COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

FY2017 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

MedStar Franklin Square 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 hospital and community based organizations to increase the impact of their efforts in the communities they serve. It is essential that hospital organizations work with community partners to identify and agree upon the top priority areas, and establish common outcome measures to evaluate the impact of these collaborative initiatives. Alignment of the community benefit operations, activities, and investments with these larger delivery reform efforts such as the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system.

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 are Medicare beneficiaries
353 Source: MFSMC Finance	23,875 Source: MFSMC Finance	21221 21220 21222 21237 21234 21236 Source: HSCRC PSA Report, 2017	University of MD Mercy Medical Center, Inc. Johns Hopkins Union Memorial Johns Hopkins Bayview Medical Center Union of Cecil County Greater Baltimore Medical Center Good Samaritan St. Joseph Source: HSCRC PSA Report, 2017	1.29% Source: MFSMC Quality Department	22.17% Source: MFSMC Quality Department	42.06% Source: MFSMC Quality Department

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.	CBSA includes residents living in zip codes 21206, 21219, 21220, 21221, 21222, 21224* Focus area : 21221 This geographic area was selected as MedStar Franklin Square Medical Center's CBSA as a result of the longstanding collaborative partnership with the Baltimore County Southeast Area Network (Southeast Network) for its community benefit efforts. *Zip Code designation was listed incorrectly in the CHNA. Programming and reporting reflect correct zip codes.	MedStar Health 2015 Community Health Needs Assessment http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf
Median Household Income within the CBSA	Baltimore County - $67,095 CBSA Range: $48,390 - $58,738 Focus Area (21221) - $51,540	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates 2015 Table https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table MedStar Health 2015 Community Health Needs Assessment http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf
Percentage of households in the CBSA with household income below the federal poverty guidelines	Baltimore County – 6.3% CBSA Range: 8.9% - 16.3% Focus Area (21221) – 9.3%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table

		MedStar Health 2015 Community Health Needs Assessment http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf
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	3.4%	http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml
Percentage of Medicaid recipients by County within the CBSA.	Baltimore County – 17.0%	2016 Maryland Medicaid e Health Statistics http://www.chpdm-ehealth.org/mco/index.cfm
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/Pages/Home.aspx	MD 2017 Ship Goal: 79.8 All Races: 79.1 White: 79.1 Black: 78	MD Vital Statistics Annual Report 2015 https://health.maryland.gov/vsa/Documents/15annual.pdf
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx	Mortality Rates (per 100,000 residents) All Races – 978.7 White – 1281.5 Black – 663.7 American Indian – 391.4 Asian or Pacific Islander - 222.8 Hispanic – 164.1	MD Vital Statistics Annual Report 2015 https://health.maryland.gov/vsa/Documents/15annual.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)	Annual number of days with daily 8-hour maximum ozone concentration over the National Ambient Air Quality Standard: Baltimore County - 15 Percent of zip codes in county with a healthy food outlet: Baltimore County – 76.5% Liquor store density rate:	http://ship.md.networkofcare.org/ph/county-indicators.aspx

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	Baltimore County - 2.1 National – 1.0 Homicide mortality rate: Baltimore County - 6.0 National – 5.1 Percent of population age 25+ with 4-year college degree or higher: Baltimore County 35.6 National 29.1 Percent of population age 16+ unemployed and looking for work: Baltimore County 6.2 % National 6.2 % Students in public schools who are eligible for free lunch: Baltimore County 38.5 %	
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	White – 64.6% Black - 26.1% American Indian 0.3% Asian 5% Baltimore County English only 85% Spanish 5%, Limited English speaking household 1% Other 10%, Limited English speaking household 2%	https://www.baltimorecountymd.gov/Agencies/economicdev/meet-baltimore-county/stats-and-figures/county-demographics.html#population-by-race U.S. Census Bureau, 2016 American Community Survey 1-Year Estimates

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: 4/7/2015

____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://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf (pg.9-12)

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: 4/7/2015

___No

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

http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf (pg.9-12)

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.

MedStar Health's vision is to be the trusted leader in caring for people and advancing health. As part of MedStar Health's fiscal 2018-2020 system strategic plan (which acts as the umbrella plan for all MedStar hospitals), community health and community benefit initiatives and tactics are organized under the Evolving Care Delivery Model domain, with recognition of health disparities and an aim to integrate community health initiatives into the interdisciplinary model of care.

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. ___CFO
3. ___Other (please specify)

Describe the role of Senior Leadership.

MedStar Franklin Square Medical Center's Board of Directors, CEO and the organization's operations leadership team work thoroughly to ensure that the hospitals strategic and clinical goals are aligned with unmet community needs through the planning, monitoring and evaluation of its community benefit activities.

ii. Clinical Leadership

1. X Physician
2. X Nurse
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

The Community Medicine Service Director (Physician) is on the Board Community Health Improvement Committee which oversees the planning, implementation and evaluation of community benefit activities, supervises the Community Health department and participates in the Community Health Needs Assessment Advisory Task Force.

The Administrative Director, Population Health (RN) is on the Board Community Health Improvement Committee which oversees the planning, implementation and evaluation of community benefit activities and facilitates the CHNA and the CHNA Advisory Task Force.

iii. Population Health Leadership and Staff

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

Vice President of Medical Affairs designated to serve as the Community Health Executive Sponsor to ensure community benefit processes and activities align with hospital's strategic priorities and population health efforts.

