COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2016 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

MedStar Union Memorial Hospital

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
209 Source: Bed Licensed Letter from DHMH	11,383 Source: UMH STAT MODEL 0616 "CENSUS" Tab	21218 21211 21213 21215 21206 21212 21239 21217 21234 21214 21222 21221 21220 21216 21202 21270 21027 21203 Source: HSCRC Acute Hospital PSA 2016	• MedStar Good Samaritan Hospital • MedStar Franklin Square Medical Center • MedStar Harbor Hospital • St. Joseph Medical Center • Greater Baltimore Medical Center • Sinai Hospital • University of Maryland Hospital • Mercy Medical Center • Johns Hopkins Hospital • Johns Hopkins Bay View Medical Center • Bon Secours Hospital Source: HSCRC Acute Hospital PSA 2016	1.0% (% of Baltimore City Patients seen at MUMH that are Uninsured Source: MedStar Patient Database (Planning Mart)	30.7% (% of Baltimore City Patients seen at MUMH that are Medicaid Source: MedStar Patient Database (Planning Mart)	55.2% (% of Baltimore City Patients seen at MUMH are Medicare Beneficiaries Source: MedStar Patient Database (Planning Mart)

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.	CBISA includes adults who reside in zip codes 21211, 21213 and 21218. Focus Area: 21218 This geographic area was selected due to its close proximity to the hospital, coupled with a high density of low-income residents.	MedStar Health 2015 Community Health Needs Assessment http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf
Median Household Income within the CBSA	Baltimore City - $41,819 CBSA Zip code 21211 – $56,429 Zip code 21213 – $31,418 Zip code 21218 - $ 38,141	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Baltimore City – 19.5% CBSA Zip code 21211 – 13.4% Zip code 21213 – 25.5% Zip code 21218 - 27.5%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table
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	Baltimore City – 11.6% CBSA Zip code 21211 – 9.0% Zip code 21213 – 11.7% Zip code 21218 - 10.5%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table

Percentage of Medicaid recipients by County within the CBSA.	Baltimore City – 31.3%	2016 Maryland Medicaid e Health Statistics http://www.chpdm-ehealth.org/mco/index.cfm
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	MD 2017 Ship Goal -79.8 Baltimore City – 74.1 African American – 72.3 White – 76.8	2014 Maryland State's Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/Pages/home.aspx 2011 Neighborhood Health Profile: Greater Govans http://health.baltimorecity.gov/sites/default/files/20%20Greater%20Govans.pdf
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Baltimore City (per 100,000 residents) All Races – 977.7 White – 930.0 Black – 1042.3 Asian or Pacific Islander – 208.8 Hispanic – 142.6	Maryland Vital Statistics Administration 2014 Report Card http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	**By County within the CBSA** Percent of zip codes in County with a healthy food outlet : Baltimore City – 48.89% State of Maryland – 40.4% Percentage of working age people who use public transportation: Baltimore City – 18.22% State of Maryland – 8.8% National – 4.7% Percentage of students who have a high school degree: Baltimore City – 63.7% State of Maryland – 79,2% HP2020 82.4%	Maryland State's Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/Pages/home.aspx

	Number of days with maximum ozone concentration over the National Ambient Air Quality Standard: Baltimore City – 20 State of Maryland – 11.7 Homeownership Rate: Baltimore City – 47.15 State of Maryland – 67.1	
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	**Demographics** Zip code 21211 Total Population – 17,080 White - 13,132 Black or African American – 2,291 Hispanic - 684 Asian – 1,076 Native Hawaiian and Other Pacific Islander – 5 Two or more races – 439 **Language** Speak only English – 88.5% Speak a language other than English – 11.5% **Demographics** Zip code 21213 Total Population –29,773 White - 1,890 Black or African American – 27,431 Hispanic - 183 Asian – 71 Two or more races – 265 **Language** Speak only English – 96.4% Speak a language other than English – 3.6% **Demographics** Zip code 21218 Total Population –49,259 White - 14,207 Black or African American – 30,541 Hispanic – 1,242 Asian – 2,555 Two or more races – 1,335 **Language** Speak only English – 91.4% Speak a language other than English – 8.6%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table

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. 6/30/2015

   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://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf

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

   __X_Yes 6/17/2015
   ___No

   If you answered yes to this question, provide the link to the document here.
   http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf
   (pg. 17-19)

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.

      MedStar Health's vision is *to be the trusted leader in caring for people and advancing health.* In the fiscal year 2013-2017 MedStar Health Strategic Plan, community health and community benefit initiatives and tactics are organized under the implementation strategy of "Develop coordinated care/population health management capabilities." At the hospital-level, community health and community benefit initiatives and tactics are organized under the "Market Leadership" focus area.

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. ___Other (please specify)

Describe the role of Senior Leadership.

President/CEO (Executive Sponsor)
MedStar Union Memorial Hospital's Board of Directors, President and the organization's operations leadership team work thoroughly to ensure that the hospitals strategic and clinical goals are aligned with unmet community needs through the planning, monitoring and evaluation of its community benefit activities

ii. Clinical Leadership

1. _x__Physician
    a. Medical Director, Shepherd's Clinic & Joy Wellness Center
2. _x__Nurse
    a. Coord - Community Education & Health Ministries
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

Medical Director
Assures the delivery of quality medical care to clients seeking services at the Shepherd's Clinic and Joy Wellness Center.

Coord - Community Education & Health Ministries
Coordinates community outreach activities with target audiences, including preparing health presentations, providing liaison services to selected groups, and promoting the hospital's mission of creating healthier, communities. Coordinates with local community groups, including churches, senior centers, and business associations, to create health programs focused on the elements of wellness.

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. _x__Individual (please specify FTE)
    a. Community Health Lead (1FTE)
    b. Manager, Finance (1 FTE)
    c. Program Director, Shepherd's Clinic Joy Wellness Center (1FTE)
    d. Administrative Coordinator, Shepherd's Clinic Joy Wellness Center (1FTE)
2. ___Committee (please list members)
3. ___Department (please list staff)
4. _x__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.

