FY2016 Community Benefit Report
Greater Baltimore Medical Center
6701 N Charles Street
Towson MD 21204

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.)

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area Zip Codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	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
Acute Care- 231 Newborn Nursery- 60 NICU- 30 Skilled Nursing- 24	16,196 Med/Surg Acute Care (excludes 3,853 births) 503 Skilled Nursing Facility	21093 21204 21286 21030 21212 21234 21236	St. Joseph Medical Center Sinai Hospital Franklin	1.66%	11.2%	32.6%

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)

The Community Benefit Service Area activities fall within the same area as the hospitals primary service area, which includes areas of Baltimore County. According to the 2014 American Community Survey, the CBSA is predominantly of middle class with an average household income of $69,638 annually. Within this population, GBMC focuses its efforts on four primary demographics that have the greatest need and where the largest impact can be made. These identified demographics include victims of sexual assault, overweight and obese community members, stroke survivors, and the low income elderly population. The service activities that have been designated to serve these identified areas of need reach a wide range of people that encompass all ages, races, and ethnicities.

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.	21093- Lutherville Timonium 21204- Towson 21286- Towson 21030- Cockeysville 21212- Baltimore 21234- Parkville 21236- Nottingham	
Median Household Income within the CBSA	21093- $86,726 21204- $77,226 21286- $66,619 21030- $100,848 21212- $93,828 21234- $58,559 21236- $69,631	2014 American Community Survey Factfinder.census.gov
Percentage of households with incomes below the federal poverty guidelines within the CBSA	21093- 4.1% 21204- 12.9% 21286- 5.4% 21030- 6.4% 21212- 7.6%	2014 American Community Survey Factfinder.census.gov

<table>
<tr><td></td><td>21234- 6.9%
21236- 4.1%</td><td></td></tr>
<tr><td>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</td><td>21093- 4.0%
21204- 6.2%
21286- 6.7%
21030- 9.1%
21212- 7.0%
21234- 10.2%
21236- 6.7%</td><td>2014 American Community Survey Factfinder.census.gov</td></tr>
<tr><td>Percentage of Medicaid recipients by County within the CBSA.</td><td><table><tr><th>REGION</th><th>Medicaid Enrollment</th></tr><tr><td>Baltimore County</td><td>13.26%</td></tr></table></td><td>Overview of Maryland Medicaid Data, 2014 http://www.mhaonline.org/docs/default-source/presentations-and-talking-points/maryland-medicaid-landscape.pdf?sfvrsn=2</td></tr>
<tr><td>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</td><td><table><tr><th>REGION</th><th>All Races</th><th>White</th><th>Black</th></tr><tr><td>Maryland</td><td>79.8</td><td>80.4</td><td>77.5</td></tr><tr><td>Baltimore County</td><td>79.4</td><td>79.5</td><td>78.4</td></tr></table></td><td>Maryland Vital Statistics Annual Report 2014 http://dhmh.maryland.gov/</td></tr>
<tr><td>Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).</td><td><table><tr><th>REGION</th><th>All Races</th><th>White</th><th>Black</th><th>Asian</th><th>Hispanic</th></tr><tr><td>Maryland</td><td>764.5</td><td>874.2</td><td>672.3</td><td>251.0</td><td>137.4</td></tr><tr><td>Baltimore County</td><td>965.4</td><td>1201.1</td><td>607.0</td><td>219.0</td><td>142.5</td></tr></table>*Per 100,000 population.</td><td>Maryland Vital Statistics Annual Report 2014 http://dhmh.maryland.gov/</td></tr>
<tr><td>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)</td><td>Baltimore County
Social-Emotional Support lacking: Adults 20.3%
College Degree: Adults 25+ 35.6%
Toxic Chemicals released annually (lbs) 117,862
Healthy Food Outlets 76.5%</td><td>Maryland State Health Improvement Process (SHIP)</td></tr>
</table>

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		
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	**21093** White alone- 31,214 Black of African American alone- 1,197 American Indian and Alaska Native alone- 86 Asian alone- 3,869 Native Hawaiian and other Pacific Islander- 5 Some other race alone- 323 Two or more races- 690 Hispanic or Latino (of any race)- 1,445 White alone, not Hispanic or Latino- 30,176 **21204** White alone- 16,814 Black of African American alone- 1,983 American Indian and Alaska Native alone- 33 Asian alone- 848 Native Hawaiian and other Pacific Islander- 6 Some other race alone- 217 Two or more races- 352 Hispanic or Latino (of any race)- 703 White alone, not Hispanic or Latino- 16,401 **21286** White alone- 16,566 Black of African American alone- 1,972 American Indian and Alaska Native alone- 26 Asian alone- 1,108 Native Hawaiian and other Pacific Islander- Some other race alone- 45 Two or more races- 334 Hispanic or Latino (of any race)- 607 White alone, not Hispanic or Latino- 16,037 **21030** White alone- 17,033 Black of African American alone- 3,732 American Indian and Alaska Native alone- 269 Asian alone- 3,346 Native Hawaiian and other Pacific Islander- 34 Some other race alone- 273 Two or more races- 634 Hispanic or Latino (of any race)- 1,425 White alone, not Hispanic or Latino- 16,221	2014 American Community Survey Factfinder.census.gov

	21212 White alone- 17,355 Black of African American alone- 13,461 American Indian and Alaska Native alone- 33 Asian alone- 948 Native Hawaiian and other Pacific Islander- Some other race alone- 251 Two or more races- 952 Hispanic or Latino (of any race)- 1,149 White alone, not Hispanic or Latino- 16,728 **21234** White alone- 45,452 Black of African American alone- 18,471 American Indian and Alaska Native alone- 57 Asian alone- 3,062 Native Hawaiian and other Pacific Islander-10 Some other race alone- 1,004 Two or more races- 1,260 Hispanic or Latino (of any race)- 2,834 White alone, not Hispanic or Latino- 43,762 **21236** White alone- 28,192 Black of African American alone- 4,797 American Indian and Alaska Native alone- 101 Asian alone- 3,001 Native Hawaiian and other Pacific Islander- 6 Some other race alone- 516 Two or more races- 1,027 Hispanic or Latino (of any race)- 1,297 White alone, not Hispanic or Latino- 27,636	
Other		

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. 03/01/2013

   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.gbmc.org/workfiles/CHNA/SecondaryDataProfile-GreaterBaltimore-2013CHNA.pdf
   http://www.gbmc.org/workfiles/CHNA/2013CHNAKIGBReport.pdf
   http://www.gbmc.org/workfiles/CHNA/GreaterBaltimoreImplementationPlan-2013.pdf

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

   _x__Yes Enter date approved by governing body here: 04/01/2013
   ___No

   If you answered yes to this question, provide the link to the document here.
   http://www.gbmc.org/workfiles/community/CommunityHealthNeedsAssessmentImplementationStrategy2014.pdf

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

      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.