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

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

The Administrative Director of Population Health is on the Board Community Health Improvement Committee which oversees the planning, implementation and evaluation of community benefit activities and supports population health strategy, design, implementation and evaluation.

iv. Community Benefit Operations

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

a. Financial Services Manager (1FTE)

b. Community Health Advocate (1FTE)
c. Administrative Director of Population Health (1FTE)

2. X Committee (please list members)
3. X Department (please list staff)
4. X Task Force (please list members)
5. ___Other (please describe)

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

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

Health Advocate gathers information and enters it into the reporting database.

The Administrative Director of Population Health compiles and validates the report.

The Community Health Improvement Committee provides oversight and direction to ensure a coordinated and comprehensive approach to identifying, developing, implementing, and evaluating programs that address the health needs of MedStar Franklin Square Medical Center's community. Membership includes:

- Chair: Board member
- Hospital President
- Community Service line Director
- Community Health Manager
- Population Health Administrative Director
- Board members
- Physicians
- Baltimore County Government representative
- Non-board member community business representatives
- Non-board member community representatives
- Finance Representative
- Vice President of the Philanthropy

The Population and Community Health Department plans, coordinates, implements, evaluate and reports community benefit activities, including the CHNA process. Staff includes:

- Administrative Director, Population Health
- Clinical Nurse Specialist
- Education Specialists
- Community Health Advocates

CHNA Advisory Task Force: The ATF participates in the development and implementation of the strategic community benefit plan. Membership:

Name	Organization	Title
Nick D'Alesandro	BC Social Services	Social Worker
Megan Doty	MSFSMC	Marketing Specialist
Tricia Isennock	MSFSMC	Administrative Director, Population Health
Terri Kingeter	Planning Office	Sector Coordinator
Scott Krugman	MSFSMC	Community Medicine

		Service Line Director
Stuart Levine	MFSMC	Vice President Medical Affairs
Patricia Norman	MSFSMC	Board Member
Sally Rixey	MSFSMC	FHC Chief of Family Practice
Don Schlimm	BC Local Mgt. Bd.	Acting Executive Director
Tobie-Lynn Smith	HCHBC	Medical Director
Rene Youngfellow	BCDH	Division Chief, Clinical Services-Center Based Services

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

Spreadsheet X yes _____no

Narrative X yes _____no

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

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

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.

1. Chronic disease self-management programs
2. Smoking Cessation program
3. Transportation company partnerships
4. Community and state group collaborations
5. Palliative Care
6. Population Health Medical Director

7. Population Health Administrative Director
8. Drive-Thru Flu Clinic
9. Healthcare for the Homeless (grant-funded)
10. Family Health Center Patient Centered Medical Home Program
11. SBIRT (partial grant-funded)
12. Data analyst
13. Financial analyst
14. Case Management – DMEs, Nebulizers, Oxygen
15. Diabetes Care Continuum work group
16. Population Health Committee

The main thrust of these investments has been to greatly expand, develop, and strengthen MedStar Franklin Square's outreach and engagement in community activities by developing partnerships with community stakeholders and organizations, engaging patients in their care, moving care from high-cost venues such as acute care hospitals and full-service Emergency Departments to the patient's community-based environment.

Initial efforts are focused on "high utilizers" of health care resources within our community, while working proactively to identify individuals who are at risk of becoming a high utilizer, and working to prevent that from occurring through our community outreach efforts. Recognizing the many social barriers to maintaining individual health make it imperative to develop collaborative working relationships with public, private, and faith based organizations to remove or mitigate the detrimental effects of those barriers.

Collaboration with other healthcare systems to meet the complex needs of our patients include the Baltimore Community Health Partnership, the Baltimore Population Health Workforce Collaborative.

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
Baltimore County Social Services	Nick D'Alesandro	Social Worker	CHNA Advisory Task Force Member Survey Distribution Focus Group
Baltimore County Department of Aging	Donna Bilz	Healthscope Coordinator	Survey Distribution Focus Group
Baltimore County Department of Health	Rene Youngfellow	Division Chief, Clinical Services-Center Based Services	CHNA Advisory Task Force Member
Baltimore County Local Management Board	Don Schlimm	Acting Executive Director	CHNA Advisory Task Force Member
Baltimore County Planning Office	Terri Kingeter	Sector Coordinator	CHNA Advisory Task Force Member Survey Distribution Focus Group
Baltimore County Public Schools	Sue Hahn	Parent Support Services	Survey Distribution Focus Group
Creative Kids	Juanita Ignacio	Director	Survey Distribution Focus Group
Health Care for the Homeless - Baltimore County	Tobie-Lynn Smith	Medical Director	CHNA Advisory Task Force Member Survey Distribution
St. Stephens AME Church	Cassandra Umoh	Program Manager	Survey Distribution Focus Group

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?

_____yes X_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.

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.

Baltimore County

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 measurable improvement in the health status of individuals served by the initiative. If the hospital is unable to provide statistical evidence of measurable 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?