The Community Health Lead serves as the coordinator of all aspects of the community health assessment process. He/she helps establish and coordinate the activities of the Advisory Task Force. The Lead also helps produce the hospital's Community Health Needs Assessment and Implementation Strategy. He/she works collaboratively with representatives from the Corporate Community Health Department and Georgetown University. The Lead also works closely with the writer. He/she reviews all narratives prior to publication.

The Financial Services Manager assists with budget, grant revenue and reporting functions of community benefit

The Shepherd's Clinic Joy Wellness Center Program Director plans, develops, coordinates, implements, and evaluates group classes (including yoga, smoking cessation, walking and dance programs), nutrition education, and integrative health services including acupuncture, massage, reflexology and meditation for the Joy Wellness Center at Shepherd's Clinic. Coordinates and oversees volunteer providers of these services. Coordinates this care with a volunteer driven multispecialty clinic in order to promote and support adherence to living a healthy lifestyle.

The Shepherd's Clinic Joy Wellness Center Administrative Coordinator provides high-quality patient service, administrative support, clinical support, and financial administration for the daily operations of a medical office practice.

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

Spreadsheet	__X___yes	_____no
Narrative	__X___yes	_____no

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

The internal review of the Community Benefit Report is performed by the Community Health Lead, the Financial Services Manager, and the CFO. The CFO provides oversight of the CBISA reporting function, auditing process and approval of Community Benefit funding. The CEO's signature is obtained through an attestation letter supporting their approval of the Community Benefit Report. The MedStar Health Corporate Office also conducts a review/audit of the hospital's Community Benefit Report annually

Task Force Members

Name/Title	Organization
Savas Karas, Board Member	MedStar Union Memorial Hospital
Derrick Adams, Board Member	MedStar Union Memorial Hospital
Sarah Fawcett Lee, Regional VP of Philanthropy	MedStar Union Memorial Hospital, Guilford resident
Glenda Skuletich, Executive Director	Shepherd's Clinic and Joy Wellness Center
Lisa Ghinger, Executive Director	Hampden Family Center
Alice Ann Finnerty, Community Leader	Guilford resident
Nichole Battle, Chief Executive Officer	Govans Ecumenical Development Corporation

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)
_____ Schools
_____ 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
Shepherd's Clinic and Joy Wellness Center	Glenda Skuletich	Executive Director	Member of Community Health Needs Assessment Advisory Task Force.
GEDCO	Nichole Battle	CEO	Member of Community Health Needs Assessment Advisory Task Force.
Hampden Family Center	Lisa Ghinger	Executive Director	Member of Community Health Needs Assessment Advisory Task Force. Provided space for education and programming.
Total Health Care, Inc.	Marcia Cort, MD	Chief Medical Officer	Collaboration around increasing access to THC's Federally Qualified Health Center

			locations and coordination of care.

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?

__X___yes _____no

- Community Health Lead

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?

Table III – Initiative I

Identified Need	Primary/Specialty Care • "Promote Access to Quality Health Care for All" is one of the top ten priority areas from Baltimore City Health Department's Healthy Baltimore 2015. • Baltimore City's percentage of uninsured patients is 14%, compared to the state's average of 11%. (American Community Survey, 2013). • 48% (n=102) of respondents indicated that to "Promote Access to Quality Health Care for All" is a top priority area (MedStar Union Memorial Hospital Community Health Needs Assessment, 2015).
Hospital Initiative	The Shepherd's Clinic and Joy Wellness Center The Shepherd's Clinic and Joy Wellness Center provide primary and specialty care and inpatient health services to uninsured adults who live in the MedStar Union Memorial's primary service area and meet financial criterion. MedStar Union Memorial Hospital provides administrative, clinical and financial support for the Shepherd's Clinic, a separate community not-for-profit health care provider.
Primary Objective	To provide primary and specialty care services via Shepherd's Clinic, a separate community not-for-profit health care provider
Single or Multi-Year Initiative –Time Period	Multi Year FY12 – FY16
Key Partners in Development and/or Implementation	Shepherd's Clinic and Joy Wellness Center, American Lung Association, American Cancer Association, American Heart Association, MEND in Hampden, Baltimore Yoga Village, MedStar Good Samaritan Hospital, Johns Hopkins University Center for Social Concern and SOURCE, University of MD Public Health and Nutrition programs, Maryland University of Integrative Health Nutrition Program, Towson University Exercise Science Program.
How were the outcomes evaluated?	Outcomes are measured in terms of patient visits to the Shepherd's Clinic and Joy Wellness Center.
Outcomes (Include process and impact measures)	NOTE: Not all Shepherd's patients utilize the Joy Wellness Center and the Wellness Center sees three types of clients, community, Shepherd's patients and MedStar (Kirk Ave site) patients. Shepherd's Clinic – FY16 Total is 3378 visits to Shepherd's Clinic. 748 of those

	unique patients seen at Shepherd's Clinic were uninsured. Joy Wellness Center – FY16 total is 932 visits to Joy Wellness Center.
Continuation of Initiative?	Yes
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Total Cost of Initiative $108,825.60 Direct Offsetting Revenue $0

Table III – Initiative II

Identified Need	Heart Disease Education and Awareness • "Promote Heart Health" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015, with a related goal of decreasing the rate of premature deaths from cardiovascular disease (CVD) by 10%. • Baltimore City's age-adjusted mortality rate from heart disease as measured by the number of heart disease deaths per 100,000 population is 242.7, compared to the state's 171.7 (Maryland State Health Improvement Process (SHIP), 2011-2013). • The majority (76.1%; n=151) of Community Input Survey respondents, who live and/or work in the CBSA, classified the incidence of heart disease as "severe" or "very severe."
Hospital Initiative	Shepherd's Clinic and Joy Wellness Center draws together individuals from surrounding neighborhoods for Heart Disease educational sessions, exercise classes, and staff training. These evidence-based programs are intended to increase the overall aptitude of its community members and promote heart healthy living.
Primary Objective	Primary Goal: To provide education and services to promote chronic disease prevention and management. Objective 1: To provide Get Heart Smart lectures to address risk factors of heart disease, healthy nutrition for primary or secondary prevention of heart disease, exercise recommendations and stress management. Objective 2: To provide nutrition education classes and food demos that focus on both heart health and diabetes prevention and health. Objective 3: To provide exercise classes through the Joy Wellness Center Objective 4: To offer community based education programs focused on heart disease, diabetes, smoking cessation, and CPR training.
Single or Multi-Year Initiative –Time Period	Multi – Year FY 12 – FY16
Key Partners in Development and/or Implementation	Shepherd's Clinic and Joy Wellness Center, American Lung Association, American Cancer Association, American Heart Association, MEND in Hampden, Baltimore Yoga Village, MedStar Good Samaritan Hospital, Johns Hopkins University Center for Social Concern and SOURCE, University of MD Public Health and Nutrition programs, Maryland University of Integrative Health Nutrition Program, Towson University Exercise Science Program, Baltimore City Health Department, CHRC.
How were the outcomes evaluated?	Outcomes are measured in terms of the number participants that attended the events/services that were provided as well as pre and post test to measure knowledge.

