FY2016 Community Benefit Reporting

Health Services Cost Review Commission

4160 Patterson Avenue

Baltimore, MD

LIVING HEALTHIER TOGETHER.

Anne Arundel Medical Center

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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 regulatory 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 meeting aggressive quality targets, the Model requires the State to 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 in this new environment, 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 operations, activities, and investments 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 (LHICs) 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) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(3) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(4) Local Health Departments;
(5) County Health Rankings (http://www.countyhealthrankings.org);
(6) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(7) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(8) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(9) CDC Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);

(10) CDC Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)
(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 such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/)
(16) CRISP Reporting Services

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

The IMPLEMENTATION STRATEGY, 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.

HSCRC Community Benefit 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).
    a. Bed Designation – The number of licensed Beds;
    b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
    c. Primary Service Area Zip Codes;
    d. List all other Maryland hospitals sharing your primary service area;
    e. The percentage of the hospital's uninsured patients by county. (please provide the source for this data, i.e. review of hospital discharge data);
    f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data, i.e. review of hospital discharge data, etc.).
    g. The percentage of the Hospital's patients who are Medicare Beneficiaries. (Please provide the source for this data, i.e. review of hospital discharge data, etc.)

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area Zip Codes:	d. All other Maryland Hospitals Sharing PSA:	e. Percentage of Hospital's Uninsured Patients,:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
415	26,074	21401 21403 21037 20715 21012 21409 21114 21146 21666 21122 20716 21113 20774 21054 21061 21032 21035	Johns Hopkins Hospital UM Baltimore Washington Medical Center Medstar Harbor Hospital	See table below	14.4% Included 'Pending Medicaid' as Medicaid admitted 7/2015-6/2016	42.6% admitted 7/2015-6/2016

Table I

e. % of uninsured patients discharged from AAMC by county (Source: internal admissions data for patients admitted 7/1/2015-6/30/2016).

County	Uninsured Discharges	% of Uninsured Discharges by County
Anne Arundel County	151	51.9%
Prince George's County	66	22.7%
Out of State	20	6.9%
Queen Anne's County	16	5.5%
Howard County	7	2.4%
Calvert County	6	2.1%
St. Mary's County	5	1.7%
Montgomery County	5	1.7%
Baltimore County	5	1.7%
Talbot County	3	1.0%
Baltimore City	2	0.7%
Caroline County	2	0.7%

Harford County	1	0.3%
Worcester County	1	0.3%
Carroll County	1	0.3%

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

a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):

(i) A list of the zip codes included in the organization's CBSA, and

(ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations reside.

(iii) Describe how the organization identified its CBSA, (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 community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/). 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) Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)

Table II

Demographic Characteristic	Description	Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	Total Population: 563,973 Male: 49.5 % Female: 50.5% Average Age: 38.9 Years Percent of Total Population by Age:	FY2016 Discharge data 2015, Nielsen, Inc. County demographic s estimate.

	0 – 4 Years: 6.1% 5 – 17 Years: 16.3% 18 – 64 Years: 63.7% 65+ Years: 13.8% Most vulnerable populations in the County include: 21403 (Annapolis/ Eastport), 21401 (Annapolis), 21226 (Curtis Bay), 21225 (Brooklyn), 21144 (Severn), 21222 (Pasadena), 21090 (Linthicum Heights), 21077 (Harmans), 21060 and 21061 (Glen Burnie), 20779 (Tracy's Landing), 20751 (Deale), 20714 (North Beach), 20711 (Lothian), 20733 (Churchton), 20764 (Shady Side)	Community Health Needs Assessment, Anne Arundel County Feb, 2016
Median Household Income within the CBSA	$92,505	Community Health Needs Assessment, Anne Arundel County, 2016
Percentage of households with incomes below the federal poverty guidelines within the CBSA	6.3% of County residents live below the poverty level (33,352 residents). 14.7% of single parent households live below the poverty level.	Community Health Needs Assessment, Anne Arundel County, 2016
For the counties within the CBSA, what is the percentage of uninsured for each county? 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	6.6% of the County is uninsured; there is disparity: 22% of Hispanic residents are uninsured	Community Health Needs Assessment, Anne Arundel County, 2016
Percentage of Medicaid recipients by County within the CBSA.	39,793 enrollees (47%) White 25,193 enrollees (30%) Black 6,349 enrollees (8%) Hispanic	Community Health Needs Assessment, Anne Arundel County, 2016
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	Life Expectancy 79.8 years	Community Health Needs Assessment, Anne Arundel County, 2016

