FY2017 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

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Submitted by Anne Arundel Medical Center

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 hospitals 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.

As provided by federal regulation (26 CFR §1.501(r)—3(b)(6)) and for purposes of this report, a **COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)** report is a written document that has been adopted for the hospital facility by the organization's governing body (or an authorized body of the governing body), and includes:

(A) A definition of the community served by the hospital facility and a description of how the community was determined;

(B) A description of the process and methods used to conduct the CHNA;

(C) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant; and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and

(F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

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 & Roadmaps (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;
(15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/); and
(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 address health needs identified by the CHNA.

Required by federal regulations, the **IMPLEMENTATION STRATEGY** is a written plan that is adopted by the hospital organization's governing body or by an authorized body thereof, and:

With respect to each significant health need identified through the CHNA, either—
(i) Describes how the hospital facility plans to address the health need; or
(ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address it.

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 total number of licensed beds
   b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
   c. Primary Service Area (PSA) zip codes;
   d. Listing of all other Maryland hospitals sharing your PSA;

e. The percentage of the hospital's uninsured patients by county. (Please provide the source for this data, e.g., "review of hospital discharge data");

f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data (e.g., "review of hospital discharge data.")

g. The percentage of the hospital's patients who are Medicare beneficiaries. (Please provide the source for this data (e.g., "review of hospital discharge data.")

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 the Hospital's Patients who are Uninsured:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
410	26,321	21401 21403 21037 21012 21114 20715 21409 21146 21122 21113 21666 20716 21061 20774 21054 21032 21060 *Used FY16 as the FY17 report was not on the HSCRC website* **Top 60% - excludes adjacent zip codes*	FY16: University of MD Johns Hopkins Hospital Harbor Hospital Baltimore Washington Medical Center *Includes those w/ 2+ overlapping zips – excluding Cecil.	***See table below** Discharges 7/1/16-6/30/17 *excl Newborns	**12%** of Inpatients discharged 7/1/16-6/30/17 *excl Newborns	**43%** of Inpatients discharged 7/1/16-6/30/17 *excl Newborns

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FY2017 % AAMC Uninsured Discharges by County

County	Uninsured Discharges	% Total Uninsured
Anne Arundel County	159	53.5%
Prince George's County	64	21.5%
Out of State	27	9.1%
Queen Anne's County	18	6.1%
Caroline County	6	2.0%
Baltimore City	5	1.7%
Calvert County	5	1.7%
Baltimore County	5	1.7%
Montgomery County	3	1.0%
Howard County	2	0.7%
Charles County	1	0.3%
Talbot County	1	0.3%
Kent County	1	0.3%
Grand Total	**297**	**100.0%**

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 (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.

      (iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., 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).

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/Pages/home.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 Chart Book 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 (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.	Most vulnerable populations in the ***Primary*** Service Area include: 21403 (Annapolis/ Eastport), 21401 (Annapolis), 21144 (Severn), 21222 (Pasadena), 21077 (Harmans), 21060 and 21061 (Glen Burnie), 20779 (Tracy's Landing), 20751 (Deale), 20714 (North Beach), 20711 (Lothian), 20733 (Churchton), 20764 (Shady Side), 20774 (Upper Marlboro), 21666 (Stevensville) **<u>Anne Arundel County</u>** Total Population: 563,973 Male: 49.5 % Female: 50.5% Average Age: 38.9 Years Percent of Total Population by Age: 0 – 4 Years: 6.1% 5 – 17 Years: 16.3% 18 – 64 Years: 63.7% 65+ Years: 13.8% **<u>Prince George's County</u>** Total Population: 919,417 Male: 48% Female: 52% Median Age: 36.1 Years Percent of Total Population By Age: Under 5 Years: 7% 5-17 Years: 16% 18-64 Years: 67% 65+Years: 11% **<u>Queen Anne's County</u>** Total Population: 49,929 Male: 49.6% Female: 50.4% Median Age: 43.5 Percent of Total Population By Age: Under 5 Years: 4.9% 5-17 Years: 21.7% 18-64 Years: 55.2% 65+Years: 18.2%	FY2016 Discharge data 2016, Nielsen, Inc. County demographic s estimate. Community Health Needs Assessment, Anne Arundel County Feb, 2016 2016 Prince George's County Community Health Needs Assessment https://www.census.gov/quickfacts/fact/table/queenannescountymaryland/AGE295216
Median Household Income within the CBSA	$92,505 Anne Arundel County $72,290 Prince George's County	Community Health Needs Assessment, Anne Arundel County, 2016 2016 Prince George's County Community Health Needs Assessment

	$85,963Queen Anne's County	https://www.census.gov/quickfacts/fact/table/queenannescountymaryland/AGE295216
Percentage of households in the CBSA with household income below the federal poverty guidelines.	**Anne Arundel County** 6.3% of County residents live below the poverty level. 14.7% of single parent households live below the poverty level. **Prince George's County** 7.0% of County residents live below the poverty level. 17.6% of single parent households love below the poverty Level **Queen Anne's County** 5.2% of County residents live below the poverty level 11% of children live in households below the poverty level	Community Health Needs Assessment, Anne Arundel County, 2016 2016 Prince George's County Community Health Needs Assessment http://queenannes.md.networkofcare.org/
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	**Anne Arundel County** 6.6% of the County is uninsured 22% of Hispanic residents are uninsured **Prince George's County** 17.5% ages 18-64 are uninsured **Queen Anne's County** 7% ages 18-64 are uninsured	Community Health Needs Assessment, Anne Arundel County, 2016 Prince George's County Health Department 2016 Health Report www.countyhealthrankings.og
Percentage of Medicaid recipients by County within the CBSA.	**Anne Arundel County** 8.19% **Prince George's County** 16.06% **Queen Anne's County** 3.07%	https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/Pages/Home.aspx	**Anne Arundel County** 79.8 Years **Prince George's County** 79.9 Years **Queen Anne's County** 79.6 Years	Community Health Needs Assessment, Anne Arundel County, 2016 http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship1
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx	**Anne Arundel County** All Races 717.2 /100,000 White: 736.9 Black, NH: 833.4 Hispanic: 418.1 **Prince George's County** All Races 720.3/100,000 White: 815.1/100,000 Black, NH: 723.9/100,000	Community Health Needs Assessment, Anne Arundel County, 2016 2016 Prince George's County Community Health Needs Assessment

	Hispanic: 390.8/100,000 **Queen Anne's County** All Races 391/100,000 White: 357/100,000 Black 31/100,000 Hispanic: n/a	https://health.maryland.gov/vsa/Documents/Preliminary_Report_2015.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://ship.md.networkofcare.org/ph/county-indicators.aspx	**Housing** **Anne Arundel County** 925 Students are homeless 9,000 families on wait list for public housing 10,000 families on wait list for Section 8 **Prince George's County** 7.1% Housing vacancies **Queen Anne's County** 83% own homes **Access to Healthy Food** **Anne Arundel County** 9.3% are food insecure 5.6% of residents SNAP or Food Stamps **Prince George's County** 7.3% are food insecure 12.4% of residents receive SNAP or Food Stamps **Queen Anne's County** 8.2% are food insecure 9.7% of residents receive SNAP or Food Stamps **Education** **Anne Arundel County** 90.7% residents have HS diploma or higher 93% Whites HS Diploma 88% Blacks HS Diploma 67% of Hispanic HS Diploma **Prince George's County** 85.6% have a HS Diploma or higher 92% Whites HS Diploma 92% of Blacks have HS Diploma 44% of Hispanics have a HS Diploma **Queen Anne's County** 91.4% have a HS diploma or higher	Community Health Needs Assessment, Anne Arundel County, 2016 Prince George's County Health Department 2016 Health Report http://queenannes.md.networkofcare.org/ www.mdfoodsystemmap.org https://www.census.gov/quickfacts/fact/table/queenannescountymaryland/AGE295216
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://ship.md.networkofcare.org/ph/county-indicators.aspx	**Anne Arundel County** 75.1% White 15.5% Black 6.4% Hispanic **Prince George's County** 14.1% White 62.1% Black, NH 16.9% Hispanic 7% Other	Community Health Needs Assessment, Anne Arundel County, 2016 2016 Prince George's County Community Health Needs Assessment