Outcomes (Include process and impact measures)	932 community members in CBSA were offered chronic disease health education, nutrition, smoking and physical activity opportunities to promote health and wellness. Outcome 1: Participants showed improvement in learning of about 44%. Knowledge included understanding risk factors, knowing numbers for blood pressure, cholesterol and blood sugars (for pre diabetics). Knowledge also includes understanding of heart healthy foods and what foods are the best choices for heart health. Outcome 2: 46 general nutrition classes were offered in FY16 that addressed risk factors for heart disease and diabetes. Through pre and post testing we've observed a 49% increase in participant knowledge of selecting healthy food options(includes knowledge of appropriate levels of sodium, fats and carbohydrates, overall nutrition, sugar reduction weight loss and portion size). Outcome 3: 100 exercise classes were offered in FY16. We tracked attendance only in these classes. Outcomes 4: The American Lung Association's Freedom From Smoking class is an 8 session, 7 week class designed for patients who are ready to stop smoking. JWC Offered Freedom From Smoking (American Lung Association) one time this year with a 100% no show rate. Our community was not ready to quit as they report very high levels of stress, however there were 12 enrolled and 2 came to one class and then dropped. In light of that we offered two other community classes within the year classes with 4 total attendees and those folks seemed more ready to discuss the process of quitting but were not ready to quit. We also offered 3 other smoking and nutrition classes and had 8 attendees who were also not ready to quit. The readiness scale we used to measure this put our community at an average of 5 out of 10 and was due to stress.
Continuation of Initiative?	Yes
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Total Cost of Initiative $0 Direct Offsetting Revenue $0

Table III - Initiative III

Identified Need	Diabetes Education • "Promote Access to Quality Health Care for All" is one of the top ten priority areas from Baltimore City Healthy Department's Healthy Baltimore 2015, with a related goal of decreasing hospitalization rate for ambulatory care sensitive indicators by 15% (Diabetes Type I, Diabetes Type II). • Baltimore City's emergency department visit rate due to diabetes per 100,000 population is 548.9, compared to the state's 204 (Maryland State Health Improvement Process (SHIP), 2014). • 63% (n=175) of responses from the 2015 MUMH Community Health Needs Assessment listed "Diabetes" as a health condition they see most in their community.
Hospital Initiative	Shepherd's Clinic and Joy Wellness Center connects individuals with health fairs, educational courses, and screenings designed to engage community members. This evidence-based programs increase the intellectual ability of those attendants and helps promote a healthy lifestyle to the neighboring public.
Primary Objective	Primary Goal: To aid in promoting healthy behaviors to reduce the risk and prevalence of diabetes Objective 1: To offer community-based healthy lifestyle lectures/classes. Objective 2: To provide smoking cessation programs. Objective 3: To offer heart health education courses Objective 4: To teach general nutrition education classes in the community and classes specifically for heart health and diabetes. Objective 5: To teach weekly exercise classes.
Single or Multi-Year Initiative – Time Period	Multi Year FY 12 – FY 16
Key Partners in Development and/or Implementation	The Shepherds Clinic (All activities coordinated by Shepherd's Clinic and Joy Wellness Center, a center partially funded by MUMH.)
How were the outcomes evaluated?	Outcomes are measured in terms of the number participants that attended the events/services that were provided as well as pre and post test to measure knowledge.
Outcomes (Include process and impact measures)	932 unique patients participated in the health fairs, education sessions, and screenings provided by Shepherd's Clinic and Joy Wellness Center. Outcome 1: The Diabetes Conversations class is a four week series designed to engage diabetics as well as those with risk for diabetes into conversation about the disease. Using the U.S. Diabetes Conversation Map tools made by Merck and Healthy

	Interactions along with collaboration with the American Diabetes Association allow us to encourage patients to become active learners and become engaged in the pursuit of self-management of their diabetes. The 4 U.S. Diabetes Conversation Map education tool helps patients understand many of the basic facts associated with diabetes, the relationship between diabetes and healthy eating, the value of monitoring and using the results, and the natural course of diabetes. The response to this class is very positive as it is less didactic in nature and more conversational. Patients arrive at their own conclusions with the help of the facilitators in the group. It is a 20% facilitator and 80% patient driven class. Educational learning with pre and post testing on knowledge of disease. Knowledge included understanding pathophysiology of disease, ABCs of DM, best nutritional choices and understanding of carbohydrates. There was a 44% increase in participant knowledge from this class. Outcome 2: <u>The American Lung Association's Freedom From Smoking class</u> is an 8 sessions, 7 week class designed for patients who are ready to stop smoking. JWC offered Freedom From Smoking (American Lung Association) one time this year with a 100% no show rate. Our community was not ready to quit as they report very high levels of stress, however there were 12 enrolled and 2 came to one class and then dropped. In light of that we offered two other community classes within the year, classes with 4 total attendees seemed more ready to discuss the process of quitting but were not ready to quit. We also offered 3 other smoking and nutrition classes and had 8 attendees who were also not ready to quit. The readiness scale we used to measure this put our community at an average of 5 out of 10 and was due to stress. Outcome 3: <u>Life Balance & Weight Management Program</u> (Diabetes Prevention Program) was offered this year and began February 2016 and will end in the next fiscal year. There were 44 registered community participants with a 50% retention rate. Core sessions have been completed with a 2% reduction overall in weight (goal is 5-7% but program isn't finished yet and some participants met goal). HbA1C decreased in 5 participants. Activity for the group increased from less than 150 minutes per week to at least 150 minutes up to 600 minutes in adhering participants by the 16th session. Post core classes will be continued in the next fiscal year to track completion and results for this program. This class was marketed for the first time, which helped our outreach and retention a great deal. There were a total of 307 visits for this program of 44 enrolled participants. <u>Living Well: Take Charge of Your Diabetes</u> (Stanford Diabetes Self-Management Program/Evidenced-based program) The Diabetes Self-Management workshop was given 2½ hours once a week for six weeks. People with type 2 diabetes attend the workshop in groups of 12-16. Subjects covered include: 1) techniques to deal with the symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear and frustration; 2) appropriate exercise for maintaining and improving strength and endurance; 3) healthy eating 4) appropriate use of medication; and 5) working more

