth since 1970, expanding its population from 47,678 in 1970 to 120,546 in the 2000 census and 146,551 in the 2010 census. The current 2014 Census Bureau estimates the population at 154,747 for a 5.6% increase in four years. The magnitude of growth can be seen in the changes in population density. The 1990 census showed that there were 219.4 individuals per square mile, which increased to 261.5 individuals per square mile by 2000, an increase of 19.2%, and to 320.2 individuals per square mile by 2010, an increase of 22.5%.

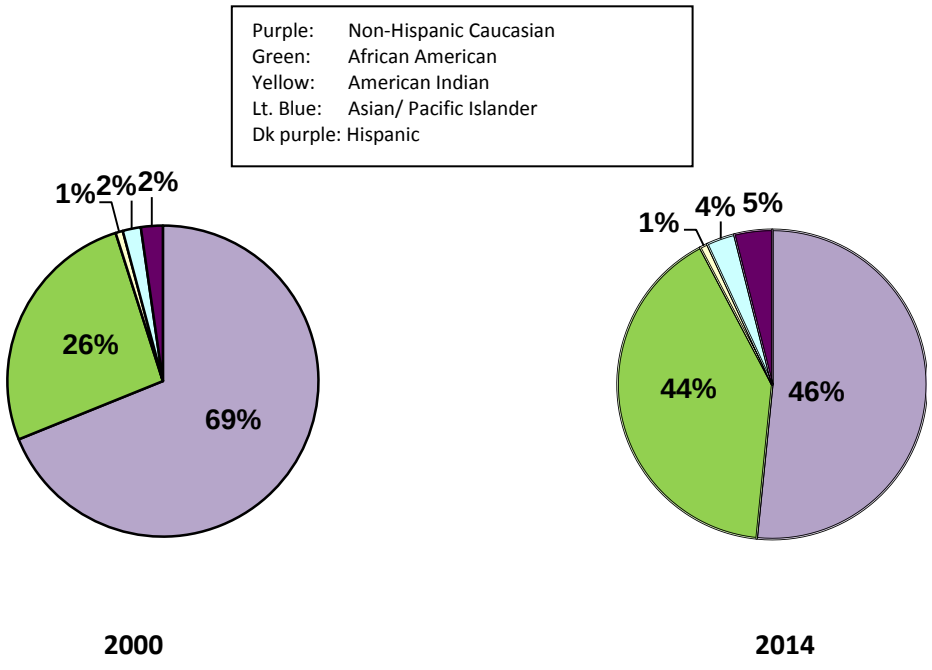
Transportation

The percent change in the population growth for Charles County has been slightly greater than the change seen in the Maryland population growth. This growth has created transportation issues for the County in particular for the "development district" in the northern part of the county where many residents commute to Washington D.C. to work. The average work commute time for a Charles County resident is 42.8 minutes which is higher than the Maryland average of 32.0 minutes. Public transportation consists of commuter buses for out-of-county travel and the county-run Van Go bus service for in-county transportation.

Diversity

As the population of the county changes, the diversity of the county also increases. The African American population has experienced the greatest increase. In 2000, African Americans made up 26% of the total Charles County population; by 2014, they comprise 43.8% of the total county population. As of 2014, minorities make up roughly 54% of the Charles County population. The Hispanic community has also seen increases over the past few years. They now comprise 5.3% of the total county population. This is the one of the highest percentages among the 24 Maryland jurisdictions. Charles County also has one of the largest American Indian/Native American populations in the state of Maryland at 0.8% of the total county population.

Race of Charles County Population, 2000 versus 2014



Source: US Census Bureau; Charles County Quick Facts; 2014

The 2014 Charles County gender breakdown is approximately 50/50. Males make up 48.2% of the population, and females make up 51.8% of the county population.

Economy

Employment and economic indicators for the county are fairly strong. The 2009-2013 US Census American Community Survey estimates found that 71.2% of the Charles County population is currently in the labor work force. The 2009-2013 5-year estimate for Charles County found that approximately 7.0% of Charles County individuals are living below the poverty level; however, this is lower than the Maryland rate of 9.8%. The Charles County median household income was $93,160, an increase of $4,335 over the 2010 estimates and well above the Maryland median household income of $73,538. The diversity of the county is also represented in the business community with 29.3% of all Charles County businesses being Black-owned firms. This is higher than the State of Maryland at 19.3%.

Education

Charles County has a larger percentage of high school graduates than Maryland (91.2% vs. 88.7%); however, Charles County has a smaller percentage than Maryland of individuals with a bachelor's degree or higher (26.7% vs. 36.8%).

Housing

There is a high level of home ownership in Charles County (79.4%), however, this is slightly down from the 2010 level (81.8%). The median value of a housing unit in Charles County is higher than the Maryland average ($297,900 vs. $292,700). Home values across Maryland have decreased and Charles County showed a similar downward trend. The average household size in Charles County is 2.88 persons.

Source: 2009-2013 US Census Bureau's American Community Survey 5 year estimates

Life Expectancy

The life expectancy for a Charles County resident, as calculated for 2013, was 78.7 years. This is slightly below the state average life expectancy of 79.6 years.

Source: 2013 Maryland Vital Statistics Report

Births

There were 1,863 births in Charles County in 2014. Charles County represents 44% of the births in Southern Maryland and 2.5% of the total births in Maryland for 2014.

Minorities made up just over half of the babies born in Charles County in 2014 (50.3%) which is in line with the composition of the county.

Source: 2014 Maryland Preliminary Vital Statistics Report

Health Disparities

Health topics where health disparities are seen for the minority population in Charles County:

Health Topic	Indicator	Rate	Source
Heart Disease Prevalence and Mortality	Rate of ED visits for hypertension per 100,000 population Age-adjusted heart disease mortality rate	White: 109.0 Black: 349.2 White: 182.7 Black: 196.9	Maryland SHIP (Prevalence: HSCRC 2014 and Mortality: 2011-2013 Maryland Vital Statistics Report)
Colon and Rectal Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 38.8 Black: 40.6 White: 16.6 Black: 30.5	2014 Cigarette Restitution Fund Program Cancer Report (2007-2011 rates)
Breast Cancer Incidence	Incidence Rates per 100,000	White: 101.7 Black: 145.6	2014 Cigarette Restitution Fund Program Cancer Report (2007-2011 rates)
Prostate Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 129.4 Black: 223.6 White: 18.4 Black: 47.8	2014 Cigarette Restitution Fund Program Cancer Report (2007-2011 rates)
Diabetes Prevalence	Unadjusted Diabetes ED Visit Rates by Black or White Race	White: 71.5 Black: 201.9	Maryland 2014 HSCRC per SHIP site
Obesity	Unadjusted % Adults at Healthy Weight	White: 25.8 Black: 30.4	Maryland 2013 BRFSS per SHIP site
STD	Rate of Chlamydia infection for all ages per 100,000 (all ages)	White-170.0 Black-842.8 American Indian: 348.8 Asian/PI: 213.4 Hispanic: 190.8	Maryland STD Prevention Program Level data 2012
Asthma	Rate of ED visits for asthma per 10,000 population	White-21.4 Black-62.5	HSCRC 2014 Per SHIP Site
Infant Mortality	Infant Mortality Rate per 1,000 births	White/Not Hispanic-Rate not calculated due to less than 5 deaths. Black-8.4	2014 Maryland Infant Mortality Report, Vital Statistics Admin.

1. Fiscal Year 2014 Maryland Medicaid Enrollment by County. Maryland Department of Health and Mental Hygiene and the Hilltop Institute. Available at http://www.chpdm-ehealth.org/index.htm.

2. 2014 Charles County Current Population Survey Data. United States Census Bureau. Available at: www.census.gov.

2. 2013 Maryland Vital Statistics Report and 2014 Maryland Preliminary Vital Statistics Report. Charles County Demographic and Population Data. Maryland Department of Health and Mental Hygiene. Available at www.vsa.maryland.gov.

3. 2009-2013 US Census Bureau, American Community Survey 5 year estimates, Charles County and Maryland. Available at www.census.gov.

4. Maryland State Health Improvement Process Measures. Accessed on October 2015. Available at: http://www.dhmh.maryland.gov/ship/SitePages/Home.aspx.

5. 2014 Maryland Cigarette Restitution Fund Program's Cancer Report. Maryland Department of Health and Mental Hygiene. Available at: http://phpa.dhmh.maryland.gov/cancer/SiteAssets/SitePages/surv_data-reports/2014%20Cancer%20Data%20Final.pdf.

6. 2012 Chlamydia Infection Rates by Race. Maryland Department of Health and Mental Hygiene. Center for Sexually Transmitted Infection Prevention.

7. 2014 Maryland Infant Mortality Report. Maryland Vital Statistics Administration. Available at: http://www.dhmh.maryland.gov/vsa/AnalyticsReports/2014.pdf.

b. Table II: Service Area Demographic Characteristics and Social Determinants:

Characteristic or determinant	Data	Source
Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, ethnicity, and average age)	**Population**: 154,747 **Sex**: • Female 51.8% • Male: 48.2% **Race and Ethnicity:** • White 48.2% • Black 43.8% • American Indian and Alaska native 0.8% • Asian alone 3.3% • Native Hawaiian and Other Pacific Islanders 0.1% • Person reporting 2 or more races 3.8% • Hispanic or Latino 5.3% • White not Hispanic 45.7% **Age:** • Persons under 5 years 6.0% • Persons under 18 years 24.9% • Persons 65 years and over 11.0%	2014 US Census *Quick Facts*

Median Household Income within the CBSA	$93,160	2009-2013 US Census *American Community Survey5 year estimate*
Percentage of households with incomes below the federal poverty guidelines within the CBSA	4.8%	2009-2013 US Census American Community Survey 5 year estimate
Estimate the percentage of uninsured people by County within the CBSA	7.4%	2009-2013 American Community Survey 5-Year Estimate
Percentage of Medicaid recipients by County within the CBSA.	15.4%	Fiscal Year 2014 Maryland Medicaid e-Health Statistics: Medicaid Enrollment Rates
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	The life expectancy from birth for a Charles County resident as calculated for 2011-2013 was 78.7 years. This is slightly below the state average life expectancy of 79.6 years. White: 78.7 Black: 78.2	2013 Maryland Vital Statistics Report. Charles County Demographic and Population Data. Maryland DHMH
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Age adjusted all-cause death rate for Charles County for 2013 is 610.3 per 100,000 population. White: 788.3 Black: 434.1 Asian/PI: 390.5 Hispanic: 104.5	2013 Charles Co. Death data, 2013 Maryland VSA Report
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)	**Access to healthy food**: • % of census tracts with food deserts: 0 **Transportation:** • Mean travel time to work: 42.8 min **Environmental Factors:** • # of days Air Quality Index exceeds 100: 1.7 • % of children tested who have blood lead	USDA 2000, Maryland SHIP 2009-2013 US Census ACS Maryland SHIP

	levels ≥ 10 mg/dl: 20% **Housing:** • Home ownership: 79.4% • Renter occupied housing: 20.6%	2009-2013 US Census Data, *American Community Survey* 5 year estimates
Available detail on race, ethnicity, and language within CBSA	• Language other than English spoken at home: 7.2% • See race and ethnicity information in "Community Benefit Service Area Target Population"	2009-2013 US Census , *American Community Survey* 5 year estimate

Access to Care	• 81.5% of Charles County residents travel outside of the county for medical care at some point.
	• % Mothers who received prenatal care 1st trimester ; 64.9%
	  ○ White/NH: 73.3%
	  ○ Black: 59.2%
	  ○ Hispanic: 55.9%
	  ○ Asian/PI: 66.7%
	• Infant Mortality Rate: 5.9 per 1000 live births
	  ○ White/NH: Not calculated due to small case count
	  ○ Black: 8.4
	• Number of federally designated medically underserved areas in Charles County: 6
	  ○ Brandywine
	  ○ Allens Fresh
	  ○ Thompkinsville
	  ○ Hughesville
	  ○ Marbury
	  ○ Nanjemoy
	• Number of physician shortage specialties in Southern Maryland: 28
	
	• Physician-to-population ratios in Southern Maryland below the HRSA benchmark for all types of physicians
		2011 Charles County Health Needs Assessment
		
		Maryland SHIP;
		
		2013 Maryland Infant Mortality Report
		
		2014 HPSA Designation
		
		2007 Maryland Physician Workforce Study
		
		2011 MD Workforce Study Health Resources and Services Administration Report

Education	• 91.2% persons 25+ high school graduates • 26.7% persons 25+ bachelor's degree or higher	2009-2013 US Census Bureau's American Community Survey 5 year estimates

II. Community Health Needs Assessment (CHNA)

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. 06/30/15

***NOTE**: This Community Benefit Report is based on the FY 12 CHNA and is the third year of the Implementation Plan. The FY 15 CHNA was completed 06/30/15 and FY 16 completes the first year of the Implementation Plan which will be reported in the FY 16 Community Benefit Report.*

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).
FY 12 CHNA: http://www.charlesregional.org/siteassets/pdfs/healthNeedsAssessment.pdf
FY 15 CHNA: http://www.charlesregional.org/siteassets/pdfs/healthNeedsAssessment2015.pdf

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

_X_Yes Enter date approved by governing body here: FY 12: 11/26/2012
FY 15: 05/26/2015

___No

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

FY 13-15 Health Improvement Plan:
http://www.charlesregional.org/siteassets/pdfs/healthImplementationPlan.pdf

FY 16-18 Health Improvement Plan:
http://www.charlesregional.org/siteassets/pdfs/healthImprovementPlanFY2016-2018.pdf

III. Community Benefit Administration

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

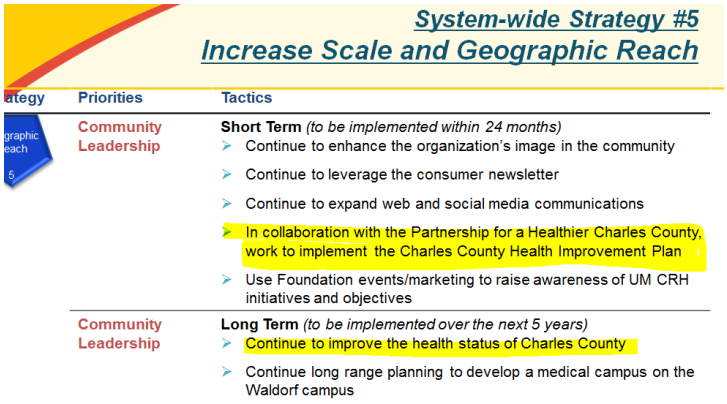
a. Is Community Benefits planning part of your hospital's strategic plan?

__x_Yes

____No

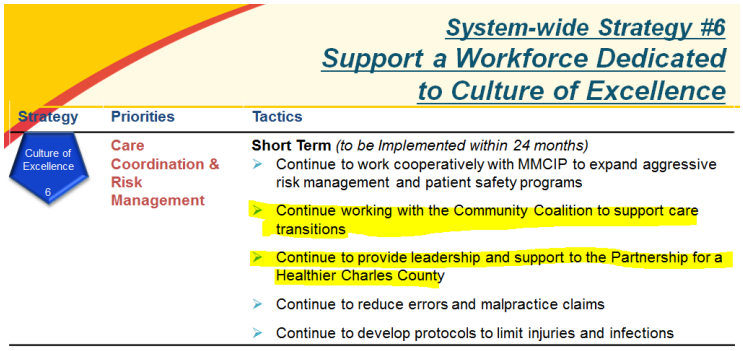
If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

The Needs Assessment and Health Improvement Plan are included in the overall UM CRMC Strategic Plan which is approved by the Board and directed by Executive Management (Senior Leadership) and implemented by the Community Benefit operations staff through the LHIC.



