

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

FY2017 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

MedStar Union Memorial Hospital

BACKGROUND

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

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

On January 10, 2014, the Center for Medicare and Medicaid Innovation (CMMI) announced its approval of Maryland's historic and groundbreaking proposal to modernize Maryland's all-payer hospital payment system. The model shifts from traditional fee-for-service (FFS) payment towards global budgets and ties growth in per capita hospital spending to growth in the state's overall economy. In addition to meeting aggressive quality targets, the model requires the State to save at least \$330 million in Medicare spending over the next five years. The HSCRC will monitor progress overtime by measuring quality, patient experience, and cost. In addition, measures of overall population health from the State Health Improvement Process (SHIP) measures will also be monitored (see Attachment A).

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

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;

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), the IRS defines a CHNA as a:

Written document developed for a hospital facility that includes a description of the community served by the hospital facility: the process used to conduct the assessment including how the hospital took into account input from community members and public health experts; identification of any persons with whom the hospital has worked on the assessment; and the health needs identified through the assessment process.

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

A description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs. It should also describe information gaps that impact the hospital organization's ability to assess the health needs of the community served by the hospital facility. If a hospital collaborates with other organizations in conducting a CHNA the report should identify all of the organizations with which the hospital organization collaborated. If a hospital organization contracts with one or more third parties to assist in conducting the CHNA, the report should also disclose the identity and qualifications of such third parties;

(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;

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions (LHICs) schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input, who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

(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
192 Source: Bed Licensed Letter from DHMH	11,004 Source: UMH STAT MODEL 0616 “CENSUS” Tab	21218 21211 21213 21215 21206 21212 21234 21239 21217 Source: HSCRC PSA Report, 2017	MedStar Good Samaritan Hospital MedStar Franklin Square Medical Center MedStar Harbor Hospital St. Joseph Medical	0.8% (% of Baltimore City Patients seen at MUMH that are Uninsured Source: MedStar Patient Database (Planning Mart)	20.9% (% of Baltimore City Patients seen at MUMH that are Medicaid, internal statistic, not from an external source) Source: MedStar Patient Database	56.3% (% of Baltimore City Patients seen at MUMH that are Medicare beneficiaries) Source: MedStar Patient Database (Planning Mart)

			Center Greater Baltimore Medical Center Sinai Hospital University of Maryland Medical Center University o Maryland Medical Center Midtown Camps University of Maryland St. Joseph Medical Center Mercy Medical Center Johns Hopkins Hospital Johns Hopkins Bay View Medical Center Bon Secours Hospital Northwest Hospital Center Source: HSCRC PSA Report, 2017		(Planning Mart)	
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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 reside.	<p>CBSA includes adults who reside in zip codes 21211, 21213 and 21218.</p> <p>Focus Area: 21218</p> <p>This geographic area was selected due to its close proximity to the hospital, coupled with a high density of low-income residents.</p>	MedStar Health 2017 Community Health Needs Assessment
Median Household Income within the CBSA	<p>Baltimore City - \$41,819</p> <p>CBSA</p> <p>Zip code 21211 – \$58,210</p> <p>Zip code 21213 – \$38,906</p> <p>Zip code 21218 - \$ 32,652</p>	Baltimore City 2017 Neighborhood Health Profile PDF – (Waverly, Bel Air-Edison, Remington-Hampden)
Percentage of households with incomes below the federal poverty guidelines within the CBSA	<p>Baltimore City – 28.8%</p> <p>CBSA</p> <p>Zip code 21211 – 10.1%</p> <p>Zip code 21213 – 29.1%</p> <p>Zip code 21218 - 23%</p>	Baltimore City 2017 Neighborhood Health Profile PDF – (Waverly, Bel Air-Edison, Remington-Hampden)
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	<p>Baltimore City – 11.7%</p> <p>CBSA</p> <p>Zip code 21211 – 7%</p> <p>Zip code 21213 – 13.9%</p> <p>Zip code 21218 – 14.7%</p>	Baltimore City 2017 Neighborhood Health Profile PDF – (Waverly, Bel Air-Edison, Remington-Hampden)
Percentage of Medicaid recipients by County within the CBSA.	Baltimore City – 31.3%	2016 Maryland Medicaid e Health Statistics http://www.chpdm-ehealth.org/mco/index.cfm

