UNIVERSITY of MARYLAND MEDICAL CENTER

Community Benefit Narrative Report

Fiscal Year 2015

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

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

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

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

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

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), the IRS defines a CHNA as a:

> Written document developed for a hospital facility that includes a description of the community served by the hospital facility: the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

The written document (CHNA), as provided in the ACA, must include the following:

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

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact the

hospital organization's ability to assess the health needs of the community served by the hospital facility. If a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties.

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility, (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions ("LHIC's)[see: http://dhmh.maryland.gov/healthenterprisezones/Documents/Local_Population_Health Improvement_Contacts_4-26-12.pdf] schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input, who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and

A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

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

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;
(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)

(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments.

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

Our CHNA is available (and has been available since 6/30/15) on the internet at:
http://umm.edu/~/media/umm/pdfs/about-us/community-outreach/ummc-chna-executive-report-fy2015.pdf?la=en

The IMPLEMENTATION STRATEGY, as provided in the ACA, must:

a. **Be approved by an authorized governing body of the hospital organization;**
b. Describe how the hospital facility plans to meet the health need, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and
c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

All of the above items are explained in detail in the CHNA posted online at:
http://umm.edu/~/media/umm/pdfs/about-us/community-outreach/ummc-chna-executive-report-fy2015.pdf?la=en

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Table I

Bed Designation	801 Licensed Beds for FY15	
Total Inpatient Discharges	30,660	
Primary Service Area (Top 60% of discharges)	**Zip Code**	**Zip Code Name**
	21001	Aberdeen
	21009	Abingdon
	21014	Bel Air
	21015	Bel Air
	21040	Edgewood
	21042	Ellicott City
	21043	Ellicott City
	21044	Columbia
	21045	Columbia
	21060	Glen Burnie
	21061	Glen Burnie
	21078	Havre De Grace
	21113	Odenton
	21117	Owings Mills
	21122	Pasadena
	21133	Randallstown
	21136	Reisterstown
	21144	Severn
	21157	Westminster
	21201	Baltimore
	21202	Baltimore
	21205	Baltimore
	21206	Baltimore

	21207	Gwynn Oak
	21208	Pikesville
	21212	Baltimore
	21213	Baltimore
	21214	Baltimore
	21215	Baltimore
	21216	Baltimore
	21217	Baltimore
	21218	Baltimore
	21220	Middle River
	21221	Essex
	21222	Dundalk
	21223	Baltimore
	21224	Baltimore
	21225	Brooklyn
	21227	Halethorpe
	21228	Catonsville
	21229	Baltimore
	21230	Baltimore
	21231	Baltimore
	21234	Parkville
	21237	Rosedale
	21239	Baltimore
	21244	Windsor Mill
	21401	Annapolis
	21601	Easton
	21613	Cambridge
	21702	Frederick

	21740	Hagerstown
	21784	Sykesville
All Other Maryland Hospitals Sharing Primary Service Area	JOHNS HOPKINS, UMROI, MERCY MEDICAL CENTER, GREATER BALTIMORE MEDICAL CENTER,UM ST. JOSEPH MEDICAL CENTER, UNION MEMORIAL, SINAI, JOHNS HOPKINS BAYVIEW MEDICAL CENTER, UM MIDTOWN, ST. AGNES, GOOD SAMARITAN, HARBOR HOSPITAL CENTER,UM UPPER CHESAPEAKE MEDICAL CENTER, BON SECOURS, FRANKLIN SQUARE, NORTHWEST HOSPITAL CENTER, HOWARD COUNTY GENERAL, ANNE ARUNDEL MEDICAL CENTER,UM BWMC, HARFORD MEMORIAL, CARROLL HOSPITAL CENTER, MEMORIAL AT EASTON, WASHINGTON COUNTY, DORCHESTER GENERAL, FREDERICK MEMORIAL	
Percentage of UMMC Patients who are Uninsured by County	**County**	**% SELF PAY**
	ALLEGANY	0.0%
	ANNE ARUNDEL	0.5%
	BALTIMORE	0.4%
	BALTIMORE CITY	0.0%
	CALVERT	0.0%
	CAROLINE	0.0%
	CARROLL	0.5%
	CECIL	0.3%
	CHARLES	0.2%
	DELAWARE	0.0%
	DORCHESTER	0.0%
	FOREIGN	0.0%
	FREDERICK	0.1%
	GARRETT	0.0%
	HARFORD	0.1%
	HOWARD	1.0%
	KENT	0.9%

	MONTGOMERY	1.5%
	OTHER STATE	0.7%
	PENNSYLVANIA	0.0%
	PRINCE GEORGES	1.0%
	QUEEN ANNES	0.0%
	SOMERSET	0.0%
	ST. MARYS	0.4%
	TALBOT	0.3%
	UNIDENTIFIED MD	0.4%
	UNKNOWN	0.0%
	VIRGINIA	0.0%
	WASHINGTON	0.2%
	WASHINGTON,DC	0.0%
	WEST VIRGINIA	0.0%
	WICOMICO	0.0%
	WORCESTER	0.5%
	TOTAL	**0.4%**
Percentage of UMMC Patients who are Medicaid by County	**County**	**% Medicaid and Medicaid HMO**
	ALLEGANY	29.5%
	ANNE ARUNDEL	25.7%
	BALTIMORE	36.4%
	BALTIMORE CITY	55.6%
	CALVERT	21.9%
	CAROLINE	31.8%
	CARROLL	18.6%
	CECIL	39.2%
	CHARLES	33.7%

	DELAWARE	0.0%
	DORCHESTER	28.3%
	FOREIGN	50.0%
	FREDERICK	23.2%
	GARRETT	45.5%
	HARFORD	23.9%
	HOWARD	16.3%
	KENT	19.1%
	MONTGOMERY	26.8%
	OTHER STATE	5.8%
	PENNSYLVANIA	50.0%
	PRINCE GEORGES	32.1%
	QUEEN ANNES	22.4%
	SOMERSET	34.8%
	ST. MARYS	28.7%
	TALBOT	21.9%
	UNIDENTIFIED MD	29.9%
	UNKNOWN	50.0%
	VIRGINIA	0.0%
	WASHINGTON	22.5%
	WASHINGTON,DC	0.0%
	WEST VIRGINIA	0.0%
	WICOMICO	25.2%
	WORCESTER	34.2%
	TOTAL	**36.8%**

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

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

The following information contained in this report is reflective of the recently completed FY2015 CHNA. Table III reflects community benefits initiatives that were completed based on the FY12 CHNA for the period of July 2012 through June 2015. The initiatives for both periods are fairly congruent.