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	All Races 717.2 /100,000 White: 736.9 Black, NH: 833.4 Hispanic: 418.1 (Note the disparity)	Community Health Needs Assessment, Anne Arundel County, 2016
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	**Housing** 925 Students are homeless 9,000 families on wait list for public housing 10,000 families on wait list for Section 8 **Access to Healthy Food** 69,000 (12%) residents live in food desert (see zip codes) 5.6% of residents SNAP or Food Stamps **Education** 90.7% residents have HS diploma or higher ed 93% Whites HS Diploma 88% Blacks HS Diploma 67% of Hispanis HS Diploma	Community Health Needs Assessment, Anne Arundel County, 2016
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	75.1% White 15.5% Black 6.4% Hispanic	Community Health Needs Assessment, Anne Arundel County, 2016
Other (Note: Disparities) Coronary Heart Disease Stroke Diabetes Infant Mortality ED Visits	Reported as age adjusted death rates: 167.2/100,000 Whites 199/100,000 Blacks Reported as age adjusted death rates: 35.9/100,000 Whites 64/100,000 Blacks Reported as age adjusted death rates: 19.3/100,000 37.6/100,000 4.0/1,000 Whites 11.2/1,000 Black 5.3/1,000 Hispanic General: 250.3/1,000 Whites 554.0/1,000 Blacks 223.0/1,000 Hispanics Diabetes:	

	141.1/100,000 Whites 463.7/100,000 Blacks 120.0/100,000 Hispanics Hypertension: 139.8/100,000 Whites 514.0/100,000 Blacks 109.5/100,000 Hispanics Asthma: 266.9/100,000 Whites 1699.5/100,000 Blacks 430.3/100,000 Hispanics	

AAMC defined the CBSA as Anne Arundel County since more than 60% of inpatient discharges come from Anne Arundel County. NOTE: In FY2017, AAMC will track and report data for its secondary market (portions of Prince George's County and the Eastern Shore (Queen Anne's, Caroline, Talbot, and Dorchester Counties).

Second, AAMC has had a collaborative relationship with partners in the County in multiple projects and initiatives, specifically, The Anne Arundel County CHNA. This work is the result of a working collaboration of the University of Maryland Baltimore Washington Medical Center, Anne Arundel Medical Center, Anne Arundel County Department of Health, and the Anne Arundel County Mental Health Agency. Since these organizations have been committed to serving the residents of Anne Arundel County, the CHNA was developed as a planning tool for use by the Healthy Anne Arundel Coalition (LHIC), both hospitals and county government agencies, and it will be used for each hospitals' community benefit plans as well as for the strategic and operational plans of Healthy Anne Arundel Coalition. Additionally, this plan will be used by other Healthy Anne Arundel Coalition partners including the City of Annapolis, Housing Authority of the City of Annapolis, Anne Arundel County Public Schools, the Community Foundation of Anne Arundel County, and MedStar Harbor Hospital.

Third, the CBSA was defined as a result of findings from the Bay Area Transformation Partnership (BATP). This regional transformation project was initiated and supported through the Health Services Cost Review Commission (HSCRC) and the Department of Health and Mental Hygiene (DHMH) to transform Maryland's health care system to be highly reliable, highly efficient, and patient-centered. HSCRC and DHMH envision a health care system in which multi-disciplinary teams can work with high need/high-resource patients to manage chronic conditions in order to improve outcomes, lower costs, and enhance patient experience. Through aligned collaboration at the regional and state levels, the state and regional partnerships can work together to improve the health and well-being of the population.

County Overview

Anne Arundel County is bordered to the North by Baltimore City, in the east by the Chesapeake bay, in the south by Calvert County, and in the west by the Patuxent River and Howard and Prince George's Counties. It lies between two major cities – Washington D.C. and Baltimore.

The County has a total area of 415 square miles**.** The northern, central and western parts are urban, while the southern part of the county is rural. There are 127 public schools, with 80,000 students. There are three institutions of higher education: Anne Arundel Community College, St. John's College and the United States Naval Academy. The county is also home Fort George Meade military installation.

The County's healthcare needs are served by two hospitals – AAMC and University of Maryland, Baltimore Washington Medical Center. Medstar Harbor Hospital is located within the Baltimore City line, but also serves residents of Norther Anne Arundel County. There are 4 Federally Qualified Health Centers, and 6 clinics offered by the health department. AAMC has 2 clinics. All serve the low income residents of the County.

