Community Benefit Report

Fiscal Year 2016

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

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

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique 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

UM Rehab & Ortho Institute 138 Beds	2,617	21229, 21228, 21207, 21223, 21217, 21061, 21216, 21045, 21215, 21042, 21227, 21043, 21044, 21060, 21122, 21784, 21201, 21244, 21157, 21225, 21222, 21230, 21771, 21144, 21117, 21133, 21206, 21046, 21218, 21136, 21158, 21205, 20723, 21208, 21213, 21075, 21093, 21113, 21234	UMMC Holy Cross Frederick Memorial UM SJMC Mercy Johns Hopkins St. Agnes Sinai Bon Secours Franklin Square Anne Arundel Union Memorial Hopkins Bayview Carroll County Harbor Hospital UMMC MIDTOWN Northwest UM BWMC GBMC Howard County General UM Rehab & Ortho	1%	21%	41%

			Good Samaritan Levindale Hebrew Geriatric			

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

UM Rehabilitation & Orthopaedic Institute

Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	21202, 21215, 21216, 21217, 21229, 21228 (Vulnerable population defined as ZIP Codes containing census tract with 20% population below poverty level and 25% population less than high school education)	American Community Survey, 2010-2014, 5-Year Estimates data from http://assessment.communitycommons.org/Footprint/
Median Household Income within the CBSA	**CBSA** $ 66,574	American Community Survey, 2010-2014, 5-Year Estimates, U.S. Census Bureau
Percentage of households with incomes below the federal poverty guidelines within the CBSA	**CBSA** 11.6%	American Community Survey, 2010-2014, 5-Year Estimates, U.S. Census Bureau
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: 8.5% Baltimore County: 7.4% Anne Arundel County: 5.4% Howard County: 4.8%	American Community Survey, 2014, 1-Year Estimates, U.S. Census Bureau
Percentage of Medicaid recipients by County within the CBSA.	Baltimore City: 32.4 % Baltimore County: 16.6% Anne Arundel County: 13.3% Howard County: 8.9%	American Community Survey, 2014, 1-Year Estimates, U.S. Census Bureau
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	**Baltimore City** All races/ethnicity: 74.1 years White: 76.8 years Black: 72.3 years **Baltimore County** All races/ethnicity: 79.4 years White: 79.5 years Black: 78.4 years **Anne Arundel County** All races/ethnicity: 79.8 years White: 79.9 years Black: 78.2 years	Maryland Vital Statistics Annual Report, 2014

	Howard County All races/ethnicity: 83.0 years White: 82.8 years Black: 81.8 years	
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	**Baltimore City** 978.5 per 100,000 population (age-adjusted rate) Crude Death Rates by Race and Ethnicity: White: 930 per 100,000 population Black: 1042.3 per 100,000 population Asian: 208.8 per 100,000 population Hispanic: 142.6 per 100,000 population **Baltimore County** (age-adjusted rate) 724.2 per 100,000 population Crude Death Rates by Race and Ethnicity: White: 1201.1 per 100,000 population Black: 607 per 100,000 population Asian: 219 per 100,000 population Hispanic: 142.6 per 100,000 population **Anne Arundel County** (age-adjusted rate) 714.1 per 100,000 population Crude Death Rates by Race and Ethnicity: White: 804.5 per 100,000 population Black: 555.4 per 100,000 population Asian: 282.9 per 100,000 population Hispanic: 132.2 per 100,000 population **Howard County** (age-adjusted rate) 562.6 per 100,000 population Crude Death Rates by Race and Ethnicity: White: 638 per 100,000 population Black: 421.6 per 100,000 population Asian: 241.6 per 100,000 population Hispanic: 86.1 per 100,000 population	Maryland Vital Statistics Annual Report, 2014

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	**Baltimore City** % Households with Severe Problems[1]: 24% % Food Insecure: 23% % Adult Smokers: 21% Violent crime per 100,000 population: 1,449 % Unemployed: 13.9% % Less than High School Education (age 25 and over) : 19.1% % Without vehicle (age 16 and over): 16.1% **Baltimore County** % Households with Severe Problems: 16% % Food Insecure: 13% % Adult Smokers: 15% Violent crime per 100,000 population: 526 % Unemployed: 7.4% % Less than High School Education (age 25 and over) : 19.1% % Without vehicle (age 16 and over): 16.1% **Anne Arundel County** % Households with Severe Problems: 15% % Food Insecure: 9% % Adult Smokers: 13% Violent crime per 100,000 population: 507 % Unemployed: 6.6% % Less than High School Education (age 25 and over) : 19.1% % Without vehicle (age 16 and over): 16.1% **Howard County** % Households with Severe Problems: 12% % Food Insecure: 8% % Adult Smokers: 10% Violent crime per 100,000 population: 201 % Unemployed: 5.1% % Less than High School Education (age 25 and over) : 19.1% % Without vehicle (age 16 and over): 16.1%	[1]Comprehensive Housing Affordability Strategy (CHAS), 2013 data from http://www.countyhealthrankings.org/ USDA Food Environment Atlas, Map the Meal Gap from Feeding America data from http://www.countyhealthrankings.org/ Behavioral Risk Factor Surveillance System data from http://www.countyhealthrankings.org/ American Community Survey, 2010-2014, 5-Year Estimates, U.S. Census Bureau
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	**CBSA** Total population: 764,057 *White: 43%* *Black or African American: 42%* *Asian: 6%* *Hispanic, Any Race: 5%* *Others: 4%* Total housing units: 328,702 Language Spoken: *English: 86%*	American Community Survey, 2010-2014, 5-Year Estimates, U.S. Census Bureau