The University of Maryland Medical Center (UMMC) is an 800-bed academic medical center which is part of the University of Maryland Medical System. Despite the larger regional patient mix of UMMC from the metropolitan area, state, and region, for purposes of community benefits programming and this report, the Community Benefit Service Area (CBSA) of UMMC is within Baltimore City.

The top nine zip codes within Baltimore City displayed in Figure 3 represent the top 66% of all Baltimore City admissions in FY'14. These nine targeted zip codes are:

21201, 21215, 21216, 21217, 21218, 21206, 21223, 21229, and 21230.

The populations in these zip codes are some of the most vulnerable, underserved residents in Baltimore City. There are significant health disparities in these zip codes when compared to other zip codes in Baltimore City and Maryland.

(See Map of CBSA to follow)

Figure 3 – Community Benefit Service Area

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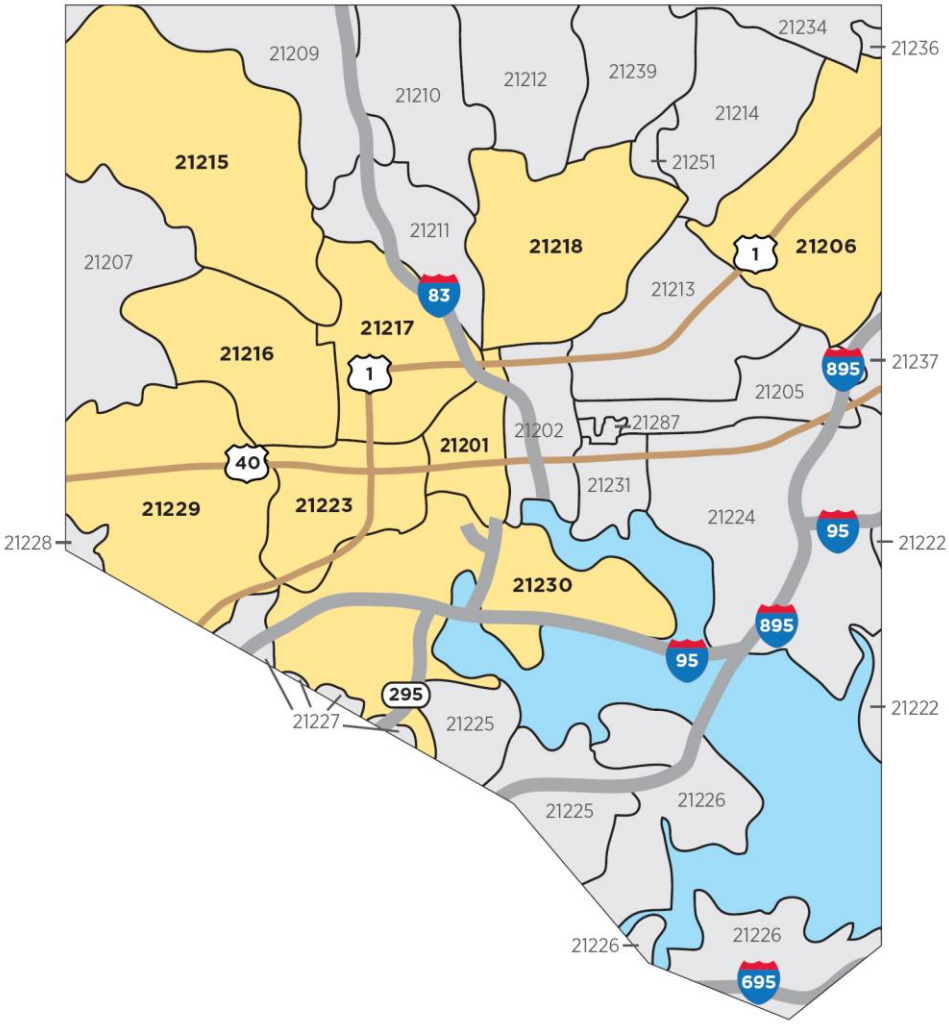
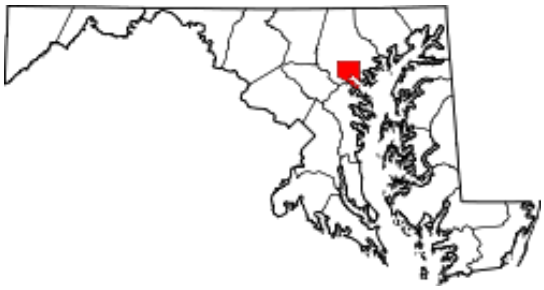
Defining the Community Benefit Service Areas within Baltimore City

YELLOW HIGHLIGHTED ZIP CODES = Top 60% of City Discharges



Baltimore City



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

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

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

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

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

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

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

3b. **In Table II, describe the population within the CBSA, including significant demographic characteristics and social determinants that are relevant to the needs of the community and *include the source of the information in each response*. For purposes of this section, social determinants are factors that contribute to a person's current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, transportation, education and healthy environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).**