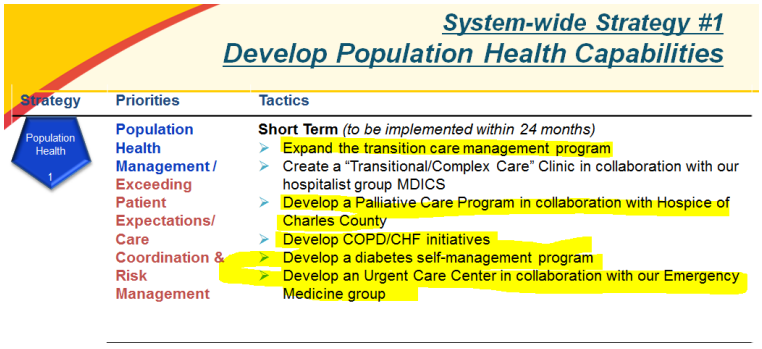
System-wide Strategy #5
Increase Scale and Geographic Reach

ategy	Priorities	Tactics
graphic each 5	Community Leadership	**Short Term** *(to be implemented within 24 months)* ➢ Continue to enhance the organization's image in the community ➢ Continue to leverage the consumer newsletter ➢ Continue to expand web and social media communications ➢ In collaboration with the Partnership for a Healthier Charles County, work to implement the Charles County Health Improvement Plan ➢ Use Foundation events/marketing to raise awareness of UM CRH initiatives and objectives
	Community Leadership	**Long Term** *(to be implemented over the next 5 years)* ➢ Continue to improve the health status of Charles County ➢ Continue long range planning to develop a medical campus on the Waldorf campus



System-wide Strategy #6
Support a Workforce Dedicated to Culture of Excellence

Strategy	Priorities	Tactics
Culture of Excellence 6	Care Coordination & Risk Management	**Short Term** *(to be Implemented within 24 months)* ➢ Continue to work cooperatively with MMCIP to expand aggressive risk management and patient safety programs ➢ Continue working with the Community Coalition to support care transitions ➢ Continue to provide leadership and support to the Partnership for a Healthier Charles County ➢ Continue to reduce errors and malpractice claims ➢ Continue to develop protocols to limit injuries and infections



System-wide Strategy #1
Develop Population Health Capabilities

Strategy	Priorities	Tactics
Population Health 1	Population Health Management / Exceeding Patient Expectations/ Care Coordination & Risk Management	**Short Term** *(to be implemented within 24 months)* ➢ Expand the transition care management program ➢ Create a "Transitional/Complex Care" Clinic in collaboration with our hospitalist group MDICS ➢ Develop a Palliative Care Program in collaboration with Hospice of Charles County ➢ Develop COPD/CHF initiatives ➢ Develop a diabetes self-management program ➢ Develop an Urgent Care Center in collaboration with our Emergency Medicine group

Source: UM CRMC Three-year Strategic Plan Document

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: Presents plan to Board of Directors; Ensures plan is included in the overall CRMC Strategic Plan
2. _X__CFO: Participates as a member of the Community Benefit Operations Team; Presents Community Benefit Report to Finance Committee of the Board; Identifies Finance Staff to report financial data; Internally audits report
3. _X_Other (please specify)Board of Directors (Governance), Executive Management Group (Resources and direction)

Describe the role of Senior Leadership:
*The UM CRMC Executive Management Group (EMG) consists of the CEO, CFO, CNO, CMO, VP of Planning, VP of Ancillary Services, VP of Human Resources, Site Director for IT, and Community Development and Planning and the Foundation. This group develops the community benefit strategic plan as part of the annual Strategic Plan planning process. Once the Board has approved the plan, EMG ensures adequate human and capital resources are dedicated to the implementation of the plan. Plan progress and outcomes are reported to EMG. This senior leadership group includes oversight of all clinical and non-clinical areas such as Nursing, Medical Staff, Case Management, and Ancillary Services. Clinical Leadership ensures participation and resources for data analysis and plan implementation.

ii. Clinical Leadership

1. _x__Physician Chief Medical Officer
2. _x__Nurse Chief Nursing Officer
3. _x__Social Worker CFO (Oversees Case Management)
4. ___ Other (please specify)

Describe the role of Clinical Leadership
*(See description of Senior Leadership Role above which includes Clinical Leadership)

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

1. _x__Individual (please specify FTE) 1.5 Director, Specialist
2. _x__Committee (please list members)
   Community Benefits Operations Team
   a. CFO, Erik Boas
      i. Oversees all HSCRC and 990 Reporting; Internally audits CB reports; Allocates resources for CB operations
   b. Director, Community Development and Planning, Joyce Riggs

i. Administers CB reporting operations including plan implementation, collaborates with strategic community partners; Oversees data collection and reporting; Provides management for LHIC

c. Decision Support Analysts (2) Edward Appaih, Tiffany Brickhouse
   i. Inputs financial data into CB data collection tool for reporting; assists with internal auditing

d. Revenue Integrity Analyst, Ruth Case
   i. Inputs salary data into CB data collection tool.

e. Community Outreach Specialist, Amy Zimmerman
   i. Implements community benefit qualifying activities and community outreach programs; Trains departmental CB reporters and manages data collection tool

f. Epidemiologist, Amber Starn, MPH
   i. Provides data and reporting for CB planning; Monitors and reports outcomes of CB Strategic Plan.

g. _X__Department (please list staff)
   i. Community Benefit Reporters: Reporters from each department in the hospital who enter community benefit qualifying occurrences
   ii. _X__Task Force (please list members)
   Local Health Improvement Coalition Subcommittee Chairs
      1. Behavioral Health Team: Karen Black, Director, Core Services Agency
      2. Access to Care Team: Chrissie Mulcahey, Dir., Health Partners Clinic
      3. Chronic Disease Management and Prevention Team: Amy Zimmerman, UM CRMC Community Outreach and Linda Thomas, Dir., Disability Services, CC Dept of Health
      4. Cancer Team: Mary Beth Klick, CC Dept of Health, Tobacco Prevention Coordinator

h. ___Other (please describe)

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

Spreadsheet	__x___yes	_____no
Narrative	__x___yes	_____no

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

The CFO reviews the report (narrative and spreadsheet) and presents the final report to the Finance Committee of the Board of Directors for approval.

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

The Finance Committee of the Board conducts the review and approval of the report and a summary of key points are presented to the full Board.

If no, please explain why.

IV. Community Benefit External Collaboration

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

a) Does the hospital organization engage in external collaboration with the following partners:

_____ Other hospital organizations
__x___ Local Health Department
__x___ Local health improvement coalitions (LHICs)
__x___ Schools
__x___ Behavioral health organizations
__x___ Faith based community organizations
__x___ 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
Charles County Dept. of Health	Dianna Abney, MD	Charles County Health Officer	Executive Committee of LHIC
Charles County Public Schools	Dr. Kim Hill	Superintendent, Charles County Public Schools	Executive Committee of LHIC
College of Southern Maryland	Dr. Brad Gottfried	President	Executive Committee of LHIC
Charles County Dept. of	William Leeble	Public Information	Steering

Health		Officer	Committee of LHIC
Charles County Public Schools	Jennifer Conte	Coordinator of Student Intervention Programs	Steering Committee of LHIC
College of Southern Maryland	Linda Smith	Project Coordinator, Safe Communities	Steering Committee of LHIC
Health Partners Clinic	Chrissie Mulcahey	Director	Chair, Access to Care Subcommittee
Charles County Dept. of Health	Mary Beth Klick	Tobacco Prevention Coordinator	Chair, Cancer Team
Charles County Core Services	Karen Black	Director	Chair, Behavioral Health Subcommittee Chair
Charles County Dept. of Health	Linda Thomas	Director	Co-chair, Chronic Disease Prevention and Management Team

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?

__x___yes _____no

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

___x__yes _____no

V. Hospital Community Benefit and Initiatives

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

1. See attached Table III for hospital initiatives.

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.

All the 11 priorities outlined in the CHNA were being addressed by UM CRMC either directly (i.e., OB Clinic, Physician Recruitment) or through partnerships with other organizations (i.e., Childhood

Obesity Program, Fetal Infant Mortality, Prostate Cancer) or through the LHIC, Partnerships for a Healthier Charles County (PHCC) which is led and primarily financed by UM CRMC. Where a need is appropriately addressed by another community entity, UM CRMC provides leadership and/or funding through the Charles County Health Improvement Plan and the local health coalition (PHCC) to communicate initiatives, provide financial support and/or assistance or data when needed and review results (i.e., Substance Abuse, Mental Health). Each LHIC team has developed and implemented strategies specific to their identified priorities and reports back quarterly to the LHIC Steering Committee. The hospital provides support and oversight to the teams as a critical member of the LHIC Steering Committee. The Hospital's Director of Community Development and Planning is the official co-chair to the county LHIC.

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)

   Several CRMC community benefit initiatives work toward the population health goals. In fact, where possible, population health goals are used as outcomes for the community benefit initiatives. For example, the Community Coalition/Cross Continuum of Care Team is an initiative which involves active participation of approximately 30 local health and social service organization which works to improve patient care transitions and reduce readmissions. Other initiatives include opening an Urgent Care Center to increase access to lower acuity health care setting, hiring a transition case manager to assure compliance post discharge and a ED Social Workers to facilitate enrollment in Medicaid and other government programs as well as other community agencies, planning for a Palliative Care program and standing up an inpatient wound healing program.

   Charles County has a long history of strong collaboration. The hospital, in partnership with the health department and the local health improvement coalition, conducted one county health needs assessment and developed one county health improvement plan. The county's short, intermediate, and long term health objectives were developed based on the established measures and objectives of the state health improvement process (SHIP).

   All community benefits activities and state health improvement process activities for Charles County are tracked by the county epidemiologist, so reports are consistent. The team leaders and participating agencies of the LHIC report each quarter to the epidemiologist. The quarterly reports submitted to SHIP staff are used to complete the hospital's fiscal year community benefits report.

   Charles County has received funding from the Maryland Community Health Resource Commission. Funding has been given to the Department of Health's Oral Health Program, the Partnerships for a Healthier Charles County (LHIC), and Health Partners Inc. All of these organizations developed programs and services aimed at addressing the priorities identified through the CHNA Process. All of the activities funded were contained in the Charles County Health Improvement Plan. The hospital was happy to lend support to all of these funded projects.

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.

2011 Maryland Health Care Workforce Study:

2011 Maryland Health Care Commission (MHCC)'s Physician Workforce Study highlighted the physician workforce in Maryland. This study looked at the HRSA Area Health Resource File for 2009 and 2010 to determine the supply of physicians in Maryland and its regions. Charles County has been included in the Southern Maryland region with Calvert and St Mary's Counties.

Looking at the table below, Southern Maryland has physician to population ratios significantly below the HRSA benchmark for all types of physicians.

Table 10: Maryland Supply by Type of Physician and Region, 2009/2010

	Total	Primary Care	Medical Specialties	Surgical Specialties	All Other
Maryland physicians per 1000, residents excluded, with all adjustments					
Baltimore Metro	2.85	0.86	0.48	0.61	0.90
Eastern Shore	1.86	0.62	0.27	0.39	0.57
National Capital	2.25	0.72	0.41	0.48	0.64
Western	2.17	0.73	0.39	0.42	0.63
Southern	1.34	0.53	0.25	0.26	0.30
Total	2.44	0.77	0.42	0.52	0.74
Memo: HRSA baseline, interns excluded, with all adjustments	1.93	0.69	0.27	0.43	0.53
Percent difference from HRSA baseline					
Baltimore Metro	48%	24%	76%	41%	70%
Eastern Shore	-4%	-10%	0%	-11%	8%
National Capital	17%	4%	49%	11%	21%
Western	12%	5%	41%	-4%	19%
Southern	-31%	-24%	-8%	-40%	-43%
Total	27%	11%	54%	19%	39%

Source: Analysis of Maryland 2009/2010 license renewal database, calculations from HRSA 2008, population counts from U.S. Bureau of the Census

The Maryland physician supply ratios were adjusted to account for variation in average patient-care hours. Even with the adjustment, Southern Maryland continued to see low physician to population ratios.

Southern Maryland region had a 26% total physician deficiency versus the HRSA standard. This was the only region in Maryland to have this deficiency. The Southern Maryland region also had physician supply deficiencies for primary care (19%), medical specialties (7%), surgical specialties (34%), and all other physicians (39%). Four out of the five physician supply deficiencies are greater than 10% below the HRSA standard.

Maryland Physician Supply Versus HRSA Standard, All Adjustments					
Region	**Total**	**Primary Care**	**Medical Specialties**	**Surgical Specialties**	**All Other**
Entire State	27%	11%	54%	19%	39%
Baltimore Metro	44%	21%	69%	40%	66%
Eastern Shore	4%	0%	8%	-2%	13%
National Capital	18%	4%	56%	8%	23%
Western	20%	12%	48%	3%	29%
Southern	-26%	-19%	-7%	-34%	-39%
Key: Green = >10%, Yellow = -10% to 10%, Red = <-10%					

Note: Positive percentage indicates supply in excess of HRSA Standard, and negative percent indicates a supply deficit compared to the HRSA Standard. Southern: Charles, Calvert, and St Mary's Counties

Study implications for Southern Maryland from the 2011 Maryland Physician Workforce Study include:

Residents are likely to travel out of area for care:

- Physicians in Southern Maryland provide about 67% of Medicare beneficiaries total Medicare physician care. Residents receive 14% of physician care in Mont/PG counties and 12% in out-of-state (probably DC)

Table 14: Intrastate Travel for Care, Medicare Fee-for-Service Part B Beneficiaries, 2009								
Maryland Residents, Physician Services Spending Per Capita								
	Physician Location							
Beneficiary Residence	Baltimore Metro	Eastern Shore	National Capital	Western	Southern	Out of state	Total	% of spending in own region
Baltimore Metro	$ 2,503	$ 12	$ 56	$ 23	$ 7	$ 74	$ 2,675	94%
Eastern Shore	$ 299	$ 1,712	$ 26	$ 6	$ 2	$ 318	$ 2,362	72%
National Capital	$ 159	$ 4	$ 2,335	$ 15	$ 73	$ 595	$ 3,181	73%
Western	$ 121	$ 8	$ 101	$ 1,834	$ 3	$ 224	$ 2,290	80%
Southern	$ 182	$ 4	$ 378	$ 6	$ 1,806	$ 316	$ 2,692	67%
Source: Analysis of Medicare 5% sample limited data set standard analytic files and denominator file, 2009								

- Southern Maryland physicians are as likely as physicians overall to participate in Medicaid/Medicare and to accept new patients.