Initiative I. Heart Disease: Stanford's Living Well with Chronic Disease Self- Management Program

A. 1. Identified Need: A. 2. How was the need identified:	Heart Disease: Evidence-based Programming for chronic disease self-management MedStar Health, Be Healthy MD, Baltimore County Department of Health effort to address need for support of people experiencing challenges related to chronic disease. The age adjusted rate of heart disease deaths per 100,000 population in Baltimore County is 174.5, compared to 169.9 in MD. Black Non-Hispanic rate in Baltimore County is 183.6 compared to 197.2 in MD. The 2017 MD Target is 166.3 The rate of ED visits for hypertension per 100,000 population in Baltimore County is 234.5 compared to 252.2 in MD. Black Non-Hispanic rate in Baltimore County is 342.4 compared to 415.1 in MD. The 2014 MD target is 234. In Maryland, in 2015, of adults considered obese, 52% had high blood pressure, 44% had high cholesterol, and 21% had diabetes. Diabetes is the sixth leading cause of death in Maryland. Diabetes also contributes to deaths from heart disease, stroke and kidney disease. 7,500 adults in Maryland die each year due to tobacco-related causes, and 150,000 more suffer from tobacco-related diseases such as COPD, emphysema or cancers. Non-smokers – especially young children (and even pets) – are also affected by tobacco through exposure to the toxins found in secondhand smoke.17.7% adults in Baltimore County smoked in 2014 compared to 14.6% in Maryland. 19.8% Black Non-Hispanic adults in Baltimore County smoked in 2014 compared to 16.8% in Maryland. Sources: MDSHIP, http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship32, 10-5-16 2011 Chronic Disease: Facts and Figures Report. Maryland Department of Health and Mental Hygiene **Need identified by: FY15 MedStar Franklin Square Community Health Needs Assessment**
B: Name of hospital initiative	Living Well - Stanford Chronic Disease Self-Management Program
C: Total number of people within target population	26.9 percent of adults are obese and 8.8 percent are diabetic in Baltimore County. Source: Maryland Department of health http://phpa.dhmh.maryland.gov/OEHFP/EH/tracking/Shared%20Documents/County-Profiles/BaltimoreCounty_Final.pdf
D: Total number of people reached by the initiative	Living Well was offered five times in FY17. Fidelity to program requires a minimum of eight participants. Due to low registration, all classes were cancelled. 0 people reached by initiative in FY17.

E: Primary objective of initiative:	The Living Well initiative is a seven-week program that provides information and teaches practical skills on managing chronic health problems. It aims to reduce the risk of type 2 diabetes and improve overall health. MFSMC's goal is to promote heart health and address risk factors of heart disease in Southeast Baltimore County.	
F: Single or multi-year plan:	Multi- year (2003-ongoing)	
G: Key collaborators in delivery:	Baltimore County Department of Aging Donna Bilz Baltimore County Department of Health Donna McCracken, RN, Maryland State Department of Health Sue Vaeth Mobilizing Active Citizens, Inc. Leigh Ann Eagle	
H: Impact of hospital initiative:	Statistical evidence of measurable improvement in health status of the target population: Due to low registration in FY17, all LW classes were canceled. Statistical evidence of measurable improvement in the health status of individuals served by the initiative: No data in FY17. Short Term Target: >=20% of class participants indicate improvement in health status at class completion Long-Term Target: reduce hospital emergency department visit rate among participants due to diabetes by 10%	
I: Evaluation of outcome	FY17 - Data not available - to be assessed in FY18	
J: Continuation of initiative:	Provider referral which was unavailable via electronic medical records, EMR, has been addressed. Providers on MedStar ambulatory EMR are now able to easily refer patients to LW classes. The Living Well Initiative will be continued indefinitely and updated based on reported outcomes.	
K: Expense:	a. LW - $7,723	b. n/a

Initiative II: Heart Disease - Diabetes Prevention Program (DPP) Centers for Disease Control Prevent T2

A. 1. Identified Need: A. 2. How was the need identified:	Heart Disease: Evidence-based Programming for chronic disease self-management MedStar Health, Be Healthy MD, Baltimore County Department of Health effort to address need for support of people experiencing challenges related to chronic disease. Request from MedStar Family Choice and State of MD to participate in the CMS demonstration project for Medicaid populations. Request from Baltimore County Department of Health to provide DPP programming for a State grant to help people at risk delay or avoid Type 2 Diabetes. The age adjusted rate of heart disease deaths per 100,000 population in Baltimore County is 174.5, compared to 169.9 in MD. Black Non-Hispanic rate in Baltimore County is 183.6 compared to 197.2 in MD. The 2017 MD Target is 166.3 The rate of ED visits for hypertension per 100,000 population in Baltimore County is 234.5 compared to 252.2 in MD. Black Non-Hispanic rate in Baltimore County is 342.4 compared to 415.1 in MD. The 2014 MD target is 234. In Maryland, in 2015, of adults considered obese, 52% had high blood pressure, 44% had high cholesterol, and 21% had diabetes. Diabetes is the sixth leading cause of death in Maryland. Diabetes also contributes to deaths from heart disease, stroke and kidney disease. 7,500 adults in Maryland die each year due to tobacco-related causes, and 150,000 more suffer from tobacco-related diseases such as COPD, emphysema or cancers. Non-smokers – especially young children (and even pets) – are also affected by tobacco through exposure to the toxins found in secondhand smoke.17.7% adults in Baltimore County smoked in 2014 compared to 14.6% in Maryland. 19.8% Black Non-Hispanic adults in Baltimore County smoked in 2014 compared to 16.8% in Maryland. Sources: MDSHIP, http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship32, 10-5-16 2011 Chronic Disease: Facts and Figures Report. Maryland Department of Health and Mental Hygiene **Need identified by: FY15 MedStar Franklin Square Community Health Needs Assessment**
B: Name of hospital initiative	Diabetes Prevention Program, DPP, Centers for Disease Control Prevent T2
C: Total number of people within target population	26.9 percent of adults are obese and 8.8 percent are diabetic in Baltimore County. Source: Maryland Department of health http://phpa.dhmh.maryland.gov/OEHFP/EH/tracking/Shared%20Documents/County-Profiles/BaltimoreCounty_Final.pdf