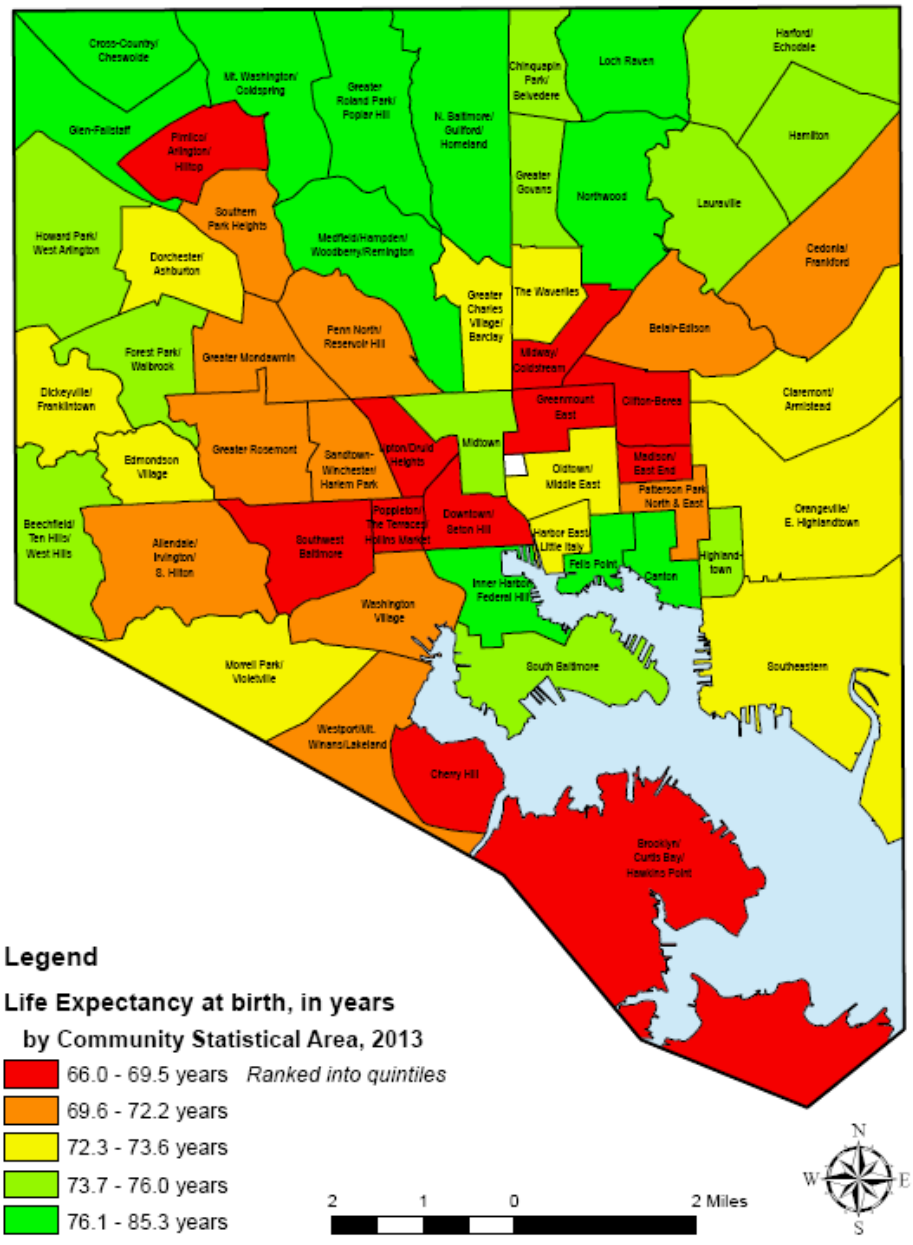
Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its Area Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf), The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Table II

CBSA Population Total	344,124
Median Household Income within the CBSA	$42,266 http://planning.maryland.gov/msdc/American_Community_Survey/2013/Income/MedHHIncome_1999_2013_WithUS.pdf
Percentage of households with incomes below the federal poverty guidelines within the CBSA	22.7% http://planning.maryland.gov/msdc/poverty/poverty.shtml
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	14% http://www.countyhealthrankings.org/app/maryland/2014/measure/factors/85/data
Percentage of Medicaid recipients by County within the CBSA.	30.9%
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Significant disparities in life expectancy by neighborhood exist in Baltimore City. Twenty year difference in life expectancies around the City. (See Map to follow)
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Crude Death Rates (per 100,000 population) All Races – 1,028.1 White/Caucasian – 1,001.2 Black/African American – 1,084.2 http://dhmh.maryland.gov/vsa/Documents/13annual.pdf
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	Percentage of HS graduates – 66% Unemployment – No Vehicle Available – 15.3% Severe Housing Problems – 24% Significant food deserts exist within Baltimore City (See Map to follow) http://www.countyhealthrankings.org/app/maryland/2015/rankings/baltimore-city/county/outcomes/overall/additional