	<u>Queen Anne's County</u> 89.7% White 6.6% Black 3.6% Hispanic	https://www.census.gov/quickfacts/fact/table/queenannescountymaryland/AGE295216
Other (ACCESS TO CARE)	**<u>Anne Arundel County</u>** Infant Mortality 4.0/1,000 Whites 11.2/1,000 Black 5.3/1,000 Hispanic General ED Visits: 250.3/1,000 Whites 554.0/1,000 Blacks 223.0/1,000 Hispanics Diabetes ED Visits: 141.1/100,000 Whites 463.7/100,000 Blacks 120.0/100,000 Hispanics Hypertension ED Visits: 139.8/100,000 Whites 514.0/100,000 Blacks 109.5/100,000 Hispanics	Community Health Needs Assessment, Anne Arundel County, 2016
	<u>Prince George's County</u> **Age adjusted death rate by leading causes of death** Heart disease – 185.8/100,000 Cancer – 166.4/100,000 Stroke 37.8/100,000 Diabetes – 29.4/100,000 **ED visits (all cause) by race**: White 206.9/1,000 Black, NH 314.9/1,000 Hispanic 167.6/1,000	2016 Prince George's County Community Health Needs Assessment
	<u>Queen Anne's County (higher than MD)</u> Very Low Birth Weight (Singleton) 1.3/1,000 Very Low Birth Weight (All) 1.7/1000 Teen Birth Rate 32.0/1,000 Binge Drinking 16.5% Adults that Smoke 19.0 %	https://phpa.health.maryland.gov/OEHFP/EH/tracking/Shared%20Documents/County-Profiles/QueenAnnesCounty_Final.pdf

The CBSA was defined as the primary service area for AAMC in which the HSCRC identified 17 zip codes that compose 60 percent of in-patient discharges during FY16. These locations include the following: Annapolis (21401, 21403, 21409), Edgewater (21037), Arnold (21012), Crofton (21114), Bowie (20715, 20716), Severna Park (21146), Pasadena (21122), Odenton (21113), Stevensville (21666), Glen Burnie (21061, 21060), Upper Marlboro (20774), Gambrills (21054), and Crownsville (21032). The following narrative will include a brief summary of Anne Arundel County, Prince George's County, and Queen Anne's county.

Anne Arundel County

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

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

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

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

The median household income is $87,430 and the median family income is $101, 268. However, there is significant income disparity. Over 6 percent of county residents live below the federal poverty guideline. Twenty five of residents live in households with less than $50,000 annual income. Nearly 43 percent of county residents live in households that have more than $100,000 of income. Furthermore, there are pockets of need that are located at the most northern and southern ends of the county, and in Annapolis. This data is reflected in Table 2.[2]

While life expectancy rose to an average of 79.8 years, cancer remains the leading cause of death and heart disease is the second cause of death. These diseases account for 47 percent of deaths in the County. Infant mortality and low birth weight are also present in the County, and it is particularly disparate for Black infants and families. While many residents have access to health insurance and Medicaid due to the expansion of the Affordable Care Act, there is a shortage of primary care physicians and mental health providers in the County. In addition, dental insurance coverage is not widely available and thus residents lack access to care. Mental health and substance use disorders greatly impact the health of county residents. Specifically, children and adolescents have experienced a 14.5 percent and 9.6 percent increase respectively. The heroin and opioid epidemic have caused a significant need for treatment services too. [3]

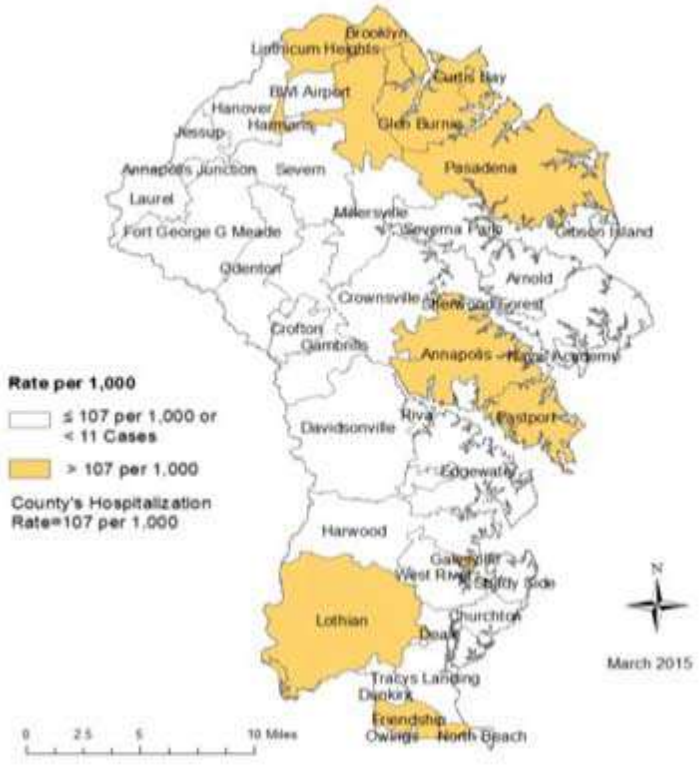
The senior population is growing in the County, and 11 percent of Medicare beneficiaries were also eligible for Medicaid. These residents are aging, have multiple chronic conditions and can impact healthcare resources. As a result, Anne Arundel Medical Center and University of Maryland Baltimore Washington Medical Center along with additional community partners established the Bay Area Transformation Project through the HSCRC Transformation program. To address the increasing and complex medical and social issues associated with the Medicare population. In FY 2015 the BATP hospitals provided care to a total of 23,477 Medicare patients, costing $260.5M. Of those, 1,152 are Medicare high-utilizers (>= 3 Inpatient/Observation >=24 hour visits in 12 months), representing $52.8M in total charges and 5,738 visits. Of the 1,152 high-utilizing Medicare patients, 590 visited AAMC, 705 visited UM BWMC, and 143 (12%) visited both hospitals. This Medicare high-utilizer population represents 5% of the 23,477 AAMC/UM BWMC Medicare patients, and 20% of the hospital-related cost of that same population. Notably, mental illness and/or substance misuse affects 66% of BATP's target Medicare population.[4]

The zip codes included in Table 2 represent geographically where the most vulnerable residents are. There are food deserts in those areas and a lack of connective transportation system. There is a higher percentage of residents without a

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

high school education. Furthermore, Lothian, Edgewater, Annapolis (21403), Churchton, Deale, Glen Burnie, Curtis Bay, Friendship, and Brooklyn have higher ED visits for behavioral health conditions as well as other illnesses and conditions. Hospitalization rates for various illnesses are higher for residents who live in these vulnerable areas.

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



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

Housing and homelessness remains a problem in the County. In 2013, resident homeowners spent 34.3% and renters spent 49.5% of their income on housing. In March, 2015, nine thousand families were on a waiting list for public housing and 10,000 families were on a waiting list for Section 8 housing. Over 2,000 individuals receive case management for homelessness and 925 children do not have a home. But, an accurate count of homeless residents does not exist.[8]

The CHNA notes other issues that affect the County as well. There is a lack of recreational and community facilities, as reported by CHNA respondents. Safe areas to play are lacking. Domestic violence is an on-going issue and there is not a

[5] Anne Arundel County Local Health Plan 2011
[6] Nielsen, Inc. 2014 county level demographic data
[7] http://www.aacounty.org/Partnership/Resources/2012_AA_County_Needs_Assessment.pdf
[8] Brown, P. & Singh, B. (2016). Community Health Needs Assessment, Anne Arundel County.

forensic examiner program at neither AAMC nor UMBWMC dues to training regulations that have affected the ability to provide care. Obesity remains an on-going health issue that affects other disease processes.