D: Total number of people reached by the initiative	DPP was offered twice in FY17. Seventeen people participated.	
E: Primary objective of initiative:	DPP aims to reduce the risk of type 2 diabetes and improve overall health. MFSMC's goal is to promote heart health and address risk factors of heart disease in Southeast Baltimore County.	
F: Single or multi-year plan:	Multi- year (2017-ongoing)	
G: Key collaborators in delivery:	Baltimore County Department of Aging Donna Bilz Baltimore County Department of Health Donna McCracken, RN, Maryland State Department of Health Sue Vaeth Mobilizing Active Citizens, Inc. Leigh Ann Eagle	
H: Impact of hospital initiative:	Statistical evidence of measurable improvement in health status of the target population: DPP to complete in May 2018. No statistical evidence of improvement. Statistical evidence of measurable improvement in the health status of individuals served by the initiative: No data in FY17. Short Term Target: >=20% of class participants indicate improvement in health status at class completion Long-Term Target: reduce hospital emergency department visit rate among participants due to diabetes by 10%	
I: Evaluation of outcome	FY17 - Data not available - to be assessed in FY18	
J: Continuation of initiative:	DPP has not yet completed a cohort. Assessment of DPP outcomes in FY18 will determine whether the initiative is continued.	
K: Expense:	a. $15,685	a. $680

Initiative III: Heart Disease - Blood pressure education and self-screening at community sites

A. 1. Identified Need: A. 2. How was the need identified:	Heart Disease: Blood Pressure Screening and Education The American Medical Association (AMA), in collaboration with Johns Hopkins Medicine (JHM) invited the Family Practice Residency to participate in a learning collaborative to assess effective ways to improve hypertension control. The age adjusted rate of heart disease deaths per 100,000 population in Baltimore County is 174.5, compared to 169.9 in MD. Black Non-Hispanic rate in Baltimore County is 183.6compared to 197.2 in MD. The 2017 MD Target is 166.3 The rate of ED visits for hypertension per 100,000 population in Baltimore County is 234.5 compared to 252.2 in MD. Black Non-Hispanic rate in Baltimore County is 342.4 compared to 415.1 in MD. The 2014 MD target is 234. In Maryland, in 2015, of adults considered obese, 52% had high blood pressure, 44% had high cholesterol, and 21% had diabetes. Diabetes is the sixth leading cause of death in Maryland. Diabetes also contributes to deaths from heart disease, stroke and kidney disease. Sources: MDSHIP, http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship32, 10-5-16 2011 Chronic Disease: Facts and Figures Report. Maryland Department of Health and Mental Hygiene **Need identified by: FY15 MedStar Franklin Square Community Health Needs Assessment**
B: Name of hospital initiative	Blood pressure education and self-screening at community sites
C: Total number of people within target population	26.9 percent of adults are obese and 8.8 percent are diabetic in Baltimore County. Source: Maryland Department of health Source: http://phpa.dhmh.maryland.gov/OEHFP/EH/tracking/Shared%20Documents/County-Profiles/BaltimoreCounty_Final.pdf
D: Total number of people reached by the initiative	41
E: Primary objective of initiative	Family Health Center BP project is part of the Improving Health Outcomes Blood Pressure Learning Collaborative, sponsored by the American Medical Association (AMA), in collaboration with Johns Hopkins Medicine (JHM). The Family Health Center at MedStar Franklin was a selected practice that was part of the AMA's Improving Health Outcomes initiative, in which the AMA and participating physicians and care teams worked with the Johns Hopkins Armstrong Institute for Patient Safety and Quality and the Johns Hopkins Center to eliminate cardiovascular

	health disparities to develop and test evidence-based recommendations to improve hypertension control.	
F: Single or multi-year plan:	Single year (FY16)	
G: Key collaborators in delivery:	IHO Strategies Donna Daniel, PhD	
H: Impact of hospital initiative:	Data not available	
I: Evaluation of outcome	N/A	
J: Continuation of initiative:	FHC continues to re-evaluate and improve the "M.A.P. framework" (measure accurately, act rapidly and partner with patients, families and communities. Action items include: • re-train and review, secret shopper • provide patients with our act rapidly brochure that contains general information and community resources. • Partnering with Giant Food for educational grocery shopping tours.	
K: Expense:	a. N/A Accounted for in GME	b. N/A