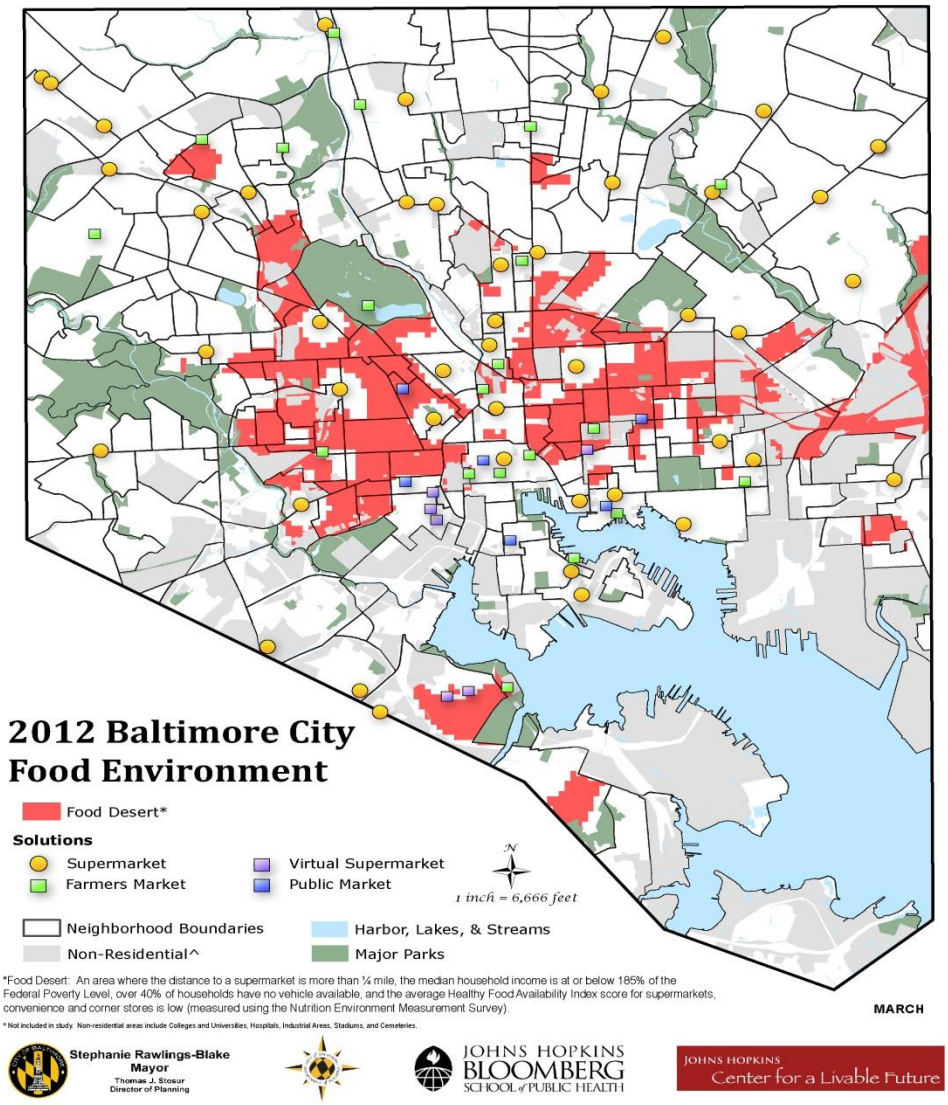
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Gender Male – 159,688 Female – 184,436 Median Age – 34.6 yrs Race White/Caucasian 81,208 Black/African American 242,172 Amer Indian/Alaska Native 1,084 Asian 8,161 Native Hawaiian/Other Pacific 205 Other 2,629 Two or More Races 8,665 Ethnicity Hispanic 8,759 Non-Hispanic 335,365 http://factfinder.census.gov
Other	(See maps to follow)

Baltimore City Life Expectancy Map



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

Baltimore City Food Environment Map



II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. **Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 4-5 within the past three fiscal years?**

__**X**__Yes
____No

Provide date here**.** **6/30/15** (mm/dd/yy)

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

http://umm.edu/~/media/umm/pdfs/about-us/community-outreach/ummc-chna-executive-report-fy2015.pdf?la=en

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

_X__ Yes 6/18/15 (mm/dd/yy) Enter date approved by governing body here:
___No

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

http://umm.edu/~/media/umm/pdfs/about-us/community-outreach/ummc-chna-executive-report-fy2015.pdf?la=en

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital? **(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b,)**

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

_X__ Yes
___No

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

Elements of the CHNA are integrated into the Strategic Plan within the following sections - Environmental Assumptions, Strategic Plan Guiding Principles, which lead to the Strategic Goals and Strategies. Specifically, the community benefit planning and findings of the CHNA are embedded within the Population Health Strategy to….."implement evidence-based community interventions targeting the West Baltimore community, to improve the health status of primary service residents". This Strategic Plan covers both campuses – University of Maryland Medical Center and UMMC Midtown Campus.

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. ___CEO
2. ___CFO
3. **_X__**Other (please specify) Senior Vice President, Strategy, Community & Business Development

Describe the role of Senior Leadership.

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

ii. Clinical Leadership

1. **_X__**Physician
2. **_X__**Nurse
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

- Provides clinical knowledge/context for needs assessment and programming
- Develops/approves protocols for health screenings
- Provides oversight to health screenings program
- Insures regulatory compliance
- Collaborates with UMB Professional Schools (Medicine, Nursing, Social Work)

iii. Community Benefit Operations

1. **_X_**Individual (please specify FTE – **3.5 FTEs)**
2. ___Committee (please list members)
3. **_X__**Department (please list staff)
   Anne D. Williams, DNP, RN – Director, Community Health Improvement
   Mariellen Synan – Community Outreach Manager
   Asunta Henry, BS – Community Health Advocate
   Lauren Davis, BA – Administrative Coordinator (.5 FTE)
4. ___Task Force (please list members)
5. ___Other (please describe)

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

Anne Williams, Director – Leads CHNA process and CB reporting process; Collaborates with numerous internal departments and Finance to produce annual reports/filings; Prepares Board summary

Mariellen Synan, Manager – Manages day-day operations and programming of community health improvement initiatives; Data entry into CBSA

Asunta Henry, CH Advocate – Manages Hypertension program and assists Manager with community events, Data entry into CBSA

Lauren Davis, Administrative Coordinator – Data entry into CBSA, Assists with event scheduling