Prince George's County

Prince George's County is bordered by Washington D.C., Montgomery County, Howard County, Anne Arundel County, Calvert County and Charles County. Located in the heart of the Baltimore/Washington corrido, it is also 37 miles south of the city of Baltimore and encompasses almost 500 square miles. It is home to several landmarks and tourist attractions such as the National Harbor, the Gaylord National Resort, MGM National Harbor, the Capital Wheel, Rosecroft Raceway, FedEx Field and the Washington Redskins. It also hosts federal programs such as NASA/Goddard Space Flight Center, Andrews Air Force Base, the President's Air Force One aircraft, Merkle Wildlife Sanctuary, National Agricultural Library, National Archives at College Park, and the USDA's Agricultural Research Center. Several higher learning facilities are there such as the University of Maryland, Bowie State University, and Prince George's Community College.

The County is home to more than 900,000 diverse residents and includes urban, suburban, and rural areas; one out of every five residents are immigrants. The county, while overall considered affluent, has many communities with higher needs and poor health outcomes. Poor social determinants of health drive many of the health disparities such as poverty, food insecurity, access to healthy food, affordable housing, employment, lack of educational attainment, and inadequate financial resources.[9]

Resources may be available in communities with greater needs, but they are often of poor quality. For example, a recent study in access to healthy foods in an urban area of the county show that there are many grocery stores, but they lack quality healthy food options. Access to health insurance through the Affordable Care Act has not helped everyone. o Many residents still lack health insurance (did not enroll or not eligible) even with the passing of the Affordable Care Act. Residents with health insurance often cannot afford their co-pays. The healthcare system is challenging to navigate, and providers and support services need more coordination. While services are available, residents lack knowledge of or how to use available resources.[10]

The county does not have enough healthcare providers to serve the residents. There is a lack of behavioral health providers, dentists, specialists, and primary care providers. Many providers do not accept public insurance such as Medical Assistance. This further limits access to care for residents. In addition, the quality of care is perceived to be low by residents. As a result, they seek healthcare is surrounding areas. There is a lack of providers who accept public insurance. Finally, there is a lack of culturally competent and bilingual providers.[11]

The 2016 Community Health Needs Assessment identified and prioritized behavioral health, metabolic syndrome (heart disease, diabetes, stroke due to risk factors), and cancer as the top health needs of county residents. Strategies to address these issues must include consideration of the disparate social determinants of health. Residents have not adopted behaviors that promote a healthy lifestyle, such as healthy eating and active living. Approximately, two-thirds of residents are obese or overweight. The lack of physical activity and increased obesity is closely related to residents with metabolic syndrome, which increases the risk for heart disease, diabetes, and stroke.[12]

Behavioral health affects individuals, families and communities. For example, EMS, hospital staff, police, and the criminal justice system see many residents needing behavioral health services and treatment. Yet, the county lacks adequate resources needed to address significant behavioral health issues and the stigma surrounding behavioral health treatment is an ongoing problem in the county. [13]

Disparity in disease among residents still remains a challenge in the County. Metabolic syndrome is a group of risk factors that raises the risk of heart disease and other health problems such as diabetes and stroke. The risk factors include: a large waist, high triglycerides, low HDL, high blood pressure, and high blood glucose. Blacks have higher incidence of these risk factors. By cancer site, Black residents have a higher incidence and mortality rates for breast, colorectal, and prostate cancers. However, White non-Hispanic residents had a higher cancer mortality rate (2014). In 2013, the County had the second highest rate of HIV diagnoses in the state, and the highest number of actual cases in the state. For adults,

[9] Prince George's County Health Department (2016). Prince George's County Community Health Needs Assessment.
[10] Prince George's County Health Department (2016). Prince George's County Community Health Needs Assessment.
[11] Prince George's County Health Department (2016). Prince George's County Community Health Needs Assessment.
[12] Prince George's County Health Department (2016). Prince George's County Community Health Needs Assessment.
[13] Prince George's County Health Department (2016). Prince George's County Community Health Needs Assessment.

Black county residents have an age-adjusted hospitalization rate due to asthma that is more than twice as high as White, non-Hispanic residents. [14]

More partnerships and collaborative efforts are needed to improve health outcomes and address social determinants of health. Care coordination and addressing systemic issues are possible solutions. Transportation barriers must be addressed and fixed. Additional funding and resources are needed to strengthen the health safety net and build capacity of local non-profits. More outreach and education is needed, and should be tailored at a community-level to be culturally sensitive and reach residents. Residents also need education about the available resources, and how to utilize and navigate them. [15]

Queen Anne's County

Over 80 percent of the geographic are of the state of Maryland is considered rural. Queen Anne's County is one of the twenty-four counties in Maryland with a rural designation. The County is bordered north by Chester River, east by Delaware & Caroline County, south by Talbot County, and west by the Chesapeake Bay. The county has a total area of 511 square miles, of which 372 square miles is land and 139 square miles is water.[16] There is one college (Chesapeake College).

Addressing health in the mid-shore region is somewhat divided at the moment. There are two groups focusing on rural health, and they run on parallel tracks. Thus, Secretary Schrader has asked the group to bring the work together and combine the needs assessments and recommendations in order to work from one plan.

The first group - the Maryland Rural Health Association set forth to update the state health plan during 2017 and was reaching all rural areas of Maryland. While Rural Maryland provides a rich culture for its community, it has negative implications in terms of access to health care. Across the 24 rural counties, they completed a Community Health Needs Assessment with a secondary data analysis and 2 focus groups from each county. Consumers identified that transportation, behavioral health treatment, and health insurance costs and network availability are barriers to care and service gaps. Providers also agreed that transportation and behavioral health treatment were barriers to access of care in addition to stable funding of resources. Consumers felt that the nursing program at Chesapeake College is a local asset to educating new healthcare workforce. This would help with the shortage of workforce. They also want telehealth option expanded to increase access to specialty healthcare. Providers felt that the mobile crisis team worked well in the community. Adding community dental clinics and pharmacy delivery programs would also work.[17]

The focus groups prioritized the health needs as obesity, behavioral health, and access to care. Consumers stated that potential solutions to the health needs of the community would be physician employment incentives to stay in the County, integrated health centers, and dental care for all. Physicians suggested a greater investment in youth programs and elderly services would address the health needs, along with additional behavioral health resources and programs.[18]

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[14] Prince George's County Health Department (2016). Prince George's County Community Health Needs Assessment.

[15] Prince George's County Health Department (2016). Prince George's County Community Health Needs Assessment.

[16] *"U.S. Decennial Census"*. United States Census Bureau. May 11, 2015.

[17] Maryland Rural Health Plan Draft (2017). Retreived from: http://www.mdruralhealth.org/wp-content/uploads/2017/09/Maryland-Rural-Health-Plan-2017-DRAFT.pdf

[18] Maryland Rural Health Plan Draft (2017). Retreived from: http://www.mdruralhealth.org/wp-content/uploads/2017/09/Maryland-Rural-Health-Plan-2017-DRAFT.pdf

Table: Data Retrieved from http://queenannes.md.networkofcare.org/

Health Care Specialty	Rate
Dental Care (# of Dentists)	**35.1/100,000**
Primary Care (# Physicians)	**39.1/100,000**
Other Primary Care Providers (# of NPs, Pas, etc)	**135.83/100,000**
Uninsured ED Visits	**5.1**

The second group – the Maryland Rural Health Workgroup convened as a result of the 2016 Legislative session. They were tasked with studying the health care needs in the five mid-shore counties - Caroline, Dorchester, Kent, Queen Anne's and Talbot. Public input was taken into account. The purpose of the study was examine challenges to health care delivery, including limited availability of health care providers and services, needs of vulnerable populations, transportation, and the economic impact of closing, partly closing, or converting health care facilities. The Work Group was also asked to review the benefits of telehealth and how the Maryland all-payer model can work to restructure the delivery of health care services in rural areas. Last, the Work Group was to recommend policy that can address the health care needs of mid-shore residents, and improve the health care delivery system.