Initiative IV: Heart Disease - Baltimore Heart-walk Partnership

A. 1. Identified Need: A. 2. How was the need identified:	Heart Disease The American Heart Association Heart Walk is a major source of funding for research, public health policy, tools and information to save and improve lives. The age adjusted rate of heart disease deaths per 100,000 population in Baltimore County is 174.5, compared to 169.9 in MD. Black Non-Hispanic rate in Baltimore County is 183.6compared to 197.2 in MD. The 2017 MD Target is 166.3 The rate of ED visits for hypertension per 100,000 population in Baltimore County is 234.5 compared to 252.2 in MD. Black Non-Hispanic rate in Baltimore County is 342.4 compared to 415.1 in MD. The 2014 MD target is 234. In Maryland, in 2015, of adults considered obese, 52% had high blood pressure, 44% had high cholesterol, and 21% had diabetes. Diabetes is the sixth leading cause of death in Maryland. Diabetes also contributes to deaths from heart disease, stroke and kidney disease. Sources: MDSHIP, http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship32, 10-5-16 2011 Chronic Disease: Facts and Figures Report. Maryland Department of Health and Mental Hygiene **Need identified by: FY15 MedStar Franklin Square Community Health Needs Assessment**
B: Name of hospital initiative	Baltimore Heart-walk Partnership
C: Total number of people within target population	26.9 percent of adults are obese and 8.8 percent are diabetic in Baltimore County. Source: Maryland Department of health Source: http://phpa.dhmh.maryland.gov/OEHFP/EH/tracking/Shared%20Documents/County-Profiles/BaltimoreCounty_Final.pdf
D: Total number of people reached by the initiative	N/A
E: Primary objective of initiative:	To raise money to support American Heart Association efforts to decrease heart disease
F: Single or multi-year plan:	Multi- year (2015-ongoing)
G: Key collaborators in delivery:	American Heart Association Million Hearts Campaign Joe Ciancaglini

H: Impact of hospital initiative:	N/A	
I: Evaluation of outcome	In FY17, 15 walkers participated for a total fundraising effort of $671.42.	
J: Continuation of initiative:	MFSMC plans to continue to support American Heart Associate as a Heart Walk Partner in FY18.	
K: Expense:	a.$686	a. n/a

Initiative V: Heart Disease – Diabetes Support Group

A. 1. Identified Need: A. 2. How was the need identified:	Heart Disease Community members, MFSMC and other local providers have requested support f or people with diabetes and those who support them. The age adjusted rate of heart disease deaths per 100,000 population in Baltimore County is 174.5, compared to 169.9 in MD. Black Non-Hispanic rate in Baltimore County is 183.6compared to 197.2 in MD. The 2017 MD Target is 166.3 The rate of ED visits for hypertension per 100,000 population in Baltimore County is 234.5 compared to 252.2 in MD. Black Non-Hispanic rate in Baltimore County is 342.4 compared to 415.1 in MD. The 2014 MD target is 234. In Maryland, in 2015, of adults considered obese, 52% had high blood pressure, 44% had high cholesterol, and 21% had diabetes. Diabetes is the sixth leading cause of death in Maryland. Diabetes also contributes to deaths from heart disease, stroke and kidney disease. Sources: MDSHIP, http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship32, 10-5-16 2011 Chronic Disease: Facts and Figures Report. Maryland Department of Health and Mental Hygiene **Need identified by: FY15 MedStar Franklin Square Community Health Needs Assessment**
B: Name of hospital initiative	Diabetes Support Group
C: Total number of people within target population	26.9 percent of adults are obese and 8.8 percent are diabetic in Baltimore County. Source: Maryland Department of health Source: http://phpa.dhmh.maryland.gov/OEHFP/EH/tracking/Shared%20Documents/County-Profiles/BaltimoreCounty_Final.pdf
D: Total number of people reached by the initiative	FY17: 11 sessions Total participants 223
E: Primary objective of initiative:	To facilitate monthly diabetes support group.

F: Single or multi-year plan:	Multi- year (ongoing)	
G: Key collaborators in delivery:	N/A	
H: Impact of hospital initiative:	Attendance data only	
I: Evaluation of outcome	N/A	
J: Continuation of initiative:	Diabetes Support Group is scheduled to continue in FY18.	
K: Expense:	a.$6,620	a. N/A

Initiative VI: Smoking Cessation – Stop Smoking Today

A. 1. Identified Need: A. 2. How was the need identified:	Smoking Cessation Partnership with Baltimore County Department of Health to achieve State Health Improvement Program goal for decreased tobacco use. 7,500 adults in Maryland die each year due to tobacco-related causes, and 150,000 more suffer from tobacco-related diseases such as COPD, emphysema or cancers. Non-smokers – especially young children (and even pets) – are also affected by tobacco through exposure to the toxins found in secondhand smoke. 17.7% adults in Baltimore County smoked in 2014 compared to 14.6% in Maryland. MD SHIP 2017 Goal: 15.5. Source: MDSHIP. 2014. [accessed July 06, 2017]. URL: http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship322011 **Need identified by: FY15 MedStar Franklin Square Community Health Needs Assessment**
B: Name of hospital initiative	Stop Smoking Today
C: Total number of people within target population	17.7% adults in Baltimore County smoked in 2014 compared to 14.6% in Maryland. Source: MDSHIP. 2014. [accessed July 06, 2017]. URL: http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship322011
D: Total number of people reached by the initiative	FY17- 51 people
E: Primary objective of initiative:	Stop Smoking Today is a six-week smoking cessation program designed to provide highly motivated adults with practical counseling, support, and the encouragement needed to become tobacco-free.
F: Single or multi-year plan:	Multi- year (2003-ongoing)
G: Key collaborators in delivery:	Baltimore County Department of Health Vickie Keller Baltimore County Southeast Area Network Terri Kingeter Tobacco-Free Baltimore County Coalition Vickie Keller
H: Impact of hospital initiative:	Statistical evidence of measurable improvement in health status of the target population: Baltimore County SHIP data indicates that the use of tobacco among adults in Baltimore County has decreased (2011: 23.5%/ 2014: 17.7%).