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

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

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

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

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

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

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

__**X**__ Other hospital organizations
__**X**__ Local Health Department
N/A_ Local health improvement coalitions (LHICs) – There is no active LHIC in Baltimore City
__**X**__ Schools
_____ Behavioral health organizations
__**X**_ Faith based community organizations
_____ Social service organizations

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

Organization	Name of Key Collaborator	Title	Collaboration Description
University of Maryland Medical Center – Midtown Campus	**Don Ray** **Multiple other staff**	**Vice President, Operations** **Mgr, Supervisor, Clinical Nutritionist**	**Strategic Leadership** **Members of joint CHI Team**
University of Maryland Medical System	**Donna Jacobs**	**Senior Vice President**	**Hosted community partner focus group**
University of Maryland – Professional Schools	**Dr. Russell Lewis, Dr. Pat McClaine Bronwyn Mayden**	**School of Medicine School of Nursing School of Social Work**	**Attended strategic retreat; Provided insight into UMB comm. initiatives**
Mt Washington Pediatric Hospital	**Melissa Beasley**	**Community Outreach Coordinator**	**Co-hosted community partner focus group; Attended strategic retreat**
Baltimore City Health Dept	**Laura Fox**	**Director, Chronic Disease Prevention**	**Provided City's & Mayor's health priorities**
University of Maryland Baltimore	**Ashley Valis**	**Director, Community Initiatives**	**Attended strategic retreat; Provided insight into UMB community initiatives**
Union Baptist Church	**Rev. Dr. Al Hathaway**	**Senior Pastor**	**Provided input re: community faith leaders' perspectives on community health priorities**

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

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

We do participate in other Coalitions sponsored by the Baltimore City Health Dept (Tobacco, Cardiovascular Disease, Flu Coalitions)

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

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

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. **Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached example of how to report.**

For example: for each principal initiative, provide the following:

a. 1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.
   2. Please indicate whether the need was identified through the most recent CHNA process.

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

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

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

e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results.

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

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

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

- What were the measurable results of the initiative?
- For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

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

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

k. Expense:
A. What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
B. Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

Several additional topic areas were identified by the Community Health Improvement Team during the CHNA process including: Behavioral/mental health, safe housing, transportation, and substance abuse. While UMMC & Midtown Campuses will focus the majority of our efforts on the identified strategic priorities outlined earlier, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through either existing clinical programs (i.e. Methadone clinics, Residential Psychiatric program) or through collaboration with other health care organizations as needed (Baltimore City Health Department, Johns Hopkins, Medstar, St Agnes, Mercy, and others for health literacy and other issues). Additionally, substance abuse programming is already integrated into either existing clinical programs

or community health programs, like – Stork's Nest and Violence Prevention programs. The additional unmet needs not addressed by UMMC/Midtown will also continue to be addressed by key Baltimore City governmental agencies and existing community-based organizations.

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

The Population Health Strategy and Implementation Plan was finalized and submitted to the State on 12/7/15. This plan will cover both the University of Maryland Medical Center and Midtown Campuses. The Community Health Needs Assessments and Community Benefits Reports are integrated into the Plan to provide a context of the community for planning purposes. Two of the five goals within the plan directly reflect the work already conducted by the Community Benefits Team. The two goals which are most closely linked to current community health improvement work are:

Goal 2: Improve patient outcomes and quality of care for patients suffering from chronic disease

Goal 3: Promote health and well-being through enhanced screening, prevention and health promotion

Beginning work with high utilizers has already started with the addition of the Living Well/Chronic Disease Self Management Program and the CDC's Diabetes Prevention Program into the community health programming. These current programs led by the Community Health Improvement Department will augment both above goals.

In addition, there are six workgroups which will be tasked with specific elements of the overall strategy. The Social Determinants of Health (SDoH)/Community Partnership Workgroup will be led by the Director of Community Health Improvement with Executive Oversight by two Senior Vice Presidents along with the Director of Population Health. Initiatives will be further developed which will address the SDoH which are barriers in the targeted West Baltimore population.

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

VI. PHYSICIANS

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

There are no gaps in the availability of specialist providers, including inpatient, outpatient, and specialty care to serve the uninsured at UMMC.

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

Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

Not applicable

VII. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):
   a. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's FAP. (label appendix I)

For ***example***, state whether the hospital:

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
  - in a culturally sensitive manner,
  - at a reading comprehension level appropriate to the CBSA's population, and
  - in non-English languages that are prevalent in the CBSA.
- posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
- provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
- provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
- includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
- discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

   b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).
   c. Include a copy of your hospital's FAP (label appendix III).
   d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

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

Attachment A

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

- Increase life expectancy

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

Table III

A. 1. Identify Need 2. Was this identified through the CHNA process?	**<u>Cardiovascular Disease/Obesity Prevention</u>** 68% of Baltimore City adults are either overweight or obese. Heart Disease is the number one leading cause of death, and stroke is the third leading cause of death in Baltimore City. Baltimore City's Hypertension ED visit rate is 658/100,000 as compared to 252/100,000 for Maryland. Significant health disparities exist among African Americans in Baltimore City. Food deserts exist in half of the targeted zips. Yes, this was identified through the CHNA process (FY12 & FY15)
B. Hospital Initiative	Fall Back into Health/Spring into Healthy Summer Health Fairs; Farmer's Market, Kids to Farmer's Market; Hypertension (HTN) Program for AA Men; Smoking Cessation Program for AA Men
C. Total Number of People Within the Target Population	CBSA Target Population = 344,124 68% overweight/obese = 234,004 658.9/100,000 Hypertension ED Visit Rate
D. Total Number of People Reached by the Initiative Within the Target Population	Health Fairs = 850+ (for 2 larger health fairs & 2,761 for all other smaller health fairs/events) Farmer's Market = approx. 2,800 Kids to Farmer's Market = 150 Hypertension (HTN) Program = 1,400 BP screens, all races/both genders, 842 African American men Smoking Cessation = 393 people educated/counseled; 18 in cessation class
E. Primary Objective of the Initiative	Provide evidence-based, innovative, and engaging programs that: 1) Reduce prevalence of obesity (children & adults) 2) Reduce prevalence of uncontrolled hypertension 3) Increase self-reported knowledge/behaviors of heart healthy lifestyle
F. Single or Multi-Year Initiative – Time Period	Multi-year initiative since 2008; Expected to continue
G. Key Collaborators in Delivery of Initiative	UMMC Staff, UM Midtown Staff, University of Maryland Baltimore, Baltimore City Health Department, American Heart Association, Union Baptist Church, Shopper's Food Warehouse, Bi-Rite, American Diabetes Association, Baltimore City Dept of Parks & Rec, Baltimore City Public Schools
H. Impact/Outcome of Hospital	<u>Health Fairs</u> – 86% of people surveyed following the health fair reported