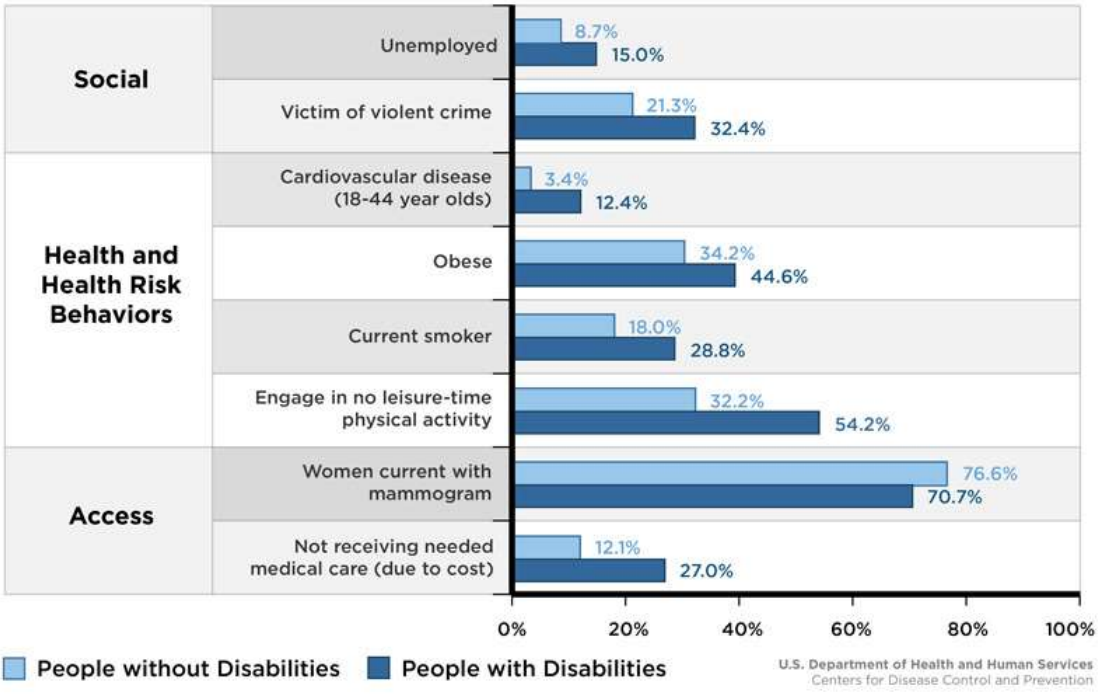
	Spanish or Spanish Creole: 4% *Indo-European languages: 4%* *Asian and Pacific Island languages: 4%* *Other languages: 2%*	
Other Infant Mortality Rate	**Baltimore City** All races/ethnicity: 10.4 per 1,000 live births White: 7.0 per 1,000 live births Black: 12.8 per 1,000 live births Hispanic: 7.6 per 1,000 live births **Baltimore County** All races/Ethnicity: 6.9 per 1,000 live births White: 3.2 per 1,000 live births Black: 14.8 per 1,000 live births **Anne Arundel County** All races/Ethnicity: 5.7 per 1,000 live births White: 3.8 per 1,000 live births Black: 12.9 per 1,000 live births **Howard County** All races/ethnicity: 4.5 per 1,000 live births White: 3.1 per 1,000 live births Black: 7.8 per 1,000 live births	Maryland Vital Statistics Annual Report, 2014
Diabetes Prevalence	Baltimore City: 13% Baltimore County: 10% Anne Arundel County: 9% Howard County: 8%	CDC Diabetes Interactive Atlas data from http://www.countyhealthrankings.org/