It was recommended through the Rural Health Workgroup that this initiative evolve into the Rural Community Health Complex Program which would be based on primary care with specialty care connected in these geographically located complexes throughout the mid shore region. It would be governed by the Rural Health Collaborative, interested health care partners targeting to improve health outcomes for residents. A centralized electronic health record would connect providers. The purpose would be to provide access to care in centrally located placed throughout the shore region. This group would seek input from local communities with regard to needs assessments, programming etc. The collaborative would need to also address the significant shortage in workforce in the mid shore region as it pertains to primary care and mental health physicians, nurse practitioners, physician assistants, and other health care workers.

The state health plan has focused on health needs that should be addressed and the rural health workgroup has focused on developing a new care delivery model to pilot on the mid shore area. All of the information can be utilized to inform an approach to care delivery in Queen Anne's County.

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Within the past three fiscal years, has your hospital conducted a Community Health Needs Assessment that conforms to the IRS requirements detailed on pages 1-2 of these Instructions?

__X__Yes Provide date approved by the hospital's governing body or an authorized body thereof here: 2/23 /16 (mm/dd/yy)

____No

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

2. Has your hospital adopted an implementation strategy that conforms to the IRS requirements detailed on pages 3-4?

__X_Yes Enter date approved by governing body/authorized body thereof here: 09/29/16

___No

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

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

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

__X_Yes
___No

If yes, please provide a specific description of how CB planning fits into the hospital's strategic plan. If this is a publicly available document, please provide a link here and indicate which sections apply to CB planning.

AAMC's mission is ***to enhance the health of the people it serves. It is also guided by its core principles of compassion, trust, dedication, quality, innovation, diversity and collaboration***. In February 2010, the Governing Board adopted a 10-year strategic plan and outlined a vision of Living Healthier Together." That means that the care that AAMC provides is centered on the patient. AAMC operates beyond the walls of the hospital and serves a broad geography and diverse population of patients. Our work builds on partnerships, relationships and connectivity. We hold shared accountability among patients, physicians, hospital, employees and community. We are driven by standards based on evidence and outcomes while remaining viable, cost-effective, and responsible.

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

Specifically, AAMC FY2017 strategic initiatives that address the CHNA and community benefit are as follows:

Initiative: 1.2.1 Build surgical GME programs and apply for Residency Review Committee
Initiative: 2.1.2 Increase focus on health equity and improve measurement of health disparities
Initiative: 2.1.3 Implement Community Health Needs Assessment (CHNA) priority action plans
Initiative: 2.2.1 Develop health system wide care management program, focusing on Community based care management
Initiative: 2.2.2 Implement comprehensive palliative care program
Initiative: 2.2.3 Implement the system wide process of care redesign and clinical integration
Initiative: 4.1.2 Expand the ambulatory provider network
Initiative: 4.2.3 Develop comprehensive mental health program
Initiative: 4.3.1 Research virtual care strategy
Initiative: 4.3.2 Explore partnerships and affiliations to foster provider integration

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

i. Senior Leadership

1. __X_CEO
2. __X_CFO
3. __X_Other (please specify)) Chief Strategy Officer, Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, President of Foundation, Vice President of the Oncology Service Line, Vice President of the Women & Children's Service Line, Executive Director of Mental Health & Substance Use

Describe the role of Senior Leadership.

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

ii. Clinical Leadership

1. _X__Physician Chief Medical Officer, Medical Director – Oncology, Medical Director – Women & Children's, Chair, Clinical Integration
2. _X_Nurse Chief Nursing Officer, Senior Nursing Directors
3. __X_Social Worker
4. __X_Other (please specify) Registered Dieticians, Health Educators, Pharmacists

Describe the role of Clinical Leadership.

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

iii. Population Health Leadership and Staff

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

   Vice President of Clinically Integrated Care & COO
   Chair, Clinical Integration

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

   Director of Community Health Improvement
   Executive Director of Collaborative Care Network
   Senior Director of Care Coordination (system)
   Vice President, Quality & Compliance

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

In the FY16 CHNA, the population health leaders and staff were instrumental in determining priorities and funding to advance care coordination, data analytics, benchmark quality care metrics. The Vice President of Clinically Integrated Care developed and implemented key scorecard metrics to monitor progress. These metrics align with the initiatives outlined in Section III.1.a above.

Currently, the Population Health Team meets bi-weekly to review progress on programs and communications. Specifically, the team reviews progress on care integration. The team includes community partners such as the

Coordinating Center, the Department of Aging and Disabilities, area health departments, skilled nursing facilities, data analytics, and other organizations as necessary to review progress continue to collaborate on projects.

iv. Community Benefit Operations

1. ___the Title of Individual(s) (please specify FTE)

    - Director, Community Health Improvement (1.0FTE)
    - Community Health Education Specialist (1.0FTE)

2. ___Committee (please list members)

    - Director, Community Health Improvement
    - Manager, Community Health
    - Community Health Specialists (2.0FTE)
    - Community Health Nurse
    - Lead, Health Resource Nurse
    - Registered Dietitian (Ad hoc)
    - Supervisor, Women and Children's Health
    - Manager, Physician Relations
    - Cancer Prevention Supervisor
    - Cancer Prevention Outreach Worker
    - Supervisor, Education and Outreach for substance use prevention
    - Heart Health Nurse

3. ___Department (please list staff)

    - Director, Community Health Improvement
    - Manager, Community Health
    - Community Health Specialists (2.0FTE)
    - Community Health Nurse
    - Lead, Health Resource Nurse
    - Registered Dietitian (Ad Hoc)

4. ___Task Force (please list members)

    - Chief Operating Office
    - Chief Financial Officer
    - Chief Strategy Officer
    - Chief Medical Officer
    - Chief, Clinical Integration
    - Vice President, Health Care Enterprises
    - Director, Community Health Improvement
    - Patient Advisors (adhoc)

5. ___Other (please describe)

The Committee and Department maintain the on-going operations review, communication and documentation of CB activities. This group of educators across the organization (cancer prevention/ smoking cessation, women's health, Pathways/ substance use prevention, dietitians, community health nurses, and health educators) meet monthly through the Community Education and Outreach Committee. This group reports regularly on past activities and future opportunities for community education and outreach. They identify populations and geographic areas in need and topics of interest. This group is responsible for implementing many of the community benefit activities across the organization. They maintain on-going communication within AAMC and the community.

The Task Force meets 2 to 3 times per year to outline strategic objective for community benefit expense. This group identifies strategic priorities based on the Community Health Needs Assessment (CHNA) and the Annual Operating Plan (AOP). They ensure that community benefit, the AOP and the CHNA are in alignment. The group also audits the financial and narrative portions of the Community benefit report. Last, it is responsible to coordinate information dissemination to the Board for reporting and approval processes.

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

Spreadsheet ___X__yes _____no

Narrative ___X__yes _____no

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

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

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

Spreadsheet __X___yes _____no

Narrative ___X__yes _____no

If no, please explain why.

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

__X____Yes _____No

If yes, please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

AAMC partnered with UM-BWMC with the Care Transformation grant. The goal is to improve care coordination between patients, health care providers, and social service providers to improve access and health outcomes, eliminate repetition in care, and reduce overall cost. In addition, there was a focus to improve access to mental health services. Project expansion is often costly. While AAMC met budget for the grant, it was imperative to allocate community benefit expense to care coordination and mental health expansion. See Table III for specific information. Specifically, There was a community benefit expense of $670,128 for care coordination expansion and $765,743 for mental health expansion.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

shared processes and outcomes, measurement, mutually reinforcing evidence based activities, continuous communication and quality improvement, and a backbone organization designated to engage and coordinate partners.