Table 13: Acceptance of Medicaid and Medicare Patients, by Region				
	Medicaid		Medicare	
Region	% of practices accepting Medicaid	Of those, % accepting new Medicaid patients	% of practices accepting Medicare	Of those, % accepting new Medicare
Percent of physicians				
Baltimore Metro	80%	88%	85%	94%
Eastern Shore	89%	90%	91%	94%
National Capital	61%	85%	79%	93%
Western	80%	85%	86%	91%
Southern	86%	86%	89%	93%
Total	75%	87%	84%	94%
Percent difference from state average				
Baltimore Metro	6%	1%	2%	1%
Eastern Shore	18%	4%	8%	1%
National Capital	-19%	-2%	-6%	-1%
Western	6%	-3%	2%	-3%
Southern	15%	-1%	6%	0%
Total	0%	0%	0%	0%
Source: Maryland license renewal survey, 2009/2010				

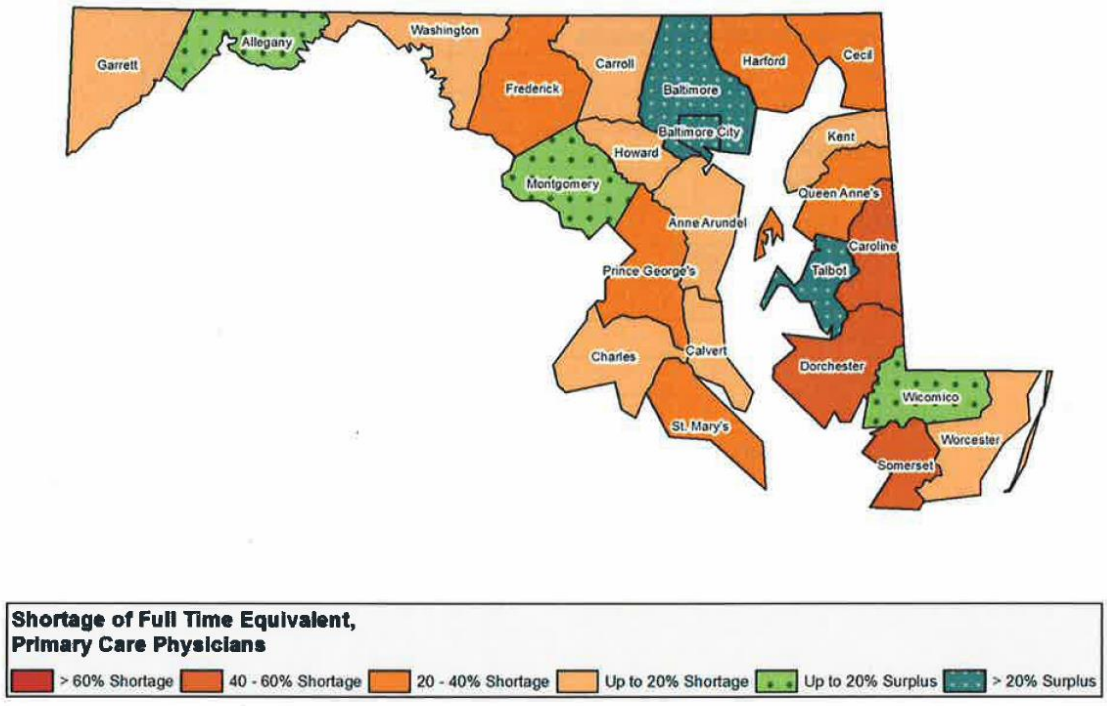
***Maryland Health Workforce Study Phase 2 Report, January 2014*:**

In January 2014, the Maryland Health Care Commission (MHCC) released a second report detailing Phase 2 of the Maryland Health Workforce Study. This study assessed health workforce distribution and the adequacy of supply. Using funding from the Robert Wood Johnson Foundation, the MHCC was able to study the Maryland healthcare workforce on the state and jurisdictional level. Phase II presents estimates of current supply and demand for health professions designated by MHCC as high priority in supporting Maryland's transition to health reform, and for which data were readily available for estimating supply and demand. These professions included primary care specialties and psychiatrists. Current supply estimates

were also presented for psychologists, social workers, counselors, physician assistants, pharmacists, registered nurses, and dentists.
Demand modeling: Estimates of the current demand for healthcare providers were developed using the IHS Healthcare Demand Micro-simulation Model. The major components of this model include: 1. A population database that contains characteristics and health risk factors for a representative sample of the population in each Maryland count; 2. Equations that relate a person's characteristics to his or her demand for healthcare services by care delivery setting; and 3. Staffing patterns that convert demand for healthcare services to demand for full time equivalent (FTE) providers.

In Charles County, the primary care FTE demand is greater than the primary care FTE supply (7.4 vs. 6.1). There is an 18% shortfall in the primary care services supply to fulfill the current demand. Charles County falls in the "Up to 20% Shortage Area" for primary care physician supply.

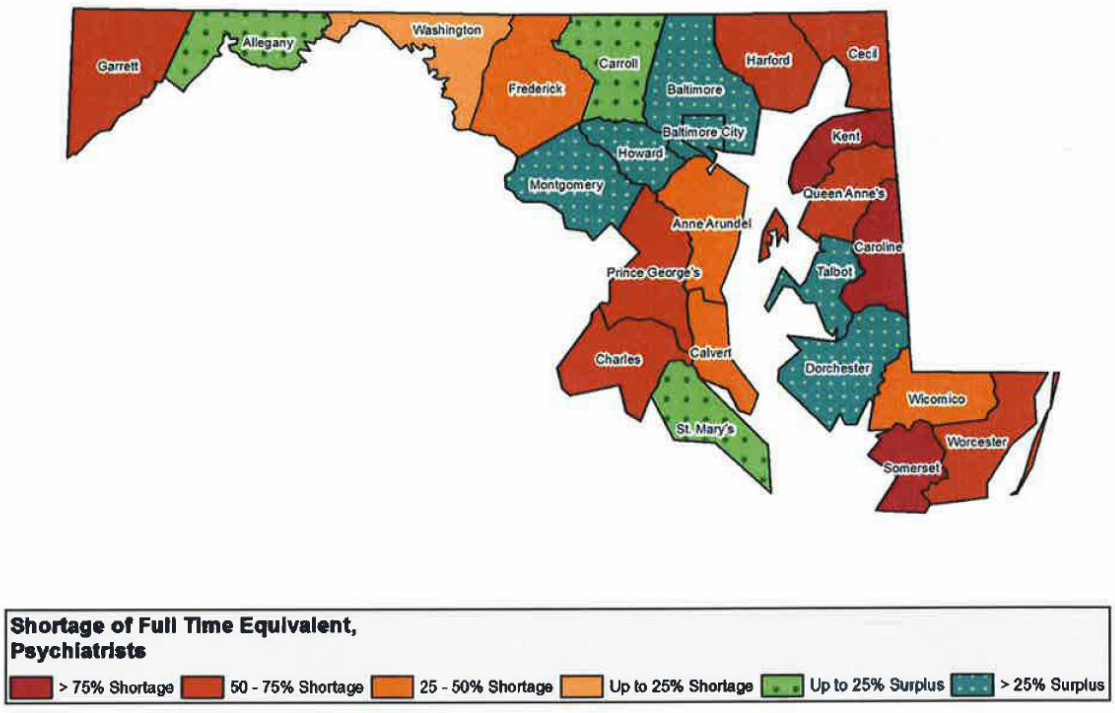
Map 1: Maryland County-Level Adequacy of FTE Primary Care Physician Supply



The FTE per 10,000 supply rates for professional counselors, social workers, and psychologists in Charles County is much lower than the rates for Maryland. The Charles County FTE rate for physician assistants is the only rate that came close to the Maryland state supply rate.

The demand for psychiatrists in Charles County is much higher than the county supply for psychiatry. Charles County has a shortage between 50-75% of full time equivalent psychiatrists.

Map 2: Maryland county-Level Adequacy of FTE Psychiatrist Supply



2011 County Physician/Nurse Specialty Data:

The US Department of Health and Human Services' Health Resources and Services Administration publishes information on the number of physicians and nurses by speciality for each state. 2011 data on the number of pediatricians, nurse practitioners, nurse midwives, general surgeons, general practitioners, OBGYN's, internal medicine physicians, and family medicine practitioners were compiled for Maryland and its jurisdictions. Specialities where Charles County is in lower half of the Maryland jurisdictions include OBGYN, nurse practitioners, and general surgeons.

***Primary Care Physicians Ratio*:**

Access to care requires not only financial coverage, but also, access to providers. While high rates of specialist physicians have been shown to be associated with higher, and perhaps unnecessary utilization, sufficient availability of primary care physicians is essential for preventive and primary care, and when needed, referrals to appropriate specialty care. Using data from the Area Health Resource File and the American Medical Association, the County Health Rankings were able to provide 2012 primary care physician ratios for all United States counties. For 2012, the Charles County primary care physician ratio was 2035:1. Primary Care Physicians (PCP) is the ratio of the population to total primary care physicians. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The 2012 Charles County PCP ratio is almost twice as high as the Maryland state ratio of 1131:1.

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.

As a result of the prevailing physician shortage (southern Maryland has the highest number of physician specialty shortages in the state); the University of Maryland Charles Regional Medical Center has an insufficient number of specialists within the medical staff. In all of these areas there are not enough physicians to care for patients including uninsured and underinsured in the hospital. Therefore, subsidies are paid to the physicians to provide on call coverage for the Emergency Department and patient care departments. For FY 2015, subsidies to physicians totaled more than $7.4 million.

Subsidized Specialty Areas:

- Anesthesiology
- Pathology
- Intensive Care
- Emergency Department
- Outpatient Practices: Surgery and OB/GYN

Non-resident house staff and hospitalist:

- Pediatric Hospitalists
- Adult Hospitalists
- OB/GYN
- Cardiology

Coverage of Emergency Call:

The following physician contracts for on-call coverage were necessary to cover emergency room call due to the physician shortage (Southern Maryland is highest in the region) in virtually all primary care and medical specialties. The entire county is a federally designated mental health professional shortage area. In the following areas, there are not enough community physicians to cover the emergency call for all patients including the uninsured and underinsured.

- Urology
- General surgery
- Orthopedics
- OB/GYN
- Neurology
- Gastroenterology
- Psychiatric Services
- ICU
- Cardiology

Physician Recruitment:

Southern Maryland had the highest percentage of physician shortages of all of the regions in Maryland (89.9%). To address the shortage, the University of Maryland Charles Regional Medical Center hired both a Chief Medical Officer and Physician Recruiter and Liaison who are working to successfully attract and retain physicians to the community. Private practice within the community is preferred, but the hospital will employ those physicians when necessary. The recruitment strategy plan was to increase primary care and specialty providers by at least seven (7) by FY 2015. The result was a recruitment of 12 new providers during that period.

The costs for recruiting physicians to meet the community need for FY 2015 was $52,812.

Table III A. Initiative: **Cancer**

a.) Identified Need	Cancer is the second leading cause of death in Charles County. It accounts for nearly one-quarter of all county deaths each year. CC prostate cancer incidence is higher than the state average and mortality for blacks is higher than the state average. The incidence of breast cancer in Charles County is higher in blacks than whites (118.1 per 100,000 to 104.8). Lung cancer mortality is the highest cancer site mortality for both Charles County men and women. A reduction in age-adjusted cancer mortality has been identified by the Maryland State Health Improvement Process measures. Yes, this was identified through the CHNA Process.
b.) Name of Hospital Initiative	Breast Cancer Luncheon, Paint the Mall Pink, and Paint the Park Pink: Increase the awareness of early detection to help reduce the mortality rate for breast cancer in the community. Educate women of all ages about the importance of breast self-exams and routine mammograms. Lung Cancer Prevention: The PHCC Cancer Team (University of Maryland Charles Regional Medical Center, Charles County Department of Health, X2Rep) expanded the Anti-Tobacco Advocate Program (ATA) to educate teens on the dangers of tobacco use so that they can become advocates on prevention to their friends and families in the community. They held a "Bowling over Butts" events was held at the Waldorf AMF. Teens and other bowlers were educated on the dangers of smoking and tobacco use. Bowling teams were "bowling over butts" to change the norms of tobacco within the county. The event was a tremendous success.. The Charles County Department of Health also conducted 3 tobacco cessation classes. The University of Maryland Charles Regional Medical Center works very closely with this program to refer all patients who indicate they smoke and want to quit. Colon and Rectal Cancer Education: The Charles County Department of Health and the University of Maryland Charles Regional Medical Center developed an outreach program to educate the community on the importance of colonoscopies with an inflatable colon for use at community events. Participants walk through a visual of a colon and see the difference types of problems that can be identified through a colonoscopy. Community Events: The Cancer Team participated in 10 community events where information on cancer screening and prevention were disseminated to interested individuals. Events including Homeless

Table III A. Initiative: **Cancer**

	Resource Day, the Charles County Fair, College of Southern Maryland Health Fair, etc.
c.) Total Number of People within the target population:	Because our focus is on the prevention of the disease and not just the treatment and survival after disease onset, we choose to target the whole county. The 2010 Charles County population was 146,551.
d.) Total Number of People reached by this initiative:	9254
e.) Primary Objective of the Initiative:	Reduce the number of deaths caused by cancer in Charles County from 199.3 to 190.8 per 100,000 or by 4.3%. Reduce the incidence of cancer in Charles County from 458.9 to 455.3 per 100,000 or by 2.9%.
f.) Single or Multi-Year Initiative Time Period	Multi-Year (2011 to present)
g.) Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, PHCC Cancer Team, Charles County Department of Health, Cambridge Oncology, Chesapeake Potomac Regional Cancer Center, La Plata Urology
h.) Impact/Outcome of Hospital Initiative	Process measures were tracked to determine the number of individuals educated on cancer risk factors and screening practices. We also tracked the number of encounters and community events aimed at raising awareness of issues surrounding cancer and the need for screening and early intervention. Impact measures included an analysis of cancer incidence and mortality rates for Charles County overall and site specific. Rates are compared to determine if county level are different from the state average rate and to determine if racial disparities are present.
i.) Evaluation of Outcome	<u>Process Measures:</u> Number of participants in the Breast Cancer Luncheon: 190 Number of people attending Paint the Park Pink event: 6854 Number of teens in attendance at Bowling over Butts event 1: 200 in attendance, 150 bowlers Number of Community Events attended: 10 Number of encounters at community events: 2000 Number of new education products purchased: 1 <u>Impact Measures:</u> 1. *Reduce the rate of deaths caused by cancer in Charles County from 199.3 per 100,000 to 190.8 per 100,000 (2007-2009 average death rate from the 2009 MD Vital Statistics Report)*

Table III A. Initiative: **Cancer**

	Update: The 2011-2013 average Charles County cancer death rate was 184.2 per 100,000. This rate is a reduction from the 2007-2009 cancer death rate of 199.3 per 100,000. This rate also exceeded the Charles County Health Improvement Plan goal of 190.8 per 100,000. 2. *Reduce the incidence rate of cancer in Charles County from 468.9 to 455.3 per 100,000 (2007 CRF Cancer Report).* Update: The 2007-2011 average Charles County all site cancer incidence rate was 427.3 per 100,000. This is a reduction from the 2003-2007 cancer incidence rate of 468.9 per 100,000. This rate also exceeded the Charles County Health Improvement Plan goal of 455.3 per 100,000.	
j.) Continuation of Initiative	Initiatives will continue but will focus on Colon and Rectal Cancer due to health disparities between county/state rates and White/AA rates.	
k.) A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $17,379	B. Direct offsetting revenue from Restricted Grants Ø