Additional Disparity Information for Baltimore and Targeted CBSA

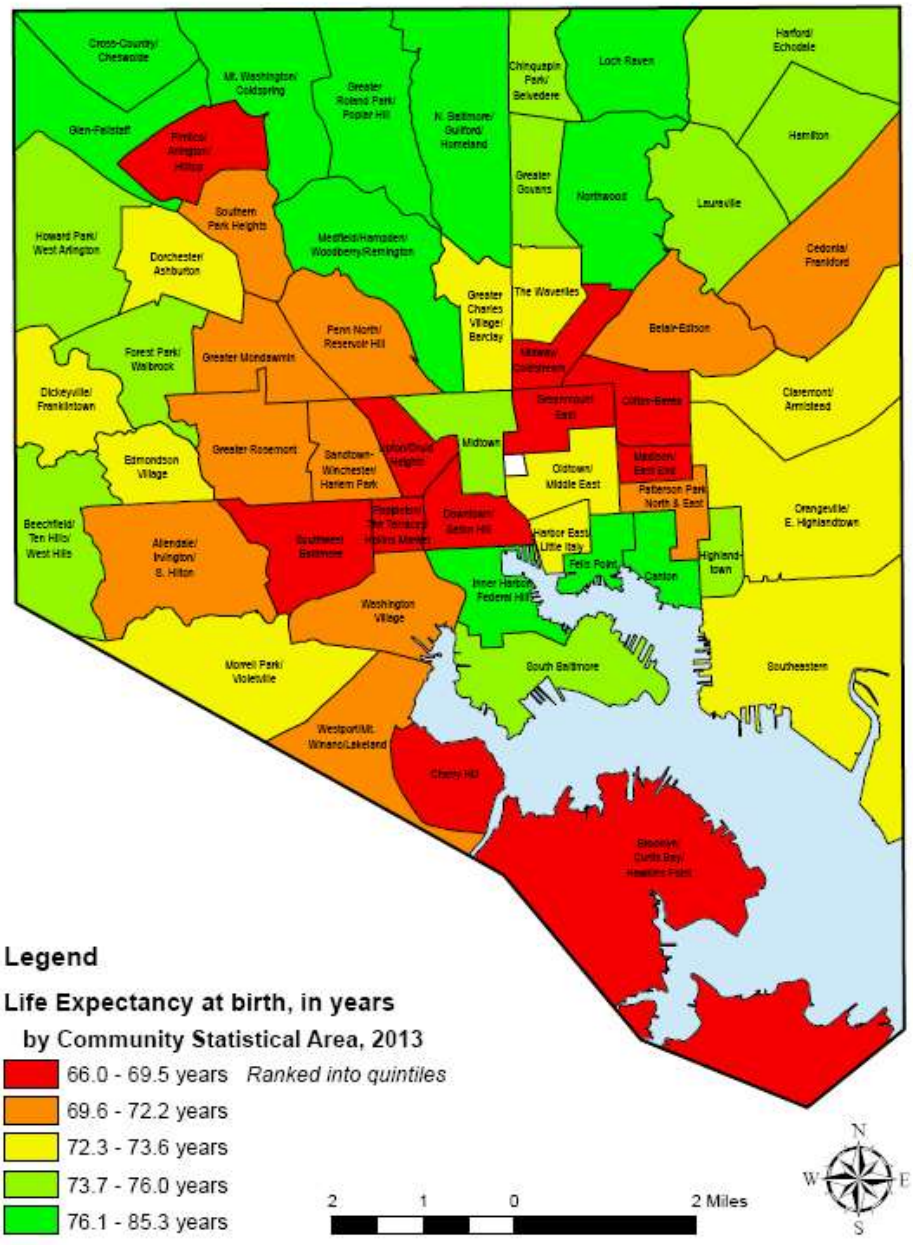
County Ranking (Out of 24 Counties in Maryland, including Baltimore City)*								
	Health Outcomes	Length of Life	Quality of Life	Health Factors	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Baltimore City	24	24	24	24	24	21	24	10
Baltimore County	14	12	17	11	9	10	12	21
Anne Arundel County	9	9	6	7	8	9	8	9
Howard County	2	2	2	1	2	1	1	7

*Source – Robert Wood Johnson Foundation, County Health Rankings, 2016
http://www.countyhealthrankings.org/app/maryland/2016/rankings/baltimore-city/county/outcomes/overall/snapshot

As evident in the Table above using the County Health Rankings, Baltimore City is the lowest ranked area in Maryland in 6 out of 8 categories. Within the City of Baltimore, there are further health disparities. In the following Life Expectancy Map, there is a 20 year difference in the life expectancy between many of the zips. In some areas of targeted CBSA, the life expectancy is equivalent to the life expectancy in Nepal and India. In the other counties, there is a higher life expectancy with better health factors, health behaviors and improved social and economic conditions. However, this Table and the rankings speak predominately about the non-disabled community. Disabled adults face unique challenges regardless of their county of residence. The below graph shows the special challenges which face the disabled population nationally as reported by the US Dept of Health and Human Services and the Centers for Disease Control.



Baltimore City Life Expectancy Map



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

http://khn.org/news/map-in-poor-baltimore-neighborhoods-life-expectancy-similar-to-developing-countries/

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

__**X**__Yes
____No

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

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

http://umrehabortho.org/~/media/systemhospitals/um-rehab/pdfs/about/2015-um-rehab-and-ortho-chna-report--rev--063016.pdf?la=en

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

_**X**__Yes **6/30/15** (mm/dd/yy) Enter date approved by governing body here:
___No

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

http://umrehabortho.org/~/media/systemhospitals/um-rehab/pdfs/about/2015-um-rehab-and-ortho-chna-report--rev--063016.pdf?la=en

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

_**X**__Yes – Strategic Planning process underway currently. Community benefits and community health needs assessment findings being added to the new Strategic Plan.
___No

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

Elements of the CHNA and community benefits are being integrated into the Strategic Plan currently within this current fiscal year. Prior Strategic Plan did not include community benefits, but with the process underway currently, this is now being included into the Plan.

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. ___CFO
3. _**X**__Other (please specify) CNO, CMO, Director of Therapy, Director of Patient Experience & Volunteers, Sr. Director of Strategic Planning & Business Development

Describe the role of Senior Leadership.