Initiative?	learning new health information; When asked before & after health fair, there was a statistically significant improvement in people knowing what their BP means – Z score = -2.3897, p = 0.01684, p <0.05. Farmer's Market - Maryland Market Money (Bonus dollars program) redeemed = $1,065; SNAP Benefits redeemed - $1,440; FVC?FMNP/SFMP redeemed - $982 Kids to Farmer's Market – Over 90% of children who attended tried a new healthy recipe with fresh produce and liked it HTN Program – 577 out of 842 AA men were identified as hypertensive in the community & educated/counseled about hypertension and prevention & referred for treatment Smoking Cessation – NRTs distributed to 9/18 class participants at Helping Up Mission; 393 others were educated about cessation and/or tobacco prevention	
I. Evaluation Outcomes:	According to the Maryland SHIP website, the following data trends are: (Source: http://dhmh.maryland.gov/ship/SitePages/Home.aspx) % of Adults at Healthy Weight – Baltimore City: 2011 = 34.5%, 2012 =39.7%, 2013 = 35% % of Children/Adolescents Who are Obese – Baltimore City: 2010 = 16.4, 2013 = 14.9 ED Visit Rate due to HTN – Baltimore City: 2012 = 591.1, 2013 = 599.6, 2014 = 658.9 Trends for adults at a healthy weight and ED visits due to HTN are performing negatively at this time for Baltimore City and especially African Americans. Prevalence trend of obese children/adolescents in Baltimore City is showing improvement.	
J. Continuation of Initiative?	Trends for adults at a healthy weight and ED visits due to HTN are performing negatively at this time for Baltimore City and especially African Americans.	
K. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Offsetting Revenue	*A. Total Cost of Initiative* *Health Fairs = $46,153* *Farmer's Market = $5,569* *Kids to Farmer's Market = $3,000* *HTN Program = $46,037* *Smoking Cessation = $6,000*	*B. Direct Offsetting Revenue from Restricted Grants* *Health Fairs = $0* *Farmer's Market = $0* *Kids to Farmer's Market = $0* *HTN Program = $46,037* *Smoking Cessation = $6,000*

A. 1. Identify Need 2. Was this identified through the CHNA process?	**<u>Maternal Child Health</u>** Infant mortality is 10.3 per 1,000 births in Baltimore making it the highest rate of infant mortality in Maryland. The Maryland 2017 goal is 6.3. The percentage of low birth weight infants born in Balto City is 11.9% - once again the highest in Maryland. The Maryland 2017 goal is 8%. Maryland 2013 prevalence of ever breastfeeding was 69.4% with the Healthy People 2020 goal at 81.9%. Yes, this was identified through the CHNA process (FY12 & FY15)
B. Hospital Initiative	Stork's Nest, Breathmobile, Safe Kids
C. Total Number of People Within the Target Population	CBSA Target Population = 184,436 Women
D. Total Number of People Reached by the Initiative Within the Target Population	Stork's Nest – 163 Breathmobile – 536 Safe Kids – 5,393
E. Primary Objective of the Initiative	Provide evidence-based, innovative, and engaging programs that: 1) Reduce low birthweight births in West Baltimore communities 2) Reduce pediatric asthma incidence and ED visits 3) Reduce unintentional injuries in children 4) Increase awareness and benefits of breastfeeding
F. Single or Multi-Year Initiative – Time Period	Multi-year initiative since 2005; Expected to continue
G. Key Collaborators in Delivery of Initiative	Zeta Phi Beta Sorority, March of Dimes, B'More Healthy Babies, Baltimore City Public Schools, Baltimore City Fire and Police Departments
H. Impact/Outcome of Hospital Initiative?	<u>Stork's Nest</u> – 84.2% Babies born >37 weeks; 80.8% babies born >2500 grams; 64.4% of SN Moms initiated breastfeeding <u>Breathmobile</u> – 51.5% of BM patients had any ED visit; Only 33.7% of those had > 2 ED visits; Only 12.3% were hospitalized; Only 34.2% missed > 5 days of school

	Safe Kids – 1)Child Passenger Safety - Car Safety Misuse Rate = 83% - All seats corrected to 100% 2) Fire Safety – Pre-program safety assessment score = 69.6% with Post-program safety assessment score = 88.5% (N = 100 third graders from 2 elementary schools) 3) Pedestrian Safety – Pre-program assessment score = 51.6% with Post-program assessment score = 96.8% (N = 50 third grade students) Breastfeeding – Just initiating initiative in FY16	
I. Evaluation Outcomes:	According to the Maryland SHIP website, the following data trends are: (Source: http://dhmh.maryland.gov/ship/SitePages/Home.aspx) % of Babies at Low Birth Rate – Baltimore City: 2011 – 11.6%, 2012 = 11.8, 2013 – 11.9 % of ED Visits r/t Asthma – Baltimore City: 2012 = 235.2/10,000 population, 2013 = 223.5, 2014 = 224.8 % of Breastfeeding - Maryland: 2013 = 69.4% ever breastfed (Source: http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf) Trends in above measures are stagnant or worsening for Baltimore City	
J. Continuation of Initiative?	Yes – Indicators are not improving and warrant continued focus	
K. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Offsetting Revenue	C. Total Cost of Initiative Stork's Nest - $18,044 Breathmobile - $177,747 Safe Kids - $61,952	D. Direct Offsetting Revenue from Restricted Grants SN = $0 Breathmobile = $171,944 Safe Kids = $0