Table III A. Initiative: **Access to Care**

a.) Identified Need	MD Health Commission reports that 83 physician specialties are in shortage in So MD. County rankings and roadmaps states CC ratio of MD's to residents is 2,111:1 as compared to 834:1 for the state of Maryland and 631:1 for the US. Yes, this was identified through the CHNA process.
b.) Hospital Initiative	Physician Recruitment and Retention: The University of Maryland Charles Regional Medical Center has worked extensively to recruit and retain qualified physicians and specialists for the hospital. Community Clinic Support: The hospital supported Health Partners Inc. with their Maryland Community Health Resource Commission grant to expand primary care services in Charles County. The grant provides one nurse practitioner at the Health Partners clinic to see county residents with medical assistance or no insurance. Transition Case Manager: To reduce intra-hospital readmissions, University of Maryland Charles Regional Medical Center hired a dedicated Transition Case Manager. The Transition Case Manager receives a daily list of readmissions from CRISP, visits and or contacts patients and evaluates the reason for their return. Based upon the assessment, the Transition Case Manager provides patient education and makes the appropriate referrals. Daily phone calls are made to former patients who are at a high risk for readmission to assure their compliance with medications and physician appointments for follow up. Community Coalition/Cross Continuum of Care Team: A Community Coalition / Cross Continuum Team was implemented by University of Maryland Charles Regional Medical Center's Case Management Department to improve patient care transitions and reduce readmissions. The Community Coalition holds monthly meetings with active participation from approximately 30 local health organizations. Recruitment Cost for Social Worker in the ED: A full- time Social Worker is added to the ED to complement the existing Case Manager and take a proactive approach to solving social issues that cause frequent revisits. Various social determinants of health needing solutions involve securing access to providers, transportation, barriers to medication adherence, substance abuse, patient/family crises and elderly neglect and abuse. The existing ED Case Manager needs to have time to focus on utilization review, correcting patient statuses and medical case management issues that cause a patient return to the ED. The Social Worker will help facilitate enrollment in Medicaid and other governmental programs and interface with the Department of Social Services and other community

Table III A. Initiative: **Access to Care**

	organizations. Recruitment of Palliative Care Program: At the present time Charles County has no physician certified in palliative care. Development of a palliative care program in collaboration with Hospice of Charles County will be consistent with the standards of care to provide a variety of treatment options to their patients with advanced chronic conditions. The new Palliative Care program will help reduce excessive use of critical care services for those patients with the worst prognoses, as well as improve patient satisfaction and better manage patients' end of life healthcare expectations. The Palliative Care Program will assure patients understand hospice services when desired and appropriate. Inpatient Wound Prevention an Healing Program: The primary goal of the new inpatient wound prevention and healing program that started in June of 2015 is to provide wound care consultations and educational support to inpatients, their families and the clinical team regarding wound care management. This service line will further function as a resource to the hospital as it relates to adherence of medical practice standards, wound related national patient safety goals (NPSG # 14), wound care product formulary development and discharge planning/transitions of care for patients with non-healing wounds. The program will improve the quality of inpatient care while enhancing the efficiency and cost effectiveness of such care. Urgent Care Center: The University of Maryland Charles Regional Medical Center has planned to open an Urgent Care Center in La Plata. This is designed to allow access for lower acuity patients from the ED to a more appropriate service level. Planning began in FY 2015. Community events: Events are held throughout the year to educate the community on free and low cost resources for individuals and families for access to primary and specialist care. Examples of such events include the Hispanic Health Fair, Homeless Resource Day, Charles County Fair.
c.) Total Number of People within the Target Population	146,551 (County Population as reported in CHNA)
d.) Total Number of People Reached by the Initiative	1,771

Table III A. Initiative: **Access to Care**

e.) Primary Objective of the Initiative	Increase primary care and specialty physician in CC by 7 providers by FY 2015.
f.) Single or Multi-Year Initiative Time Period	Multi-year initiative (2011-present)
g.) Key Partners in Delivery	University of Maryland Medical System, Partnerships for a Healthier Charles County, Health Partners, Inc, Maryland Community Health Resource Commission, Charles County Department of Health, Greater Baden Medical Center
h.) Impact/Outcome of Hospital Initiative	The means of evaluation for this objective is an increase in the number of primary care and specialty providers currently practicing within Charles County. Our measure of impact will be a reduction in ED utilization due to better chronic disease and medication management in the primary care setting. Process measures include the number of community events attended, the number of encounters at those events, the number of people who met with health exchange navigators and assistors, and the number of people who left those events with health insurance.
i.) Evaluation of Outcome	Process Measures: Number of community event attended: 24 Number of encounters at community events: 1150 Number of people who met with navigators/assistors: 32 Number of people who left with health insurance: 19 Numbers for Transition Case Manager: 243 Number of attendees for the Community Coalition: 243 Number of patients treated through the Inpatient Wound Prevention and Healing program: 60 Impact Measures: The hospital was able to recruit 12 new health care providers from 2012-2015. Additionally, 3 community providers were established by the Charles County Department of Health's Western County Family Medical Center, Health Partners, and Greater Baden Medical Center. Charles County saw a large reduction in the percentage of ED patients without health insurance from 15.4% in 2009 to 9.0% in 2014. ED Visit Rates for Mental health and addictions-related conditions decreased from 2013 to 2014; however, ED visit rates for hypertension, diabetes, asthma, and dental health increase from 2013 to 2014.

Table III A. Initiative: **Access to Care**

j.) Continuation of Initiative	Initiatives will continue in the next fiscal year.	
k.) A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $171,715	B. Direct Offsetting Revenue from Restricted Grants N/A

Table III A. Initiative**: Accident/Injuries**

a.) Identified Need	Accidents are the 4th leading cause of death for Charles County residents. Charles County had one of the highest injury-related death rates in the state of Maryland (9th out of 24 jurisdictions). 2009 Vital Statistics Report and 2008 Injuries in Maryland report Motor Vehicle incidence is the second leading cause of injuries at 99.5 per 100,000 (2008 Injuries in Maryland Report) Fall-related hospitalizations increase with age. The 2008 Charles County fall-related hospitalization rate among the elderly was 289.1 per 100,000 (2008 Injuries in MD Report) Yes, this was identified through the CHNA Process.
b.) Name of Hospital Initiative	AARP Senior Driver Safety Course: This course is sponsored by the University of Maryland Charles Regional Medical Center. The course is designed to reduce the changes for traffic violations, accident, and chances for injury. They update driving skills and their knowledge of the rules and hazards of the road. They also learn about normal age-related physical changes and how to adjust their driving to compensate. Child Safety Seat Inspections: University of Maryland Charles Regional Nurses along with the Maryland State Police offer free community child safety seat inspections and installation education for parents at various community events. Matters of Balance: Matters of Balance is an evidence-based program geared at fall prevention in the elderly population. It has been successfully implemented through the Department of Aging since 2011 and supported by the Accident and Injury Prevention Team of the LHIC. Arthritis Foundation Evidence-Based Programs: The Charles County Department of Aging conducted several evidence-based program from the Arthritis Foundation to increase the strength and flexibility of seniors with arthritis. Stronger seniors may lead to better balance and less fall injuries. Those classes included: • Arthritis Foundation Tai Chi Program • Walk with Ease Program This project was supported by the Accident and Injury Prevention Team of the LHIC. Regional Workshop for Clinicians on Older and Medically At-Risk Drivers: The hospital, in collaboration with the Maryland Motor Vehicle Administration and the Partnerships for a Healthier Charles County, conducted a workshop for clinicians to: 1.) Recognize the need to consider medical fitness to drive in all clinical assessment, particularly those involving elderly patients 2.) Recognize the unique challenges and

Table III A. Initiative**: Accident/Injuries**

	risks faced by older drivers, and the role of driver rehabilitation as an effective means to extending driving ability 3.) Highlight the techniques to identify problems with medical fitness to drive and effective methods for interacting with and evaluating older drivers 4.) Understand the purpose of MVA's medical review process to evaluate drivers' functional ability to drive safely and how it works; and to describe the role of professionals in assessing and referring medically at-risk drivers.
c.) Total Number of People within the target population:	Charles County Population over the age of 65 years: 16,121
d.) Total number of people reached by the initiative:	391
e.) Primary Objective of the Initiative	Reduce the rate of hospitalizations due to falls in Charles County from 289.1 per 100,000 to 259. Reduce hospitalization rates due to motor vehicle incidents in Charles County from 99.5 to 89.5 per 100,000.
f.) Single or Multi-Year Initiative Time Period	Multi-year Initiatives
g.) Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, Partnerships for a Healthier Charles County, Charles County Department of Aging, AARP Driver Safety Council, Maryland State Police, Richard R. Clark Senior Center, Indian Head Senior Center, Maryland State Highway Administration's Potomac Region Highway Safety Coordinator, Maryland Motor Vehicle Administration
h.) Impact/Outcome of Hospital Initiative	Process measures included the tracking of program participants, successful completion of evidence-based programs, and the number of workshops conducted. Impact measures examine the rate of hospitalizations in Charles County due to falls among the elderly and due to motor vehicle incidents.
i.) Evaluation of Outcome	<u>Process Measures:</u> Number of participants in the AARP Senior Driver Safety Course: 35 Number of child safety seats installed or inspected: 100 Number of participants successfully completing the Matters of Balance Program: 14 Number of participants successfully completing the Arthritis Foundation evidence-based programs: 172 Number of clinicians and stakeholders in attendance at workshop: 70 <u>Impact Measures:</u> 1. *Reduce the rate of hospitalizations due to falls by the elderly population in Charles County from 289.1 to 259 per 100,000*.

Table III A. Initiative**: <u>Accident/Injuries</u>**

	<u>Update:</u> The 2011 Charles County fall-related crude hospitalization rate was 268.8 per 100,000. This is a decrease from the baseline rate of 289.1 per 100,000. However, it does not meet the Charles County Health Improvement Plan goal of 259 per 100,000. 2. *Reduce the rate of hospitalizations due to motor vehicle incidence in Charles County from 99.5 to 89.5 per 100,000*. <u>Update:</u> The 2011 Charles County motor vehicle incident-related crude hospitalization rate was 87 per 100,000. This is an improvement from the baseline rate of 99.5 per 100,000. This rate meets the goal of 89.5 per 100,000 from the Charles County Health Improvement Plan.	
j.) Continuation of Initiative	Initiative will be continued	
k.) A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $7,235	B. Direct offsetting revenue from Restricted Grants Ø

Table III A. Initiative**: Chlamydia Infection**

a.) Identified Need	Chlamydia infection rate: 493.2 per 100,000 (rates significantly higher in CC AA population and in young population 15-19 years) Approximately, 5% Chlamydia prevalence in county. Chlamydia infection rate is a priority measure established by the Maryland State Health Improvement Process. Yes, this was identified as a need from the CHNA Process.
b.) Name of Hospital Initiative	Pre-conceptual Health Campaigns: The Charles County Department of Health's Minority Infant Mortality Reduction Program educated the county population, men and women, on the importance of being healthy and free of STI's before getting pregnant. This program was supported by the Healthy Babies Team of the LHIC.
c.) Total Number of People within the Target Population	5% of county population: 7328
d.) Total Number of People Reached by the Initiative within the Target Population	12,695
Primary Objective of the Initiative	Reduce the rate of Chlamydia infections among Charles County African Americans by 10% from 569.6 per 100,000 to 512.5.
Single or Multi-Year Initiative Time Period	Multi-year initiative (2011-2015)
Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, Charles County Fetal and Infant Mortality Review Board, Charles County Department of Health's Minority Infant Mortality Reduction Program (MIMR)
Impact/Outcome of Hospital Initiative?	Process measures include the number of community events sponsored or attended and the number of people receiving pre-conceptual health education messages.
Evaluation of Outcome	Process measures: Number of community events sponsored or attended:27 Number of racial/ethnic minorities receiving pre-conceptual health education messages: 12,695 Impact Measures: 1*. Reduce the rate of Chlamydia infections among Charles County African Americans by 10% from 569.6 per 100,000 to 512.5*. Update:

Table III A. Initiative**: Chlamydia Infection**

	The 2012 Charles County African American Chlamydia rate was 842.8 per 100,000. This is an increase from the baseline rate of 569.6 per 100,000. This does not meet the Charles County Health Improvement Plan goal of 512.5. The rate has gone in the opposite direction.	
Continuation of Initiative	Initiatives have been completed. This health condition was not identified in the next CHNA process.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $4,260	B. Direct offsetting revenue from Restricted Grants Ø

Table III A. Initiative: **Dental Health**

a.) Identified Need	Of the children (aged 4-20) enrolled in a Medicaid MCO greater than 320 days only 46.2% received preventive dental service in the past year (FHA 2009). In 2009, 53.4% of Charles County children aged 4-20 years enrolled in a Medicaid MCO received a dental service in the past year. This measure is one of the priority areas identified through the Maryland State Health Improvement Process. Yes, this was identified through the CHNA Process.
b.) Name of Hospital Initiative	Dental Health Expansion/ED Diversion Program: The Charles County Department of Health received grant funding from the Maryland Community Health Resource Commission to expand dental health services by one day a week. The program also increases the sealant program to all Charles County schools, not just the Title 1 schools. It is hoped that increased services will lead to less emergencies and decrease ED utilization for dental health emergencies. The dental clinic has begun taking walk-ins to their evening dental clinics on Wednesdays. They have added another day to their dental clinics. The University of Maryland Charles Regional Medical Center is a key partner in the referral of patients to the dental clinic for emergency services instead of the hospital emergency department. The Oral Health Program is also very active in the community. There is a community health worker who attends community events to educate on good oral health. Information Dissemination: The Partnerships for Healthier Charles County's (LHIC) Access to Care Team displays a banner each year in August during the Back to School shopping time to educate parents on the availability of free or low cost dental services within the county. Mission of Mercy (MOM): The Southern Maryland Mission of Mercy was held July 18th and 19th at North Point High School in Waldorf, Maryland. A total of 706 patients were seen during this two day event. A total of 6033 procedures were performed (including x-rays and exams). The total value of services rendered was $873,145 (does not include RXs). The average number of procedures per patient was 7.7 (includes x-rays and exams). The average value of services rendered per patient was $1147. The average wait time was 5 hours and 4 minutes.
c.) Total Number of People within the target population	All county citizens have the potential to be impacted by oral health problems. Therefore, all citizens are targeted with our campaigns Charles County 2010 Population: 146551

Table III A. Initiative: **Dental Health**

d.) Total Number of people reached by the initiative	2530
e.) Primary Objective of the Initiative	Increase the proportion of Medicaid children and adolescents who received any dental care services in the past year from 53.4% to 56.3% (2009 Maryland SHIP).
f.) Single or Multi-Year Initiative Time Period	Multi-Year (2013 to present)
g.) Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, PHCC Access to Care Team, the Charles County Department of Health, Charles County Public Schools, local dentists and all MOM volunteers, and the Maryland Community Health Resource Commission.
h.) Impact/Outcome of Hospital Initiative	Process measures track the number of people served through the dental clinic and the number of people educated on oral health in the community. MOM process measures include the number of people served, the number of services rendered, types of procedures given. Impact measures: The measure of evaluation includes a trend analysis of dental health service usage among Medicaid MCO children to determine if increases in usage have been documented. We will also be tracking to see if there is a reduction in the number of ED visits due to dental health emergencies. We are still working to obtain this information from IT.
i.) Evaluation of Outcome	<u>Process measures:</u> Number of unduplicated patients in Year 1: 1028 Number of community events attended: 25 Number of patients who received dental services at Mission of Mercy: 706 Number of encounters at community events: 762 Number of clinicians educated on available dental services: 34 <u>Breakdown of Referral Sources to the Dental Clinic</u>: Dental Offices 2% Interagency 5% Community Health Fairs 10% Emergency Department 2% Insurance 2% Self Referral 79% <u>Mission of Mercy Process Measures:</u> Number of people served: 706 Number of procedures performed: 6033 Average number of procedures per patient: 7.7 Average Wait time: 5 hours, 4 minutes