At the foundation of the GBMC Healthcare strategic plan is the commitment "to provide the highest quality care to our community, embracing healthcare reform." The vision and strategy is aligned with many of the elements identified in the Community Health Needs Assessment, including access to care for community members.

"This transformation will include building relationships between patients and their healthcare team, comprised of physicians, nurse practitioners, and healthcare navigators. This team will focus on a patient's wellness and long term care, rather than the traditional model of episodic care (i.e. waiting until an individual has a problem and then "fixing" that problem). In order to help us meet these objectives, we will implement the latest healthcare information technology tools such as Electronic Medical Recores (EMR) and Computerized Physician Order Entry (CPOE); reduce waste and improve operational performance using LEAN tools; promote improved clinical outcomes through evidence-based medicine and continue educating system leaders; develop a network of community-based and GBMC employed clinical providers – Greater Baltimore Health Alliance (GBHA) – that will offer high quality and convenient healthcare. The future of healthcare is about integrating care and access and addressing the overall wellness of the community." (excerpt from Strategic Plan document)

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

i. Senior Leadership

1. _x__CEO
2. _x__CFO
3. _x__Other (Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, VP of Post-Acute Care)

The executive team is primarily responsible for the strategic development of community outreach programs within GBMC. Needs identified through the Community Health Needs Assessment are discussed and prioritized by leadership, where planning follows on how to address those needs. Leadership is responsible for conveying these and leading implementation through partnering with clinical leadership and teams.

ii. Clinical Leadership

1. _x__Physician
2. _x__Nurse
3. _x__Social Worker
4. _x__Other (Care managers, Care Coordinators and Transitional Care Guides)

Describe the role of Clinical Leadership

Clinical leadership is primarily responsible for the implementation of clinical programs designed for improvements in patient care and long-term health of the patient community.

iii. Population Health Leadership and Staff

1. ____ Population health VP or equivalent (please list)

2. ____ Other population health staff (please list staff)

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

iv. Community Benefit Operations

1. ___Individual (please specify FTE)
2. _x__Committee (please list members)
3. ___Department (please list staff)
4. ___Task Force (please list members)
5. ___Other (please describe)

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

Colleen Finnegan- Data compilation and reporting

George Bayless- Vice President of Finance

Kim Davenport- Community Outreach Manager

Laura Schein- Community Outreach Oncology Services

Carolyn Candiello- Vice President of Quality and Patient Safety

Gregory Schaffer- Community Publications

Joseph Hart- Spiritual Support

Susan Martielli- Vice President of Legal Services

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

The Community Benefit report is reviewed for accuracy by the internal audit component of the Compliance Department. The report is subsequently provided to the Audit Committee, a Board sub-committee for approval within the IRS-990 filing process.

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
_____ 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
Sheppard Pratt	N/A	N/A	Commissioned consulting firm to perform a CHNA within the local area
St. Joseph Hospital	N/A	N/A	Commissioned consulting firm to perform a CHNA within the local area

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 __x___no

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

_____yes __x___no

a. 1. Identified Need 2. Was this identified through the CHNA process?	The *Maryland 2012 Uniform Crime Report* documents 17,615 domestic violence (DV) crimes in the State with 21% originating where GBMC is located--Baltimore County. Many victims do not report or reach out to available services on their own, but may avail themselves of services offered through a hospital. Hospital-based programs also have heightened ability to reach the following underserved groups: high risk victims, including the elderly, victims with disabilities, pregnant victims, victims with injuries, and victims in felony cases who may be brought to the hospital for a forensic examination; underserved populations including minorities, the under-insured and uninsured. Additionally, the SAFE program provides forensic evaluation for both sexual and intimate partner violence victims that is critical for law enforcement investigation and prosecution.
b. Hospital Initiative	Maintain 24/7, 365 days a year Forensic Nurse examiner coverage for victims of all ages. In particular, this year GBMC SAFE has worked to bolster available forensic capacity for the pediatric population. Maintain 24/7, 365 days per year Advocate coverage for DV and SA victims providing crisis counseling, safety planning, service referral, information on victim's rights, and follow-up services. Initiate community awareness events such as the Walk-a-Mile, grassroots fundraisers, and school/college/community partner presentations.
c. Total Number of People Within the Target Population	GBMC has strong institutional capacity to serve our patient demographic, which is primarily women from Baltimore County, but also Baltimore City, Harford County and Howard County. Annually GBMC sees almost 27,000 in-patient cases, 60,000 Emergency Room visits and has over 1,500 affiliated physicians. GBMC's 40 physician practices reach 250,000 people. GBMC was founded by the Hospital for the Women of Maryland, Baltimore City and we are the hospital women in our communities trust for their care.
d. Total Number of People Reached by the Initiative Within the Target Population	The SAFE Program saw approximately 150 patients in the last fiscal year and will be exceeding that going forward. The SAFE DV Program provided advocacy and crisis intervention to 339 individuals. The Walk-a-mile event had over 150 participants and volunteers, and community outreach exceeded 1000 students, EMS, Police and other organizations which received information regarding the SAFE Program. The grassroots bull roast was attended by 400 members of the community.
e. Primary Objective of the Initiative	The primary objective is to maintain 24/7 coverage for victims, where we provide early forensic examinations and connect victims with any resources they may need such as continued medical care or psychological counseling. We also strive to raise awareness in the community about the services we provide, while we are the only hospital in all of Baltimore County to provide forensic services and one of only two to offer hospital-based advocacy.
f. Single or Multi-Year Initiative –Time Period	Multi Year – ongoing and continual