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

ii. Clinical Leadership

1. **_X**__Physician CMO
2. **_X**__Nurse
3. ___Social Worker
4. _X_Other (please specify) As a rehabilitation hospital, numerous rehab staff, ie physical therapists, occupational therapists, etc participate

Describe the role of Clinical Leadership

- Provides clinical knowledge/context for needs assessment and programming
- Develops/approves protocols for health screenings
- Provides oversight to health screenings & outreach programs

iii. Community Benefit Operations

1. **_X**_Individual (please specify FTE – (**1.5 FTEs)**
2. _ _Committee (please list members)
3. ___Department (please list staff)
4. ___Task Force (please list members)
5. _X__Other (please describe)

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

Pam Bechtel – Coordinates the reporting for the community benefit report and volunteer activities

Michelle Larcey – Coordinates the reporting for the community benefit report, works with various departments for reporting

Lori Patria – Leads the adaptive sports program, rehab programs, and assists with community benefits tracking

Anne Williams – Provides oversight and guidance to community health improvement initiatives and regulatory requirements

Cindy Kelleher – Leads overall effort in both the development and reporting of community benefits

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

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

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

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

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

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

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

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

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

Organization	Name of Key Collaborator	Title	Collaboration Description
University of Maryland Medical Center	Anne Williams	Director, Community Health Improvement	Consultant to process
University of Maryland Medical System	Donna Jacobs	Senior Vice President	Hosted community partner focus group
BARS	Pam Lenhart	Director	Key informant on identifying needs of disabled community
Dept of Rehabilitation Services	Darice Bunch Polly Huston	Supervisor Director	Key informant on identifying needs of disabled community
Mayor's Office on Disabilities	Dr. Nollie Wood	Executive Director	Understand key elements of ADA, assisting City with accessibility issues

Mount de Sales Academy	Annie McDonald	Athletic Director	Key informants on needs of private schools sports programs
Howard County Public Schools	Kerrie Wagaman John Davis	Coordinator of Health Services Coordinator of Athletics	Key informants on needs of public schools sports programs

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

__X___yes _____no **N/A**

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 **N/A**

Donna Jacobs, Senior Vice President, UMMS attends the new meetings on behalf of all of the UMMS Baltimore-based hospitals

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

a. 1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with

other public and private organizations.
2. Please indicate whether the need was identified through the most recent CHNA process.

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

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

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

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

f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)

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

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

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

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

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

k. Expense:
A. what were the hospital's costs associated with this initiative? The amount reported

should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
B. of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

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

   Priorities as identified in the FY15 CHNA include:

   - Quality of Life (for the disabled community)
   - Community Education/Awareness (of the disabled in the community)
   - Transition to Community
   - Dental Care (for the disabled population)

   - Health Literacy (UMMS Priority)

   Additional 21201community needs which are not directly addressed by the above priorities include:

   - No health insurance
   - No transportation
   - Local MDs not part of the insurance plans
   - Behavioral/mental health

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

   The Population Health Strategy and Implementation Plan was finalized. This plan covers both the University of Maryland Medical Center and Midtown Campuses with some integration with UM Rehab & Ortho Institute. The Community Health Needs Assessments and Community Benefits Reports are integrated into the Plan to provide a context of the community for planning purposes. There are six workgroups which will be tasked with specific elements of the overall strategy. Initiatives will be further developed which will address the SDoH which are barriers in the targeted West Baltimore population. UM Rehab & Ortho Institute will be part of the West Baltimore Transformation Grant along with the University of Maryland Medical Center and Midtown Campuses. Additionally, UM Rehab has 4 Patient Navigators who are dedicated for population health initiatives. To support the population health initiatives with chronic high utilizers, UM Rehab & Ortho Institute has begun to offer the Living Well/Chronic Disease Management Program to patients and the community.

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
http://dhmh.maryland.gov/ship/SitePages/Home.aspx
COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

VI. PHYSICIANS

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

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

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please 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 – **Not Applicable**

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)	

VII. APPENDICES

To Be Attached as Appendices:

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

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

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
  - in a culturally sensitive manner,
  - at a reading comprehension level appropriate to the CBSA's population, and

        - in non-English languages that are prevalent in the CBSA.
    - posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
    - provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
    - provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
    - includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
    - besides English, in what language(s) is the Patient Information sheet available;
    - discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

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

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

Attachment A

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

- Increase life expectancy
- 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

Table III – Health Literacy

Identified Need	Health Literacy During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Health Literacy. This need was identified both years and was based on the low rates of high school completion rates as well as public in the CBSA targeted zip codes as outlined below. Baltimore City Data: Overall high school completion rate in Baltimore City is 80.3%. However, within the targeted CBSA zip codes, the high school completion rate ranges from 73.1% to 86.8%. These rates are far lower than the State of Maryland average of 87%.. As a result of a lack of health literacy is the overall misuse of emergency services when urgent care or preventive/primary care is, at times, more appropriate. In a survey of Baltimore City residents during the FY15 CHNA, 69% of residents reported they did not have health insurance. When further questioned, many participants actually had the new ACA health care coverage but didn't know that it covered preventive care and didn't understand the process of selecting a physician for primary care. Therefore, many individuals do not pursue primary/preventive care and eventually seek emergency care after a problem becomes significantly worse. Health literacy is a significant social determinant of health in Baltimore City which affects patients' health outcomes and speaks to the identified need, and subsequently, the UMMC and UMMS priority of Health Literacy.
Hospital Initiatives	To work on the issue of health literacy, UMMC had one major initiative to address the above identified need with healthcare professionals in FY16. **Health Literacy** (for professionals)

Primary Objectives	**Health Literacy**
	1) Develop video for healthcare professionals on importance of health literacy
	2) Post video on staff intranet
	3) Engage staff in at least 5 key organizational staff meetings
	4)
	• Description: Provide health literacy information to health care professionals to inform their practice
	• Metrics:
	  • Video developed
	  • Video posted on the intranet
	  • # of key organizational staff meetings
	  • # of meetings where video shown
	  • # of healthcare professionals watching video
	  • # of page views

Single or Multi-Year Initiative Time Period	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.