Table III A. Initiative**: <u>Dental Health</u>**

	Top 10 Procedures Performed • X-rays and Exams • Surgical Removal • Extractions single tooth • Prophylaxis • Fluoride • Extraction Impact Part Bony • Extract Root Surgical • Post Comp – 2 surface • Post Comp – 1 surface • Debridement <u>Impact Measure:</u> 1. *Increase the proportion of Medicaid children and adolescents who received any dental care services in the past year from 53.4% to 56.3% (2009 Maryland SHIP).* <u>Update:</u> In 2013, 50.7% of Charles County children aged 4-20 years enrolled in a Medicaid MCO received a dental service in the past year (Maryland SHIP). This is a decrease from the 2009 percentage of 53.4%. This does not meet the Charles County Health Improvement Plan goal of 56.3%. The percentage went in the opposite direction.	
j.) Continuation of Initiative	This initiative was started through a 3-year grant and will continue.	
k.) A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $9,878	B. Direct offsetting revenue from Restricted Grants Ø

Table III A. Initiative**: Diabetes**

a.) Identified Need	The 2007-2009 death rate for people in Charles County with diabetes mellitus 34.1 per 100,000 people. This is highest among the other So MD counties and higher than the state average (2009 MD Vital Statistics Report). Approximately 7.4% of CC adults report having diabetes (2010 MD BRFSS). Emergency Department visit rates due to diabetes show a disparity among Charles County African Americans. The same is true for Maryland African Americans. Therefore, this priority has been established by the Maryland State Health Improvement Process. Yes, this was identified through the CHNA process.
b.) Name of Hospital Initiative	Diabetes Education Classes: Conduct free or low cost diabetic education in the county. The University of Maryland Charles Regional Medical Center is providing free diabetes education classes to the public bi-monthly. The goal is to collect data on participants and become recertified by ADA. Diabetes Education Fair: The University of Maryland Charles Regional Medical offered a free diabetes education fair to community residents. The outreach event covered topics that include overall management of diabetes, lowering HbA1C levels, diabetes medications, diabetes nutritional strategies and blood sugar testing. Participants were offered a free HbA1C screening. Clinician Survey: Communicate with community physicians to determine barriers for diabetic patients. The PHCC (LHIC) Chronic Disease Prevention Team created a diabetic survey for physician PCP practices asking physicians what the barriers to care are for their patient population that struggle to manage their diabetes. The goal was to have the survey be no more than five questions. The survey was completed and will be used in the next year. Chronic Disease Self-Management Program or Living Well: The Charles County Department of Aging has conducted Stanford's Chronic Disease Self Management Program, also known as Living Well with Chronic Conditions, at the county senior centers. The program is designed to help participants set realistic goals and learn to self manage their chronic conditions. Only 1 class could be conducted this year due to lack of trained staff. However, the program will be expanded in the next fiscal year with the help of other county agencies. The University of Maryland, Health Partners, the Charles County Department of Health, and Shah Associates had staff trained in the Chronic Disease Self Management Program in June 2015 and will begin

Table III A. Initiative**: Diabetes**

	conducting classes in Winter 2016.
c.) Total number of people within the target population	2/3 of the Charles County population is overweight or obese and therefore, at risk to develop diabetes. They are our target population for this initiative. Target population: 98,190
d.) Total number of people reached by the initiative	117
e.) Primary Objective of the Initiative	Reduce the death rate from diabetes in Charles County 2 % or to 33.4 deaths per 100,000. Reduce the prevalence of diabetes in Charles County by 2% or to 5.4%.
f.) Single or Multi-Year Initiative Time Period	Multi-year Initiative (2012-present)
g.) Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, PHCC Chronic Disease Prevention Team, Charles County Department of Health, Health Partners, Charles County Department of Aging.
h.) Impact/Outcome of Hospital Initiative	Process measures are tracked to determine the number of new programs established and the number of participants in those programs. The diabetes program conducts pre and post tests to examine increases in diabetes knowledge. Impact data examined includes diabetes prevalence and mortality rates for Charles County. Additionally, BRFSS data on co-morbidities and diabetic complications are examined to see if county diabetics are under control.
i.) Evaluation of Outcome	<u>Process Measures:</u> Number of diabetes education classes conducted:12 Number of participants in diabetes classes: 77 Number of participants in diabetes class who saw a knowledge increase from pre to post test: 51 Number of participants at diabetes education fair: 30 Number of chronic disease self management classes conducted: 1 Number of participants completing the chronic disease self management classes: 10 <u>Impact Measures:</u> **Diabetes Mortality:** 1. *Reduce the death rate from diabetes in Charles County from 34.1 per 100,000 to 33.4 per 100,000 (2007-2009 average death rate from MD*

Table III A. Initiative**: <u>Diabetes</u>**

	Vital Statistics Report). <u>Update</u>: The 2011-2013 Charles County diabetes death rate was 22.8 per 100,000. This is a significant reduction from the 2007-2009 rate of 34.1 per 100,000 and exceeded the goal set in the Charles County Health Improvement Plan of 33.4 per 100,000. **Diabetes Prevalence** 2. *Reduce the prevalence of diabetes in Charles County from 7.4% to 5.4% (2010 BRFSS).* <u>Update</u>: 2013 BRFSS: 8.3% of Charles County residents report that they have diabetes. This is an increase from the 2010 Charles County diabetes prevalence of 7.4%. The goal for 2014 was not met.	
j.) Continuation of Initiative	Initiatives will continue in the next fiscal year since increases have been seen in the county's diabetes prevalence.	
k.) A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $14,733	B. Direct offsetting revenue from Restricted Grants Ø

Table III A. Initiative**: Heart Disease**

a.) Identified Need	Heart disease is the leading cause of death for Charles County residents. Heart disease accounts for 1/4 of the county deaths each year. The rate of ED visits for hypertension per 100,000 population is higher in blacks (368.1) than whites (194.1). This is a priority measure with the Maryland State Health Improvement Process. This was identified as a need through the CHNA process.
b.) Name of Hospital Initiative	Free Blood Pressure Screenings: Following the ABC's of the Maryland Million Hearts Initiative, the University of Maryland Charles Regional Medical Center and the Charles County Department of Health, have been providing blood pressure screening and risk assessments at community events. Those with elevated blood pressure have been advised on the importance of following up with their PCP on ways to reduce their blood pressure. Million Hearts Initiative: The Charles County Department of Health received a grant from the Maryland Community Health Resource Commission to incorporate blood pressure screenings and assessments into the health department dental clinic and at community events. The community health worker assesses residents, refers them to primary care and other community services as needed, and provides follow-up on those cases. The Chronic Disease Prevention Team of the LHIC works on this initiative with the Department of Health. Healthy Heart Classes: The free class focuses on educating participants on lipids, cholesterol, sodium and nutritional factors that affect blood pressure and lowering cardiac risk factors through nutritional strategies. Information will also be provided on what healthy weight is and dietary strategies for obtaining a healthy weight. Healthier Hearts Support Group: This group meets every other month to provide support, education and socialization to people with heart disease, their family members and caregivers. Members take part in discussions and learn skills to manage their condition and improve their quality of life. Topics covered include: how blood pressure works, lowering secondary cardiac risk factors, exercise programs and understanding medicines and treatment. Stroke Risk Factors, Symptom Awareness and Education: 5k Run/Walk for Wellness and Celebrate La Plata Day Event: Community Run/Walk educating the public on early signs, symptoms and risk factors for stroke.

Table III A. Initiative**: <u>Heart Disease</u>**

	<u>Free Stroke Support Group:</u> Monthly support group for stroke survivors and caregivers offered by a physical therapist and speech therapist. All community members are invited to attend.
c.) Total Number of people within the target population	Approximately one-third of the Charles County has hypertension and is at risk for heart disease. The target population estimate is 48362 people.
d.) Total Number of people reached by the initiative	5827
e.) Primary Objective of the Initiative	Reduce the number of deaths from heart disease in Charles County from228.5 per 100,000 to 211 per 100,000 or 7.5% improvement.
f.) Single or Multi-Year Initiative Time Period	Multi-year initiatives (2011-present)
g.) Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, Charles County Department of Health, PHCC (LHIC) Chronic Disease Prevention Team, Hospital Auxiliary.
h.) Impact/Outcome of Hospital Initiative	Process measures were tracked for number of people receiving blood pressure screenings, number of community events attended, the number of participants at support group, number of people screened at health events. Impact measures include heart disease mortality as well as ED visit rates for hypertension.
i.) Evaluation of Outcome	<u>Process Measures:</u> Number of blood pressure screenings conducted in Dental Clinic: 887 Number of blood pressure screenings conducted at community events: 317 Number receiving blood pressure education in dental clinic: 698 Number receiving blood pressure education in community: 2995 Number of community events attended: 29 Number of blood pressure screenings by hospital staff:676 Number of participating in the community 5K: 63 Number of people participating in the stroke support group: 162 Number of people attending Heart Healthy Eating: 12 Number of attending the Healthier Hearts Support Group: 29

Table III A. Initiative**: <u>Heart Disease</u>**

	<u>Impact:</u> 1. *Reduce the rate of deaths in Charles County from heart disease from 228.5 per 100,000 to 211 per 100,000 (2007-2009 average death rate from the 2009 MD Vital Statistics Report).* <u>Update</u>: The 2011-2013 average death rate for heart disease in Charles County was 184.7per 100,000. This is a significant improvement from the 2007-2009 Charles County heart disease death rate of 228.5 per 100,000. This rate also exceeded the Charles County Health Improvement Plan goal of 211 per 100,000. There was a reduction in the ED visit rate for hypertension for Charles County Whites from 221.9 to 194.1. However, the ED visit rate for Charles County Blacks increased from 368.1 to 458.1.	
j.) Continuation of Initiative	Initiatives will continue in the next fiscal year due to the amount of population affected by this health condition.	
k.) A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $13,794	B. Direct offsetting revenue from Restricted Grants Ø

Table III A. Initiative**: Healthy Babies**

a.) Identified Need	The 2010 Charles County Infant Mortality rate was 7.4 per 1,000 live births. The infant mortality rate among Charles County Blacks was significantly higher than the rate among Charles County Whites (10.4 vs. 4.7). The percent of Mothers who received prenatal care 1st trimester was 65.5%. It is highest among Charles County Whites at 72.4%. It was lowest among Hispanics at 52.9%. o White/NH: 72.4% o Black: 61.3% o Hispanic: 52.9% Access to prenatal care is a measure of the Maryland State Health Improvement Process. This was identified as a need through the CHNA Process.
b.) Name of Hospital Initiative	"Our Babies Matter" program: The Charles County Department of Health, in collaboration with the Charles County FIMR Board received DHMH funding to address minority infant mortality in Charles County. A program called "Our Babies Matter" has been developed with the help of many community partners. Women recruited to the program participate in an educational group through pregnancy, delivery, and the first year of baby's life. There are also community events and educational forums on preconceptual health and safe sleeping geared toward women and men. The program also developed "strollercise", a walking program for moms with babies. The Healthy Babies Team of the LHIC supported this initiative. Fetal Infant Mortality Review Board: The FIMR board meets monthly at the University of Maryland Charles Regional Medical Center. Other key partners to address infant mortality include, the hospital, the Charles County Department of Health, March of Dimes, Catholic Charities, Charles County Board of Education and the Judy Centers.
c.) Total Number of People within the Target Population	Charles County Population of Child-bearing age (18-44 years): 24687
d.) Total Number of People reached by the Initiative	21604
e.) Primary Objective of the Initiative	Reduce the infant death rate from 7.4 per 1,000 live births to 6.6 deaths per live births. Reduce infant death rate from 10.4 for blacks to 6.6 per 1,000.

Table III A. Initiative**: Healthy Babies**

f.) Single or Multi-Year Initiative Time Period	Multi-year initiative (2011-2015)
g.) Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, Charles County Fetal and Infant Mortality Review Board, Charles County Department of Health, Health Partners, Bel Alton HS CDC, NAACP, Catherine Foundation, March of Dimes, Charles County Department of Social Services, Charles County Public Schools, Pastoral Council, Local Pediatricians, Healthy Babies Team (LHIC).
h.) Impact/Outcome of Hospital Initiative	Process measures include the number of programs initiated, the number of community events hosted, the number of DVD's distributed, the number of moms educated, and the number of physicians recruited. Impact measures include an examination of Charles County infant mortality rates by race. There is also an analysis of pregnancy outcome data such as access to prenatal care by race/ethnicity.
i.) Evaluation of Outcome	Process measures: Number of community events sponsored or participated in: 27 Number of Fetal Infant Mortality Board Staff Hours: 40 Number of meetings held: 10 Number of people at events: 4328 Number of referrals made to needed services: 26 Number of women enrolled in the Our Babies Matter support group:73 Number of people received health education messages: 21604 Number of educational materials disseminated: 5968 Number of media messages: 10 Number of new partnerships established to address infant mortality: 15 Impact Measures: 1. *Reduce the infant death rate from 7.4 per 1,000 live births to 6.6 deaths per 1000 live births*. Update: The 2013 Charles County infant mortality rate was 7.8 per 1,000 live births. This is a slight increase from the baseline rate of 7.4 per 1000 live births. This does not meet the Charles County Health Improvement Plan goal of 6.6 per 1000 live births. 2. *Reduce infant death rate from 10.4 for Charles County African Americans to 6.6 per 1000 live births*. Update: The 2013 Charles County Black infant mortality rate was 7.3 per 1000 live births. This is a large reduction from the baseline rate of 10.4 per 1000 live births. However, this does not meet the Charles County Health Improvement Plan goal of 6.6 per 1000 live births.