effectively with health care providers. Participants made weekly action plans, shared experiences, and helped each other solve problems they encounter in creating and carrying out their self-management program. This class was offered once this year for 11 participants. 7 completed the class with 4 drop outs. There were a total of 43 visits for these classes.

(Diabetes) Private Diabetes Self-Management Appointments

The program provides private Diabetes Self-Management appointments with RN volunteers/interns – clinical oversight from Joy Wellness Program Director and Shepherd's Clinic Medical Director and Nurse Coordinator. It also provides one-on-one appointments to discuss how to manage diabetes and continue to help participants understand the primary role they have in their disease management. Diabetes Self-Management consultations cover medications and adherence, nutrition recommendations, exercise recommendations and behavior change. We track attendance only. In FY16, there were a total of 133 Diabetes Self-Management consultations.

Outcome 4: (Heart/Diabetes) Continued Private Nutrition Appointments

Continued private nutrition appointments with MUIH nutrition Interns and volunteer RDs – clinical oversight from intern preceptor and Joy Wellness Program Director and the Shepherd's Clinic Medical Director. One on one appointment to help participants with weight loss, diabetes management, and risk factor management for heart disease. We track attendance only. In FY16 there were a total of 102 nutrition consultations (included in heart numbers).

Food Demo Classes one to two times each week of the year. These classes are ongoing and drop in classes that encourage patient participation and behavior change. Average increase in learning was about 30% increase in our participants learning of better foods to choose (includes knowledge of appropriate levels of sodium, fats and carbohydrates, overall nutrition, sugar reduction weight loss and portion size). We find that our patients are knowledgeable but due to other reasons they have a hard time implementing strategies for change (work, family, stress and convenience for making their own meals). Nutrition classes, demonstrations and lectures run weekly and are offered to community members. Most nutrition education classes and food demos focus on both heart health and diabetes prevention and health. There were 81 classes offered and 204 visits and 123 unique participants in FY16.

Outcome 5: Exercise Classes

This year in addition to continued ongoing exercise lectures, we implemented exercise classes for Joy Wellness Center community members. These are hour long classes designed to support diabetes education and heart health recommendations. Classes are from 1-3 times per week and are an hour long of aerobic and strength training and some dance. There were a total of 275 exercise visits and we served 142 unique individuals in FY 16. Yoga numbers are listed under stress management, last year the numbers were

	listed under exercise.
Continuation of Initiative?	Yes
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Total Cost of Initiative Shepherds Clinic Expenses $68,172 Joy Wellness Expenses $108,824 Direct Offsetting Revenue $0

Table III – Initiative IV

Identified Need	Cancer Screenings • "Encourage early detection of cancer" is one of the top ten priority areas from Baltimore City Health Department's Healthy Baltimore 2015. • Baltimore City's age-adjusted mortality rate from cancer as measured by the number of cancer deaths per 100,000 population is 212.4, compared to the state's 163.8 (Maryland State Health Improvement Process (SHIP), 2011-2013).
Hospital Initiative	Breast and cervical cancer and colorectal cancer screenings Union Memorial offers free breast and cervical cancer screenings for women who meet specific income and insurance requirements. Screening includes a breast exam, Pap test and mammogram all within one day.
Primary Objective	Provide free or low-cost screening for individuals who are uninsured or underinsured and meet certain income requirements to enable early detection of cancer-related illness/disease. Proved access to follow-up care when necessary.
Single or Multi-Year Initiative –Time Period	Multi-Year Colon: FY16-FY18 Breast: FY13-FY17
Key Partners in Development and/or Implementation	Maryland Department of Health and Mental Hygiene, Cigarette Restitution Fund: Colon Maryland Department of Health and Mental Hygiene: Breast
How were the outcomes evaluated?	Outcomes are measured in terms of the number of individuals who receive free screenings.
Outcomes (Include process and impact measures)	219 underserved individuals received free Breast/Cervical cancer screenings

	86 individuals received Colorectal Cancer screenings	
Continuation of Initiative?	Yes	
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Total Cost of Initiative Breast and cervical cancer: $379,350 Colorectal cancer: $10,126	Direct Offsetting Revenue Breast and cervical cancer: $216,911 Colorectal cancer: $0