Key Partners in Development and/or Implementation	UMMS System hospitals, UMMC Dept of Communications, Healthcare professionals across the UMMS system	
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above.	
Outcomes (Include process and impact measures)	**Health Literacy Objectives:** Metrics: • Video developed • # of meetings where video shown • # of healthcare professionals watching video • # of page views Outcomes: • Video developed and finalized 4/2016 • 2 major organizational meetings with video shown • Over 50 professionals watched video in meetings • 61 page views on the intranet where video is posted – www.umm.edu/community (only for April - June 2016)	
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative Approx. $10,000 to develop video (utilized across UMMS)	B. Direct offsetting revenue from Restricted Grants $0

Table III – Adapted Sports Program

Identified Need	Through patient and staff focus groups as well as key informant interviews, the Adapted Sports Program was identified as part of the Community Health Needs Assessment in FY15 as a valued service which is currently provided. A need to expand the program was also identified to further meet health, fitness, social, and overall quality of life needs in the community.
Hospital Initiative	The Adapted Sports Program maximizes participation for individuals with disabilities in adapted recreational and competitive sports, in order to promote independence, self-confidence, health and overall well-being through structured, individual and team sports Programs offered are: Adapted Sports Festival, Wheelchair Basketball Clinic, Wheelchair Rugby Team, Adapted Golf Program, Amputee Walking/Running Clinic.
Primary Objectives	Adapted Sports Program 1)Increase physical activity (Maryland SHIP) 2)Increase awareness & benefits of adapted sports for disabled individuals 3)Increase awareness in healthcare providers of adapted sports for the disabled 4)Increase self-reported quality of life of disabled Description: Provide adapted sports programs to educate disabled adults in the community about a variety of ways to stay physically active Metrics: • # of participants • # of health care students/professionals aware of adapted sports for disabled adults • Self-reported benefits to participants
Single or Multi-Year Initiative Time Period	All programs are multi-year, ongoing initiatives.
Key Partners in Development and/or Implementation	United States Olympic Committee United States Paralympic Committee Dankmeyer, Inc. Baltimore Municipal Golf Corporation - Forrest Park Golf Course Baltimore City Recreation and Parks Baltimore County Recreation and Parks
How were the outcomes evaluated?	Participants of the various programs were surveyed.

Outcomes (Include process and impact measures)	Participation in all adapted sports activities was tracked. **1,021 people participated in the Adapted Sports Program with an additional 180 participants who are either allied health professionals or students in allied health professional schools**. Feedback in all activities was collected; response from the participants was overwhelmingly positive. Participants report improvement in endurance, speed and wheelchair maneuverability, knowledge of wheelchair sports and overall improved confidence to try other adapted sports. Participants also reported that they were more likely to participate in other programs offered in their local community such as Baltimore Adapted Recreational Sports and Baltimore City Rec and Parks programs.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $59,531	B. Direct offsetting revenue from Restricted Grants N/A

Table III – Dental Clinic

Identified Need	Through patient and staff focus groups as well as key informant interviews, the Dental Clinic was identified as part of the Community Health Needs Assessment as a valued service currently provided.
Hospital Initiative	The UM Rehabilitation & Orthopaedic Institute Dental Clinic serves children and adults who have limited access to oral health care in the community. This population includes special health care needs (SHCN) patients (individuals who are mentally and/or physically disabled), as well as many children in the Maryland Medicaid Program. The Dental Clinic at UM Rehab is one of the few providers in the state who serves both pediatric and adult SHCN populations. These individuals may not receive care otherwise as many dentists in the community are not comfortable performing dental services for special health care needs patients. The Dental Clinic at UM Rehab partners with a number of area colleges to offer dental and hygiene students hands-on experience to provide preventive services for its patients .Overall, the program helps reduce health care costs and improve patient care by treating dental disease in the Dental Clinic instead of in the ER.
Primary Objectives	Dental Clinic 1)Increase children receiving dental care (Maryland SHIP) 2)Decrease emergency department visit rate for dental care (Maryland SHIP) 2)Increase number of dental treatments available to disabled population (Program goal) Description: Provide dental care and treatment for disabled adults and children within Maryland Metrics: • # of visits • % of treatments which were preventive (preventing emergent care)
Single or Multi-Year Initiative Time Period	Ongoing initiative; has existed for many years and will continue indefinitely.
Key Partners in Development and/or Implementation	University of Maryland School of Dentistry • Hygienist program • 4th year dental students (externship program) Baltimore City Community College • Hygienist program Community College of Baltimore County, Dundalk • Hygienist program
How were the outcomes evaluated?	Outcomes are evaluated by tracking the number of visits that take place in the Dental Clinic each year, and measuring the percent of visits that are preventive.