g. Key Collaborators in Delivery of the Initiative	GBMC SAFE & Domestic Violence Program staff Volunteers within the hospital Baltimore County Police Department Maryland States Attorney Office	
h. Impact/Outcome of Hospital Initiative?	Over 150 Patients were seen in the SAFE Program, and the program successfully expanded its service to care for pediatric sexual abuse victims, an underserved population in Baltimore County. Additionally, 339 victims of abuse benefitted from advocacy and safety planning. We serve patients whose assault occurred in Baltimore County but often care for victims of surrounding jurisdictions and other states. Patients that presented to the Emergency Department without the presence of law enforcement received counseling by a Forensic Nurse Examiner to assist these patients in their decision to either notify police of their assault and have a forensic examination; have a forensic examination without reporting the assault to the police (they will have 90 days to make a decision about reporting) or receive medical services only where they are given antibiotics to prevent infections and emergency contraception. Additionally, the Walk-a-mile event had over 150 participants and volunteers, and community outreach exceeded 1000 students, EMS, Police and other organizations which received information regarding the SAFE Program. The grassroots bull roast was attended by 400 members of the community.	
i. Evaluation of Outcomes:	The Outcomes of this initiative are evaluated by the number of victims who receive forensic exams as well as attendance numbers for community outreach and engagements. Baltimore County police SVU are continuing to utilize the SAFE Program as the **Baltimore County** SAFE Center. Baltimore County Crimes Against Children Unit is now starting to utilize the SAFE Program for the 12 and under population.	
j. Continuation of Initiative?	Yes.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	$334,666	$103,311

Initiative 2- Access to Care for Low Income Seniors

a. 1. Identified Need 2. Was this identified through the CHNA process?	As identified by both the Key Informant and Secondary data profile portion of the Community Health Needs Assessment, access to care is one of the most significant barriers to satisfying the health needs of the community. Finding access to appropriate care can prove to be a difficulty particularly for low income seniors within our service area.
b. Hospital Initiative	In order to address the largest need identified by the Community Health Needs Assessment, GBMC has made an effort to improve access to care wherever possible. The organization has dedicated a full time geriatric nurse practitioner to go out into the community and service the healthcare needs of low income seniors within its service area.
c. Total Number of People Within the Target Population	1,700 people
d. Total Number of People Reached by the Initiative Within the Target Population	Patient visits- 1,740 Vaccinations- 300 Referrals- 115 Glucose screenings- 84
e. Primary Objective of the Initiative	GBMC employs a nurse practitioner whose sole responsibility is to provide education and primary care services within Towson's low income senior living facilities. This was a service that had at one time been provided by Baltimore County, but has since been discontinued, allowing GBMC to make an impact on our community health. The primary objective of the initiative is to coordinate care and provide guidance to finding and receiving the appropriate healthcare resources for the targeted low income senior population. In addition to helping the target population locate appropriate resources, direct care is provided to patients on a temporary basis until they have been able to establish a primary care provider.
f. Single or Multi-Year Initiative –Time Period	Multi year
g. Key Collaborators in Delivery of the Initiative	The facilities service include: Tabco Towers, Virginia Towers, Trinity House, Parkview/Timothy House, Village Crossroads (I & II), Mission Helpers, Gallagher House, Aigburth Vale, ACTC Key Partners: - Catholic Charities: partnered on a grant to improve Aging in Place - St. Ambrose Housing - Inspirit Counseling Services: partnered in a grant to provide in home counseling services - Towson University community health nursing students - Towson University occupational therapy students - Stevenson University community health nursing students - Aigburth Vale - Mission Helpers of the Sacred Heart

	- Notre Dame of Maryland pharmacy students	
h. Impact/Outcome of Hospital Initiative?	Throughout fy16 our nurse practitioner was able to make 1,740 visits to seniors throughout the community. During these visits she was able to provide vaccinations and glucose screenings as a measure for preventative health. Providing these low income seniors with information regarding their health allows them to make better healthcare decisions. In turn, providing these resources has allowed for better health outcomes including less frequent hospital stays with the reduction in length of stay, resources, and waste.	
i. Evaluation of Outcomes:	The effectiveness of the initiative is evaluated by the quantity of visits made to patients. The number of at risk seniors who receive vaccinations and glucose screenings as a result of education is another example of evaluation criteria. In addition, a patient satisfaction survey is conducted to allow GBMC to measure satisfaction amongst patients served.	
j. Continuation of Initiative?	Yes.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Direct expense- $135,448	Offsetting revenue- $11,173

Initiative 3- Run GBMC Obesity Program

l. a. Identified Need 2. Was this identified through the CHNA process?	Obesity is an important health issue that has become increasingly prevalent in today's society. Obesity is a serious concern as it can be a contributing factor to a variety of other health conditions such as diabetes and heart disease. Data from the Maryland Behavioral Risk Factor Surveillance System (BRFSS) demonstrated that the GBMC Service Area has a higher percentage of residents that are overweight/obese (68.1%) when compared to the state and the nation (both 64.9%).
b. Hospital Initiative	In order to address the growing need of weight management, GBMC made an effort to create a running program for the hospitals bariatric patients. The hospital dedicated employee volunteers to engage every Saturday in a running program along-side the targeted patient population.
c. Total Number of People Within the Target Population	3,901
d. Total Number of People Reached by the Initiative Within the Target Population	100 patients
e. Primary Objective of the Initiative	The goal of Run GBMC was to get patients engaged in starting a healthier lifestyle, with the goal of completing GBMC's annual Father's Day 5k. Giving patients the opportunity to gain necessary tools and education on physical activity allowed for these patients to start a journey to lose weight and gain a better health status in general.
f. Single or Multi-Year Initiative –Time Period	January 2nd 2016 – June 18th 2016 Single year
g. Key Collaborators in Delivery of the Initiative	Employee volunteers including physicians and nurses
h. Impact/Outcome of Hospital Initiative?	Every Saturday the group of volunteers and patients would practice for 1.5 hours where even with the snow, the group only missed a total of 3 Saturdays within the 6-month period. Initially, the goal of the program was to get the patients at a point where they were able to complete the annual Father's Day 5k. At first most patients were only able to walk or run a mile at a time. By the end of the program most patients were able to complete 5 miles at a time. This then evolved into 95 of the original 100 patients deciding to compete in the Baltimore Running Festival.
i. Evaluation of Outcomes:	The effectiveness of the initiative is evaluated by the number of participants to complete the Father's Day 5k.
j. Continuation of Initiative?	No