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

__X___Other hospital organizations

__X__Local Health Department

__X___Local health improvement coalitions (LHICs)

__X___ Schools

__X___Behavioral health organizations

__X___Faith based community organizations

__X___Social service organizations

__X__Post-acute care facilities

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct a CHNA. Provide a brief description of collaborative activities indicating the roles and responsibilities of each partner and indicating the approximate time period during which collaborative activities occurred (please add as many rows to the table as necessary to be complete).

Organization	Name of Key Collaborator	Title	Collaboration Description
Anne Arundel County Department of Health	Jinlene Chan; AZ Snyder	Health Officer & Director of Planning	Lead in CHNA collaboration; Collaboration with LHIC (Obesity prevention, Co-Occurring, and Access to care committees)
UM-BWMC	Becky Paesch; Laurie Fetterman	Senior VP of Strategic Planning; Manager Strategic Planning	Partner in conducting CHNA; LHIC support (see above), BATP implementation, infant mortality reduction
Partnership for Children Youth & Families	Pam Brown	Executive Director	Author of CHNA, LHIC partner and support

Anne Arundel County Mental Health Agency	Adrienne Mickler	Director	Partner in Conducting CHNA; LHIC partner and support
Anne Arundel Department of Aging	Karissa Gowin	Assistant Director	Provided input to CHNA; Collaboration with LHIC BATP
Anne Arundel County Office of the County Executive	Yveola Peters	Community	Assisted with identifying/promoting focus groups; LHIC Support

CHNA Partners and Projects

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

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

CHNA Methodology

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

The remainder of the report was researched and written via Pam Brown, Partnership for Children Youth and Families in Anne Arundel County. Dr. Brown has extensive expertise in conducting qualitative research and she is a collaborative

community partner. The qualitative data was derived from a series of key informant interviews and focus groups with county leaders and residents. The interviews depicted qualitative data gathered from 12 key informants:

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

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

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

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

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

1. Improved care coordination for patients with chronic conditions, including care transitions and care coordination. NOTE: Chronic conditions include heart disease, cancer, and diabetes as outlined in Chapter 1 of the CHNA.

2. Mental health and substance use

    a. Increase number of beds for mental health and substance abuse, including adolescents

    b. Integration of mental health at primary care level

    c. Increase/ improve access to psychiatrists, including Spanish speaking providers

3. Infant Mortality

4. Senior In Home Care - Palliative Care

5. Improved resource planning for North County and South County

a. Increase number of community clinics

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

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

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

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

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

__X___yes _____no

If the response to the question above is yes, please list the counties for which a member of the hospital organization co-chairs the LHIC.

Anne Arundel County

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

___X__yes ____no

If the response to the question above is yes, please list the counties in which a member of the hospital organization attends meetings or is a member of the LHIC.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

Please use Table III to provide a clear and concise description of the primary need identified for inclusion in this report, 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.

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

a. 1. Identified need: This may have been identified through a CHNA, a documented request from a public health agency or community group, or other generally accepted practice for developing community benefit programs. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include a description of the collaborative process used to identify common priority areas and alignment with other public and private organizations.

   2. Please indicate how the community's need for the initiative was identified.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based community health improvement initiatives may be found on the CDC's website using the following links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/), or from the County Health Rankings and Roadmaps website, here: http://tinyurl.com/mmea7nw.
   (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 or other negative health factor 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,

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. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.

h. Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.

   Describe here the measure(s)/health indicator(s) that the hospital will use to evaluate the initiative's impact. The hospital shall evaluate the initiative's impact by reporting (in item "i. Evaluation of Outcome"):

   (i) Statistical evidence of measurable improvement in health status of the target population. If the hospital is unable to provide statistical evidence of measurable improvement in health status of the target population, then it may substitute:

(ii) Statistical evidence of measureable improvement in the health status of individuals served by the initiative. If the hospital is unable to provide statistical evidence of measureable improvement in the health status of individuals served by the initiative, then it may substitute:

(iii) The number of people served by the initiative.

Please include short-term, mid-term, and long-term population health targets for each measure/health indicator. These should be monitored and tracked by the hospital organization, preferably in collaboration with appropriate community partners.

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? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)

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? If not, why? 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, and grants associated with the fiscal year being reported.
B. Of the total costs associated with the initiative, what amount, if any, was provided through a restricted grant or donation?

NOTE: Table III are based on the priorities from FY2016 Community Health Needs Assessment.

Table III – Care Coordination

A. 1. Identified Need: A. 2. How was the need identified:	Improved community care coordination for patients with chronic disease. Through a combination of staff and outsourcing, AAMC is focusing on care management across a continuum of care, including patients with complex, high needs, patients with chronic conditions at "rising risk", readmissions, transitional care and specialized needs (e.g., pharmacist for medication reconciliation, COPD navigator). FY16 Community health Needs Assessment and Transformation Grant through HSCRC.
B: Name of hospital initiative	Implement community based care coordination for high risk patients to reduce unnecessary utilization. • Increase care coordination by partnering with The Coordination Center and Johns Hopkins Health Care • Provide Transportation Vouchers • Implement Pulmonary Health navigator
C: Total number of people within target population	11 % percent of Medicare beneficiaries are eligible for Medicaid. FY 2015 the BATP hospitals provided care to a total of 23,477 Medicare patients, = $260.5M. Of those, 1,152 are Medicare high-utilizers (>= 3 Inpatient/Observation >=24 hour visits in 12 months), representing $52.8M in total charges and 5,738 visits. Of the 1,152 high-utilizing Medicare patients, 590 visited AAMC, 705 visited UM BWMC, and 143 (12%) visited both hospitals. This Medicare high-utilizer population represents 5% of the 23,477 AAMC/UM BWMC Medicare patients, and 20% of the hospital-related cost of that same population.
D: Total number of people reached by the initiative	5,281
E: Primary objective of initiative:	Reduce un-necessary utilization and charges for chronic disease patients who frequent acute care settings. Improve the self management skills of these patients and families.
F: Single or multi-year plan:	Multi-year Plan
G: Key collaborators in delivery:	AAMC is partnering with hospital staff, UM-BWMS, The Coordinating Center, CRISP, Anne Arundel County Department of Aging and Disabilities, Care Managements Services by Johns Hopkins Healthcare and Healthy Anne Arundel. Other groups that participate are skilled nursing facilities, home health agencies, and hospice providers.
H: Impact of hospital initiative:	AAMC – 3-month pre/post – Medicare FFS - 244 patients had a decrease in charges of $2,831,773. All-Payer results for the same time period for 296 patients demonstrated a decrease in charges of $3,241,397. (NOTE: This is

	for all Medicare duals engaged in the care transformation project that is grant funded through HSCRC. At this point, AAMC cannot determine individual impact of programs, but AAMC can measure the overall change).		
I: Evaluation of outcome	Approximately 55% of patients agree to care coordination services in the outpatient setting. Of those accepting services, nearly 50% reached their care goals with their care manager. Approximately, $6300 per Medicare recipient was saved as a result of on-going care management in a community setting.		
J: Continuation of initiative:	Yes, AAMC is launching a new care management re-design and implementation to further expand care coordination across the ambulatory and community settings.		
K: Expense:	a.Total cost: **$1,055,128.00**	b. offsetting revenue **$385,000.00**	c. Community Benefit **$670,128.00**