Outcomes (Include process and impact measures)	In FY16, dental visits that occurred in the Dental Clinic were tracked; **8,975 dental visits occurred. The number of visits was measured, and 64% (or 5744) were preventive; only 5% (or 449) were emergent** .	
Continuation of Initiative	Has existed for many years and will continue indefinitely	
C. Total Cost of Initiative for Current Fiscal Year D. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $46,286	B. Direct offsetting revenue from Restricted Grants N/A

Table III – Living Well with Chronic Disease Community Education

Identified Need	Through patient and staff focus groups as well as key informant interviews, Living Well with Chronic Disease classes were identified as part of the Community Health Needs Assessment as a valued service to meet the need of increasing participants' confidence, understanding and skills in managing chronic medical conditions.
Hospital Initiative	The classes provide education and information for individuals and caregivers through engaging, evidence-based programs. Living Well with Chronic Disease follows Stanford's chronic disease self-management program. The classes are offered as a 6-week course covering the following topics: Managing Medication, Managing Stress, Attending Regular Doctor Appointments, Healthy Eating and Exercise and Improving Quality of Sleep.
Primary Objectives	Living Well with Chronic Disease Education 1)Decrease preventable hospitalizations related to management of chronic conditions related to disability Description: Provide education and information for individuals and caregivers through engaging, evidence-based program – Living Well with Chronic Disease (Stanford) Metrics: • # of classes/cohorts • # of participants • Self-reported benefits
Single or Multi-Year Initiative Time Period	Multi-Year Initiative; classes are planned several times/year.
Key Partners in Development and/or Implementation	Maryland's Maintaining Active Citizens (MAC) Maryland Department of Health and Mental Hygiene Stanford University
How were the outcomes evaluated?	Attendees of the chronic conditions classes were surveyed.
Outcomes (Include process and impact measures)	In FY16, the first two 6-week sessions were conducted with a total of 11 people participating. Attendees reported that they are more confident in managing their chronic medical conditions and have a better understanding of how to manage their symptoms; they also reported knowing how to develop action plans and follow them.
Continuation of Initiative	Living Well with Chronic Disease classes will continue as long as there continues to be interest and perceived benefit to our participants

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $3,978	B. Direct offsetting revenue from Restricted Grants N/A

Table III – Support Groups

Identified Need	Through patient and staff focus groups as well as key informant interviews, support groups were identified as part of the Community Health Needs Assessment as a valued service to meet the need to increase knowledge, decrease stress, improve coping strategies, and have support of a peer group.
Hospital Initiative	The hospital provides monthly support groups to current and past patients as well as individuals living in the community with the associated diagnosis. Support groups are also open to caregivers through the Caregiver Support Group as well as the diagnosis-specific support groups: Spinal Cord Injury, Amputee, Brain Injury and Stroke.
Primary Objectives	Support Groups 1)Decrease social isolation, depression, and/or anxiety in adults with disabilities in the community 2)Increase coping skills and sense of adjustment in adults with disabilities in the community
Single or Multi-Year Initiative Time Period	All programs are multi-year, ongoing initiatives.
Key Partners in Development and/or Implementation	Amputee Coalition of America Christopher and Dana Reeves Foundation
How were the outcomes evaluated?	Participants of the various programs were surveyed. Topics are solicited by participants on a regular basis and program evaluation information is obtained regarding satisfaction and effectiveness of the program.
Outcomes (Include process and impact measures)	Attendance for each support group was taken at each meeting every month; in all. **A total of 1,119 people participated**. Feedback received from the participants included feeling less isolated, alone and distressed after attending support group. They report feeling comfortable with expressing their frustrations with either the impact of their injury/disease or their new role as a caregiver, without being judged. Caregivers also report improved coping skills with an increased consciousness about caring for themselves while caring for their loved ones.
Continuation of Initiative	All Support Groups will be continued as long as there continues to be interest and perceived benefit to our participants

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $21,431	B. Direct offsetting revenue from Restricted Grants N/A

Table III – Think First for Teens Program

Identified Need	Through patient and staff focus groups as well as key informant interviews, the Think First for Teens program was identified as part of the Community Health Needs Assessment as a valued service to meet the need of reducing the accident/injury rate in the teen population. Injury is the leading cause of death and disability among children, teens and young adults. The most frequent causes of these injuries are motor vehicle crashes, violence, falls, sports and recreation. Research has shown that youth are amenable to changing their behaviors when information is provided by a perceived by a peer.
Hospital Initiative	UM Rehab is a Chapter of the National Think First, National Injury Prevention Foundation. The Think First Program is a program provided by a health care professional and an individual who has had either a spinal cord injury or brain injury with the goal of encouraging youth to "Think First", minimize risk-taking behaviors and make decisions that will ensure their safety. This program is offered to local high schools and middle schools.
Primary Objectives	Think First for Teens 1)Increase the number of high school students enrolled in Think First program 2)Increase in students' self-reported knowledge or behavior changes as a result of program
Single or Multi-Year Initiative Time Period	This is a multi-year initiative
Key Partners in Development and/or Implementation	Baltimore City Public Schools Baltimore County Public Schools
How were the outcomes evaluated?	Feedback was collected from participants via written surveys completed at the end of each presentation.
Outcomes (Include process and impact measures)	Presentations were conducted this year at 3 high schools and 1 middle school for a total of **21 presentations with 470 students participating**. Feedback was collected via written surveys completed at the end of each presentation. Students readily identified benefits from the presentations including ways they can alter their behavior to increase their safety whether wearing protective equipment when playing sports, wearing their seat belt, or finding alternative ways to get home instead of riding with individuals under the influence of drugs or alcohol.
Continuation of Initiative	Ongoing - Think First for Teens program will be continued as long as there continues to be interest and perceived benefit to our participants