	Source: MDSHIP. 2014. [accessed July 06, 2017]. URL: http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship322011 Statistical evidence of measurable improvement in the health status of individuals served by the initiative: FY17- 9 The number of people served by the initiative. FY17- 36 Short Term Target: >=50 % of program participants complete the Stop Smoking Today program. Long-Term Target: Achieve an abstinence rate >= 25% among program completers	
I: Evaluation of outcome	Participation and quit rates are documented and reported to Baltimore County Tobacco Coalition and MedStar Cancer Network. In FY17, Stop Smoking Today (SST) was offered eight times. Participants received up to 650 minutes of intensive counseling. According to the Clinical Practice Guidelines for Treating Tobacco Use and Dependence, interventions that include >300 minutes of contact time/counseling had an estimated abstinence rate of 25.5%. Stop Smoking Today FY17 #Registrants – 51 #Attended- 36 #Participants who completed program – 26 #Participants who quit – 9 Quit rate for completers – 35% Overall class average quit rate – 38.5%	
J: Continuation of initiative:	Baltimore County adult residents continue to use tobacco at a higher rate than the State of Maryland. Stop Smoking Today will be continued indefinitely and updated based on current research and best practices	
K: Expense:	a.$45,144	b. N/A

Initiative VII: Improved Birth Outcomes – Healthy Babies Collaborative

A. 1. Identified Need: A. 2. How was the need identified:	Improved Birth Outcomes Data collected and recorded by the Baltimore County Local Management Board indicates that infant mortality and low birth weight rates are particularly high in the census tracts 4505.03 and 4505.04 in the 21221-zip code area of Baltimore County. Babies born with a low birth weight are at increased risk for serious health consequences including disabilities and death.). Both Maryland's and Baltimore County's low birth weight percentages (8.6, 8.8 respectively) are higher than the national average. The 2017 MD Goal is 8%. Black Non-Hispanic averages are 121% in Maryland and 12.4% in Baltimore County. SHIP http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship3 , accessed 6-28-17 **Need identified by: FY15 MedStar Franklin Square Community Health Needs Assessment, Baltimore Local Management Board request for assistance**
B: Name of hospital initiative	Healthy Babies Collaborative
C: Total number of people within target population	Women of childbearing age and parents of young children who are living in census tracts 4505.03 and 4505.04 in the 21221-zip code area. The total population is 11,118.
D: Total number of people reached by the initiative	N/A
E: Primary objective of initiative:	Support babies being born healthy and being raised in safe and stable families and communities in southeast Baltimore County. Serve in a leadership role in the Healthy Babies Collaborative, provide a weekly breastfeeding support group in Essex at Creative Kids Center, assess community factors associated with poor birth outcomes in Essex, identify evidence-based programming to address identified risk factors and provide health education and services to support Southeast Network partner initiatives to address identified risk factors.
F: Single or multi-year plan:	Multi- year (2013-ongoing)
G: Key collaborators in delivery:	Abilities Network Tomeaka Jupiter Baltimore County Department of Health Laura Culbertson, RN

	Baltimore County Department of Planning Terri Kingeter Baltimore County Department of Social Services Aimee Bollinger-Smith Baltimore County Health Coalition Della Leister Baltimore County Local Management Board Don Schlimm Baltimore County Public Schools Barb Masiulis, RN LifeBridge Health Beth Huber St. Stephen AME Church OMT Cassandra Umoh United Way of Central Maryland Peggy Gagen
H: Impact of hospital initiative:	Statistical evidence of measureable improvement in the health status of individuals served by the initiative: FY17: # unique participants- 54 # total attendees – 331 # mom initiating breastfeeding- 14 # mom achieving 3 months breastfeeding- 16 # mom achieving 6 months breastfeeding- 5 # mom achieving 12 months breastfeeding- 4 Note: the # of moms reaching intervals is only reflective if mom attended the group at the time of the interval to be captured for reporting. The number of people served by the initiative: FY17:108 Short Term Target: infrastructure formation and sustainability for Collaborative projects Long-Term Target: Decrease low birth weight rate in participating target population by 10%
I: Evaluation of outcome	Continuing infrastructure work has led to sustained Breastfeeding Moms Lunch and identification of a partner and funding for Family Stability Initiative program, a multifaceted evidence based program to improve housing and school stability. FY18 plans include a Moms club and a resource event to provide resources and engage the community.
J: Continuation of initiative:	Baltimore County residents continue to identify transportation as a barrier. Breastfeeding Moms Lunch is scheduled to continue in FY18 in the target neighborhood for mothers unable to attend a

	similar program on hospital grounds. Healthy Babies Collaborative is scheduled to continue in FY18.	
K: Expense:	a.$62,439	B$36,707.