Table III – Mental Health

B. 1. Identified Need: A. 2. How was the need identified:	Expansion of Mental Health Services (outpatient) FY16 Community Health Needs Assessment
B: Name of hospital initiative	1. Open partial Hospitalization Program 2. Implement Behavioral Health Navigators
C: Total number of people within target population	The Emergency Department rate for Mental Health Disorders (SHIP data) for Anne Arundel County is 4509/100,000 (highest of the service area) and it is above the Maryland goal. The suicide rate in 10.4/100,000 and it is also above the Maryland goal. Anne Arundel County rates are used since they are the highest in the service area.
D: Total number of people reached by the initiative	186 Encounters – Partial Hospitalization Program (Note: Program was opened during FY17) 1,048 Encounters – Behavioral Health Navigators
E: Primary objective of initiative:	The Partial Hospital Program (PHP) is a time-limited, structured program of psychotherapy and other therapeutic services specifically designed to meet the mental health needs of persons in an acute psychiatric crisis. The program provides approximately six and half hours of structured treatment Monday through Friday. The program treats both adults and adolescents 13 years of age and older who meet medical criteria for admission. The psychiatric partial hospitalization program provides emergency coverage 24 hours per day, seven days per week to all patients enrolled in the program. These services are intended to be the first level of crisis intervention whenever needed by the patient. The program provides these services by phone, and face-to face, if warranted by the patient's presentation, during the program's operating hours. After hours, the program provides an emergency phone number that will access a clinician and/or physician directly. The responding clinician provides a brief assessment and intervention by phone. It is expected that patient's experiencing an acute psychiatric crisis can be treated in this setting without the need to go to an ED, unless experiencing suicidality. Patients can be referred by their PCP or treating psychiatrist without the need for a visit to the ED. The BHN program was developed to assist primary care, pediatric and OB/GYN physicians in assessing and linking their patients 13 years and older who require immediate mental health and SU services, with appropriate treatment within a 48-hour time period.
F: Single or multi-year	Multi-year Plan
G: Key collaborators in delivery:	Participating Hospital Staff (AAMC) Anne Arundel County Department of Health, Anne Arundel Mobile Crisis Unit, community mental health

	providers, LHIC and its partners .	
H: Impact of hospital initiative:	Rates for mental health in the area have not improved at this time. Yet, AAMC is still building the program to meet the needs of the community. It is expected that the programs will have positive impact in the future.	
I: Evaluation of outcome	The mental health program has seen 186 patients through the partial hospitalization program and served 1,048 referrals for behavioral health.	
J: Continuation of initiative:	Yes, AAMC is launching a new care management re-design and implementation to further expand care coordination across the ambulatory and community settings.	
K: Expense:	Total Direct Costs **$765,743.0**	Net Community Benefit **$765,743.00**

Table III – Substance Use

C. 1. Identified Need: A. 2. How was the need identified:	Substance Abuse Yes this was identified through the CHNA process.
B: Name of hospital initiative	3. Pathways Family Wellness Workshops 4. Access to treatment vis 12 step recovery programs and Charity Care 5. Community education related to substance use disorders, including opioid use prevention education 6. Community collaborations to expand reach.
C: Total number of people within target population	ED visits for Substance Use Disorders (S.H.I.P Data) is 1541.3/100,000and it is above the MD 2017 goal. The drug induced death rate in Anne Arundel County is 20.3 compared to the state goal of 12.3 (Anne Arundel County rates are used since they are highest in the service area)
D: Total number of people reached by the initiative	7,457
E: Primary objective of initiative:	#1 Provide on-going weekend retreats to support families affected by substance abuse #2 Reduce the burden of substance abuse in the County; Provide immediate access to substance use providers to patients, particularly underserved #3 Prevent children from using/ abusing substances #4 Educate physicians, providers, and pharmacists about the dangers of opioid prescription over use.
F: Single or multi-year plan:	Multi-year Plan
G: Key collaborators in delivery:	Hospital Staff (AAMC), Anne Arundel County Public School Staff, Anne Arundel County Department of Health, Anne Arundel County Department of Juvenile Justice, Anne Arundel County Courts, Anne Arundel County Department of Health, Anne Arundel Mental Health Agency, Partnership for Children Youth and Families, UM BWMC, and the County Executive's Office
H: Impact of hospital initiative:	Pathways sponsored 19 Family Wellness weekends that served 224 individuals. AAMC sponsored 12 step and recovery programs on campus for 300 encounters. A health educator worked in schools and community organizations to provide education on substance use prevention to 6000 students. AAMC

	provided 300 individuals with free recovery care. A Community Health Nurse provided education to 25 provider offices.		
I: Evaluation of outcome	There are not enough substance use providers in the County to affect change at this time. However, the County Executive's Office has implemented new task forces to further advance this work.		
J: Continuation of initiative:	Yes, substance abuse are significant needs in the County.		
K: Expense:	Total Direct Costs $404,677.00	Grant: $21,890.00	Net Community Benefit $380,447.00

Table III – Palliative Care

D. 1. Identified Need: A. 2. How was the need identified:	Palliative Care for patients with advanced chronic disease Yes this was identified through the CHNA process.		
B: Name of hospital initiative	AAMC Palliative Care Program – Inpatient and Outpatient clinics		
C: Total number of people within target population	It is estimated that the growth of seniors in the County will from 99,086 to 140,000 and have an exponentially increasing impact on resources and health care		
D: Total number of people reached by the initiative	1,613 encounters		
E: Primary objective of initiative:	Provide specialized medical care for people with serious illnesses or conditions to improve quality of life for patients and their families and to provide care and treatment that is consistent with patients' values. This includes helping patients find relief from symptoms, pain and stress.		
F: Single or multi-year plan:	Multi-year		
G: Key collaborators in delivery:	AAMC, Hospice of the Chesapeake, Chesapeake Palliative Medicine, Anne Arundel County Department of Aging and Disabilities, Seasons Hospice, Compass Hospice, and patients and family advisors		
H: Impact of hospital initiative:	The team reached 5.66% of inpatient hospital discharges (goal is 6%). The team saw 1,418 inpatients and nearly 200 patients in the ambulatory clinic.		
I: Evaluation of outcome	See above. Healthcare costs and patient satisfaction will be the primary measures of success for FY18 and beyond.		
J: Continuation of initiative:	Yes, this is a new initiative for AAMC.		
K: Expense:	Total Direct Costs $634,326	Grant: $0	Net Community Benefit $634,326

Table III – Infant Mortality

E. 1. Identified Need: A. 2. How was the need identified:	Infant Mortality 2016 Community Health Needs Assessment
B: Name of hospital initiative	1. Breast Feeding Support Program 2. Safe Sleep Promotion and Education 3. Free childbirth care to underserved communities
C: Total number of people within target population	Anne Arundel County: Infant mortality rate for all babies in the County = 5.7/1000. 12.9/1000 for Blacks. Low birth weight (risk factor) is 8.9/1000 for all babies. 13.9/1000 for Blacks. Prince George's County: 8.9/1,000 births (over the state average) Queen Anne's County: n/a
D: Total number of people reached by the initiative	23,792 encounters
E: Primary objective of initiative:	Increase awareness in the community regarding good infant care. • Promote breastfeeding concepts in all populations. This is advocated by March of Dimes to improve infant health. • Promote and educate all parents and families about safe sleep options. In Anne Arundel County, SIDS cases doubled last year due to unsafe sleep habits. • Low income women cannot afford childbirth classes. AAMC educators brought and taught the classes in the communities.
F: Single or multi-year plan:	Multi-Year
G: Key collaborators in delivery:	Participating Hospital Staff (AAMC), Anne Arundel County Department of Health, March of Dimes, Centro De Ayuda (Center of Hope), Chrysalis House, Housing Authority of the City of Annapolis, schools, faith based organizations.
H: Impact of hospital initiative:	Safe Sleep education – reached 23,000 individuals Free childbirth classes to underserved women – 552 encounters Breastfeeding support – 240 encounters
I: Evaluation of outcome	AAMC is collaborating with the health department and UMBWMC to coordinate efforts across the county to engage women in prenatal care earlier. Infant Mortality has remained the same in most of the population, but it has decreased from 16.1/1000 to 12.9/1000 for Blacks since 2012. (Anne Arundel County Report Card). AAMC provides free education at Centro De-Ayuda and at Chrysalis House

	in Anne Arundel County. We will expand free education services in Prince George's and Queen Anne's Counties in FY18.		
J: Continuation of initiative:	Yes.		
K: Expense:	Total Direct Costs $15,400	Grant: $0	Net Community Benefit $15,400.00

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples: the fact that another nearby hospital is focusing on that identified community need, or that the hospital does not have adequate resources to address it.) This information may be copied directly from the section of the CHNA that refers to community health needs identified but unmet.