Table III – Initiative V

Identified Need	Volunteer opportunities in workplace settings for young adults with intellectual and developmental disabilities. Increasingly, people with intellectual and developmental disabilities are moving into a broader array of job opportunities and they want a career, not just a job. One way to help them build their skills and to open more options is through intensive education and internship programs. (Source: Arc Baltimore)
Hospital Initiative	Site location for Arc Baltimore's Project SEARCH The Arc Baltimore connects individuals with intellectual and developmental disabilities with a wide variety of employment opportunities in the community. Each type of job is intended to allow the person to earn a paycheck and enjoy the satisfaction of a job well done. Depending both on the abilities of the individuals and the needs of the employers, The Arc's Community Employment division works to provide both initial work experiences as well as stepping stones to more challenging and higher paying jobs.
Primary Objective	MedStar Union Memorial Hospital to be a host site for Project SEARCH which prepares young adults with intellectual and developmental disabilities for competitive employment.
Single or Multi-Year Initiative – Time Period	Single – FY2016 – ongoing
Key Partners in Development and/or Implementation	The ARC Baltimore
How were the outcomes evaluated?	Outcomes are measured based on the student intern's performance and compliance with MedStar's policies and regulations. High school students and adults with disabilities receive the opportunity to explore career options and develop real job skill that will allow them to live/work more independently.
Outcomes (Include process and impact measures)	7 interns volunteer 4.5 hours a day for three ten-week internships. Departments included Calvert Outreach, Cardiac Cath lab, Dietary, Hand Center, Health Information Management, Patient Transportation, Radiology, OR/ SPD, Fitness center, 9th floor Nursing Unit, The Front Door Gift Shop, Shipping and Receiving, Materials Management MGSH, Out Patient Pharmacy MGSH, and Laboratory Services MGSH.

Continuation of Initiative?	Yes
Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	Total Cost of Initiative $85,657 Direct Offsetting Revenue $0

Initiative VI

Identified Need	Cardiovascular Disease - Heart Disease/ Obesity Heart disease is the leading cause of death in Baltimore City • "Promote Heart Health" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015, with a related goal of decreasing the rate of premature deaths from cardiovascular disease (CVD) by 10%. • Baltimore City's age-adjusted mortality rate from heart disease as measured by the number of heart disease deaths per 100,000 population is 242.7, compared to the state's 171.7 (Maryland State Health Improvement Process (SHIP), 2011-2013). • Approximately one in three Baltimore City residents is obese. • In 2013, only 16.7% of Baltimore City residents were getting the recommended amount of weekly physical activity http://health.baltimorecity.gov/sites/default/files/HealthyBaltimore2015_May2016Update_web.pdf
Hospital Initiative	Blood Pressure Screening
Primary Objective	To identify people in the Hampden community with hypertension. To raise awareness and provide educational material related to hypertension and cardiovascular disease.
Single or Multi-Year Initiative Time Period	Multi-Year – FY15- FY18
Key Partners in Development and/or Implementation	Hampden Family Center
How were the outcomes evaluated?	• Number of screening events at Hampden Family • Number of blood pressure screenings • Number of participants referred for above normal blood pressure readings
Outcomes	• Number of screening events at Hampden Family - 8 • Number of blood pressure screenings - 66 • Number of participants referred to primary care physician for above normal blood pressure readings – 6

Continuation of Initiative	Yes
A. Total Cost of Initiative for Current Fiscal Year B. B. What amount is Restricted Grants/Direct offsetting revenue	Total Cost of Initiative Blood Pressure Screening Program Cost =$3,166.20 Direct offsetting revenue from Restricted Grants $0

Initiative VII

Identified Need	Cardiovascular Disease - Heart Disease/ Obesity Heart disease is the leading cause of death in Baltimore City • "Promote Heart Health" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015, with a related goal of decreasing the rate of premature deaths from cardiovascular disease (CVD) by 10%. • Baltimore City's age-adjusted mortality rate from heart disease as measured by the number of heart disease deaths per 100,000 population is 242.7, compared to the state's 171.7 (Maryland State Health Improvement Process (SHIP), 2011-2013). • Approximately one in three Baltimore City residents is obese. • In 2013, only 16.7% of Baltimore City residents were getting the recommended amount of weekly physical activity http://health.baltimorecity.gov/sites/default/files/HealthyBaltimore2015_May2016Update_web.pdf
Hospital Initiative	• Fitness for 50's Exercise Program Fitness program include low impact aerobics, strength training, and stretching. Participants are encouraged to participant at their individual fitness level.
Primary Objective	Increase awareness of healthy behaviors and provide exercise classes that prevent/decrease obesity and reduce the risk of heart disease.
Single or Multi-Year Initiative Time Period	Multi-Year – FY15- FY18
Key Partners in Development and/or Implementation	GEDCO • Hampden Family Center
How were the outcomes evaluated?	• Number of participants enrolled • Number of classes held • Number of encounters • Demographic information of participants

Outcomes	Fitness for 50's Exercise Program • Number of participants enrolled - 25 • Number of classes held - 42 • Number of encounters -373 • Demographic information of participants - Majority of participants are white and live in 21211
Continuation of Initiative	Yes
Total Cost of Initiative for Current Fiscal Year What amount is Restricted Grants/Direct offsetting revenue	Total Cost of Initiative Fitness for 50's Exercise Program Cost =$3,166.20 Direct offsetting revenue from Restricted Grants =$0

Initiative VIII

Identified Need	Diabetes Prevention Pre-diabetes among people aged 20 years or older, United States, 2012 In 2009−2012, based on fasting glucose or A1C levels, 37% of U.S. adults aged 20 years or older had pre-diabetes (51% of those aged 65 years or older). Applying this percentage to the entire U.S. population in 2012 yields an estimated 86 million Americans aged 20 years or older with pre-diabetes
Hospital Initiative	"Life Balance/Weight Management Program" (National Diabetes Prevention Program) A yearlong evidenced-based program designed to help participants adopt healthy lifestyle behaviors.
Primary Objective	To reduce the risk of developing Type 2 diabetes by losing 5-7 % of total body weight and exercising for at least 150 minutes per week
Single or Multi-Year Initiative Time Period	Multi-Year 2015 – ongoing
Key Partners in Development and/or Implementation	Hampden Family Center
How were the outcomes evaluated?	• Number of participants enrolled • Number of participants completing program • Number of participants with weight loss of 5 –7% • Number participants exercising 150 minutes per week
Outcomes	Life Balance/Weight Management held at MGSH • Start Date –September 2015 • End Date – August 2016 • Number of participants enrolled – 6 • Number of participants in program at end of FY 16 – 2 • Participant's weight loss at end of FY16 (June) 7% of body weight loss -1

	5% of body weight loss - 1 • Participant's minutes of exercise at end of FY16 (June) 150 minutes of exercise per week – 2 (Only 2 participants in the program at the end of FY 16. Program is schedule to end in August 2016. One participant lost approximately 50 pounds, reversed her A1c from 6.5 to 5.7 and under physician's care, was able to stop taking her oral hypoglycemic medication.)
Continuation of Initiative	Yes – Currently Pending CDC Recognition Planning to expand this program
Total Cost of Initiative for Current Fiscal Year What amount is Restricted Grants/Direct offsetting revenue	Total Cost of Initiative Life Balance/Weight Management Program Cost =$3,166.20 Direct offsetting revenue from Restricted Grants $0

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.