Initiative VIII: Access to Mainstream Resources

A. 1. Identified Need: A. 2. How was the need identified:	Access to Mainstream Resources Partnership with MedStar and community service providers in Southeast Network to assist residents with identification of and access to mainstream resources to maintain and improve health. Healthy Babies Collaborative target population is 11,118, with 16.8% in 4505.03 and 15.3% in 4505.04 living below the poverty line, and 42.2 and 47.8% respectively living below 200% of the poverty line. However, according to the United Way ALICE Project (Asset Limited Income Constrained Employed), the Household Survival Budget in the state of Maryland for a family of four (two adults with one infant and one preschooler) is $61,224, but the median income in our two target census tracts is $41,290 and $34,679. Community Benefit Service Area (seven zip code areas, including HBC) income range is: $48,390 - $58,738 Percentage of households with incomes below the federal poverty guidelines within the CBSA - 8.9% - 16.3% 31.96% of the Hospitals patients are Medicaid recipients. Need identified by: FY15 MedStar Franklin Square Community Health Needs Assessment
B: Name of hospital initiative	Access to Mainstream Resources
C: Total number of people within target population	Approximately 20,000 based on HBC and % of Hospital Medicaid recipients
D: Total number of people reached by the initiative	231

E: Primary objective of initiative:	To Improve health outcomes for Medicaid and self-paid patients by providing social resources. Assess patients for mainstream service needs prior to discharge, identify local mainstream service resources, partner with identified resources for a direct point of contact, provide mainstream services support assistant to assist with resource eligibility and enrollment and provide eligibility education and enrollment assistance for patients in need of mainstream services. Aunt Bertha to be piloted. Alternate risk assessment tools being evaluate	
F: Single or multi-year plan:	Multi- year	
G: Key collaborators in delivery:	Southeast Network Partners Terri Kingeter Baltimore Health Coalition Laura Culbertson Baltimore County Departments of Health Elise Andrews Local Management Board Don Schlimm Planning Terri Kingeter Social Services Aimee Bollinger Smith Uber for transportation	
H: Impact of hospital initiative:	Statistical evidence of measureable improvement in the health status of individuals served by the initiative: FY17Aunt Bertha referrals: 308 The number of people served by the initiative. 39 Short Term Target: >=20% of class participants indicate improvement in health status at class completion Long-Term Target: reduce hospital emergency department visit rate among participants due to diabetes by 10%.	
I: Evaluation of outcome	FY17 Aunt Bertha pilot completed, directory of service providers available.	
J: Continuation of initiative:	Baltimore County residents continue to identify transportation as a barrier. Economic status depressed; working with Baltimore Population Health Workforce Collaborative.	
K: Expense:	a. $2633	b. NA

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.

Issue	Evidence	Explanation	Name of community based lead organizations and/or key stakeholders (These are organization that would be interested in these findings)
Housing	35% of CHNA respondents identified homelessness affecting the quality of life. 21% of CHNA respondents indicated affordable housing as a needed service in the community (MedStar Franklin Square Medical Center Community Health Needs Assessment, 2015).	The hospital does not have the expertise to have a leadership role in these areas. When possible, the hospital will support stakeholders by contributing to initiatives and participating in conversations on the topics – particularly as they relate to health status and health outcomes.	Baltimore County Department of Planning
Transportation	8% of CHNA respondents identified better public transportation as a needed service (MedStar Franklin Square Medical Center Community Health Needs Assessment, 2015). MSFSMC charity care for transportation assistance increased 66% in FY2014 from that of FY2013 (MedStar Franklin Square Medical Center Community Benefits Report to HSCRC, 2014).		MD Department of Transportation Maryland Transit Authority

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)

MFSMC works toward the State's initiatives for improvement in population health through our attempt to achieve the Triple Aim of enhanced patient care, improved population health and reduced health care costs. Using the benchmarks established by Healthy People 2020, the State Health Improvement Plan and Baltimore County Health Coalition, the CHNA evaluated the current community health status and established aligned community benefit priorities. Through collaboration with extensive partnerships across service sectors, innovative evidence-based programs have been facilitated to meet the identified needs; examples include: Stanford chronic disease management programs, CDC National Diabetes Prevention Program, Healthy Babies Collaborative (using Collective Impact model), the Family Health Center's patient-centered medical home model and smoking cessation programming. Hot-spotting analysis has resulted in focused use of resources for maximum impact for community collaborations and for readmission reduction efforts, especially for Medicare, Medicaid and CHIP beneficiaries.

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.

    a. MedStar Franklin Square Medical Center (MFSMC) is in a HRSA-designated medically underserved area. Many of the services provided by MFSMC would otherwise not be available in our service area due to lack underinsurance or uninsured patients and availability to healthcare resources. Many of the needs of the larger uninsured or underinsured population are addressed by our financial assistance policy. We posed this issue to our physician leadership and case management staff who identified several areas of concern: Timely placement of patients in need of inpatient psychiatry services, limited availability of outpatient psychiatry services, and limited availability of inpatient and outpatient substance abuse treatment.