k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	$10,040	

Initiative 4- Yoga for Stroke Survivors

1. a. Identified Need 2. Was this identified through the CHNA process?	As identified by the Community Health Needs Assessment, the management of chronic health issues is a serious need in the community. There are many stroke survivors throughout the community who have exhausted their compensated rehabilitation, creating an opportunity for GBMC to assist survivors regain mobility lost as a result of a stroke.
b. Hospital Initiative	GBMC is offering a yoga class for stroke survivors in an effort to help the survivors regain lost mobility and function. Prior to the beginning of the program, all participants are screened by a Physical Therapist. The Physical Therapist screens for past medical and surgical history, range of motion, strength, balance and functional mobility to ensure the patient is able to safely participate in the class. Participants are also asked to list their goals for the yoga program.
c. Total Number of People Within the Target Population	386
d. Total Number of People Reached by the Initiative Within the Target Population	Classes were held on Mondays and Fridays for 37 weeks during FY16. The average class size on Monday was 14 Clients while Fridays had an average of 8.
e. Primary Objective of the Initiative	The Yoga for Stroke Survivors program is designed to address the disabilities that result from a stroke and provide a network of social support from others having similar experiences.
f. Single or Multi-Year Initiative –Time Period	Multi-year
g. Key Collaborators in Delivery of the Initiative	Body Harmony

h. Impact/Outcome of Hospital Initiative?	The yoga class has had a positive impact on many of the participants. The staff have reported seeing changes in decreased flexed posture, decrease tone, improved strength and flexibility, improved transfers, improved mood, and body awareness. As well as the staff reporting improvements, feedback from participants was also positive. They reported better movement, increased strength, improved breath control, decreased tone, improved functional mobility, posture, speaking quality, weight loss, decreased stress and anxiety, and improved concentration.	
i. Evaluation of Outcomes:	The primary evaluation of this program is based on the number of stroke survivors, retention of participants, and feedback from participants themselves.	
j. Continuation of Initiative?	yes	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	$1,626	

V. 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.

   GBMC continues to fund anesthesia, obstetrical, and orthopedic services to Medicaid and uninsured patient populations. GBMC has generally covered this by agreeing to provide physicians with payment for their surgical services that come through the emergency department where the patient is considered to be indigent.

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	
Non-Resident House Staff and Hospitalists	
Coverage of Emergency Department Call	
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VI. 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
- Reduce infant mortality
- 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
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- 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 hospital ED visits from asthma
- Reduce hospital ED visits related to mental health conditions
- Reduce hospital ED visits related to addictions
- Reduce Fall-related death rate

FY 2015 Community Benefit Report Filing
Description of Financial Assistance Policy

GBMC has designed its Financial Assistance Policy with the intention of ensuring free and/or reduced care is available to patients. In administering its Financial Assistance Policy, GBMC utilizes an automated resource for scanning a patient's financial profile and/or an application process. Because GBMC's application process allows for a net asset test (i.e., a patient's necessary living expenses are taken into account), patients at or above 300% of the Federal Poverty Guidelines will typically qualify for free and/or reduced care.

In addition, GBMC has taken significant measures to ensure that its Financial Assistance Policy is both visible and accessible to patients by enacting the following measures:

1. **Availability of Applications & Brochures**

   - Via website
   - All hospital patient registration areas; including admitting, emergency department, laboratory stations, clinics and radiology services
   - GBMC owned physician offices
   - Billing Office
   - Included in each billing statement to patient

   In addition, to the availability of applications and brochures, signs describing the existence of a Financial Assistance Policy and opportunity for financial assistance are also prominently displayed throughout the hospital.

2. **Direct Assistance**

   Utilizing the admitting and insurance verification process, prior to discharge, the Patient Financial Services department attempts to assist many patients with financial evaluations in order to determine the availability for financial assistance and/or qualifying insurance coverage. In addition, during the account resolution process, staff is also trained to evaluate a patient's unique circumstances and attempt to direct patients to financial assistance when appropriate.

   GBMC will also assist patients in enrolling for State Medical Assistance coverage.

3. **Education**

To ensure that employees are qualified to direct patients in accessing financial assistance, new employees and volunteers are specifically educated during new-hire orientation programs on how to obtain financial assistance applications and brochures.

Appendix II

Greater Baltimore Medical Center's Financial Assistance Policy has not changed in response to the Affordable Care Act.

Greater Baltimore Medical Center
Patient Financial Assistance Services
Financial Assistance Policy

I. PURPOSE

To establish guidelines assuring consistency in the implementation of the Financial Assistance Program.

POLICY

GBMC recognizes its obligation to the communities it serves to provide medically necessary care to individuals who are unable to pay for medical services regardless of race, color, creed, religion, gender, national origin, age, marital status, family status, handicap, military status, or other discriminatory factors.

The Financial Assistance procedures are designed to assist uninsured individuals or individuals who qualify for less than full coverage under federal, state or local programs, or individuals whose patient balances after insurance exceed their ability to pay.

While flexibility in applying guidelines to an individual patient's situation is clearly needed, certain objective criteria are essential to assure consistency in the implementation of the Financial Assistance Program.