Description of the CBSA

The County population estimates 556,348 residents and the demographics are as follows: 75.1% White, 15.5% Black, and 6.4%% Hispanic. The population has grown 11.2% since 2000 with the Hispanic population growing the fastest. Seniors are also a rapidly growing population.[1]

The median household income is $87,430 and the median family income is $101, 268. However, there is significant income disparity. Over 6 percent of county residents live below the federal poverty guideline. Twenty five of residents live in households with less than $50,000 annual income. Nearly forty three percent of county residents live in households that have more than $100,000 of income. Furthermore, there are pockets of need that are located at the most northern and southern ends of the county, and in Annapolis. This data is reflected in Table 2.[2]

While life expectancy rose to an average of 79.8 years, cancer remains the leading cause of death and heart disease is the second cause of death. These diseases account for 47 percent of deaths in the County. Infant mortality and low birth weight are also present in the County, and it is particularly disparity for Black infants and families. While many residents have access to health insurance and Medicaid due to the expansion of the Affordable Care Act, there is a shortage of primary care physicians and mental health providers in the County. In addition, dental insurance coverage is not widely available and thus residents lack access to care. Mental health and substance use disorders greatly impact the health of county residents. Specifically, children and adolescents have experienced a 14.5 percent and 9.6 percent increase

[1] Brown, P. & Singh, B. (2016). Community Health Needs Assessment, Anne Arundel County.
[2] Brown, P. & Singh, B. (2016). Community Health Needs Assessment, Anne Arundel County.

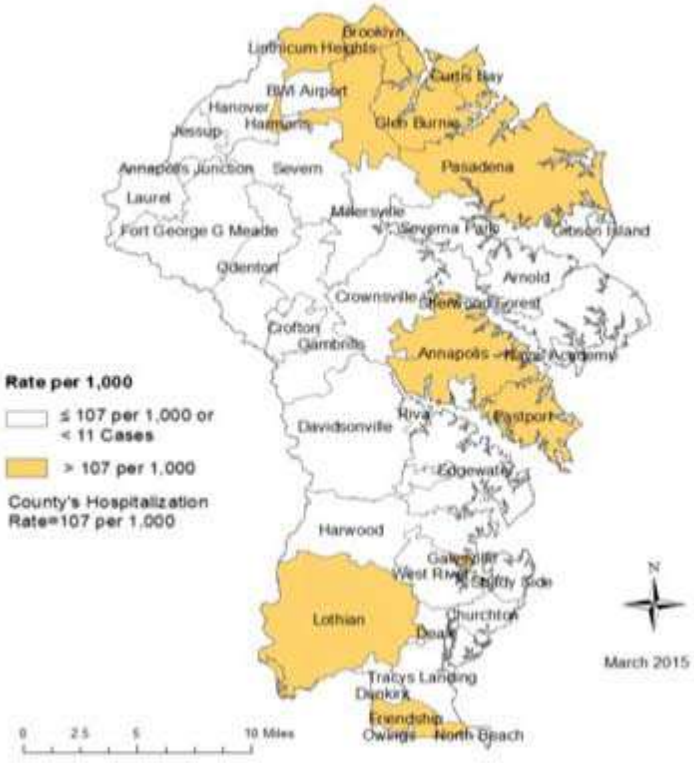
respectively. The heroin and opioid epidemic have caused a significant need for treatment services too. [3]

The senior population is growing in the County, and 11 percent of Medicare beneficiaries were also eligible for Medicaid. These residents are aging, have multiple chronic conditions and can impact healthcare resources. Specifically, in FY 2015 the BATP hospitals provided care to a total of 23,477 Medicare patients, costing $260.5M. Of those, 1,152 are Medicare high-utilizers (>= 3 Inpatient/Observation >=24 hour visits in 12 months), representing $52.8M in total charges and 5,738 visits. Of the 1,152 high-utilizing Medicare patients, 590 visited AAMC, 705 visited UM BWMC, and 143 (12%) visited both hospitals. This Medicare high-utilizer population represents 5% of the 23,477 AAMC/UM BWMC Medicare patients, and 20% of the hospital-related cost of that same population. Notably, mental illness and/or substance misuse affects 66% of BATP's target Medicare population.[4]

The zip codes included in Table 2 represent geographically where the most vulnerable residents are. There are food deserts in those areas and a lack of connective transportation system. There is a higher percentage of residents without a high school education. Furthermore, Lothian, Edgewater, Annapolis (21403), Churchton, Deale, Glen Burnie, Curtis Bay, Friendship, and Brooklyn have higher ED visits for behavioral health conditions as well as other illnesses and conditions. Hospitalization rates for various illnesses are higher for residents who live in these vulnerable areas.