Issue	Evidence	Explanation	Lead
Housing	In the 2015 MUMH Community Health Input Survey, when asked which services are needed most in our community, 40% (n=102) of respondents stated "Affordable Housing".	The hospital does not have the expertise to have leadership role in these areas. When possible, the hospital will support stakeholders by contributing to initiatives and participating in conversations on the topics – particularly as they relate to health status and health outcomes.	Housing Authority of Baltimore City; Department of Housing and Community Development; community organizations
Density of Liquor Stores, Tobacco Retail, Fast Food, Carryout and Corner Stores.	The density of Liquor Stores, Tobacco Retail, Fast Food, Carryout and Corner Stores is very high in the identified target area, as ranked in the 2011 Baltimore City Neighborhood Health Profiles.		Baltimore City Planning Department, Baltimore City Liquor License Board, Maryland Department of Health and Mental Hygiene

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)

In alignment with the State's population health strategy, the goals of the community benefit initiatives are to promote health and wellness and improve health knowledge and behaviors among communities and populations disproportionately affected by highly prevalent diseases and conditions. According to Maryland's State Health Improvement Process, 30% of all deaths were attributed to heart disease and stroke. MUMH's primary focus from fiscal year 2016 – 2018 is to implement evidence-based interventions that address chronic disease, specifically targeting heart disease, stroke, diabetes and obesity; and access to care.

MUMH was also awarded a two-year grant from CHRC in efforts to expand access to affordable, high-quality health care services in underserved areas of the state. Awarded funds allowed the

hospital to open a new FQHC site operated by Total Health Care on the hospital's campus. The FQHC serves patients from Baltimore City who are chronically ill and who are frequent uses of the hospital ED and inpatient services.

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.

   Gaps identified by MedStar Union Memorial Hospital are:
   - Timely placement of patients in need of inpatient psychiatry services
   - Limited availability of outpatient psychiatry services
   - Limited availability of inpatient and outpatient substance abuse treatment
   - Medication assistance
   - Dentistry

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**
Hospitalist & Primary Care	MedStar Union Memorial Hospital is a safety net hospital with a considerable uninsured and underinsured population with no primary care physicians. Subsidy is required to maintain sufficient coverage.
Women and Children	MedStar Union Memorial Hospital's professional services are utilized to support community outreach efforts to local patients and neighboring families. Furthermore, MedStar provides call coverage by telephone for the Emergency Department, inpatient Orthopedic, and Hand Surgery pediatric patients.
Renal Dialysis	The demand for dialysis services in the immediate area surrounding MedStar Union Memorial is high and is expected to increase. The outpatient dialysis center at the hospital is consistently full and maintains a waitlist for services. Renal specialists are in high demand in this market. Subsidy is required to maintain sufficient coverage.

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).

VII. APPENDICES

Appendix I
Description of Financial Assistance Policy

MedStar Union's FAP and financial assistance contact information is:

- available in both English and Spanish
- posted in all admissions areas, the emergency room, and other areas of facilities in which eligible patients are likely to present
- provided with financial assistance contact information to patients or their families as part of the intake process
- provided to patients with discharge materials
- included in patient bills

Patient Financial Advocates visit all private pay patients and are available to all patients and families to discuss the availability of various government benefits, such as Medicaid or state programs, and assist patients with qualification for such programs, where applicable.

Appendix II
Financial Assistance Policy Changes

Since the Affordable Health Care Act took effect, MedStar Health has made the following changes to its Financial Assistance Policy:

- Includes state and federal insurance exchange navigators as resources for patients
- Defines underinsured patients who may receive assistance
- Began placing annual financial assistance notices in newspapers serving the hospitals' target populations
- Added section 2 under responsibilities (see Appendix III)

Appendix III
Financial Assistance Policy

Title:	**Hospital Financial Assistance Policy**
Purpose:	To ensure uniform management of the MedStar Health Corporate Financial Assistance Program within all MedStar Health hospitals
Effective Date:	07/01/2011

Policy

1. As one of the region's leading not-for-profit healthcare systems, MedStar Health is committed to ensuring that uninsured patients within the communities we serve who lack financial resources have access to necessary hospital services. MedStar Health and its healthcare facilities will:

1.1 Treat all patients equitably, with dignity, with respect and with compassion.
1.2 Serve the emergency health care needs of everyone who presents at our facilities regardless of a patient's ability to pay for care.
1.3 Assist those patients who are admitted through our admissions process for non-urgent, medically necessary care who cannot pay for the care they receive.
1.4 Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep its hospitals' doors open for all who may need care in the community.

Scope

1. In meeting its commitments, MedStar Health's facilities will work with their uninsured patients to gain an understanding of each patient's financial resources prior to admission (for scheduled services) or prior to billing (for emergency services). Based on this information and patient eligibility, MedStar Health's facilities will assist uninsured patients who reside within the communities we serve in one or more of the following ways:

1.1 Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
1.2 Assist with consideration of funding that may be available from other charitable organizations.
1.3 Provide charity care and financial assistance according to applicable guidelines.
1.4 Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
1.5 Offer periodic payment plans to assist patients with financing their healthcare services.

Definitions

1. **Free Care**
Financial assistance for medically necessary care provided to uninsured patients in households between 0% and 200% of the FPL.

2. **Reduced Cost-Care**
Financial assistance for medically necessary care provided to uninsured patients in households between 200% and 400% of the FPL.

3. **Medical Hardship**
Medical debt, incurred by a household over a 12-month period, at the same hospital that exceeds 25% of the family household income.

4. **Maryland State Uniform Financial Assistance Application**
A uniform data collection document developed through the joint efforts of Maryland hospitals and the Maryland Hospital Association.