A. Eligible/Ineligible Services

1. Services considered medically necessary are covered under the program

2. Services considered elective (i.e. cosmetic) are not covered under the program unless directly to related or part of a medically necessary procedure

3. Applicants meeting eligibility criteria for Federal Medicaid must apply and be determined ineligible prior to Financial Assistance consideration

B. Referral Sources

1. Financial Assistance referrals will generally originate in the Insurance Verification, Advocacy and Collection/Insurance departments accompanied with a **Financial Evaluation** (Attachment #1) and **Medical Assistance Eligibility Check List** (Attachment #1a)

2. Other referral sources include social services, physician offices, administration, etc.

3. GBMC recognizes the importance of communicating the availability of the Financial Assistance Program to all patients

    a. The Financial Assistance Application and brochures explaining the program are located on the GBMC website

    b. Brochures and applications are available in all GBMC owned physician offices and in all hospital registration areas

    c. All new employees and volunteers are educated during their orientation programs with regard to the Financial Assistance Program and how to assist patients in obtaining applications and brochures

C. Financial Eligibility Criteria

1. Eligibility is based on gross household income

2. Gross household income is defined as wages and salaries from all sources before deductions

3. Other financial information such as liquid assets and liabilities are considered

4. Annual household income criteria is 300% of the current poverty guidelines published in the Federal Register

5. Applicants that exceed established household income levels may still be eligible when additional factors such as disposable net income are considered (See "Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines")

D. Household Income

1. Household Income to be considered

    a. All wages and salaries

    b. Social Security, veteran's benefits, pension plans, unemployment and worker's compensation, trust payments, child support, alimony, public assistance, strike benefits, union funds, income from rent, interest and dividends or other regular support from any person living in the home

    c. Generally, the availability of liquid assets including cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, etc. exceeding 2 months of living expenses will be considered (referred to in the policy as Liquid Assets)

d. Based on individual circumstances, allowances can be made to have liquid assets exceed the two month test up to $25,000

2. Proof of Household Income (Attachment #2)

a. One or more of the following items may be requested from the applicant to verify income for each income producing member of the household. Monthly household income is prorated to determine annual household income level.

b. Two recent pay stubs reflecting year-to-date earnings for each family member who is a guarantor or could be deemed responsible for the account.

c. Most recent income tax return(s) with W2s

d. Social Security Award Letter(s)

e. Most recent unemployment insurance stub

f. Two most recent checking and savings account statements

g. Two most recent investment statements (money market, CD, stocks, etc.)

h. Letter from federal, state or local agency verifying the amount of assistance awarded

i. Applicants claiming zero household income must supply proof of how their living expenses are paid with a notarized letter of support. Cancelled checks and/or receipts may also be required if another individual is paying patient's bills

j. Medical Assistance denial or spend-down determination letter

k. Identified asset transfers within a 12-month period of application may be factored into determining eligibility.

l. Other pertinent household income verification documentation as required

E. Expenses

1. Expenses to be considered (also see "Questionable Expenses" under "Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines")

2. All reasonable living expenses (mortgage/rent, utilities and loan/credit card payments)

   a. Either land-line telephone or cell phone bill will be considered (not both)

   c. A monthly car payment of up to $450 for one car is allowed
   The maximum allowance per family (2 adults) is $900
   Any amount over the above allowance will be considered within the miscellaneous allowance

   d. Payments for recreational items such as boats, motorcycles, etc. are not allowable expenses Exception: if motorcycle is only source of transportation

   e. Expenses for Cable TV, Dish TV and/or Internet are considered within the miscellaneous allowance

   f. Expenses for second homes are not allowable expenses (however, income from rental properties will be counted as Household Income)

   g. $150 food allowance will be given for patient; and $75 food allowance for each additional family member

   h. $300 miscellaneous allowance will be given for ancillary living expenses (i.e.: gas for automobile, grooming items, automobile maintenance, tuition and tithing)

3. Medical expenses

   1. Up to $100 in prescription expenses per person will be considered without receipts

   2. Prescription expenses that exceed $100 per person cannot be considered unless patient provides receipts for the two prior months

   3. Medical expenses are considered upon proof from patient of active payment arrangements

PROCEDURES

A. **Application Process**

1. Patients may request Financial Assistance prior to treatment or after billing

a. A new application must be completed for each new course of treatment with the following exceptions:

Inpatient and outpatient Medicare patients are certified for one year (see "Medicare Patients")

Inpatient and outpatient non-Medicare patients are certified for 6 months. However, if it is determined during the course of that period that the patient meets Medical Assistance eligibility criteria they are required to pursue Medicaid prior to receiving additional Financial Assistance

Mitigating circumstances impacting eligibility period are identified. (examples include favorable changes in the applicant's income, winning a lottery, receiving notable inheritance, etc..) These determinations are made at the discretion of the Collection Manager and/or Director of Patient Financial Services.

3. At the time of application all open accounts are eligible for consideration with the potential exception of patients who are in bad debt status and did not respond to collection activity or statements prior to write-off of account(s)

4. The signed/completed **Financial Evaluation** is referred to the Financial Assistance Department

   a. Combined account balance(s) greater than $2,500

      1. Completed **Financial Evaluation**

      2. Proof of household income

      3. Credit bureau report obtained and reviewed to verify information, develop additional sources for funds and utilized as a collection tool found

   b. Combined account balance(s) less than $2,500

      1. Completed **Financial Evaluation**

      2. Proof of household income

      3. Credit bureau report may be obtained and reviewed if household income and/or household expense discrepancies are found

   c. Accounts are approved or denied based on household income criteria and applicant cooperation

B. Household Income Criteria for Financial Assistance Approval / Denial

1. Combined gross household income less than 300% of the poverty guidelines

   a. Applicants are eligible for 100% Financial Assistance

   b. However, applicants with liquid assets including cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, etc., not exceeding $25,000, who meet the income eligibility requirements, will be considered for assistance at the discretion of the Director of Patient Financial Services and/or the Financial Assistance Committee. Inability to replenish the resource and/or current usage of the resource to cover allowed living expenses may qualify the applicant for assistance.

   c. Applicants with liquid assets (described above) exceeding $25,000, may not qualify for assistance. However, at the discretion of the Chief Financial Officer, inability to replenish the resource and/or current usage of the resource to cover allowed living expenses may qualify the applicant for full or partial assistance

2. Combined gross household income greater than 300% of the poverty guidelines and the patient is still unable to make acceptable payment arrangements (minimum - $25 per month)

   a. Applicants are reviewed on a case-by-case basis (see "Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines")

C. Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines

1. Applicants whose gross household income exceeds 300% of the poverty guidelines but state they are still unable to pay all or part of their account balance(s) may be further evaluated for Financial Assistance

2. In these cases, consideration is given to expenses, disposable net household income, total liquid assets and account balance(s)