[3] Brown, P. & Singh, B. (2016). Community Health Needs Assessment, Anne Arundel County.
[4] Target population data supplied by Berkeley Research Group (BRG) 'High Utilizer Strategy' report dated November 19, 2015

Map: Hospitalization rate per 1,000 for Anne Arundel County (2013)



An inadequate public transportation system in the County is a barrier for employment and healthcare. The County is situated along the western shore of the Chesapeake Bay and consists of a series of peninsulas which makes a comprehensive public transportation system too expensive to maintain.[5] As a result, there are not adequate local bus lines to service many areas of the County. South County has only three bus stops in the Edgewater area which leaves a great portion of southern Anne Arundel County without public transportation. Public transportation is in need of additional routes. As a result, only 3.3 percent of Anne Arundel County residents utilize public transportation to get to work.[6] Annapolis does operate a growing transit system, but it does not serve areas outside of the city. There ae a few connections with the County bus service to sites such as the Casino at Arundel Mills and Fort Meade. The lack of public transportation is a significant issue throughout the County, since residents are limited in employment and access to healthcare.[7]

Housing and homelessness remains a problem in the County. In 2013, resident homeowners spent 34.3% and renters spent 49.5% of their income on housing. In March, 2015, nine thousand families were on a waiting list for public housing and 10,000 families were on a waiting list for Section 8 housing. Over 2,000 individuals receive case management for

[5] Anne Arundel County Local Health Plan 2011
[6] Nielsen, Inc. 2014 county level demographic data
[7] http://www.aacounty.org/Partnership/Resources/2012_AA_County_Needs_Assessment.pdf

homelessness and 925 children do not have a home. But, an accurate count of homeless residents does not exist.[8]

The CHNA notes other issues that affect the County as well. There is a lack of recreational and community facilities, as reported by CHNA respondents. Safe areas to play are lacking. Domestic violence is an on-going issue and there is not a forensic examiner program at either AAMC nor UMBWMC dues to training regulations that have affected the ability to provide care. Obesity remains an on-going health issue that affects other disease processes.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?

   __X__Yes
   ____No

   Provide date here. 02/23 /2016 (mm/dd/yy)

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

http://www.aahs.org/community/

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 3?

   X___Yes (mm/dd/yy) Enter date approved by governing body here: 09/29/2016
   ___No

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

   http://www.aahs.org/community/

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. Are Community Benefits planning and investments part of your hospital's internal strategic plan?

      _X Yes
      ___No

[8] Brown, P. & Singh, B. (2016). Community Health Needs Assessment, Anne Arundel County.

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.

Then, AAMC uses a strategic planning framework that categorizes 35 initiatives into 5 strategic goal areas (Quality, Community Health, Workforce, Growth, and Finance). Senior leadership, clinical leadership, and administrative leadership identify opportunities for growth and health improvement through planning retreats, meetings, and data analysis. These initiatives are chosen based on their ability to have significant impact on the care of patients and the community we serve to improve health, increase quality, reduce costs, and strengthen workforce. Leaders identify Community Benefit through the strategic initiatives and report the data and information to Department of Community Health Improvement for collection and analysis. Community Health tracks the data and reports monthly to leadership through the True North Metrics process.

Specifically, FY2016 AAMC strategic initiatives that address the CHNA and community benefit are as follows:

2.1.2 – Community – Increase focus on health equity and improve measurement of health disparities
2.1.3 –Community - Implement Community Health Needs Assessment priority action plans
2,2,1 – Community – Develop health system wide care management program
2.2.2 – Community – Implement comprehensive palliative care program
2.2.3 – Community - Implement the system wide care process of care re-design and clinical integration
2.2.4 – Community - Expand participation in the Collaborative Care Network
4.1.2 - Growth – Expand the ambulatory provider network
4.2.3 – Growth - Develop comprehensive mental health program
4.3.1 – Growth – Research virtual care strategy
4.3.2 – Growth – Explore partnerships and affiliations to foster provider integration

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

   i. Senior Leadership

      1. __X_CEO
      2. __X_CFO

3. __X_Other (please specify) Chief Strategy Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, President of Foundation

Describe the role of Senior Leadership.

As senior leaders, they are involved in driving the process as described in 1a.

ii. Clinical Leadership

1. _X__Physician
2. _X__Nurse
3. _X__Social Worker
4. _X__Other (please specify) Health educators and Registered Dietitians

Describe the role of Clinical Leadership

Clinical chairs, nursing leaders, and community health department staff also have significant input into the process described in 1a.

iii. Population Health Leadership and Staff

1. __X__ Population health VP or equivalent (please list)
   Vice President of Clinically Integrated Care & COO
   Chair, Clinical Integration
2. __X__ Other population health staff (please list staff)
   Director of Community Health Improvement
   Executive Director of Collaborative Care Network
   Senior Director of Care Coordination (system)

Describe the role of population health leaders and staff in the community benefit process.