We followed an unbiased process to narrow more than 50 community health needs to the top 5priorities. While it would be ideal to address each of the 50 needs, unfortunately the needs to be address outstripped the resources of any one organization.. Therefore a methodology to determine prioritization was utilized;). First, a visual model of the CHNA was developed to condense a 150+ page document into a workable tool. Executive council, service line leaders, and patient advisors were convened to review the model and review the findings of the CHNA. Participants were asked to rank their top 3 priorities of health needs and recommendations, with 1 being the highest ranked need. Ballots were collected and weighted values were recorded for those needs that were ranked.

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

Finally, recommendations and needs were grouped to together to determine the final five prioritized health needs. Senior Leadership approved the needs in June, 2016. The implementation plan was written and board approved as of September 29, 2016.

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

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

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

PHYSICIANS

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

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

   Maryland fares better at a 9 percent rate of insured residents as compared to Maryland (12 percent) and the US (11 percent). However, access to primary care and other specialties is worse in Anne Arundel County as compared to Maryland and the US. In fact, the patient to primary care physician ratio in Anne Arundel (1430:1) is worse than in Maryland (1045:1) and the U.S. benchmark (1131:1) meaning that more individuals are seeking care from fewer providers. This shortage results in seriously limited access to primary care in parts of our Community Benefit Service Area. Building primary care access is essential to the hospital's strategic plan, Vision 2020. Increased accessibility and coordinating health care increased the focus on prevention and improving the population health of our CBSA. [19]

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

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	Breast Center, Oncology Center, Obstetric Care, survivorship program, pain management center, and surgical specialists
Non-Resident House Staff and Hospitalists	AAMC would not be able to maintain coverage for 24 hours a day/ 7 days per week. This includes hospitalist and intensivist service, obstetrics, and the pediatric hospitalist teams.
Coverage of Emergency Department Call	AAMC reimburses them for charity care and call coverage. Our ED serves over 90,000 patients per year and this subsidy ensures that patients have access to high quality physician care.
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	Primary care, psychiatry and surgeons (All noted in CHNA as needed provided)
Other – (provide detail of any subsidy not listed above – add more rows if needed)	Hospice, Behavioral Health Program

[19] County Health Rankings (2016) Robert Wood Johnson Foundation.

Attachment A

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

- Increase life expectancy

AAMC focuses on prevention of disease. As a result, we provide over 200 health talks and health fairs (1,556 hours) and community benefit $78,92660, flu shot clinics (1,401 vaccines provided and $48,366 community benefit), blood pressure and cholesterol screenings (5,015 hours and community benefit $162,002), vascular screenings (community benefit $65,000) that advise and guide community members to better health.

- Reduce infant mortality

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

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

AAMC provides on-going Living Well with Diabetes in partnership with the Anne Arundel County Department of Aging (Community Benefit $18,800). A newly established Diabetes program started FY16, so additional care plans, standard orders, and staff education will be provided to reduce re-admissions from diabetes. In FY17, considerable work was done to implement processes and care management to better support patients from in-patient to out-patient to prevent re-admissions. AAMC has a pediatric nurse navigator (grant funded, no community benefit associated with this initiative) to work with high risk children to prevent asthma admissions. Another care manager works with adults to manage post-discharge patients who have COPD and CHF. Often patients who are admitted through the ED do not have primary care physicians. AAMC established 2 clinics for primary care to better manage hypertension, establish follow up patients, etc. (Community Benefit $931,584).

- Reduce the % of adults who are current smokers

AAMC supports a 2.0FTE Tobacco Cessation Specialists to promote Community Health Education about the effects of smoking (heart and lung disease, etc.) to adults, adolescents and children through a variety of forums including but not limited to schools, faith based organizations, neighborhood meetings, etc. We reached 10,000 individuals in FY17. This staff also helps current smokers quit. An additional 4,100 encounters were captured in FY17. AAMC has been committed to provide these services for over 20 years and the current adult smoking rate is 15.5% which is slightly higher than the Maryland rate, but meets the 2017 target. ($213,490 Community Benefit)

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

AAMC supports a 2.0FTE Tobacco Cessation Specialist to promote Community Health Education about the effects of smoking (heart and lung disease, etc.) to adults, adolescents and children through a variety of forums including but not limited to schools, faith based organizations, neighborhood meetings, etc. We reached 10,000 individuals in FY17. AAMC also supports an additional 1.0FTE Tobacco Cessation Specialist to help current smokers quit. An additional 4,100 encounters were captured in FY17. AAMC has been committed to provide these services for over 20 years and the current adult smoking rate is 19.1% which is higher than the Maryland rate and the 2017 target. (Included in previous bullet point)

- Reduce the % of children who are considered obese

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

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

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

- Increase the % vaccinated annually for seasonal influenza

AAMC vaccinates all 4,800 employees, 1,100 physicians, vendors, patients and visitors to the campus. Not all of this is community benefit, but 1400 vaccinations were provided to the community at large for a total community benefit of $39.966.

- Increase the % of children with recommended vaccinations

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

- Reduce new HIV infections among adults and adolescents

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

- Reduce diabetes-related emergency department visits

AAMC has expanded access to primary care providers via 2 sliding scale clinics, Fast Care Centers, Kent Island urgent Care Center, and another primary clinic in collaboration with Arundel Lodge. Furthermore, medication reconciliation was performed with many at-risk patients. Free Living Well with Diabetes Classes were provided to the community free of charge. The Diabetes and Endocrine Center at AAMC provided free care to patients who could not afford it. Over 20,000 encounters were provided in FY16 and a Community Benefit of $1,978,481.

- Reduce hypertension related emergency department visits

AAMC has expanded access to primary care providers via 2 sliding scale clinics, Fast Care Centers, Kent Island urgent Care Center, and another primary clinic in collaboration with Arundel Lodge. Furthermore, medication reconciliation was performed with many at-risk patients. AAMC also invested in a Community Health Nurse to run community based education programs. 11,000 encounters were provided in FY17 and a Community Benefit of $1,541,244. Also refer to Table III, Initiative 1.

- Reduce hospital ED visits from asthma

See above.

- Reduce hospital ED visits related to mental health conditions

See Table III, Initiative 2

- Reduce hospital ED visits related to addictions

See Table III, Initiative 4

- Reduce Fall-related death rate

See Table III, Initiative 1.

Appendix 1

AAMC's Financial Assistance Policy

Description

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

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

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

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

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

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

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

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

Appendix II

AAMC's Financial Assistance Policy

Changes since the ACA

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

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

	Patient Financial Services – Hospital Financial Assistance, Charity Care, Billing & Collection Policy
Dates Previously Reviewed/Revised: **Newly Reviewed By:** **Effective Date: December 1, 1997** **Review Date: August 15, 2012** **F&A Committee Approval: September 21, 2012** **Board of Trustees Approval: September 27, 2012**	**Owner:** Director of Patient Financial Services Reviewed (date & initials): _____
Approver Title: Chief Financial Officer _____ Approval Signature	

Scope: Anne Arundel Medical Center

Policy Statement:
To promote access to all for medically necessary services regardless of an individual's ability to pay, to provide a method of documenting uncompensated care and to ensure fair treatment of all applicants and applications

Purpose:
- To assure the hospital communicates patient responsibility amounts in a fair and consistent manner.
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices, effective June 1, 2009
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To define the hospital's decision making process for referral for collection or legal action.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices, effective June 1, 2009

Hospital Financial Assistance Communications
- The Financial Assistance Signage is conspicuously displayed in English & Spanish in the Emergency Department, Cashiering & Financial Counseling.
- Financial Assistance Policy as well as a printable Uniform Financial Assistance application is posted on the AAMC website.
- English/Spanish table top tents display this information at every patient entry point and it is included in each patient guide located in the inpatient rooms.
- Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.
- The financial assistance application is available at all registration points – but in particular the Emergency Department.