3. Disposable net income is defined as gross household income less deductions and expenses (Program allows $250 disposable income for one person and $75 for each additional family member.) Disposable income (exceeding $250 for one person and $75 for each additional family member) will be used to determine patient's ability to pay)

a. The applicant is required to supply proof of "questionable" expenses

1. "Questionable" expenses are defined as any expense item that appears to be overstated/understated and/or not reasonable or customary

b. A credit bureau report is required to evaluate the application (regardless of account balance)

c. Patients whose disposable income is within the limits stated above and whose liquid assets do not exceed the standard (See Household Income); are eligible for 100% Financial Assistance

d. Patients who exceed the asset standard (See Household Income) are ineligible for Financial Assistance and need to make payment arrangements (See Resource Payment Arrangements)

e. Eligibility for patients who have excess disposable income is determined based on ability to satisfy outstanding balance(s) within timeframe defined (See Financial Assistance With Resource) All exceptions will be reviewed by the Director of Patient Financial Services

4. Applicants approved for 100% Financial Assistance (See "Processing Approved Applications")

D. Financial Assistance With Resource

1. Resource amounts are determined based on the applicant's ability to pay a portion of their account balance(s) without causing undue financial hardship \ using the following guidelines

2. Outstanding balance(s) owed to GBMC are divided by excess disposable income to determine the number of months needed to pay the outstanding balance(s) in full

3. Excess disposable income determines the amount of the monthly payment (See Resource Payment Arrangements for standards)

4. Outstanding balance(s) that cannot be satisfied within 24 months will be reduced by the difference between the total outstanding balance(s) and the total required patient payment amount (excess disposable income multiplied times 24 months)

5. All resource amounts are reviewed and approved by the Director and Collection Manager

6. Approval process

a. The completed **Financial Evaluation** (including resource recommendation), **Authorization Form** (Attachment #3) and documentation is forwarded to the Collection Manager

b. The Collection Manager will ensure that all required authorization signatures are obtained

7. When authorization is obtained the patient is mailed a **Financial Assistance Reduction Letter** (Attachment #6) and a **Financial Assistance Promissory Note** (Attachment #6A) outlining the terms and conditions of the agreement

8. The **Financial Assistance Promissory Note** must be returned within 14 days. Failure to do so may result in the patient's ineligibility for Financial Assistance

a. Signed promissory notes are forwarded to the Collection Manager (see "Processing Approved Applications")

E. Resource Payment Arrangements

1. Resource payment arrangements will not exceed 24 months

a. Every effort is made to liquidate the resource amount within the earliest possible time frame

2. The minimum monthly payment amount is $25

a. Patient is set up under a contract in Meditech with an alert on Patient Overview screen (alert is set to remind collector that partial write-off occurred in the event of patient default on resource payments)

b. Patients are automatically sent monthly statements through Meditech indicating their monthly payment amount, due date and account balance(s)

4. If a patient qualifies for Financial Assistance with a resource and has multiple account balances, all account balances are allowanced leaving only one open account (if possible) for the resource amount

a. A weekly Meditech work list is reviewed to determine if patients are delinquent with their payments

b. Failure to pay as agreed will result in the patient being responsible for

both the allowance amount and the unpaid resource balance

c. Forward the delinquent account to the Collection Manager

d. The Collection Manager/ or designee reverses the Financial Assistance allowance

e. Patient is sent a final demand letter

F. Authorization For Financial Assistance

$1 - 2,499	- Coordinator
$2,500 - 5,000	- Collection Manager
$5,001 - 10,000	- Director of Patient Financial Services
GT $10,000	- EVP/CFO

G. Incomplete / Uncooperative

1. Failure to supply required information or to communicate reason for delay within 10 days may result in the applicant's ineligibility for Financial Assistance

H. Processing Approved Applications

1. Completed applications are forwarded to the Collection Manager with all appropriate supporting documentation

2. The Collection Manager will ensure that each applicant has met household income requirements, supplied appropriate supporting documentation and that proper authorization signatures are obtained

   a. The Collection Manager or designee applies the Financial Assistance adjustment and files the **Financial Evaluation**, **Authorization Form** and related documentation

3. The patient is sent a Financial Assistance Award Letter (Attachment #4)

I. Processing Denied Applications

1. Applicants that are determined to be ineligible based on household income and/or asset criteria are sent a Financial Assistance Denial Letter Attachment #5)

2. Patients have the right to appeal denials. Final appeal decisions are at the sole discretion of the next level of required signature authority. (Example – Director of Patient Financial Services to review appeal for Collection Manager level denial)

J. Medicare Patients

1. Medicare patients are required to supply a copy of their Social Security Award Letter on a yearly basis

2. Medicare patients are certified for 1 year. However, if it is determined during the course of that year that the patient meets Medical Assistance eligibility criteria they will be required to pursue Medicaid prior to receiving additional Financial Assistance

3. The Financial Assistance Department will refer Medicare patients meeting Medicaid eligibility criteria to the Advocacy Department for processing

K. Medicaid Resources

1. Medicaid resources are automatically reviewed for Financial Assistance when a copy of the Department of Social Services (DSS) **0102 Form** (Attachment #7) is supplied to the Financial Assistance Department

2. DSS income calculations and Financial Assistance program allowances are used to calculate patient's disposable income (see "Gross Household Income Is Greater Than 300% Poverty Guidelines")

L. Recurring Accounts

1. Patients are certified 6 months for Non Medicare and 1 year for Medicare. Based on each unique situation, these periods may be extended at the discretion of the Director of Patient Financial Services.

2. If patients are admitted or start a new course of treatment, they are screened for Medicaid and/or reevaluated for Financial Assistance

M. Financial Assistance Statistical Reporting

1. The Collection Manager or designee is responsible for completing all monthly and year-to-date statistical analysis as required.

II. ASSUMPTIVE FINANCIAL ASSISTANCE

Assumptive Financial Assistance is a program run in partnership with TransUnion credit reporting agency. Self-pay Emergency Department cases are referred to TransUnion, who utilizes a proprietary credit scoring system to determine likelihood of ability to pay based on estimated income and family size. The results from the TransUnion credit scoring are compared to GBMC's Financial Assistance eligibility criteria and a decision is made to write off or to pursue collection.