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $4,339	B. Direct offsetting revenue from Restricted Grants N/A

Financial Assistance Policy Description

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

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

UM Rehabilitation and Orthopedic Institute makes every effort to make financial assistance information available to our patients including, but not limited to:

- Signage in main admitting areas and emergency rooms of the hospital
- Patient Handbook distributed to all patients
- Brochures explaining financial assistance are made available in all patient care areas
- Patient Plain Language Sheets – Newly revised in June 2016, This handout was revised and is at the 5th grade reading level (available in English, Spanish, French, & Chinese based on top languages spoken by UMMC patients) – See English version attached in Appendix 4
- Patient Information Sheets (available in English, Spanish, French; Russian; Chinese; Korean; Vietnamese; Tagalog) – See attached English version in Appendix 4
- Appearing in print media through local newspapers

ACA Health Care Coverage Expansion Description

Since implementation of the Affordable Care Act's (ACA) Health Care Coverage Expansion Option became effective on January 1, 2014, there has been a decrease in the number of patients presenting to the hospital in either uninsured and/or self-pay status. Additionally, the ACA's Expansion Option included a discontinuation of the primary adult care (PAC) which has also reduced uncompensated care. While there has been a decrease in the uncompensated care for straight self-pay patients since January 1, 2014, the ACA's Expansion Option has not completely eradicated charity care as eligible patients may still qualify for such case after insurance.

The following additional changes were also made to the hospital's financial assistance policy pursuant to the most recent 501(r) regulatory requirements:

1. **LANGUAGE TRANSLATIONS**
    a. Requirement: The new 501(r) regulations lowered the language translation threshold for limited English proficient (LEP) populations to the lower of 5% of LEP individuals in the community served/1000-LEP individuals. UM Rehabilitation & Orthopedic Institute translated its financial assistance policy into the following languages: English, Spanish, French; Russian; Chinese; Korean; Vietnamese; Tagalog

2. **PLAIN LANGUAGE SUMMARY**
    a. Requirement: The new 501(r) regulations require a plain language summary of the FAP that is clear, concise, and easy for a patient to understand. UM Rehabilitation & Orthopedic Institute created a new plain language summary of its financial assistance policy in addition to its already-existing patient information sheet.

3. **PROVIDER LISTS**
    a. Requirement: The new 501(r) regulations require each hospital to create and maintain a list of all health care providers (either attached to the FAP or maintained as a separate appendix) and identify which providers on that list are covered under the hospital's FAP and which providers are not. UM Rehabilitation & Orthopedic Institute maintains that list which is available for review.

University of Maryland Medical Center University of Maryland Medical Center Midtown Campus University of Maryland Rehabilitation & Orthopaedic Institute University of Maryland St. Joseph Medical Center University of Maryland Baltimore Washington Medical Center	**The University of Maryland Medical System** **Central Business Office** **Policy & Procedure**	*Policy #:*	TBD
		Effective Date:	07/01/2016
	Subject: **FINANCIAL ASSISTANCE**	*Page #:*	1 of 9
		Supersedes:	07-01-2015

POLICY

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

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

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

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

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

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

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

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

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

University of Maryland Baltimore Washington Medical Center (UMBWMC) adopted this policy effective July 1, 2016.

PROGRAM ELIGIBILITY

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

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

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

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

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

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

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

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

Presumptive Financial Assistance

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

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

n. St. Clare Outreach Program eligible patients

o. UMSJMC Maternity Program eligible patients

p. UMSJMC Hernia Program eligible patients

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

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

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

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.
2. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.
   d. Upon receipt of the patient's application, they will have thirty (30) days to submit the required documentation to be considered for eligibility. If no data is received within the 30 days, a denial letter will be sent notifying that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The Financial

Assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.

3. There will be one application process for UMMC, MTC, UMROI, UMSJMC and UMBWMC. The patient is required to provide a completed Financial Assistance Application orally or in writing. In addition, the following may be required:
   a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...
   b. A copy of their most recent pay stubs (if employed) or other evidence of income.
   c. A Medical Assistance Notice of Determination (if applicable).
   d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.

A written request for missing information will be sent to the patient. Oral submission of needed information will be accepted, where appropriate.

4. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.
   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.
      i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
      ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
         (1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.

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

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

   Extraordinary Collection Actions (ECAs) may be taken on accounts that have not been disputed or are not on a payment arrangement. Except in exceptional circumstances, these actions will occur no earlier than 120 days from submission of first bill to the patient and will be preceded by notice 30 days prior to

commencement of the action. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

i) Garnishments may be applied to these patients if awarded judgment.

ii) A lien will be placed by the Court on primary residences within Baltimore City. The facility will not pursue foreclosure of a primary residence but may maintain our position as a secured creditor if a property is otherwise foreclosed upon.

iii) Closed account balances that appear on a credit report or referred for judgment/garnishment may be reopened should the patient contact the facility regarding the balance report. Payment will be expected from the patient to resolve any credit issues, until the facility deems the balance should remain written off.