<p>Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx</p>	<p>Baltimore City – 73.6 Years</p> <p>CBSA Zip code 21211 – 76.5 Years Zip code 21213 – 72 Years Zip code 21218 – 72 Years</p>	<p>Baltimore City 2017 Neighborhood Health Profile PDF – (Waverly, Bel Air-Edison, Remington-Hampden)</p>
<p>Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).</p>	<p>Baltimore City (per 100,000 residents) All Races – 1,050 White – 1,050 Black – 1,175 Asian or Pacific Islander – 289 Hispanic – 190</p>	<p>Baltimore City Health Department – Community Health Assessment 2017</p>
<p>Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx</p>	<p>By County within the CBSA</p> <p>Percent of zip codes in County with a healthy food outlet : Baltimore City – 48.89% State of Maryland – 40.4%</p> <p>Percentage of working age people who use public transportation: Baltimore City – 18.5% State of Maryland – 8.7%</p> <p>Percentage of students who have a high school degree: Baltimore City – 82.5% State of Maryland – 89.4%</p> <p>Number of days with maximum ozone concentration over the National Ambient Air Quality Standard: Baltimore City – 20 State of Maryland – 11.7</p> <p>Homeownership Rate: Baltimore City – 47.1 State of Maryland – 66.8</p>	<p>Baltimore City Department of Health</p> <p>U.S. Census Bureau-Quick Facts</p>

<p>Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx</p>	<p>Demographics Zip code 21211 Total Population – 17,351 White - 13,453 Black or African American – 2,317 Hispanic - 606 Asian – 845 Native Hawaiian and Other Pacific Islander – 3 Two or more races – 461 Language Speak only English – 89.3% Speak a language other than English – 10.7%</p> <p>Demographics Zip code 21213 Total Population –32,733 White - 2,014 Black or African American – 29,975 Hispanic - 361 Asian – 131 Native Hawaiian and Other Pacific Islander – 2 Two or more races – 414 Language Speak only English – 96.7% Speak a language other than English – 3.3%</p> <p>Demographics Zip code 21218 Total Population –49,796 White - 13,370 Black or African American – 31,777 Hispanic – 1,444 Asian – 2,866 Two or more races – 1,145 Language Speak only English – 90.5% Speak a language other than English – 9.5%</p>	<p>U.S. Census Bureau, 2010-2017 American Community Survey 5- Year Estimates</p> <p>http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table</p>
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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?

Yes Provide date approved by the hospital's governing body or an authorized body thereof here: 3/12/2015

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

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

Yes Enter date approved by governing body/authorized body thereof here:
3/12/2015

No

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

http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf
(pg. 17-19)

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

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. CEO
2. CFO
3. Other (please specify)

Describe the role of Senior Leadership.

President/CEO (Executive Sponsor)

MedStar Union Memorial Hospital's Board of Directors, President and the organization's operations leadership team work thoroughly to ensure that the hospital's 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. Physician
2. Nurse
3. Social Worker
4. Other (please specify)

Describe the role of Clinical Leadership

Medical Director (Physician)

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

Coordinator - Community Education & Health Ministries (Nurse)

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

iii. Population Health Leadership and Staff

1. Population health VP or equivalent (please list)
 - a. Dr. Martin Binstock, Vice President of Medical Affairs
2. Other population health staff (please list staff)

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

The Vice President of Medical Affairs is 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.

iv. Community Benefit Operations

1. the Title of Individual(s) (please specify FTE)
 - a. Community Health Lead (1FTE)
 - b. Manager, Finance (1 FTE)
 - c. Program Director, Shepherd's Clinic Joy Wellness Center (1FTE)
 - d. Administrative Coordinator, Shepherd's Clinic Joy Wellness
2. Committee (please list members)
3. Department (please list staff)
4. Task Force (please list members)
5. Other (please describe)

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

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

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

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

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

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

Spreadsheet yes no

Narrative yes no

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

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

Advisory Task Force Members

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

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

Spreadsheet yes no

Narrative yes no

If no, please explain why.