A. **Eligible/Ineligible Services**

1. Only bills for uninsured patients for services incurred in the Emergency Department are eligible for Assumptive Financial Assistance screening at this time

2. Patients seen in the Emergency Department as the result of a motor vehicle accident or for which any third party liability may exist will not be considered under the Assumptive Financial Assistance program

3. Uninsured patients seen in the Emergency Department under Emergency Petition will not be condisered under the Assumptive Financial Assistance program until the Maryland Medicaid Psych program (MAPS) has been billed

V. PROCESSES UTILIZED BY TRANSUNION TO DETERMINE ELIGIBILITY STATUS

A. TransUnion accesses credit data, via the Healthcare Revenue Cycle Platform (HRCP). TransUnion built and maintains a proprietary matching algorithm to select consumer credit files, including data like; name, address, SSN, Soundex and other criteria to match input inquiries to the correct credit file. This algorithm is used to match hundreds of millions of credit inquiry requests each year. It is constantly reviewed and maintained to provide accurate credit data to tens of thousands of customers. The minimum customer input requirement is name and \ address. TransUnion also accepts, SSN, previous address and date of birth input as part of its matching algorithm. HRCP then employs proprietary algorithms and expert business rules to match each hospital's own charitable, regulatory guidelines and policies to patient qualifications.

B. HRCP employs a proprietary algorithm to estimate minimum family income and size. The algorithm uses information like debt to income ratios, current financial obligations that are being met, residual income for household members and cost of living calculations to estimate the minimum monthly income. HRCP also estimates family size based upon data such as, joint credit accounts, authorized users of credit cards, etc. The algorithm calculates FPL based upon these data. Customers may evaluate and configure certain parts of the algorithm like residual income to level the estimates for cost of living differences in geographic areas.

C. Under the Fair Credit Reporting Act (FCRA) and other privacy regulations,

TransUnion cannot disclose financial information regarding individual consumers to anyone without satisfying permissible purpose requirements.

D. The HRCP proprietary algorithm used for estimating FPL (minimum estimated family income and size) uses both credit data and other calculations like residual income and cost of living. In the absence of credit data, other calculations are used and can be configured to consider certain geographic cost of living differences as stated above. In such instances where credit data is absent, it is recommended to further qualify FPL if possible through documentation or patient interviews.

VI. ASSUMPTIVE FINANCIAL ASSISTANCE PROCEDURES

A. Identifying Patients For Assumptive Financial Assistance Write-offs

1. Up to three invoices per Emergency Room visit will be sent to each uninsured patient for hospital charges incurred. In addition, at least one phone call will be generated to the patient by the Patient Liability Staff.

2. Patient Financial Services may accelerate the screening process based on individual patient experience or accumulated historical data.

3. The invoices will be generated at the time of final billing of the patient's account and then 30 days from initial billing and then 60 days from intial billing

4. Within 10 days after the final invoice has generated, a file will be created to identify all accounts that have remained in a self pay status (excluding motor vehicle accidents, emergency petitions, and other third party liability)

5. The file will be sent to TransUnion for credit scoring **(see VI. on page 12 for Processes Used By TranUnion To Determine Eligibility Status)**

6. TransUnion will return the file with the credit scoring for each individual

a. **Meets Charity Guidelines** means the patient income is below 300% of the Federal Poverty Guidelines and the patient does not have the ability to pay. The patient qualifies for a write off of their Emergency Room bill under the Assumptive Financial Assistance write off code (CHAASSUMP) in Meditech.

b. Collect Hospital Charges, Pursue Payment Arrangement or Question Household Income means the patient appears to have the ability to pay and the Patient Liability staff will pursue a payment plan or offer Financial Assistance Screening through our non-assumptive program

c. **No Credit Found** means the patient demographic information did not match any information in the TransUnion data bank. The Patient Liability staff will pursue the patient and if additional or corrected demographic information is uncovered, they will have the patient rescreened through TransUnion.

d. **Social Security Number not issued by Social Security** Administration or Social Security Number used in death benefits requires that we pursue patient. If the Patient Liability staff uncovers a data entry error with regard to Social Security Number they will have the patient rescreened through Trans Union.

B. Reversal Of Assumptive Financial Assistance Write-offs

1. If verifiable insurance is uncovered at anytime after the Assumptive Financial Assistance write-off, the write-off will be reversed and the patient's insurance billed

C. Assumptive Financial Assistance Statistical Reporting

1. The Collection Manager or designee is responsible for completing all monthly and year-to-date statistical analysis as required.

Review Cycle: Annual

Approved By: Eric Melchior,
Executive Vice-President and CFO
July 2009

GBMC
6701 North Charles Street
Baltimore, MD 21204

PERMISSIONS / ACKNOWLEDGEMENTS – Page 1 of 4

USE AND DISCLOSURE OF HEALTH INFORMATION – I authorize GBMC Healthcare and independent physicians or other practitioners providing services by or in the Health System to disclose any health information related to this hospitalization for my treatment as well as use of routine Health System operations and payment for services and associate care. I further authorize release of health information pertaining to this hospitalization to other health care providers for continuing care and treatment.

HEALTH INFORMATION EXCHANGES – We participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a state-wide health information exchange. As permitted by law, your health information will be shared among several health care providers or other health care entities in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. This means we may share information we obtain or create about you with outside entities (such as doctors' offices, labs, or pharmacies) or we may receive information they create or obtain about you (such as medical history or billing information) so each of us can provide better treatment and coordination of your healthcare services. You may "opt-out" and prevent searching of your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Even if you opt-out, a certain amount of your information will be retained by CRISP and your ordering or referring physicians, if participating in CRISP, may access diagnostic information about you, such as reports of imaging and lab results.

ASSIGNMENTS OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS – I hereby authorize payment directly to GBMC Healthcare of hospital benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer, or insurance company to or for the patient unless the account is paid in full upon discharge. I also authorize payment of surgical or medical, including major medical benefits, directly to attending physicians, but not to exceed charges for these services. I understand that I am financially responsible to the hospital and physicians for charges, whether or not covered by this assignment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts may bear interest at the legal rate. I further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverages are subject to coordination of benefits clause. I understand that I am responsible for any deductibles, coinsurance, or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), "opt-out" plan, "out-of-network" preferred, and indemnity benefits and for payment of services not covered under my policy or those services I elect to receive if denied for coverage by my insurer. I will contact my insurer or Health Advocacy Unit of the Attorney General's Office to learn how to appeal adverse decisions made by my insurer.