A. 1. Identify Need 2. Was this identified through the CHNA process?	**<u>Violence Prevention</u>** Homicide is the 6th leading cause of death in Balto City. Homicide rate is much higher in 5/9 of the targeted zips and at same rate in 1 zip. Homicide is the number 1 killer of African American men ages 19-24 yrs. Alcohol/ substance use & distractions impairs driving & lead to preventable accidents. Yes, this was identified through the CHNA process (FY12 & FY15)
B. Hospital Initiative	Violence Intervention Program (VIP), My Future My Career, Promoting Healthy Alternatives for Teens (PHAT), Trauma Prevention Programs (including Distracted Driving)
C. Total Number of People Within the Target Population	In one of the targeted CBSA zip codes (21223), the homicide rate is 44.2/10,000 population and domestic violence is 66.3/10,000, so over 100,000 people in the targeted CBSA zips are at risk for violence.
D. Total Number of People Reached by the Initiative Within the Target Population	VIP - 1,662 encounters with 42 registered participants Domestic Violence Project – 126 PHAT program – 25 Trauma Prevention – 11,795
E. Primary Objective of the Initiative	Provide evidence-based, innovative, and engaging programs that: 1) Reduces recidivism due to violent injury and domestic violence 2) Promote violence prevention and education in youth 3) Promote trauma prevention (distracted driving, driving while intoxicated)
F. Single or Multi-Year Initiative – Time Period	Multi-year initiative since 1998; Expected to continue
G. Key Collaborators in Delivery of Initiative	UMMC partners with Baltimore City Police Commissioner, Baltimore City Police Dept., Baltimore City Public Schools, Baltimore City Health Dept., HSCRC, and DPSC Secretary
H. Impact/Outcome of Hospital Initiative?	As a result of the VPP program (of 42 clients), there were: <u>Recidivism</u>: 2 clients - Only 4.76% had a repeat admission secondary to violence <u>Job/Employment</u>: 9 clients - 21% of clients became gainfully employed <u>School</u> :1 client – Returned to school

I. Evaluation Outcomes:	Baltimore City's homicide rate this year is the highest on record since the 1990s. The rate is approx. 1/day with half of them occurring in the targeted CBSA. Since the unrest in the spring, violence prevalence has increased. (Source: http://data.baltimoresun.com/bing-maps/homicides/?)	
J. Continuation of Initiative?	Yes – Violence indicators are on sharp increase especially since April 2015 and warrant continued focus.	
K. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Offsetting Revenue	E. Total Cost of Initiative All Violence Prevention Initiatives = approx. $150,000	F. Direct Offsetting Revenue from Restricted Grants All Violence Prevention Initiatives = $100,900

A. 1. Identify Need 2. Was this identified through the CHNA process?	**Workforce Development** 11% Unemployment rate in Baltimore City with targeted CBSA zip codes much higher (17.5% and 19.6% in 6/9 zips) Yes, this was identified through the CHNA process (FY12 & FY15)
B. Hospital Initiative	HCA Interns, Project Search, BACH Fellows, Youthworks, Building STEPS, Dress for Success
C. Total Number of People Within the Target Population	7.4% of Baltimore City is unemployed (April '15); therefore approx. 25,000 people within the targeted CBSA
D. Total Number of People Reached by the Initiative Within the Target Population	379 individuals
E. Primary Objective of the Initiative	Provide evidence-based, innovative, and engaging programs that increase: 1) Number of people gainfully employed 2) Employment diversity of under-represented groups in health care
F. Single or Multi-Year Initiative – Time Period	Multi-year initiative since 2003; Expected to continue
G. Key Collaborators in Delivery of Initiative	UMMC partners with University of Maryland Baltimore, the ARC of Baltimore, Baltimore City Public Schools, Baltimore City, Division of Rehabilitation Services, Building STEPS, Center for Urban Families, Association for Black Charities
H. Impact/Outcome of Hospital Initiative?	379 youth and adults benefited from the workforce development initiatives. 36% (137/379) of the people served by the various workforce development programs were hired as a result of these programs. WD provides on-the-job training, soft skills training, internships, tutoring, and several educational programs for minorities and youth in the CBSA.
I. Evaluation Outcomes:	Baltimore City's unemployment increase to a high of 8.1% in June 2015. Typically, it remains at 7-8%. (Source: http://www.dllr.state.md.us/lmi/laus/)
J. Continuation of Initiative?	Yes, Unemployment rate is on the rise and this warrants continued focus.

K. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Offsetting Revenue	G. Total Cost of Initiative All initiatives - $233,600	H. Direct Offsetting Revenue from Restricted Grants $80,000 for HCA Interns program

Appendix 1

Financial Assistance Policy Description

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

It is the policy of the UMMS Entities to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The Financial Clearance Program Policy is a clear, comprehensive policy established to assess the needs of particular patients that have indicated a possible financial hardship in obtaining aid when it is beyond their financial ability to pay for services rendered.

UMMC makes every effort to make financial assistance information available to our patients including, but not limited to:

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

Appendix 2

Financial Assistance Policy Changes since ACA Description

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

Appendix 3

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

POLICY

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

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

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

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

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

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

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

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

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

PROGRAM ELIGIBILITY

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

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

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

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

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

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

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

Coverage amounts will be calculated based upon 200-300% of income as defined by Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care.