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

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 Management

The main thrust of these investments has been to greatly expand, develop, and strengthen MedStar Union Memorial Hospital 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 Joy Wellness Center, Shepherd's Clinic, Govans Ecumenical Development Corporation, and Friendship Baptist Church.

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?

Other hospital organizations

Local Health Department

Local health improvement coalitions (LHICs)

Schools

Behavioral health organizations

Faith based community organizations

Social service organizations

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

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

_____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?

Table III – Initiative I – Chronic Disease Prevention and Management

<p>A. 1. Identified Need:</p>	<p>Chronic Disease Prevention and Management</p> <p>During the FY15 Community Health Needs Assessment the need for chronic disease programs was identified. Advisory Task Force members compiled Baltimore City Health Department data and survey responses from the community and identified this need. MedStar Union Memorial Hospital (MUMH) and Shepherd’s Clinic have had a longstanding relationship to address this community need. MUMH continues to support Shepherd’s Clinic and Joy Wellness Center as a site for community wellness and prevention programs.</p> <p>Baltimore City: Age-adjusted Mortality Rate (Deaths per 10,000) 24.4%. Number one cause of death in Baltimore City in 2017. https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports</p> <p>BCHD released a report -- <i>Healthy Baltimore 2015</i> -- that summarized 55 neighborhood health profiles and identified CVD as a leading cause of death, with a 20-year life-expectancy gap between high-income and low-income neighborhoods. https://health.baltimorecity.gov/node/155</p> <p>The majority (76.1%; n=151) of Community Input Survey respondents, who live and/or work in the CBSA, classified the incidence of heart disease as “severe” or “very severe.”</p> <p>There is a Healthy Baltimore 2015 goal of increasing the percent of adults with high blood pressure on medication by 10%. Baltimore City’s emergency department visit rate due to hypertension is 615/100,000 persons, compared to 265/100,000 for the state (MD SHIP, 2013).</p>
<p>A. 2. How was the need identified:</p>	<p>Shepherd's Clinic and Joy Wellness Center</p>
<p>B: Name of hospital initiative</p>	<p>Shepherd's Clinic and Joy Wellness Center</p>
<p>C: Total number of people within target population</p>	<p>Baltimore City: Age-adjusted Mortality Rate (Deaths per 10,000) 24.4%. Number one cause of death in Baltimore City in 2017. https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports</p>
<p>D: Total number of people reached by the initiative</p>	<p>566</p>
<p>E: Primary objective of initiative:</p>	<p>The Shepherd’s Clinic and Joy Wellness Center provides weekly</p>