5. **Maryland Patient Information Sheet / MedStar Patient Information Sheet (Non-Maryland Hospitals)**
A patient education document that provides information about MedStar's Financial Assistance policy, and patient's rights and obligations related to seeking and qualifying for free or reduced cost medically necessary care.

Responsibilities

1. Each facility will post the policy, including a description of the applicable communities it serves, in each major patient registration area and in any other areas required by applicable regulations, will communicate the information to patients as required by this policy and applicable regulations and will make a copy of the policy available to all patients. Additionally, the Maryland Patient Information Sheet / MedStar's Patient Information Sheet will be provided to inpatients on admission and at time of final account billing.

2. MedStar Health believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. The charity care, financial assistance, and periodic payment plans available under this policy will not be available to those patients who fail to fulfill their responsibilities. For purposes of this policy, patient responsibilities include:

2.1 Completing financial disclosure forms necessary to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.

2.2 Working with the facility's financial counselors and other financial services staff to ensure there is a complete understanding of the patient's financial situation and constraints.

2. 3Completing appropriate applications for publicly-funded healthcare programs. This responsibility includes responding in a timely fashion to requests for documentation to support eligibility.

2. 4 Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.

2 .5 Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

2.6 It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

3. Uninsured patients of MedStar Health's facilities may be eligible for charity care or sliding-scale financial assistance under this policy. The financial counselors and financial services staff will determine eligibility for charity care and sliding-scale financial assistance based on review of income for the patient and their family (household), other financial resources available to the patient's family, family size, and the extent of the medical costs to be incurred by the patient.

4. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

4.1 Federal Poverty Guidelines. Based on family income and family size, the percentage of the then-current Federal Poverty Level (FPL) for the patient will be calculated.

4.1.1 Free Care: Free Care will be available to uninsured patients in households between 0% and 200% of the FPL.

4.1.2 Reduced Cost-Care: Reduced Cost-Care will be available to uninsured patients in households between 200% and 400% of the FPL. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

4.1.3 Ineligibility. If this percentage exceeds 400% of the FPL, the patient will not be eligible for Free Care or Reduced-Cost Care assistance (unless determined eligible based on Medical Hardship criteria, as defined below).

4.2 Basis for Calculating Amounts Charged to Patients: Free Care or Reduced-Cost Care Sliding Scale Levels:

	Financial Assistance Level Free / Reduced-Cost Care	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services1**	**Washington Facilities and non-HSCRC Regulated Services**
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

4.3 **MedStar Health Washington DC Hospitals** will comply with IRS 501(r) requirements on limiting the amounts charged to uninsured patients seeking emergency and medically necessary care.

4.3.1 Amounts billed patients who qualify for financial assistance will be an average of the three best negotiated commercial rates.

4.3.2 MedStar Health will calculate the average of the three best negotiated commercial rates annually.

5. FINANCIAL ASSISTANCE: ADDITIONAL FACTORS USED TO DETERMINE ELIGIBILITY FOR MEDICAL ASSISTANCE: MEDICAL HARDSHIP.

5.1 MedStar Health will evaluate patients for Medical Hardship Financial Assistance if they exceed the 400% of the FPL and are deemed ineligible for Free Care or Reduced-Cost Care.

5.2 Medical Hardship is defined as medical debt, incurred by a household over a 12-month period, at the same hospital that exceeds 25% of the family household income.

5.3 MedStar Health will provide Reduced-Cost Care to patients with income below 500% of the FPL that, over a 12 month period, has incurred medical debt at the same hospital in excess of 25% of the patient's household income. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

5.4 A patient receiving reduced-cost care for medical hardship and the patient's immediate family members shall receive/remain eligible for Reduced-Cost medically necessary care when seeking subsequent care for 12 months beginning on the date which the reduced-care was received. It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

5.5 If a patient is eligible for both Free Care / Reduced-Cost Care, and Medical Hardship, the hospital will employ the more generous policy to the patient.

5.6 Medical Hardship Reduced-Care Sliding Scale Levels:

	Financial Assistance Level – Medical Hardship	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Facilities and non-HSCRC Regulated Services**
Less than 500%	**Not to Exceed 25% of Household Income**	**Not to Exceed 25% of Household Income**

6. METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE: INCOME AND ASSET DETERMINATION.

6.1 Patients may obtain an application for Financial Assistance Application:

6.1.1 On Hospital websites

6.1.2 From Hospital Patient Financial Counselor Advocates

6.1.3 By calling Patient Financial Services Customer Service

6.2 MedStar Health will evaluate the patient's financial resources (assets convertible to cash) by calculating a pro forma net worth **EXCLUDING**:

6.2.1 The first $150,000 in equity in the patient's principle residence

6.2.2 Funds invested in qualified pension and retirement plans where the IRS has granted preferential treatment

6.2.3 The first $10,000 in monetary assets e.g., bank account, stocks, CD, etc

6.3 MedStar Health will use the Maryland State Uniform Financial Assistance Application as the standard application for all MedStar Health Hospitals. MedStar Health will require the patient to supply all documents necessary to validate information to make eligibility determinations.

6.4 Financial assistance applications and support documentation will be applicable for determining program eligibility one (1) year from the application date. Additionally, MedStar will consider for eligibility all accounts (including bad debts) 6 months prior to the application date.

7. PRESUMPTIVE ELIGIBILTY

7.1 Patients already enrolled in certain means-tested programs are deemed eligible for free care on a presumptive basis. Programs eligible under the MedStar Health financial assistance program include, but may not be limited to:

7.1.1 Maryland Primary Adult Care Program (PAC)

7.1.2 Maryland Supplemental Nutritional Assistance Program (SNAP)
7.1.3 Maryland Temporary Cash Assistance (TCA)
7.1.4 Maryland State and Pharmacy Only Eligibility Recipients
7.1.5 DC Healthcare Alliance or other Non-Par Programs
7.2 Additional presumptively eligible categories will include with minimal documentation:
7.2.1 Homeless patients
7.2.2 Deceased patients with no known estate
7.2.3 Members of a recognized religious organization who have taken a vow of poverty
7.2.4 All patients based on other means test scoring campaigns
7.2.5 All secondary balances after primary Medicare insurance where patients meet income and asset eligibility tests
7.2.6 All spend-down amounts for eligible Medicaid patients.