7. If a patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
8. A letter of final determination will be submitted to each patient who has formally submitted an application.
9. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds may be issued back to the patient for credit balances, due to patient payments, resulted from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.
10. Patients who have access to other medical care (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.
11. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.
12. The Financial Assistance Program will accept all other University of Maryland Medical System hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.
13. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.
14. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.
    a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
    b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

Financial Hardship

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

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

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

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

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

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

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

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

Appeals

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

Judgments

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

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

MD DHMH 2016 Income Elig Limit Guidelines		Income Level Up to 200% Pt Resp 0%	S L I D I N G S C A L E	Income Level Pt Resp 10%	Income Level Pt Resp 20%	Income Level Pt Resp 30%	Income Level Pt Resp 40%	Income Level Pt Resp 50%	Income Level Pt Resp 60%	Income Level Pt Resp 70%	Income Level Pt Resp 80%	Income Level Pt Resp 90%
HH	100% MD DHMH	100% Charity		90% Charity	80% Charity	70% Charity	60% Charity	50% Charity	40% Charity	30% Charity	20% Charity	10% Charity
Size	Max	Max		Max	Max	Max	Max	Max	Max	Max	Max	Max
1	$16,395	$32,790		$34,430	$36,069	$37,709	$39,348	$40,988	$42,627	$44,267	$45,906	$49,184
2	$22,108	$44,216		$46,427	$48,638	$50,848	$53,059	$55,270	$57,481	$59,692	$61,902	$66,323
3	$27,821	$55,642		$58,424	$61,206	$63,988	$66,770	$69,553	$72,335	$75,117	$77,899	$83,462
4	$33,534	$67,068		$70,421	$73,775	$77,128	$80,482	$83,835	$87,188	$90,542	$93,895	$100,601
5	$39,248	$78,496		$82,421	$86,346	$90,270	$94,195	$98,120	$102,045	$105,970	$109,894	$117,743
6	$44,961	$89,922		$94,418	$98,914	$103,410	$107,906	$112,403	$116,899	$121,395	$125,891	$134,882
7	$50,702	$101,404		$106,474	$111,544	$116,615	$121,685	$126,755	$131,825	$136,895	$141,966	$152,105
8	$56,443	$112,886		$118,530	$124,175	$129,819	$135,463	$141,108	$146,752	$152,396	$158,040	$169,328

Effective 7/1/16

Appendix 4

Financial Help for Patients to Pay Hospital Care Costs

If you cannot pay for all or part of the care you receive from our hospital, you may be able to get **free** or **lower cost** services.

PLEASE NOTE:

1. We treat all patients needing emergency care, no matter what they are able to pay.
2. Services provided by physicians or other providers may not be covered by the hospital Financial Assistance Policy. You can call (410) 821-4140 if you have questions.

HOW THE PROCESS WORKS:

When you become a patient, we ask if you have any health insurance. We will not charge you more for hospital services than we charge people with health insurance. The hospital will:

1. Give you information about our financial assistance policy, or
2. Offer you help with a counselor who will help you with the application.

HOW WE REVIEW YOUR APPLICATION:

The hospital will look at your ability to pay for care. We look at your income and family size. You may receive free or lower costs of care if:

1. Your income or your family's total income is low for the area where you live, or
2. Your income falls below the federal poverty level if you had to pay for the full cost of your hospital care, minus any health insurance payments.

PLEASE NOTE: If you are able to get financial help, we will tell you how much you can get. If you are not able to get financial help, we will tell you why not.

HOW TO APPLY FOR FINANCIAL HELP:

1. Fill out a **Financial Assistance Application Form**.
2. Give us all of your information to help us understand your financial situation.
3. Turn the Application Form into us.

PLEASE NOTE: The hospital must screen patients for Medicaid before giving financial help.

OTHER HELPFUL INFORMATION:

1. You can get a **free copy** of our Financial Assistance Policy and Application Form:
   - ***Online*** at http://umm.edu/patients/financial-assistance
   - ***In person*** at the Financial Assistance Department – University of Maryland Medical System, 11311 McCormick Road, Ste 230, Hunt Valley, MD 21031
   - ***By mail***: call (410) 821-4140 to request a copy
2. You can call the Financial Assistance Department if you have questions or need help applying. You can also call if you need help in another language. Call: (410) 821-4140

Revised 6/2016

Appendix 5

Mission
University of Maryland Rehabilitation & Orthopaedic Institute delivers innovative, high-quality, and cost effective rehabilitation and surgical services to the community and region. We provide:

- An interdisciplinary continuum of care including inpatient and outpatient surgery, rehabilitation and additional services as required.
- A proactive environment for patient safety, implementing improvements as patient safety risks are identified.
- A site for public and professional health care education and research.

Vision
UM Rehabilitation & Orthopaedic Institute's vision is to become widely recognized as an integral component of the University of Maryland Medical System in its role as:

- A regional hospital specializing in the provision of acute, chronic and outpatient rehabilitation services;
- A regional hospital specializing in the provision of a full array of orthopaedic services for adults and children;
- A high quality provider of specialized medical/surgical programs.

Values
Quality and Compassionate Care
Excellence in Service
Respect for the Individual
Patient Safety
Quality in Research and Education
Cost Effectiveness