PERMISSIONS / ACKNOWLEDGEMENTS – Page 2 of 4

MEDICARE/MEDICAID PATIENT CERTIFICATION (for Medicare/Medicaid patients only) –
I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

I understand that I have been instructed to leave all valuables at home, give such valuables to a friend or family member, or if that is not possible, to deposit such valuables with the GBMC Security Office. I understand that I am responsible for safekeeping such items as eyeglasses, dentures, or hearing aides, or any of my property while it is in my possession or under my control. I release the hospital from any responsibility for loss of any item not deposited with the Security Office.

Has the patient received the Notice of Privacy Practices?
_____ Yes
_____ No

Reason no NOPP given:
_____Newborn
_____Patient Unable to Accept

PATIENT FINANCIAL POLICY
We are committed to providing you with quality and affordable health care. You are receiving this information because under Maryland law, GBMC must have a financial assistance policy and must inform you that you may be entitled to receive financial assistance for the cost of medically necessary hospital services if you have a low income, do not have insurance or your insurance does not cover your medically necessary hospital care and you have a low income.

Hospital Financial Assistance Policy:

· GBMC provides emergency and urgent care to all patients regardless of ability to pay.

· GBMC offers several programs to assist patients who are experiencing difficulty paying their hospital bills.

· GBMC complies with Maryland's legal requirement to provide financial assistance based on income level and family size.

· GBMC Patient Representatives are available to assist you with the application process **(see contact information on page 4)**, or you may access an application by going to http://www.gbmc.org/ (go to the Patient & Visitors Tab and then click Financial Support).

PERMISSIONS / ACKNOWLEDGEMENTS – Page 3 of 4

Patient Rights:

· Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill.

· If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance **(see contact information on page 4)**.

· You may be eligible for Maryland Medical Assistance a program funded jointly by the state and federal governments **(see contact information on page 4)**.

Patients' Obligations:

· For those patients with the ability to pay their hospital bill, it is the obligation of the patient to pay the hospital in a timely manner.

· GBMC makes every effort to see that patient accounts are properly billed. It is your responsibility to provide correct insurance information.

· If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under GBMC's financial assistance policy, or if you cannot afford to pay the bill in full you should contact the Patient Financial Services department promptly to discuss this matter **(see contact information on page 4)**.

· If you fail to meet your financial obligations for services received, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact Patient Financial Services to provide update/corrected information **(see contact information on page 4)**.

Insurance: We participate in most insurance plans, including Medicare. Please remember to always bring your insurance card with you when you come for a visit.

· **Co-payments and deductibles -** All co-payments and deductibles must be paid at the time of service. This arrangement may be part of your contractual agreement with your insurance company. Please assist us by being prepared to submit your co-payment for each visit.

· **Referrals/Authorizations/Pre-certifications -**You may be responsible for obtaining precertification, submitting a referral and/or authorization prior to being seen, if required by your insurance carrier (except Medicare). Please obtain your pre-certification, referral and/or authorization from your primary care physician and submit at the time of service.

· You may also be responsible for tracking your referrals (number of remaining visits and expiration date). Please obtain additional or new referrals as necessary.

· **Non-covered services** – Some, and perhaps all of the services you receive may be noncovered or not considered reasonable or necessary by your insurance company. Please contact your insurance company with any questions you may have regarding coverage. If your insurance does not cover the service it does not necessarily mean that you do not need the service. Your physician will explain why he or she thinks that you can benefit from a service or procedure. If you elect to receive the non-covered service, you will be financially responsible.

PERMISSIONS / ACKNOWLEDGEMENTS – Page 4 of 4

· **Medicare patients** – If we believe you are receiving a service that Medicare considers not reasonable or necessary for your condition, you will be notified in writing on a form called an Advance Beneficiary Notice of Non-coverage (ABN). This will provide you with the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal Medicare's decision.

· **Claims submission** – We will submit your claim(s) and assist in any way we reasonably can to ensure claim payment. Your insurance company may require you to supply certain information directly. The

balance of your claim is your responsibility regardless of your insurance company payment and GBMC is not party to that contract.

· **Coverage changes** – Please notify us before your next visit of any coverage changes so that we may assist you in maximizing your benefits.

· **Acceptable forms of payment** – We accept personal checks, money orders, Visa, MasterCard, Discover, American Express and we offer payment plans.

Physician Services:

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement. Depending upon your treatment plan, you may receive separate bills for all services rendered including but not limited to, GBMC, the physician treating you, Charles Emergency Physicians, Advanced Radiology, Physicians Anesthesia Associates, Radiation Oncology Healthcare, Greater Baltimore Pathology Associates, Pediatric Physicians, etc.

Contact Information:

· **GBMC Patient Representatives are available Monday through Friday, from 8:00 a.m. to 6:00 p.m., at (443) 849-2450, option 1, or at 1-800-626-7766, option 1.**

· Our representatives can assist you with applying for Maryland Medical Assistance or you may also obtain information about or apply for Maryland Medical Assistance by contacting your local Department of Social Services by phone at 1-800-332-6347; TTY: 1-800-925-4434; or on the Internet at www.dhr.state.md.us.

I have read and understand in its entirety the information provided in this document and agree to follow its guidelines.

_____ _____

Signature of Patient or Responsible Party Date

_____

Relationship to Patient
(if signed by person other than the patient)

FY 2015 Community Benefit Report Filing
Mission, Vision & Values Statement

MISSION

Health. Healing. Hope.

The mission of GBMC is to provide medical care and service of the highest quality to each patient leading to health, healing and hope.

VISION

To every patient, every time, we will provide the care that we would want for our own loved ones. GBMC also dedicates itself to the guiding principle that *"the patient always comes first."*

GREATER VALUES

The values of GBMC are our GREATER Values of Respect, Excellence, Accountability, Teamwork, Ethical Behavior and Results.