The Population Health Team meets weekly to review progress on programs and communications. Specifically, the team reviews progress on care integration. The team includes community partners such as the Coordinating Center, the Department of Aging and Disabilities, the health department, skilled nursing facilities, data analytics, and other organizations as necessary to review progress continue to collaborate on projects.

iv. Community Benefit Operations

1. _X__Individual (please specify FTE) (.5FTE)
2. _X__Committee (please list members) – see description below
3. _X__Department (please list staff) – Community Health Department (Director, Community Outreach Coordinator, Community Health Nurse)
4. ___Task Force (please list members)- Under development for FY17

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.

A group of educators across the service lines (cancer prevention/ smoking cessation, women's health, Pathways/ substance use prevention, dietitians, community health nurses, and health educators meet monthly through the Community Education and Outreach Committee. This group reports regularly on past activities and future opportunities for community education and outreach. They identify populations and geographic areas in need and topics of interest. This group is responsible for implementing many of the community benefit activities across the organization.

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?)

Senior leadership (CEO, CFO, CSO, COO) reviews and approves the narrative and spreadsheet prior to submission to the HSCRC. The Strategic Planning Sub-Committee of the Board of Trustees completes the review of the narrative and spreadsheet in January (the month after submission). The spreadsheet is included as part of the financial audit process that the hospital undergoes annually and 990 Form submission to the IRS annually.

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. See above for explanation.

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
__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
Anne Arundel County Department of Health	Jinlene Chan; AZ Snyder	Health Officer & Director of Planning	Lead in CHNA collaboration; Collaboration with LHIC (Obesity prevention, Co-Occurring, and Access to care committees)
UM-BWMC	Becky Paesch; Laurie Fetterman	Senior VP of Strategic Planning; Manager Strategic Planning	Partner in conducting CHNA; LHIC support (see above), BATP implementation, infant mortality reduction
Partnership for Children Youth & Families	Pam Brown	Executive Director	Author of CHNA, LHIC partner and support
Anne Arundel County Mental Health Agency	Adrienne Mickler	Director	Partner in Conducting CHNA; LHIC partner and support
Anne Arundel Department of Aging	Karissa Gowin	Assistant Director	Provided input to CHNA; Collaboration with LHIC BATP
Anne Arundel County Office of the County	Yveola Peters	Community	Assisted with identifying/promoting focus

Executive			groups; LHIC Support

CHNA Partners and Projects

The Table shows the partners involved in conducting the CHNA (see below for specific participants). Each organization utilizes the CHNA for its own purpose, but the partners collaborate to extend the work of the LHIC (Healthy Anne Arundel Coalition). The LHIC has identified obesity prevention, behavioral health, and access to care as their prioritized health needs. Each need has a dedicated committee to flesh out objectives, work plans, necessary resources etc. Each partner has leadership roles on the LHIC Steering Committee and/or subcommittees. We assist with providing resources, oversight, etc. to achieve the goals of each subcommittee.

Other partners include key LHIC members such as Anne Arundel County Department of Recreation and Parks, Anne Arundel Community College, Anne Arundel County Department of Social Services, Anne Arundel County Public Schools, Office of Economic Development, Care First/ Blue Cross Blue Shield, the Office of the Mayor of the City of Annapolis, and the NAACP. Together, the organizations can exchange ideas, maximize resource allocation, develop a county-wide program, and work together to meet targeted goals. There is a collaborative working arrangement in the County. Specifically, each April, the County hosts Healthy Anne Arundel Month. Each organization has the opportunity to showcase programs that reduce the health needs of the County. This increases awareness and fosters community.

CHNA Methodology

The CHNA report analyzed data from secondary and qualitative sources and individuals. The secondary data was gathered from a variety of local, state and national sources. Population and socioeconomic statistics were compiled using data from the United States (U.S.) Census Bureau's Population Estimates Program and the American Community Survey 1-Year and 5-Year Estimates. Birth and death data files were obtained from the Maryland Department of Health & Mental Hygiene, Vital Statistics Administration. The emergency department and inpatient hospital discharge data files were obtained from the HSCRC for topics like birth, mortality and hospital utilization. Other data sources used for this report were: Maryland Vital Statistics Annual Reports, Maryland Department of Health and Mental Hygiene's Annual Cancer Reports, Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention's CDC WONDER Online database, centers for Medicare and Medicaid Services, National Vital Statistics Reports, County Health Rankings and a variety of local databases. The Anne Arundel County Health Department conducted the secondary data analysis via the on-staff epidemiologist.