Thank you for choosing Anne Arundel Medical Center for your health care needs. We understand this can be a challenging time for our patients, and we know that the financial aspect of hospitalization sometimes can be confusing.

To take the confusion out of the payment process, our Patient Financial Services Team is available to help you understand your hospital bill. We also can help you with payment options, including whether you are eligible for financial assistance through federal and state programs. We can answer general questions about the manner in which your insurance company processed your bill.

We have prepared this brochure to help answer the most commonly asked questions about billing. If your specific question is not listed here, please contact 443-481-6500 Monday – Friday between 8:30 a.m. and 4:00 p.m.

Patient Financial Services Resources

Our Financial Counseling team is located at the Medical Park Campus, 2001 Medical Parkway, Annapolis, Maryland.

You may make an appointment to meet with a financial coordinator by calling:

Financial Assistance 443-481-1401

Medical Assistance application 443-481-1401

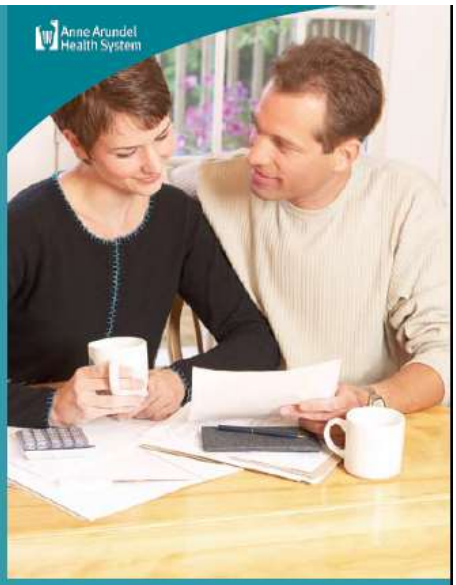
Payment Arrangements 443-481-1401

If you have received a bill and have questions or wish to discuss payment arrangements you may call:

Questions about your bill 443-481-6500

Payment Arrangements..... 443-481-6500

Anne Arundel Health System



Patient Billing Information Q&A

Patient Billing Information Q&A

What is included in my hospital bill?
Your bill from Anne Arundel Medical Center is for services you receive from nurses, social workers, dietitians, therapists and other staff. It also includes charges for your room, meals, linens, supplies, medications, diagnostic tests and supervised professional services, such as those of respiratory and physical therapists.

What is not included in my hospital bill?
You will be billed separately by your physicians, consulting physicians, and surgeons for services they provide to you. These services are NOT included in your hospital bill. Each physician who cares for you will send you a separate bill for services they provided. This includes physicians who may have treated you in the Emergency Department; those you may never see, including physicians who interpret diagnostic studies, such as X-rays, EKGs, and certain laboratory specimens; and anesthesiologists, staff pediatricians or internal medicine physicians who may have treated you during your stay.

How does health insurance billing work?
When you receive services at Anne Arundel Medical Center, we will bill your health insurance provider on your behalf. To do this, and to assure the hospital is paid for services provided to you, we need a copy of your insurance card. We must supply complete and accurate information to your health plan, including your full name, address, phone number, date of birth, and Social Security number. Incomplete or incorrect information could mean a denial from your insurance provider. You could be held responsible for the balance of the invoice when an insurance provider delays, denies, or makes partial payment. Your insurance company may also require that you make your co-payment at the time of service.

If you cannot or will not provide complete insurance and subscriber information Anne Arundel Medical Center cannot submit your bill to your insurance company. If that is the case, you will be a "self pay" patient and we will ask you for a deposit for services. All cosmetic services and services not deemed medically necessary by your insurance company must be paid in full and in advance of the service.

What if I Have a Managed Care or HMO Plan?
If you have a managed care or HMO plan and you are admitted to our emergency room, your plan may require you to contact your local office to obtain authorization for your admission within 24 hours of an emergency admission. Your health insurance card should provide you with your plan's telephone number. Anne Arundel Medical Center staff will attempt to contact your insurance plan with notification of your inpatient admission. Most HMO plans require you to obtain a referral or authorization for certain non-emergency services. Anne Arundel Medical Center will help you obtain the authorization.

Many HMOs require you to receive diagnostic services such as laboratory tests and X-rays at a designated provider, not at the hospital's outpatient department.

What if my visit involves worker's compensation?
If we do not receive worker's compensation information from you or your employer you will be responsible for your bill. It is important that you provide your medical insurance benefit information as well, so any required authorizations or other steps to ensure coverage are followed. This will assist in protecting you and the hospital financially should worker's compensation deny payment. We need a copy of the denial in order to bill your insurance.

What if my visit is due to a motor vehicle accident?
Anne Arundel Medical Center does not bill auto insurance providers. MVA patients are responsible for payment of services provided. It is important that you provide your medical insurance benefit information as well, so any required authorizations or other steps to ensure coverage are followed. This will assist in protecting you and the hospital financially should the auto insurance deny payment. We need a copy of the denial in order to bill your insurance.

What does Medicare Cover?
"Medical Necessity" is a term used by Medicare to describe the services Medicare feels are "reasonable and necessary" for the treatment or diagnosis of an illness or injury. In most cases Medicare provides payment for "medically necessary" services. If your physician prescribes a service that may not be covered by Medicare you will be asked to sign an Advance Beneficiary Notice before service is provided stating that Medicare is not likely to pay for the service. By signing this form you agree to be responsible for payment.

What are my options under Medicare?
If you have an Advance Beneficiary Notice you can sign it and agree to pay for the services yourself or you can refuse the service or treatment. If you refuse the service or treatment, we encourage you to talk with your physician about options that would be covered under Medicare. You have the right to appeal a Medicare decision of non-coverage. If you would like to file an appeal or have other Medicare-related questions, please call the Medicare Beneficiary Hotline at 1-800-633-4227.

What if I can't pay on time?
We understand that certain circumstances may make it difficult for you to pay your bill on time. However, if your account becomes past due, Anne Arundel Medical Center will take action to recover the amount owed. Please call 443-481-6500 between the hours of 8:30 a.m. – 4:00 p.m., Monday through Friday, to discuss your circumstances. We want to help you protect your credit.

What if I am unable to pay any portion of my bill?
If you are unable to pay your bill we can help you apply for state and federal programs that may pay all or a portion of your bill. Please call 443-481-1401 for assistance. Anne Arundel Medical Center offers financial assistance for those who do not qualify for state or federal programs but meet certain federal poverty guidelines. Also, you may be eligible for a partial reduction on the amount you owe.

For more information about patient financial services resources and telephone numbers, see the back of this brochure.

Appendix V

Mission: To enhance the health of the people we serve

Vision 2020: Living Healthier Together

Values:

COMPASSION

It happens in a hundred different ways every day. An encouraging word for a patient. Empathizing with a family. Making a co-worker's day a little smoother. Compassion is at the heart of our mission.

TRUST

This is the foundation of our culture -- patients and families putting their trust in us.

DEDICATION

Caring for patients requires selflessness and teamwork. We are thousands of people in jobs of every description all committed to the same goals.

QUALITY

Quality means meeting the high standards of excellence we expect of each other and that our patients deserve. Together we achieve better outcomes and experiences.

INNOVATION

Since our founding in 1902, we have been at the forefront of advancements in technology and patient care to benefit the people of our communities.

DIVERSITY

We benefit and draw strength from our differences. Diversity is our daily experience, a journey – not a destination.

COLLABORATION

In partnership with many, we work together toward our vision: *living healthier together*.