Table III A. Initiative**: Healthy Babies**

	The percent of Mothers who received prenatal care 1st trimester went down slightly from 65.5% to 64.9%. It is highest among Charles County Whites at 73.3%. It was lowest among Hispanics at 55.9%. • White/NH: Increased from 72.4% to 73.3% • Black: Decreased from 61.3% to 59.2% • Hispanic: Increased from 52.9% to 55.9% • Asian: 66.7% (was not available previously)	
j.) Continuation of Initiative	This initiative is complete. The Our Babies Matter Program lost their funding through the Maryland Department of Health and Mental Hygiene (DHMH).	
k.) A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $9,667	B. Direct offsetting revenue from Restricted Grants Ø

Table III A. Initiative**: Mental Health**

a.) Identified Need	12% of Charles County BRFSS respondents reported that they have been diagnosed with an anxiety disorder (2009 BRFSS). 14% of Charles County BRFSS respondents reported that they have been diagnosed with a depressive disorder (2009 BRFSS). The 2007-2009 Charles County suicide rate was 12.3 per 100,000 population, well above the state level. Mental Health ED Visit Rate: 3045.8 per 100,000. CC White rate: 3907.5, CC AA rate: 2675.8, CC Asian rate: 410.8, CC His rate: 352.7. Mental Health ED rate has increased from 2535.6 in 2010 to 3045.8 in 2013. Charles County has a Mental Health Professional Shortage Area for the entire county. 3 providers are needed. ED Visit Rates have been identified as a priority measures through the Maryland State Health Improvement Process. Yes, this was identified as a need through the CHNA Process.
b.) Name of Hospital Initiative	The Mental Health Team of the Local Health Improvement Coalition (LHIC) supported the following projects: Mental Health First Aid: The Charles County Core Service Agency has been training school personnel, local law enforcement, first responders, and other community members on Mental Health First Aid. The Charles County Public Schools had a staff member trained as a trainer. This staff member trained all school counselors, principals, and other interested staff in May 2015. Mental Health First Aid is a well-known and evidence-based program to help community members to identify the signs and symptoms of mental health disorders and how to mitigate situations. Out of the Darkness Walk: The second Southern Maryland Out of the Darkness Walk was held in September 2014 in Port Tobacco, MD. The event was well attended and exceeded fundraising goals for suicide prevention efforts. Community Awareness Events to raise awareness of mental health and substance use disorders: The events raise awareness and provide information and resources to those who may be in need of treatment for one or both of those disorders. Media Campaigns: Freedom Landing, a mental health provider in Charles County, has begun writing monthly article on mental health issues in a Southern Maryland health magazine. This is a new way to increase awareness to a large number of residents on mental health and the

Table III A. Initiative**: Mental Health**

	resources available in the county to address it. Video PSA: The Charles County Department of Health ran the video Anonymous People in the main clinic lobby for 5 days in the month of September. Many people had the opportunity to view the video while waiting in the clinic for family planning, STI, dental, or WIC services. PSA Campaign: The Charles County Core Service Agency had an awareness campaign in Spring 2015 with signs about suicide prevention on the county's local transit system, VanGo.
c.) Number of people within the target population	12% anxiety prevalence: approximately 17586 people 14% depression prevalence: approximately 20517 people Target population: 17586+20517=38,103
d.) Number of people served by the initiative	3165
e.) Primary Objective of the Initiative	Reduce the rate of suicide from 12.2 to 9.1 per 100,000 population. Increase the proportion of persons with co-occurring substance abuse and mental health disorders who receive treatment for both. Reduce the rate of ED visits due to behavioral health disorders from 2535.6 to 2281.9 per 100,000.
f.) Single or Multi-Year Initiative Time Period	Multi-year (2012 to present)
g.) Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, PHCC Behavioral Health Team, Charles County Core Service Agency, Vesta Inc, Freedom Landing, NAMI Southern Maryland , Charles County Public Schools, College of Southern Maryland
h.) Impact/Outcome of the Hospital Initiative	Process measures will track the number of people educated in mental health first aid, the number of community events hosted, and the number of people attending in community events. Impact measures: We will use Maryland Vital Statistics report to look for any change in suicide death rates. Maryland SHIP data will provide HSCRC statistics regarding ED visit rates due to mental health disorders. Proportion of people in public mental health treatment admission and very satisfied with treatment from 25.5% to 28% (PMHS Outcome Measurement System). Proportion of people receiving treatment for co-occurring disorders:

Table III A. Initiative**: Mental Health**

	Measure will be the Crystal Report MARS0002 for Dual Diagnosis with SMI/SED. Decrease by 10% from 2010 baseline of 11.8% to 10.62%.
i.) Evaluation of Outcome	Process Measures: Number of adult mental health first aid trainings held:8 Number of youth-focused mental health first aid trainings held: 7 Number of people educated on adult mental health first aid: 33 Number of people educated on Youth Mental Health First Aid: 159 Number of community events hosted: 8 Number of encounters at community events: 2500 Number of mass media campaigns: 3 Number of people participating in the suicide prevention and awareness walks: 473 Impact Measures: The Charles County ED visit rate due to mental health disorders increased from 2535.6 per 100,000 in 2010 to 3053.0 per 100,000 in 2013. *Increase the proportion of adults and children with mental health disorders who receive treatment. Measures of success will be those with depressive disorders who receive treatment from 55% to 60% and an increase in public mental health treatment admissions that are very satisfied with treatment from 25.5% to 28% (Public Mental Health System Outcome Measurement System).* Update: The percentage of Charles County adults in the public mental health system (PMHS) who reported that they are very satisfied with their treatment and recovery decreased from 25.5% at baseline to 19.9% for 2014. This does not meet the Charles County Health Improvement Plan goal of 28% very satisfied. The measure went in the opposite direction. Unfortunately, the measure of those with depressive disorders who receive treatment has not been replicated by the Maryland Behavioral Risk Factor Surveillance System. Therefore, we do not have an update for this measure. *Reduce the rate of suicide from 12.3 to 9.1 per 100,000 population (2007-2009 average death rate, 2009 MD Vital Statistics Report).* Update: The 2010-2012 Charles County Suicide Rate was 10.2 per 100,000. This is a reduction from the 2007-2009 average suicide death rate of 12.3 per 100,000. However, the 2010-2012 suicide rate does not meet the Charles County Health Improvement Plan goal of 9.1 per 100,000.

Table III A. Initiative**: Mental Health**

	Increase the proportion of persons with co-occurring substance abuse and mental health disorders who receive treatment for both. Measure will be the Crystal Report for Dual Diagnosis SMI/SED. Increase by 10%. Update: For Fiscal Year 2014, 382 Charles County consumers in the Public Mental Health System were dually diagnosed with mental health and substance use disorders. The Charles County PMHS has seen a 45% increase in the number of consumers who are dually diagnosed in the past two fiscal years. The 45% increase far exceeded the Charles County Health Improvement Plan goal of a 10% increase.	
j.) Continuation of Initiative	Initiatives will continue in next fiscal year. This priority has been identified as a priority in the 2015 CHNA Process.	
k.) A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $4,260	B. Direct offsetting revenue from Restricted Grants Ø

Table III A. Initiative**: Obesity**

a.) Identified Need	Prevalence of overweight in HS students: 17% overall, • Hispanic (25%) and AA (18%) more likely to report being overweight. Obese: 12% overall • Hispanic (13%) and AA (13.5%) more likely to report being obese. Adults: 72.1% overweight or obese Charles County has the second lowest percentage of adults at a healthy weight (27.9%). CC AA less likely to be at a healthy weight (24.8%) than CC Whites (31.7%). The percentage of children who are obese and the percentage of adults at a healthy weight have both been identified as priorities through the Maryland State Health Improvement Process. Yes, this was identified through the CHNA Process.
b.) Name of Hospital Initiative	Youth Triathlon: The University of Maryland Charles Regional Medical Center, in collaboration with the Charles County Department of Health and Charles County Parks and Rec, hosted a youth triathlon in July 2014. Community 5K: The University of Maryland Charles Regional Medical Center, in collaboration with the Charles County Department of Health and Charles County Parks and Rec, hosted a community 5K in October 2014. They also offered blood pressure screening and stroke prevention at this event. School Wellness Champions: With support of the Chronic Disease Team of the LHIC and funding from the Community Transformation Grant, four Title One schools in Charles County were chosen for the School Wellness champion program. One staff members from each school was assigned as a wellness champion and tasked with developing at least one healthy event each month within the school. These included flash mobs, new opportunities for physical activity in the school day, or healthier foods at school events or parties. Maryland Healthiest Businesses: The Charles County Department of Health, with support from the University of Maryland Charles Regional Medical Center, received a worksite wellness readiness grant from the Maryland Healthiest Businesses. Businesses who enroll will receive help to complete the CDC Worksite Wellness Scorecard. Once weaknesses and gaps are identified, the businesses are given resources and recommendations on how they can make changes to their current wellness policies and how to become healthier worksites. Charles County Fair: 300 apples distributed. Kids played nutrition games

Table III A. Initiative**: Obesity**

	and learned information about healthy eating before they were given an apple. 1000 encounters at the health department and hospital fair booths to learn about healthy eating and physical activity.
c.) Total Number of People within the Target Population	72.1% of the Charles County adults (18+) are either overweight or obese: 83,791 29% of CC HS students (15-19 years) are overweight or obese: 1689 Target population: 1689+83791=85,480
d.) Total Number of People Reached by this Initiative	9057
e.) Primary Objective of the Initiative	Decrease the percent of children and adolescents who are obese from 13.3 to 11.2 percent. Increase the percent of adults who are at a healthy body mass index (healthier weight) from 29.4 to 30.4 percent (<25) by 2014.
f.) Single or Multi-Year Initiative Time Period	Multi-Year Initiative (2012-present)
g.) Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, Charles County Department of Health, The Judy Centers, Charles County Community Services, College of Southern Maryland, University of Maryland Extension Office, Charles County Public Schools, Maryland Healthiest Businesses Initiatives, Community Transformation Grant
h.) Impact/Outcome of Hospital Initiative?	Process measures on number of individuals reached through health education and preventive screenings, number of encounters at community events, number of schools involved in school-based programs, number of businesses recruited for Maryland Healthiest Businesses. Outcome measures evaluate any reduction in childhood obesity percentages for the county using the Youth Risk Behavior Survey data for children aged 13-18 years. The Behavioral Risk Factor Surveillance System is used to determine any reductions in adult obesity percentages.
i.) Evaluation of Outcomes	<u>Process Measures:</u> Number of apples distributed at the fair: 300 Number of health education encounters at the fair: 1000 Number of children participating in the Youth Triathlon: 131 Number of people participating in the 5K: 63 Number of school participating in wellness champion program: 4 Number of schools implementing comprehensive school physical activity programs and receiving TA or support from health department: 4

Table III A. Initiative**: <u>Obesity</u>**

	Number of schools implementing improved nutrition standards and receiving TA or support from health department: 4 Number of students participating in wellness champion activities: 6041 Number of parents participating in wellness champion activities: 1522 Number of businesses enrolled in the Maryland Healthiest Businesses Initiative: 10 Number of worksites implementing active living strategies: 10 Number of worksites implementing nutrition and beverage standards: 8 <u>Impact:</u> 1. *Decrease the percent of adults who are at a healthy BMI from 29.4% to 30.4% (2010 BRFSS)* <u>Update:</u> According to the 2013 BRFSS, the percent of Charles County residents at a healthy BMI was 27.9%. This is a decrease from the 2010 BRFSS percentage of 29.4% for Charles County. The Charles County Health Improvement Plan goal of 30.4% was not met, and the percentage went in the opposite direction. 2*. Decrease the percent of children and adolescents who are obese from 13.3% to 11.2% (2006 MYRBS)* <u>Update</u>: 2013 MYTRBS: 12.3% of 13-18 year old students are obese. Improvement has been made since the 2006 Charles County percentage of 13.3%; however, the Charles County Health Improvement Plan goal of 11.2% was not met.	
j.) Continuation of Initiative	Initiatives will continue in next fiscal year.	
k.) A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $6,119	B. Direct offsetting revenue from Restricted Grants Ø

University of Maryland Charles Regional Medical Center FY 2015

Table III A. Initiative**: <u>Substance Use Disorders</u>**

a.) Identified Need	Adults Charles County Behavioral Risk Factor Surveillance System (BRFSS) data: • 4% adults chronic alcoholics • 18% binge drinking in past month Adult National Survey of Drug Use and Health(NSDUH): Southern Maryland Regional Data: • 51% have used alcohol in past month (18-25); • 10.5% have abused prescription drugs in last yr (18-25 yrs). Youth Tobacco and Risk Behavior Survey (YTRBS): • 61% of HS students have used alcohol; • 36% of youth have used marijuana; • 11% of youth have used cocaine; • 20% youth have abused prescription drugs/heroin Addictions related ED visit rate: 1200.4 per 100,000. CC White 1500, CC AA rate 1122.8, CC Hispanic 261.2. CC rate has increased from 868.6 in 2010 to 1200.4 in 2013. Drug-induced death rate: 11.2 per 100,000, CC White 17.3. ED visit rates for addictions-related conditions and drug-related death rates are established measures from the Maryland State Health Improvement Process. Yes, this was identified as a need through the CHNA Process.
b.) Name of Hospital Initiative	<u>Community Events</u>: The PHCC (LHIC) Behavioral Health Team and the Charles County Substance Abuse Advisory Coalition attended community events in order to educate the community and parents about the dangers of underage drinking and the consequences of providing alcohol to minors. Some events include: the Charles County fair, Homeless Resource Day, and the Living Healthy and Drug Free in Charles County Awareness Day. <u>Drug-free events</u>: The Charles County Public Schools, in partnership with the Charles County Sheriff's Office, the Charles County Commissioners, and the Charles County Substance Abuse Advisory Coalition, held the 29th annual Project Graduation for all Charles County graduating seniors. The event is a drug and alcohol free celebration held after the high school graduation nights. Seniors and their guests are presented with information on the dangers of underage drinking. The Charles County Substance Abuse Advisory Coalition also held its annual fishing derby to get children outdoors and talk to them about safety and being drug-free. This was supported by the PHCC (LHIC) Behavioral Health Team <u>Alcohol Awareness Campaigns:</u> Media campaigns were used to raise

	awareness and present information on substance use and underage drinking to the community. The Charles County Substance Abuse Advisory Coalition used three campaigns to educate the community on the dangers of underage drinking and the consequences of providing alcohol to minors. The BUZZKILL campaign targeted young adults who may be providing alcohol to minors. The Parents Who Host Lose the Most campaign educates parents on the consequences of providing alcohol to underage youth. And the Talk. They hear you. campaign was initiated by SAMHSA to help parents start the conversation early on the dangers of alcohol use. Billboard campaigns were used for the BUZZKILL and Parents who Host campaigns. Billboard campaigns were also used to address marijuana, opiates, and prescription drug abuse. This was supported by the PHCC (LHIC) Behavioral Health Team. Online Newsletter: The College of Southern Maryland has begun using the Student Health 101 online newsletter to educate all students on health issues, including smoking cessation, the dangers of binge drinking, stress, sleep, and other health conditions. This was supported by the PHCC (LHIC) Behavioral Health Team. Law Enforcement Response to underage drinking: The Charles County Sheriff's Office and the La Plata Police Department conducted 21 party patrols and alcohol surveillance activities in fiscal year 2015. The Party Patrols were a multi-pronged effort for underage alcohol enforcement. Officers were instructed to check neighborhoods for underage parties, as well as monitor police calls and also respond to any calls for service in reference to underage parties or loud parties. Officers also conducted surveillance at liquor establishments in reference to illegal underage alcohol possession, and third party situations involving adults furnishing alcohol to minors. The dates of the assignments coincided with three of our county's high school Prom nights, and these operations were conducted during the prime hours for parties and alcohol activity (2200 – 0200 hrs.). This was supported by the PHCC (LHIC) Behavioral Health Team. Substance Use Disorder Informational Forum: As a follow-up to the May listening forum, the Charles County Drug and Alcohol Council decided that an educational forum for parents and the community should be planned for this fall. The Behavioral Health Team of the local health improvement coalition (LHIC) has taken the lead on the development of this forum. It was held on October 15th at St Charles High School from 4-9. The key note speaker was from the Upside Down Brain organization who gave a presentation on the effects of drugs and alcohol on the development of the brain and how that can subsequently affect a

	person's life. It was very well received by the audience. There were also shorter presentations that addressed many different topics of concern such as the signs of possible drug addiction that parents need to look for, where to go if your child or family member is in need of substance abuse services and the support services available to families in recovery. Speakers included Judge Harrington of the Family Recovery Court and representative from the Sheriff's Office. Community agencies and resources set up tables outside of the auditorium with information for those attending. This was supported by the PHCC (LHIC) Behavioral Health Team. It is estimated that approximately 175 people were in attendance for this event. Naloxone Training of First Responders: . A total of 31 law enforcement officers from the Charles County Sheriff's Office and La Plata Police Department were trained in Naloxone distribution on June 25 and 26, 2015. An additional 25 officers were trained on July 16, 2015. The remaining officers will be trained on July 24, 2015 and the first week of August. This was supported by the PHCC (LHIC) Behavioral Health Team. Opiate Awareness Campaign: An awareness campaign was conducted in the county using ads on VanGo buses (county public transit system). In November 2014, three bus ads with the tagline "Opiates kill" and another regarding prescription drug abuse were placed on county transit buses that circulate the county. The ads will run for a 90 day period and will be seen throughout the county. This was supported by the PHCC (LHIC) Behavioral Health Team. Upside-Down Presentation: The Charles County Public Schools, in partnership with the Charles County Substance Abuse Advisory Coalition, the College of Southern Maryland, the PHCC (LHIC) Behavioral Health Team, and the Charles County Department of Health, held a presentation entitled "Addiction in the Brain" on May 11, 2015. The presentation was held at the College of Southern Maryland and was open to all school and health professionals in the county. Continuing education credit was available through the College of Southern Maryland. Attendance was approximately 200 people. Frank Kros, from the Upside Down Organization, was the presenter for the Addiction in the Brain presentation. The presentation was divided into four parts: Brain 101: An Introduction to Brain Anatomy and Chemistry; Cortisol: the Mysterious Motivator known as Stress; The Adolescent Brain; and Addiction in the Brain: the 4 "What's." Evaluations from the presentation highly rated this event. Community members and key stakeholders have already requested an additional presentation in the next fiscal year. County Planning Forum Conducted: The PHCC (LHIC) Behavioral Health