8 MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS

8.1 In the event a patient is denied financial assistance, the patient will be provided the opportunity to appeal the MedStar Health denial determination.
8.2 Patients are required to submit a written appeal letter to the Director of Patient Financial Services with additional supportive documentation.
8.3 Appeal letters must be received within 30 days of the financial assistance denial determination.
8.4 Financial assistance appeals will be reviewed by a MedStar Health Appeals Team. Team members will include the Director of Patient Financial Services, Assistance Vice President of Patient Financial Services, and the hospital's Chief Financial Officer.
8.5 Denial reconsideration decisions will be communicated, in writing, within 30 business days from receipt of the appeal letter.
8.6 If the MedStar Health Appeals Panel upholds

9. PAYMENT PLANS

9.1 MedStar Health will make available interest-free payment plans to uninsured patients with income between 200% and 500% of the FPL.
9.2 Patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to meet these continuing responsibilities, the patient will become financially responsible for the original amount owed, less any payments made to date.

10 BAD DEBT RECONSIDERATIONS AND REFUNDS

10.1 In the event a patient who, within a two (2) year period after the date of service was found to be eligible for free care on that date of service, MedStar will initiate a review of the account(s) to determine the appropriateness for a patient refund for amounts collected exceeding $25.
10.2 It is the patient's responsibility to request an account review and provide the necessary supportive documentation to determine free care financial assistance eligibility.
10.3 If the patient failed to comply with requests for documentation, MedStar Health will document the patient's non-compliance. The patient will forfeit any claims to a patient refund or free care assistance.
10.4 If MedStar Health obtains a judgement or reported adverse information to a credit reporting agency for a patient that was later to be found eligible for free care, MedStar Health will seek to vacate the judgement or strike the adverse information.

Exceptions

1 PROGRAM EXCLUSION
MedStar Health's financial assistance program excludes the following:

1.1 Insured patients who may be "underinsured" (e.g. patient with high deductibles/coinsurance)
1.2 Patient seeking non-medically necessary services, including cosmetic procedures

1.3 Non-US Citizens,
1.3.1 Excluding individuals with permanent resident /resident alien status as defined by the Bureau of Citizenship and Immigration Services has issued a green card
1.4 Patients residing outside a hospital's defined zip code service area
1.4.1 Excluding patient referral between MedStar Health Network System
1.4.2 Excluding patients arriving for emergency treatment via land or air ambulance transport
1.4.3 Specialty services specific to each MedStar Health hospital and approved as a program exclusion
1.5 Patients that are non-compliant with enrollment processes for publicly –funded healthcare programs, charity care programs, and other forms of financial assistance

As stated above, patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to meet these continuing responsibilities, the patient will become financially responsible for the original amount owed, less any payments made to date.

What Constitutes Non-Compliance
Actions or conduct by MedStar Health employee or contract employee in violate of this Policy.

Consequences of Non-Compliance
Violations of this Policy by any MedStar Health employee or contract employee may require the employee to undergo additional training and may subject the employee to disciplinary action, including, but not limited to, suspension, probation or termination of employment, as applicable.

Explanation And Details/Examples
N/A

Requirements And Guidelines For Implementing The Policy
N/A

Related Policies
N/A

Procedures Related To Policy
Admission and Registration
Financial Self Pay Screening
Billing and Collections
Bad Debt

Legal Reporting Requirements
HSCRC Reporting as required – Maryland Hospitals Only
Year End Financial Audit Reporting
IRS Reporting

Reference To Laws Or Regulations Of Outside Bodies
Maryland Senate Bill 328 Chapter 60 – Maryland Hospitals Only
COMAR 10.37.10 Rate Application and Approval Procedures – Maryland Hospitals Only
IRS Regulations Section 501(r)

Right To Change Or Terminate Policy
Any change to this Policy requires review and approval by the Legal Services Department.
Proposed changes to this Policy will be discussed with all affected parties at both the Business Unit and Corporate levels of the Organization.
The Corporation's policies are the purview of the Chief Executive Officer (CEO) and the CEO's management team
The CEO has final sign-off authority on all corporate policies.

Appendix IV
Hospital Patient Information Sheet

MedStar Union Memorial Hospital is committed to ensuring that uninsured patients within its service area who lack financial resources have access to medically necessary hospital services. If you are unable to pay for medical care, have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability, you may qualify for **Free or Reduced Cost Medically Necessary Care**.

MedStar Union Memorial Hospital meets or exceeds the legal requirements by providing financial assistance to those individuals in households below 200% of the federal poverty level and reduced cost-care up to 400% of the federal poverty level.

Patients' Rights

MedStar Union Memorial Hospital will work with their uninsured patients to gain an understanding of each patient's financial resources.

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

Patients' Obligations

MedStar Union Memorial Hospital believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

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

Contacts

Call 410-933-2424 or 1-800-280-9006 (toll free) with questions concerning:

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

For information about Maryland Medical Assistance
Contact your local Department of Social Services at 1-800-332-6347. For TTY, call 1-800-925-4434.

Learn more about Medical Assistance on the Maryland Department of Human Resources website.

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

Appendix V
Hospital's Mission, Vision, Value Statement

MedStar Union Memorial Hospital

Mission

MedStar Union Memorial Hospital, a member of MedStar Health, provides safe, high quality care, excellent service and education to improve the health of our community.

Vision

The trusted leader in caring for people and advancing health.

Values

- **S**ervice: We strive to anticipate and meet the needs of our patients, physicians and co-workers.
- **P**atient First: We strive to deliver the best to every patient every day. The patient is the first priority in everything we do.
- **I**ntegrity: We communicate openly and honestly, build trust and conduct ourselves according to the highest ethical standards.
- **R**espect: We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.
- **I**nnovation: We embrace change and work to improve all we do in a fiscally responsible manner.
- **T**eamwork: System effectiveness is built on collective strength and cultural diversity of everyone, working with open communication and mutual respect.

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