The remainder of the report was researched and written via Pam Brown, Partnership for Children Youth and Families in Anne Arundel County. Dr. Brown has extensive expertise in conducting qualitative research and she is a collaborative community partner. The qualitative data was derived from a series of key informant interviews and focus groups with county leaders and residents. The interviews depicted qualitative data gathered from 12 key informants:

- CEO, Anne Arundel Medical Center (AAMC)
- CEO, University of Maryland, Baltimore Washington Medical Center
- Executive Director, Anne Arundel County Mental Health Agency
  Health Officer, Anne Arundel County Department of Health
- Health Consultant, Anne Arundel County
- Director, Anne Arundel County Crisis Response
- Clinical Director, Anne Arundel County Mental Health Agency
- Community Health Director, AAMC
- Two county legislative leaders
- Director, Anne Arundel County Department of Aging and Disabilities
- Program Director, Domestic Violence Program, YWCA of Annapolis and Anne Arundel County

Additional data and information was gathered from 8 focus groups and included many community constituents. They are as follows:

- **Emergency Department and Emergency Response**. Personnel from both hospitals' ERs, the EMS system, Anne Arundel County fire Department, and County Public School System psychologists and counselors (18).
- **Low-Income Youth**. Job seekers, high school drop outs, Medicaid recipients, single parents (8).
- **North County**. Community members, substance abuse professionals, health professionals, law enforcement, council member (12)
- **South County**. Community members, substance abuse professionals, law enforcement, health professionals (10)
- **Behavioral Health**. Residential providers, crisis response, mental health professionals, behavioral health providers (9)
- **Behavioral Health** Parents, mental health providers (5)
- **Seniors**. Three groups including professionals, care coordinators and senior citizens (20)
- **Hispanic Community.** Consumers, attorneys, non-profit leader (6).

The CHNA identified more than 50 community health needs. While many of the needs overlap or are needs we currently address, it is important to prioritize needs to support a strategic framework, maximize resources, and have an impact. (See Section V, #2 for AAMC's process to determine identified health needs).

Through a very structured strategic prioritization planning process, AAMC determined the top 5 needs to be:

1. Improved care coordination for patients with chronic conditions, including care transitions and care coordination. NOTE: Chronic conditions include heart disease, cancer, and diabetes as outlined in Chapter 1 of the CHNA.
2. Mental health and substance use
    a. Increase number of beds for mental health and substance abuse, including adolescents
    b. Integration of mental health at primary care level
    c. Increase/ improve access to psychiatrists, including Spanish speaking providers
3. Infant Mortality
4. Senior In Home Care - Palliative Care
5. Improved resource planning for North County and South County
    a. Increase number of community clinics

There is continued collaboration not between the CHNA partners to improve health in Anne Arundel County. UMBWMC elected similar health needs to address. They prioritized the following:

1. Access to care and utilization
2. Chronic health conditions
3. Behavioral health
4. Maternal and child health
5. Community support

AAMC's prioritized health needs are very similar to the needs that UMBWMC chose. Currently, the hospitals are collaborating on the BATP project which addresses improved care conditions, behavioral health, access to palliative care, and providing resources and support to the vulnerable communities. They are plans for FY17-18 for both hospitals to work with the health department to develop a strong pre-natal program for underserved women in the county.

Both hospitals co-chair the LHIC, with the Health Officer serving as Chair of the committee. All organizations are committed to partnering and supporting the initiatives of the LHIC. Specifically, the needs are obesity, behavioral health, and access to care. AAMC provides staff to all sub-committees and support as needed to promote their work. The health department has taken the lead on these initiatives (all outlined in the CHNA) since they are public health measures.

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

Christine Crabbs, Director of Community Health at AAMC is Vice Chair of Healthy Anne Arundel (LHIC).

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

Charlotte Wallace, Community Health RN at AAMC, serves on the Obesity Prevention Sub Committee of Healthy Anne Arundel. Alexis Aguilar, care manager, serves on the Access to Care Sub-Committee of Healthy Anne Arundel. Amanda Larkins serves on the Behavioral Health Sub Committee of Healthy Anne Arundel.

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 links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/)
(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? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)

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.

We followed provided an unbiased process to narrow more than 50 community health needs to 5. While it would be ideal to address each of the 50 needs, there are not adequate resources that one organization has to address each one. Therefore a methodology to determine prioritization was utilized; a similar model that was utilized for the prioritization process in 2015 for the Continuum of Care Gap Analysis (AAMC). First, a visual model of the CHNA was developed to condense a 150+ page document into a workable tool. Executive council, service line leaders, and patient advisors were convened to review the model and review the findings of the CHNA. Participants were asked to rank their top 3 priorities of health needs and recommendations, with 1 being the highest ranked need. Ballots were collected and weighted values were recorded for those needs that were ranked.