Table III A. Initiative**: <u>Substance Use Disorders</u>**

	Team, in collaboration with the Charles County Department of Health, the MD DHMH, and the Maryland Women's Coalition on Health Care Reform, conducted an Access to Care Forum on Behavioral Health for Charles County on July 11, 2014. The event was held at the College of Southern Maryland. Key stakeholders from the community were present to discuss the challenges and barriers to accessing behavioral health care and to develop action steps for improvement. Presentations were given in the morning to describe the scope of the problem and available resources. Then 5 breakout sessions were conducted to talk about the various barriers to access to care for behavioral health. Action plans were developed and discussed with the large group. There was a total of 50 participants at this event. <u>Southern Maryland Regional Event Conducted</u>: Various members of the Charles County LHIC participated in the Southern Maryland Opioid Overdose Prevention and Response Symposium on July 1, 2014. This regional meeting was held to discuss the problem in Southern Maryland and the resources/initiatives in each county. The event was organized by the three Southern Maryland health officers. A total of 90 people were in attendance at this event.
c.) Number of people within the target population	Approximately half of Charles County adults have consumed a substance in the past month: 73,276. 61% of HS Students surveyed reported they had consumed a substance in the past month. 61% of CC population 15-19 years: 3553 Target Population: 3553+73276=77279
d.) Number of people reached by the initiative within the target population	10221
e.) Primary Objective of the Initiative	Reduce the number underage 12th graders using alcohol to 62.1% or a 10% reduction and having 5 or more drinks in one setting to 43.2% or a 10% reduction. Increase the number of people receiving treatment for abuse or dependence of opiates, and/or illicit drugs in the past year from 225 to 250. Increase the number of county hospitals and primary care settings implementing SBIRT and increase the number of persons referred in the hospital ED for substance abuse treatment from 85 to 100.
f.) Single or Multi-Year Initiative Time Period	Multi-year (2012 to present)

Table III A. Initiative**: <u>Substance Use Disorders</u>**

g.) Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, PHCC Behavioral Health Team, Charles County Department of Health, College of Southern Maryland, Charles County Substance Abuse Advisory Coalition, Charles County Sheriff's Office, Citizens for Substance Free Youth, Charles County Public Schools, Charles County Commissioners, Walden Sierra, State Highway Administration's Potomac Regional Traffic Safety Coordinator
h.) Impact/Outcome of Hospital Initiative?	Process measures will track the number of community events hosted, and the number of people attending in community events, etc. to determine if we have met the goals and expectations set by those programs. All performance measure tracked throughout the year. <u>Impact measures:</u> New Maryland Youth Risk behavior survey data was released in May 2014. Data on 30-day use and binge drinking were examined to determine if any reductions can be seen. Additionally, the CORE Alcohol and Drug Survey was conducted at the College of Southern Maryland to determine if any changes have been made in binge drinking levels and in perceptions of harm and acceptance for binge and underage drinking. SMART data (all individuals receiving substance use disorder treatment through a publicly funded program) will be tracked for increases in the number of people receiving treatment for opiates and illicit drugs. Enhanced communication between the health department and hospital case managers will help to track the number of hospital staff using SBIRT and the number of people they refer to the health department for substance use treatment from the ED.
i.) Evaluation of Outcome	<u>Process Measures:</u> Number of community events attended: 15 Number of encounters at community events: 8175 Number of PSA's developed: 2 Number of video documentaries produced on drug use: 1 Number of online newsletters sent to college students on alcohol, smoking, and health: 7 Number of students receiving the newsletters: 1500 Number of alcohol awareness campaigns: 3 Number of opiate awareness campaigns: 1 Number attending community educational forum on drug use: 175 Number attending behavioral health planning forum: 50 Number attending regional forum on opiate overdose response: 90 Number of officers trained in Naloxone administration: 31 Number of community leaders attending presentation on the affects of drugs on the brain: 200 Number of banners hung at local ballpark on alcohol: 2

Table III A. Initiative**: <u>Substance Use Disorders</u>**

	Impact Measures: 1*. Reduce the proportion of high school students who have used alcohol from 69% to 62.1% or a 10% reduction and having 5 or more drinks in one setting from 48% to 43.2% or a 10% reduction (2010 Charles County Adolescent Survey).* <u>Update:</u> The 2013 Maryland Youth Tobacco and Risk Behavior Survey found that 61% of Charles County high school students have had at least one drink of alcohol during their lifetime. This is a reduction from the 2007 reported percentage of 69%. This percentage has exceeded the Charles County Health Improvement Plan of 62.1%. 2*. Increase the proportion of persons with co-occurring substance abuse and mental health disorders who receive treatment for both. Measure will be the Crystal Report for Dual Diagnosis SMI/SED. Increase by 10%.* <u>Update:</u> For Fiscal Year 2014, 382 Charles County consumers in the Public Mental Health System were dually diagnosed with mental health and substance use disorders. The Charles County PMHS has seen a 45% increase in the number of consumers who are dually diagnosed in the past two fiscal years. The 45% increase far exceeded the Charles County Health Improvement Plan goal of a 10% increase. 3*. Increase the number of people receiving treatment for abuse or dependence of opiates and/or illicit drugs in the past year from 225 to 250 or a 10% increase*. <u>Update:</u> From 2011 to 2012, there has been a 4.6% increase in the number of opiate-related admissions to treatment in state funded programs. This does not meet the Charles County Health Improvement Plan goal of a 10% increase, but it is moving in the appropriate direction. Enhanced communication between the health department and hospital case managers will help to track the number of hospital staff using SBIRT and the number of people they refer to the health department for substance use treatment from the ED. Hospital staff were not trained in SBIRT in FY15 and therefore did not use the screening. The Behavioral Health Team is working on a SBIRT training in FY2016 as well as an enhanced system for tracking and referral.
j.) Continuation of Initiative	Initiatives will continue in next fiscal year.

Table III A. Initiative**: <u>Substance Use Disorders</u>**

k.)	A. Total Cost of Initiative	B. Direct offsetting revenue from Restricted Grants
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	$4,260	Ø

Appendix I
HSCRC Community Benefit Report FY 2015
Financial Assistance Policy Description
University of Maryland Charles Regional Medical Center (UM CRMC)

UM CRMC posts its charity care policy, or a summary thereof, as well as financial assistance contact information in admissions areas, emergency rooms, business offices and other areas of the facility where eligible patients are likely to present. In addition, the policy is available on the UM CRMC website and is posted in the local paper twice each year.

The FAP is written in a culturally sensitive and at an appropriate reading level. It is available in English and Spanish. All Patient Access Customer Service Staff have training in the financial assistance process.

During the intake or discharge process or when there is contact regarding a billing matter, if a patient discloses financial difficulty or concern with payment of the bill, the patient is provided with FAP information. A packet with the application, criteria and a documentation checklist is provided. Assistance completing the application is available. Additionally, assistance is provided for patients or their families in qualification and application of government benefits, Medicaid and other state programs. Once an application is processed and if it is deemed incomplete, a letter is sent to the patient requesting the missing or incomplete items. Patients may call the Call Center or come into the Patient Access Office for assistance.

Appendix II
HSCRC Community Benefit Report FY 2015
ACA Health Care Coverage Expansion Description
University of Maryland Charles Regional Medical Center

The implementation of the Affordable Care Act's (ACA) Health Care Coverage Expansion Option became effective on January 1, 2014. There has been a substantial decrease in the number of patients presenting to the hospital in either uninsured and/or self-pay status.

Additionally, the ACA Health Care Coverage Expansion Option included a discontinuation of the primary adult care (PAC) which has also reduced uncompensated care since January 1, 2014.

While there has been a decrease in the uncompensated care for straight self-pay patients, it has not completely irradiated charity care as patients may still be eligible, if qualified, after insurance.

UNIVERSITY of MARYLAND
CHARLES REGIONAL
MEDICAL CENTER

Organizational Policy & Procedure Manual

TITLE: GUIDELINES FOR THE FINANCIAL ASSISTANCE PROGRAM

POLICY NUMBER: AD-0150

EFFECTIVE: January, 1999 LAST REVISED: February, 2015

POLICY:

1. This policy applies to University of Maryland Charles Regional Medical Center (UM CRMC). UM CRMC 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.

2. It is the policy of UM CRMC 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.

3. UM CRMC will publish the availability of Financial Assistance on a yearly basis in the local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Signage in key patient access areas will be made available. A Financial Assistance Information Sheet will be provided to patients receiving inpatient services, and a Financial Assistance Information Sheet made available to all patients upon request.

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

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

PROCEDURE:

I. Program Eligibility

A. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, UM CRMC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. UM CRMC reserves the right to grant Financial Assistance without formal application being made by our patients.

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

1. Services provided by healthcare providers not affiliated with UM CRMC (e.g., home health services)

2. Patients whose insurance denies coverage for services due to patient's non compliance of insurance restrictions, rules and access (e.g., insurance requires use of capitated facility and patient was non compliant; therefore claim was denied), 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 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
6. Physician charges related to the date of service are excluded from UM CRMC's financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly

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

1. Refusal to provide requested documentation or providing incomplete information
2. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to UM CRMC 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 UM CRMC
5. Failure to make appropriate arrangements on past payment obligations owed to UM CRMC (including those patients who were referred to an outside collection agency for a previous debt)

6. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program
7. Refusal to divulge information pertaining to legal liability claim

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

D. Patients who indicate they are financially unable to pay an outstanding balance(s) shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance (See Section III below) eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership.

E. Standard financial assistance coverage amounts will be calculated based upon 200-300% of income, and hardship will be calculated based on hardship guidelines as defined by federal poverty guidelines and follows the sliding scale.

II. Presumptive Financial Assistance

A. Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance form and/or supporting documentation on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with Financial Assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UM CRMC 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. If patient is receiving any of the programs listed below and completed an application for financial assistance, the application may be processed to provide patient with a longer term of assistance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. Active Medical Assistance pharmacy coverage
2. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums)
3. Primary Adult Care ("PAC") coverage
4. Homelessness
5. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
6. Maryland Public Health System Emergency Petition patients
7. Participation in Women, Infants and Children Programs ("WIC")
8. Food Stamp eligibility
9. Eligibility for other state or local assistance programs

10. Patient is deceased with no known estate
11. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program

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

1. Purely elective procedures (e.g., Cosmetic procedures) are not covered under the program.

III. Medical Hardship

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

1. Medical Hardship criteria is State defined:
   a. Combined household income less than 500% of federal poverty guidelines
   b. Having incurred collective family hospital medical debt at UM CRMC exceeding 25% of the combined household income during a 12-month period. The eligibility period is 12-month from the date that the Medical Hardship application was approved.
   c. The medical debt includes co-payments, co-insurance, and deductibles.

B. Patient balance after insurance:

1. UM CRMC applies the State established income, medical debt and time frame criteria to patient balance after insurance applications.

C. Coverage amounts will be calculated based upon zero - 500% of income as defined by federal poverty guidelines and follows the sliding scale below:

Sliding Scale

FINANCIAL ASSISTANCE – INCOME GUIDELINES

		% of Federal Poverty Level Income - 2015											
		Up to 200%	Up to 210%	Up to 220%	Up to 230%	Up to 240%	Up to 250%	Up to 260%	Up to 270%	Up to 280%	Up to 300%	300% - 500%	
Size of Family Unit	FPL Income	Standard Financial Assistance - % of Reduction in Charges										Medical Hardship	
		100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	Patient Responsibility is 25% of Income	
1	11,770	23,540	24,717	25,894	27,071	28,248	29,425	30,602	31,779	32,956	35,310	35,310	58,850 (3)
2	15,930	31,860	33,453	35,046	36,639	38,232 (2)	39,825	41,418	43,011	44,604	47,790	47,790	79,650
3	20,090	40,180	42,189	44,198	46,207	48,216	50,225	52,234	54,243	56,252	60,270	60,270	100,450
4	24,250	48,500	50,925	53,350	55,775	58,200	60,625	63,050	65,475	67,900	72,750	72,750	121,250
5	28,410	56,820 (1)	59,661	62,502	65,343	68,184	71,025	73,866	76,707	79,548	85,230	85,230	142,050
6	32,570	65,140	68,397	71,654	74,911	78,168	81,425	84,682	87,939	91,196	97,710	97,710	162,850
7	36,730	73,460	77,133	80,806	84,479	88,152	91,825	95,498	99,171	102,844	110,190	110,190	183,650
8	40,890	81,780	85,869	89,958	94,047	98,136	102,225	106,314	110,403	114,492	122,670	122,670	204,450

For families with more than 8 persons, add $4,160 for each additional person.

Patient Income and Eligibility Examples:

Example #1	Example #2	Example #3
- Patient earns $59,500 per year - There are 5 people in the patient's family - The % of potential Finance Assistance coverage would equal 90% (they earn more than $56,820 but less than $59,661)	- Patient earns $39,000 per year - There are 2 people in patient's family - The % of potential Financial Assistance coverage would equal 50% (they earn more than $38,232 but less than $39,825)	- Patient earns $58,000 per year - There is 1 person in the family - The balance owed is $20,000 - This patient qualifies for Hardship coverage; patient portion is 25% of $58,850 ($14,588)

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

E. Individual patient situation consideration:

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

F. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance programs, UM CRMC is to apply the greater of the two discounts.