Presumptive Financial Assistance

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

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

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

a. Purely elective procedures (example – Cosmetic) are not covered under the program.

b. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.
2. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.
   d. Upon receipt of the patient's application, they will have twenty (20) days to submit the required documentation to be considered for eligibility. If no data is received within the 20 days, a denial letter will be sent notifying that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.
3. There will be one application process for UMMC, MTC, UMROI, and UMSJMC. The patient is required to provide a completed Financial Assistance Application. In addition, the following may be required:
   a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...
   b. A copy of their most recent pay stubs (if employed) or other evidence of income.
   c. A Medical Assistance Notice of Determination (if applicable).

d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.

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

   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.

      i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
      ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
         (1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.

5. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

6. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination, up to 3 years prior, and up to six (6) calendar months in to the future. However, there are no limitations on the Financial Assistance eligibility period. Each eligibility period will be determined on a case-by-case basis. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department.

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

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

9. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds may be issued back to the patient for credit balances, due to patient payments, resulted from approved financial assistance on considered balance(s).

10. Patients who have access to other medical care (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.

11. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.

12. The Financial Assistance Program will accept all other University of Maryland Medical System hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.

13. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.

14. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.
    a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
    b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

Financial Hardship

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

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

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

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

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

Medical Debt is defined as out of pocket expenses for the facility charges incurred here at UMMC, MTC, UMROI, and UMSJMC for medically necessary treatment.

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

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

Appeals

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

Judgments

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

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

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

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

UNIVERSITY of MARYLAND MEDICAL CENTER

MARYLAND HOSPITAL PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy

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

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

Patients' Rights

University of Maryland Medical Center will work with their uninsured patients to gain an understanding of each patient's financial resources.

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

Patients' Obligations

University of Maryland Medical Center believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

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

Contacts:

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

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

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

Physician charges are not included in hospitals bills and are bill separately.

UNIVERSITY of MARYLAND
MEDICAL CENTER

HOJA DE INFORMACION PARA EL PACIENTE DEL HOSPITAL DE MARYLAND

Politica de Ayuda financiera del Hospital

El Centro Medico de la Universidad de Maryland provee servicios de salud sin inportar la capacidad de pago del individuo. La atencion puede darse sin cargo, o con cargo reducido para aquellos que no posean seguro de salud, cobertura de Medicare/Asistencia Medica, o no tengan los medios para abonar. La elegibilidad para recibir atencion sin cargo, cargo reducido, o a pagar en un determinado plazo, es decidido caso por caso. Si Ud. no tiene capacidad de pagar por la atencion medica, puede calificar por la atencion medica necesaria sin costo o costo reducido al no poseer otros medios de pago, litigio o responsabilidad de tercera persona.

El Centro Medico de la Universidad de Maryland cubre o excede los requerimientos legales para proveer asistencia financiera a aquellas personas con ingresos por debajo del 200% del nivel federal de pobreza, reduciendo el costo de la atencion hasta en un 300% del nivel de pobreza federal.

Derechos de los pacientes

El Centro Medico de la Universidad de Maryland trabajara para una comprension de los recursos financieros de sus pacientes sin seguro.

- Proveeran de ayuda en la inscripcion en programas publicos establecidos (ej. Medicaid) u otras consideraciones de medios disponibles en instituciones de caridad.
- Si Ud. no califica para Asistencia Medica, o asistencia financiera, puede ser elegido para un plan de pagos de sus cuentas de hospital.
- Si Ud. considera que fue erroneamente referido a una agencia de cobranzas, tiene el derecho de contactarse con el hospital para requerir asistencia. (Ver abajo contacto de informacion)

Obligaciones de los pacientes

El Centro Medico de la Universidad de Maryland considera que los pacientes poseen resposabilidades relacionadas con el aspecto financiero del cuidado de salud requerido. De nuestros pacientes se espera que:

- Cooperen brindando siempre informacion completa y precisa sobre seguros y situacion financiera.
- Mantenga el cumplimiento establecido en los terminos del plan de pagos.
- Notificar a tiempo, a los contactos abajo enumerados, de cualquier cambio de situacion.

Contactos:

Llame al 410-821-4140 o sin cargo al 1-877-632-4909 por preguntas concernientes a:

- Su cuenta de hospital
- Sus derechos y obligaciones concernientes a su cuenta de hospital
- Como aplicar para Medicaid de Maryland
- Como aplicar por atencion sin cargo o cargo reducido

Por informacion acerca de Asistencia Medica de Maryland

Contactese con su Departamento de Servicios Sociales local 1-800-332-6347 o 1-800-925-4434
O visite: www.dhr.state.md.us
Los cargos del medico no se incluyen en las cuentas del hospital y se facturan por separado.

Appendix 5

Our Mission

University of Maryland Medical Center is the academic flagship of the University of Maryland Medical System. Its mission is to provide health care services on its two campuses for the Baltimore community, the State of Maryland and the nation. In partnership with the University of Maryland School of Medicine and the University of Maryland health professional schools, we are committed to:

- Delivering superior health care
- Training the next generation of health professionals
- Discovering ways to improve health outcomes worldwide

Source: Vision, Mission and Values - University of Maryland Medical Center http://umm.edu/about/mission-and-vision#ixzz3cUw0vRnF

Our Vision:

UMMC will be known for providing high value and compassionate care, improving health in Maryland and beyond, educating future health care leaders and discovering innovative ways to advance medicine worldwide.

Source: Vision, Mission and Values - University of Maryland Medical Center http://umm.edu/about/mission-and-vision#ixzz3cUwFj4UW

Our Commitment to Excellence:

Five Pillars We Focus on Every Day

Our Community Health Improvement Mission: To empower and build healthy communities