The health needs were narrowed from more than 50 needs to 33 health needs. The 33 needs were weighted against several criteria gleaned from recommendations by Kaiser Permanente, Catholic Health Association, and Robert Wood Johnson. The criteria included: existence of health disparity with need, the ability to have an impact on the need, the presence of existing resources to address the need, access/quality/affordability issues that are related to the need, evidence based approaches to address need, availability of clinical resources to address need, and the existence of barriers to addressing need (environmental, socio-economic, and health behaviors). Each need was evaluated against each criteria with a rating scale of Yes=3, Maybe=2 and No=1. Twelve needs were found through this process.

Finally, recommendations and needs were grouped to together to determine the final five prioritized health needs. Senior Leadership approved the needs in June, 2016. The implementation plan was written and board approved as of September, 2016.

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)

AAMC works with various community partners through the LHIC (Healthy Anne Arundel Coalition), the Conquer Cancer Advisory Committee, and the Peri-natal loss committee to identify gaps in services and areas to address needs. Partners include Anne Arundel County Health Department, Department of Aging and Disabilities, UM-BWMC, and other community based partners.) ***See Appendix A for specific examples that completely describe AAMC's work to address the SHIP measures.***

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
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.

AAMC provides low cost care to the un-insured and underinsured through 3 clinics, our Fast Care locations, Kent Island Urgent Care. Specialty care is arranged through these clinics and care managers with our own providers.

According to the 2015 County Health Rankings, Maryland fares better at a 9 percent rate of insured residents as compared to Maryland (12 percent) and the US (11 percent). However, access to primary care and other specialties is worse in Anne Arundel County as compared to Maryland and the US. In fact, the patient to primary care physician ratio in Anne Arundel (1430:1) is worse than in Maryland (1045:1) and the U.S. benchmark (1131:1) meaning that more individuals are seeking care from fewer providers. This shortage results in seriously limited access to primary care in parts of our Community Benefit Service Area. Building primary care access is essential to the Hospital's strategic plan, Vision 2020. Increased accessibility and coordinating health care increased the focus on prevention and improving the population health of our CBSA.

Access to mental health providers is also worse in Anne Arundel County as compared to Maryland and the US. According to the 2015 County Health Rankings, the ratio of mental health providers to patients is 718:1 as compared to Maryland (502:1) and the US (386:1).

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to 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.

Table IV – Physician Subsidies

Category of Subsidy	Explanation of Need for Service
Hospital-Based physicians	Breast Center, Oncology Center, Obstetric Care, survivorship program, pain management center, and surgical specialists
Non-Resident House Staff and Hospitalists	AAMC would not be able to maintain coverage for 24 hours a day/ 7 days per week. This includes hospitalist and intensivist service and the pediatric hospitalist teams.
Coverage of Emergency Department Call	AAMC reimburses them for their charity care and their call coverage. Our ED serves 93,475 patients per year and this subsidy ensures that patients have access to high quality physician care.
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	Primary care, psychiatry and surgeons (All noted in CHNA as needed provided)
Other – (provide detail of any subsidy not listed above – add more rows if needed)	Hospice, Behavioral Health Program

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

- besides English, in what language(s) is the Patient Information sheet available;
- 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) SELECT POPULATION HEALTH MEASURES FOR TRACKING AND MONITORING POPULATION HEALTH

- Increase life expectancy

AAMC focuses on prevention of disease. As a result, we provide over 160 health talks and health fairs (1,465 hours and community benefit $48,60, flu shot clinics (2,500 vaccines provided and $71,000 community benefit), blood pressure and cholesterol screenings (8,500 hours and community benefit $258,710), vascular screenings (community benefit $65,000) that advise and guide community members to better health.

- Reduce infant mortality

See Table III – Initiative 4 for specific details and data.

- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization

AAMC provides on-going Living Well with Diabetes in partnership with the Anne Arundel County Departme.t of Aging (Community Benefit $7,100). A newly established Diabetes program started FY16, so additional care plans, standard orders, and staff education will be provided to reduce re-admissions from diabetes. In FY17, a diabetes navigator will be hired to manage patients from in-patient to out-patient to prevent re-admissions. AAMC has a pediatric nurse navigator (grant funded, no community benefit associated with this initiative) to work with high risk children to prevent asthma admissions. Another care manager works with adults to manage post-discharge patients who have COPD and CHF. Often patients who are admitted through the ED do not have primary care physicians. AAMC established 2 clinics for primary care to better manage hypertension, establish follow up patients, etc. (Community Benefit $915,000).