G. Patient is required to notify UM CRMC of their potential eligibility for this component of the financial assistance program.

IV. Asset Consideration

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

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

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

V. Appeals

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

B. Appeals can be initiated in writing.

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

D. Appeals are documented. They are then reviewed by the next level of management above the representative who denied the original application.

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

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

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

VI. Procedures

A. UM CRMC will provide a trained person or persons who will be responsible for taking Financial Assistance applications in Patient Access and Patient Accounts. These staff can be Financial Counselors, Billing Staff, Customer Service, etc.

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

1. Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.
2. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
3. UM CRMC will not require documentation beyond that necessary to validate the information on the Financial Assistance Application.
4. Applications initiated by the patient will be tracked, worked and eligibility determined within 30 days of receipt of completed application. A letter of final determination will be submitted to each patient that has formally requested financial assistance.
5. Incomplete applications/missing documentation will be noted in patient's account, and original documents will be returned to patient with instruction to complete and return for processing.

C. In addition to a completed Financial Assistance Application, patients may be required to submit:

1. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable).
2. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.
3. Proof of social security income (if applicable)
4. A Medical Assistance Notice of Determination (if applicable).
5. Proof of U.S. citizenship or lawful permanent residence status (green card)

6. Reasonable proof of other declared expenses
7. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

D. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UM CRMC guidelines.

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

    a. If the patient does qualify for financial clearance, appropriate personnel will notify scheduling department who may then schedule the patient for the appropriate service.
    b. If the patient does not qualify for financial clearance, appropriate personnel will notify the scheduling staff of the determination and the non-emergent/urgent services will not be scheduled.
    c. A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.

E. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following three (3) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.

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

1. Post approval discovery of an ability to pay
2. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to CMC

G. Patients with three (3) or twelve (12) months certification periods have the responsibility (patient or guarantor) to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

H. If patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER

TITLE: **GUIDELINES FOR THE FINANCIAL ASSISTANCE PROGRAM**

FUNCTION: Administrative

POLICY NUMBER: AD-0150

ISSUE DATE: 01/99

REVIEW/REVISED DATE:

Revised: 04/00
Revised: 07/03
Revised: 04/06
Revised: 04/10
Revised: 02/13
Revised: 02/15
Revised: 05/01
Revised: 01/04
Revised: 05/07
Revised: 03/11
Name Change: 07/13
Revised: 06/02
Revised: 11/04
Revised: 05/08
Revised: 02/12
Revised: 03/14

APPROVED BY:

Louis Jenkins, Jr.
Chair, Board of Directors

Date

Noel Cervino
President & CEO

Date

Erik Boas
Sr. Vice President, Finance/CFO

Date

NOTE: This policy was previously LD-004 (as of 04/10).

Disclosure Statement

Effective July 1, 2013, the name of Civista Health, Inc. was changed to University of Maryland Charles Regional Health, Inc. and the name of Civista Medical Center, Inc. was changed to University of Maryland Charles Regional Medical Center. For purposes of all Policies and Procedures, these new names are now operational and any inadvertent mention of Civista Health, Inc. or Civista Medical Center is now incorrect.

The shared drive is the official location for Organizational Policies and Procedures for University of Maryland Charles Regional Medical Center. The original of this Organizational Policy and Procedure document with required signature is available for review during regular business hours by contacting the Information Technology Department at 301-609-4495. University of Maryland Charles Regional Medical Center reserves the right to update or modify all policies, procedures, and forms at any time and without prior notice, by posting the revised version on this drive. **NOTE:** To ensure the integrity of these documents, each page is either scanned or converted and placed on this drive as a duplicate of the original.

UNIVERSITY of MARYLAND
CHARLES REGIONAL HEALTH

Patient Account Department

5 Garrett Avenue
P.O. Box 1070
La Plata, Maryland 20646
301-609-4400 | 301-609-4411 FAX
Charlesregional.org

FINANCIAL ASSISTANCE CHECKLIST

The following information must be submitted in order for your application to be considered:

- **A completed application (attached).**
- **If you meet the qualification guidelines for Medical Assistance, you are required to provide an Approval, Denial letter or receipt from application submission from Medical Assistance – apply directly with your county Department of Social Services for Medical Assistance.**

Charles County Resident

Charles County Department of Social Services
200 Kent Ave
LaPlata, Maryland 20646
(301) 392-6400

- **Most current tax return.**
- **Your two most recent pay stubs.**
- **If you are unemployed, you need obtain a wage history statement from the unemployment office stating you have not received any wages; if unable to obtain, please supply a letter of support.**

Department of Labor, Licensing and Regulation
(800) 827-4839

- **Proof of Income- social security award letter or copy of check.**
- **Copy of your most recent bank statement for your checking and savings accounts.**

NOTE: All requested documentation MUST be submitted in order to process your application in a timely manner.

If assistance is needed in completing information necessary to process your application, please contact our office at (301) 609-4400.

Return application and all required forms to:

Hand deliver:	Mail:
Call Center **(near the Outpatient Dept)** Ground floor of the Hospital Hours of Operation: 8am to 5:30 pm	University of Maryland Charles Regional Medical Center Patient Financial Assistance PO Box 1070 LaPlata, MD 20646

Steps to completing the Financial Assistance Application

The Financial Aid Application form must be written clearly and legible in ink. The patient or guarantor's signature is required. A Financial Aid Application can be completed on any patient who informs us that they cannot afford to pay for services rendered regardless of the financial class.

Family Size/Household Members

Enter the number of people living in the patient's household. If the person is an adult, the family size includes the applicant, their spouse, any minor children that are supported, and any adults for whom the primary individual is legally responsible. If the applicant is a minor (under 18 years old), the family size includes either parents (or parent's spouse), minor siblings, and any adults in the family for whom the parents are legally responsible. A pregnant woman counts as two family members. The hospital will not count a parent or spouse in their family size if that person has abandoned them. And the hospital will not count a spouse who does not support the applicant if they are separated or divorced. Make sure the patient is included. As a rule, the number of people within the household should be the same number of family members claimed on the Federal Income Tax Return.

Proof of Income (about your income)

The best proofs of income are the following documents:

- Federal or state income tax returns; if self employed provide your 1099
- Paycheck stubs
- W-2 forms
- A letter from your employer on company letterhead stating your income, or a statement of your income from any government agency that provides you benefits
- If you are receiving Social Security benefits, you must show your annual statement from the Social Security Administration, or a copy of your Social Security check, or your bank statements from the three months before the hospital service that show the direct deposit of your check.

If the applicant does not have any of the above proofs of their income, then two (2) paycheck stubs from immediately before their hospital service will be accepted. If they do not have a paycheck stub, they may sign a paper attesting to what their income was for the last 12 months.

Definition of "Annual" or "Yearly" Income

Yearly Income: The sum of the total gross income of the household for the prior 12-month period. All types of income must be included:

- Salary (gross wages before taxes)
- Public Assistance (cash assistance)
- Social Security Benefits
- Unemployment Benefits and Workers' Compensation
- Veterans Benefits
- Alimony and Child Support
- Pension Payments
- Insurance and Annuity Payments

University of Maryland Charles Regional Medical Center—Financial Assistance Application

TELL US ABOUT YOURSELF

Applicant's Name _____ Date of Birth _____
First Middle Last

Home Address _____
(include Street Address and P.O. Box)

_____
City State Zip Code

Home Number _____ Cell Phone Number _____

Social Security Number _____ US Citizen YES NO
Permanent Resident YES NO

Martial Status **Single** **Married** **Widow** **Divorced** **Separated**

Spouse's Name _____ Social Security Number _____

HOUSEHOLD MEMBERS (List Dependents Name, Age and Relationship to Applicant)

Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____
Name _____ Age _____ Relationship _____

MEDICAL ASSISTANCE

Do you receive any type of state or county assistance? YES NO
Have you applied for Medical Assistance? YES NO
If yes, what was the date you applied? _____
If yes, what was the determination? DENIED_____ APPROVED _____ SPEND DOWN _____
Medical Assistance Number _____

NOTE: Attach copy of the receipt, Approval or Denial letter from Medical Assistance

ABOUT YOUR INCOME

Employer Name _____ Phone Number _____

Work Address _____
(include Street Address and PO Box) City State Zip Code

Spouse Employer Name _____ Phone Number _____

Work Address _____
(include Street Address and PO Box) City State Zip Code

FAMILY INCOME

	MONTHLY AMOUNT		MONTHLY AMOUNT
Applicant's Employment (before taxes)	$ _____	Spouse's Employment (before taxes)	$ _____
Disability Benefits	$ _____	Veteran's Benefits	$ _____
Retirement/Pension Benefits	$ _____	Alimony	$ _____
Social Security Benefits	$ _____	Strike Benefits	$ _____
Public Assistance Benefits	$ _____	Military Allotment	$ _____
Unemployment Benefits	$ _____	Rental Property Income	$ _____
Farm or Self Employment	$ _____	Other Income Source	$ _____

Total Monthly Income $ _____

LIQUID ASSETS

For UM CRMC use only:

CURRENT BALANCE	
Checking Account	$ _____
Savings Accounts	$ _____
Stocks, Bonds, CD, or Money Market	$ _____
Other Accounts	$ _____
TOTAL	$ _____

OTHER ASSETS (If you have any of the following items, please list the type and approximate value.)

Home	Loan Balance $ _____	Approximate value $ _____
Automobile	Make/Model _____ Year _____	Approximate value $ _____
Automobile	Make/Model _____ Year _____	Approximate value $ _____
Boat/ATV	Make/Model _____ Year _____	Approximate value $ _____
Other Property	_____ (please specify)	Approximate value $ _____

TOTAL $ _____

MONTHLY EXPENSES

			MONTHLY AMOUNT
Rent _____	Mortgage	_____ (please check one)	$ _____
Utilities:	Telephone	$ _____	
	Electric/Gas	$ _____	
	Cable	$ _____	
	Water	$ _____	
	Trash	$ _____	Total Utilities $ _____
Car Payment(s)			$ _____
Credit Card(s)	_____ Name	_____ Name _____ Name	$ _____
Car Insurance			$ _____
Health Insurance			$ _____
Other Medical Expenses			$ _____
Other Expenses			$ _____
		TOTAL	$ _____

I understand that the information I have submitted is subject to verification by University of Maryland Charles Regional Medical Center and by signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ Applicant's Signature Date

_____ Spouse's Signature Date

APPENDIX IV

Contact Information

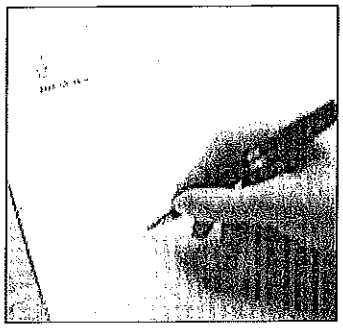
If you feel your rights have been violated in any way, please contact Performance Improvement immediately by calling 301-609-4310.

Contact & Phone Numbers:
For customer Service in Billing, the hours of operation are 8:30am–4:00pm., Monday through Friday. We can be reached at 301-609-4400

Patient Financial services:
301-609-4400

Maryland Medical Assistance
800-284-4510

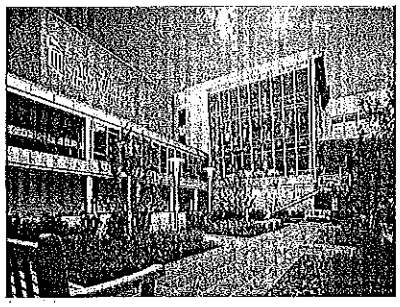
Department of Labor, Licensing and Regulation:
301-645-8712



5 Garrett Ave.
PO Box 1070
La Plata, MD 20646
Phone: 301-609-4000
www.charlesregional.org

UNIVERSITY of MARYLAND
CHARLES REGIONAL
MEDICAL CENTER

PATIENT INFORMATION



Patient's Rights & Obligations

You have the right to:

1. Receive care and treatment at this hospital despite the ability to pay.
2. Receive consideration and respect by the staff during every phase of your care.
3. Be treated with dignity, respecting your spiritual, cultural, and personal values and beliefs.
4. Have respect for your privacy and for the confidentiality of information about you and your medical condition.
5. Be involved in decisions affecting your health care and well-being.
6. Know the name of the physician responsible for directing and coordinating your care as well as the names of other hospital caregivers.
7. Be informed about procedures and treatment and to refuse treatment as permitted by law.
8. Have questions answered about your condition and course of treatment.
9. Expect the health care professionals will accept and act upon your reports of pain and will provide education and resources available relating to pain management.
10. Be informed of available resources for resolving disputes, grievances, and conflicts.
11. Receive a written bill stating the Medical Center's charges.

You have the responsibility to:

1. Provide, to the best of your ability, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
2. Ask questions and request clear explanations of your care treatments and service in order to make informed decisions.
3. Follow the care, treatment, and service plan developed.
4. Be responsible for the outcomes if you do not follow the care, treatment and service plan provided to you.
5. Provide a copy of your advance directives power of attorney or domestic partnership affidavit if you have created such documents, to those responsible for your care while you are in the hospital.
6. Know and follow hospital rules and regulation, showing respect and consideration for other patients and individuals providing your health care.
7. Meet the financial commitments made with UM Charles Regional Medical Ctr.
8. Inform UM Charles Regional Medical Ctr as soon as possible if you believe that any of your rights have been or may be violated. You may do this at any time by calling the Office of the President at 301-609-4265 or Performance Improvement at 301-609-4310.

Hospital billing can be confusing. We hope that this brochure answers some of the questions that you may have regarding billing.

Physician Billing

You will receive multiple bills for your visit to the emergency room; as well as multiple bills for outpatient/inpatient services. Charles Regional Medical Center will submit a bill to you or your insurance company for our facility charges and/or the "technical" portion of the services. Your physician, surgeon, anesthesiologist, pathologist, radiologist, cardiologist, and Emergency Department physician will bill you separately for their professional services. Please contact them directly with your billing questions.

Emergency Medical Associates
240-686-2310

Radnet
301-438-5000

New Bridge Anesthesia
Anesthesia
301-638-4400

Professional Management, Inc.
Pathology
410-931-0400

Charles Regional Medical Center understands that patients may be faced with a difficult financial situation when they incur medical bills that are not covered by insurance. We encourage every patient and family to pursue all available programs that may be offered through the local Department of Social Services.

Financial Assistant

Charles Regional Medical Center can offer financial assistance to our patients who are denied state assistance. Please speak with a Customer Service Representative to determine if you may be eligible for either full or discounted services under this program. You may also contact a Customer Service Representative at 301-609-4400 for further information. Our financial aid programs will only apply to your hospital bills, and again, we encourage you to contact the Department of Social Services for assistance in paying your medical bills.

5 Garrett Ave.
PO Box 1070
La Plata, MD 20646
Phone: 301-609-4000
www.charlesregional.org

APPENDIX V

UNIVERSITY of MARYLAND
CHARLES REGIONAL HEALTH

OUR MISSION

University of Maryland Charles Regional Health exists to always provide excellent patient care as measured by the population's health, clinical outcomes, patient satisfaction and cost effectiveness.

OUR VISION

University of Maryland Charles Regional Health will remain the premier place to receive care and the premier place to provide care.