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 – Hospitalists/Palliative Care	MFSMC provides Inpatient Acute Care services to many patients in Baltimore County who would otherwise not have access to health care facilities. Palliative Care is essential to ensuring patients are receiving pain and symptom management as well as psychosocial and spiritual support to seriously ill patients in the acute care setting. The overall goal of both Hospitalists and Palliative Care is to improve care, decrease suffering, and ensure quality and safe care is being provided to all patients at MFSMC. Being the easiest accessible acute care setting to the many underinsured or uninsured patients in our service area, it is crucial that MFSMC continue to provide these services.
Non-Resident House Staff and Hospitalists – Primary Care/Family Health	Accessibility to Primary Care services is crucial to the health and wellness of the population. To promote healthy lifestyles and a focus on awareness of one's health. The PCC provides these services to many patients who utilize public transportation to obtain health services by being located on MFSMC's campus. The lack of Primary Care and Family Health Services in our service area would lead to a decrease in health and life quality in the community which would eventually translate to increased hospital utilization.

Physician Provision of Financial Assistance	MedStar Franklin Square Medical Center (MFSMC) is in a HRSA-designated medically underserved area. Many of the services provided by MFSMC would otherwise not be available in our service area due to underinsured or uninsured patients and limited availability to healthcare resources. Many of the needs of the larger uninsured or underinsured population are addressed by our financial assistance policy.
Physician Recruitment to Meet Community Need	The recruitment of physicians is a key part of providing quality services to patients on MFSMC's service area along with patients from other communities who choose to utilize MFSMC services. Access to health care resources, both Primary Care and Specialty Services, allows for patients to easily address their health concerns.
Other – (provide detail of any subsidy not listed above – add more rows if needed) Women's Services	OB/GYN services in the MFSMC community are key to maintaining healthy relationships with patients and their families. The quality of services provided along with the easily accessible facilities in the MFSMC area allow for effective and efficient care to take place for women who need both general women's health services along with treatment and advice during and after pregnancy. Many areas in the MFSMC service area include underinsured or uninsured patients. This being said, many other health networks do not provide services in these areas to patients who are unable to pay making it crucial for MFSMC to maintain the services provided for women in the community.

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):

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

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

      - Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
        - in a culturally sensitive manner,
        - at a reading comprehension level appropriate to the CBSA's population, and
        - in non-English languages that are prevalent in the CBSA.
      - Posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;

- Provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
- Provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
- Includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills;
- Besides English, in what language(s) is the Patient Information sheet available;
- Discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).

c. Include a copy of your hospital's FAP (label appendix III).

d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

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

Appendix I
Financial Assistance Policy

MedStar Franklin Square's FAP and financial assistance contact information is:

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

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

Appendix II
Changes to Financial Assistance Policy

There have been no changes in the Financial Aid Policy at MedStar Franklin Square since the ACA Health Care Coverage Expansion Option became effective (January 1, 2014). The current policy meets all ACA requirements.

Appendix III

Financial Assistance Policy

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

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

Patients' Rights

MedStar Franklin Square Medical Center will work with their uninsured patients to gain an understanding of each patient's financial resources.

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

Patients' Obligations

MedStar Franklin Square Medical Center believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

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

Contacts

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

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

For information about Maryland Medical Assistance

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

Learn more about Medical Assistance on the Maryland Department of Human Resources website: www.dhr.maryland.gov/fiaprograms/medical.php

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

Additional Billing Information

You will receive a statement for hospital services approximately one week after your discharge. As a courtesy, your insurance company will be billed for the services you received. You may request a preliminary statement of hospital services when you are discharged. Please note, the statement may not reflect all charges for services you received. If you wish, you may pay the known self-pay portion of your bill at this time and take advantage of a 2% discount. After your insurance pays, you may be responsible for additional amounts due.

Uninsured patients are required to pay their bills when they are discharged or to make arrangements for payment through the Patient Advocacy Department. If you are uninsured and need to apply for assistance to cover your hospital bill or to speak with a Patient Advocate, call 443-777-7323 or 443-777-7732.

Appendix IV

MedStar Health

MARYLAND HOSPITAL PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy

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

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

Patients' Rights

Medstar Franklin Square Medical Center will work with their uninsured patients to gain an understanding of each patient's financial resources.

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

Patients' Obligations

MedStar Franklin Square Medical Center believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

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

Contacts:

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

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

For information about Maryland Medical Assistance

Contact your local Department of Social Services

1-800-332-6347 TTY 1-800-925-4434

Or visit: www.dhr.state.md.us

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

(This sheet is also available in Spanish.)

Appendix V

MedStar Franklin Square Medical Center

Mission

MedStar Franklin Square Medical Center, a member of MedStar Health, provides safe, high quality care, excellent service and education to improve the health of our community.

Vision
The trusted leader in caring for people and advancing health.

Values

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

Attachment A

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

- Increase life expectancy
- Reduce infant mortality
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers
- Reduce the % of youth using any kind of tobacco product
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- Increase the % vaccinated annually for seasonal influenza
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce hospital ED visits from asthma
- Reduce hospital ED visits related to mental health conditions
- Reduce hospital ED visits related to addictions
- Reduce Fall-related death rate