- Reduce the % of adults who are current smokers

AAMC supports a 1.0FTE Tobacco Cessation Specialist to promote Community Health Education about the effects of smoking (heart and lung disease, etc.) to adults, adolescents and children through a variety of forums including but not limited to schools, faith based organizations, neighborhood meetings, etc. We reached 9,000 individuals in FY16. AAMC also supports an additional 1.0FTE Tobacco Cessation Specialist to help current smokers quit. An additional 1500 encounters were captured in FY16. AAMC has been committed to provide these services for

over 20 years and the current adult smoking rate is 15.5% which is slightly higher than the Maryland rate, but meets the 2017 target. (Community Benefit $132,288)

- Reduce the % of youth using any kind of tobacco product

AAMC supports a 1.0FTE Tobacco Cessation Specialist to promote Community Health Education about the effects of smoking (heart and lung disease, etc.) to adults, adolescents and children through a variety of forums including but not limited to schools, faith based organizations, neighborhood meetings, etc. We reached 9,000 individuals in FY16. AAMC also supports an additional 1.0FTE Tobacco Cessation Specialist to help current smokers quit. An additional 1500 encounters were captured in FY16. AAMC has been committed to provide these services for over 20 years and the current adult smoking rate is 17.7% which is higher than the Maryland rate and the 2017 target. (Community Benefit $132,288)

- Reduce the % of children who are considered obese

AAMC supports Healthy Anne Arundel (LHIC for the County) and their efforts to reduce obesity in the County.

- Increase the % of adults who are at a healthy weight

AAMC supports Healthy Anne Arundel (LHIC for the County) and their efforts to reduce obesity in the County.

- Increase the % vaccinated annually for seasonal influenza

AAMC vaccinates all 4,800 employees, 1,100 physicians, vendors, patients and visitors to the campus. Not all of this is community benefit, but 2500 vaccinations were provided to the community at large for a total community benefit of $70,674.

- Increase the % of children with recommended vaccinations

This is a public health initiative, led by the Anne Arundel County Health Department.

- Reduce new HIV infections among adults and adolescents

This is a public health initiative, led by the Anne Arundel County Health Department.

- Reduce diabetes-related emergency department visits

AAMC has expanded access to primary care providers via 2 sliding scale clinics, Fast Care Centers, Kent Island urgent Care Center, and another primary clinic in collaboration with Arundel Lodge. Furthermore, medication reconciliation was performed with many at-risk patients. AAMC also provide AAMC also invested in a Community Health Nurse to run community based education programs. Over 20,000 encounters were provided in FY16 and a Community Benefit of $2,791,855.

- Reduce hypertension related emergency department visits

See Above.

- Reduce hospital ED visits from asthma.

See Above

- Reduce hospital ED visits related to mental health conditions

See Table III, Initiative 2.

- Reduce hospital ED visits related to addictions

See Table III, Initiative 3.

Appendix 1

AAMC's Financial Assistance Policy

Description

The Financial Assistance Signage is conspicuously displayed in English & Spanish in the Emergency Department, Cashiering & Financial Counseling.

Financial Assistance Policy as well as a printable Uniform Financial Assistance application is posted on the AAMC website.

English/Spanish table top tents display this information at every patient entry point and it is included in each patient guide located in the inpatient rooms.

Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.

The financial assistance application is available at all registration points – but in particular the Emergency Department

A brochure "What you need to know About Paying for Your Health Services" is available at every patient access point. The brochure was developed by Patient Financial Services with guidance from Public Relations. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish. Also, it is posted on AAMC's website.

It is mandatory that all inpatients receive the "What you need to know about paying for your health services" brochure as part of the admission packet.

Informational "business cards" are available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital Financial Counseling office for assistance.

Appendix II

AAMC's Financial Assistance Policy

Changes since the ACA

Given the January 1, 2014, Affordable Care Act implementation and Medicaid Expansion many individuals are eligible for Medicaid coverage or may purchase medical benefits through the National Health Care Exchange.

The hospital's financial counseling workflow has been redesigned to promote enrolling patients for Medicaid. AAMC employs 3 Financial Advocates certified by the State of Maryland to complete Hospital Presumptive Eligibility applications for immediate temporary Medicaid coverage as well as the full long term Medicaid applications.

Appendix III

SEE FOLLOWING PAGE

Appendix IV

SEE FOLLOWING PAGE

Appendix V

SEE FOLLOWING PAGE