Table III – Initiative II – Access to Care

<p>A. 1. Identified Need:</p>	<p>Access to Care</p> <p>“Promote Access to Quality Health Care for All” is one of the top ten priority areas from Baltimore City Health Department’s Healthy Baltimore 2015.</p> <p>Baltimore City’s percentage of uninsured patients is 14%, compared to the state’s average of 11%. (American Community Survey, 2013).</p> <p>48% (n=102) of respondents indicated that to “Promote Access to Quality Health Care for All” is a top priority area (MedStar Union Memorial Hospital Community Health Needs Assessment, 2015).</p> <p>Access to care was identified as a community need through MedStar Union Memorial’s CHNA.</p> <p>The initiative is to provide primary and specialty care and inpatient health services to uninsured adults who live in the MedStar Union Memorial’s primary service area and meet financial criterion. MUMH provides administrative, clinical and financial support for the Shepherd’s Clinic, a separate community not-for-profit health care provider.</p> <p>Executive leadership from MedStar Health has representation on the Shepherd’s Clinic Board of Directors. Employed MUMH physicians serve as the Shepherd’s Clinic medical director and associate medical director. Rotating MUMH physician services at Shepherd’s Clinic include endocrinology, cardiology and the internal medicine residency program. Each year, a team of approximately 250 volunteers manage nearly 4,000 patient visits each year. MedStar Union Memorial physicians, retired physicians, nurses and therapists are mainstays of the volunteer workforce. MedStar Union Memorial also covers</p>
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<p>A. 2. How was the need identified:</p>	<p>expenses for a paid program director and administrative coordinator, for the Joy Wellness Center.</p>
<p>B: Name of hospital initiative</p>	<p>Access to Care/Shepherd's Clinic</p>
<p>C: Total number of people within target population</p>	<p>The median household incomes in the Shepherds Clinic and Joy Wellness Center communities are below median household income. 23% of families live in poverty in surrounding areas. 36.6% of families live below a \$24,999/year income and are underserved. 14.7% are uninsured.</p> <p>http://health.baltimorecity.gov/neighborhood-health-profile-reports</p>
<p>D: Total number of people reached by the initiative</p>	<p>FY 17 - 549 participants Referrals to MUMH in FY17 - 979</p>
<p>E: Primary objective of initiative:</p>	<p>This initiative provides primary and specialty care and inpatient health services to uninsured adults who live in the MedStar Union Memorial's primary service area and meet financial criterion. MUMH provides administrative, clinical and financial support for the Shepherd's Clinic, a separate community not-for-profit health care provider.</p> <p>Executive leadership from MedStar Health has representation on the Shepherd's Clinic Board of Directors. Employed MUMH physicians serve as the Shepherd's Clinic medical director and associate medical director. Rotating MUMH physician services at Shepherd's Clinic include endocrinology, cardiology and the internal medicine residency program. Each year, a team of approximately 250 volunteers manage nearly 4,000 patient visits each year. MedStar Union Memorial physicians, retired physicians, nurses and therapists are mainstays of the volunteer workforce. MedStar Union Memorial also covers expenses for a paid program director and administrative coordinator, for the Joy Wellness Center.</p>

	The goal of this program is to increase access to primary care, specialty care and inpatient health services for low-income, uninsured persons who do not qualify for Medicaid.	
F: Single or multi-year plan:	Multi-year	
G: Key collaborators in delivery:	Shepherd's Clinic	
H: Impact of hospital initiative:	Shepherd's Clinic visits = 3,444 Joy Wellness Center visits = 2,897	
I: Evaluation of outcome	Patients are given free primary care and educational programming for disease prevention through the Shepherd's Clinic and Joy Wellness Center. Shepherd's continues with their relationship to MUMH to aid in offering free care to keep patients well in community.	
J: Continuation of initiative:	Plan to continue program	
K: Expense:	a. \$68,172	b. \$0

Table III – Initiative III – Diabetes Management

<p>A. 1. Identified Need:</p>	<p>Diabetes Management</p> <p>The need for chronic disease programs, such as diabetes management, was identified during the FY15 CHNA process. The Advisory Task Force members compiled BCHD data and survey responses from the local community and identified this need. MUMH and Shepherd’s Clinic have had a longstanding relationship to address this community need. MUMH continues to support Shepherd’s Clinic and Joy Wellness Center as a site for community wellness and prevention programs.</p> <p>29.1 million people or 9.3% of the U.S. population have diabetes.</p> <p>Diabetes was the seventh leading cause of death in the United States in 2010 based on the 69,071 death certificates in which diabetes was listed as the underlying cause of death. In 2010, diabetes was mentioned as a cause of death in a total of 234,051 certificates.</p> <p>Diabetes may be underreported as a cause of death. Studies have found that only about 35% to 40% of people with diabetes who died had diabetes listed anywhere on the death certificate and about 10% to 15% had it listed as the underlying cause of death.</p> <p>In 2003–2006, after adjusting for population age differences, rates of death from all causes were about 1.5 times higher among adults aged 18 years or older with diagnosed diabetes than among adults without diagnosed diabetes.</p> <p>http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf</p> <p>Age- adjusted mortality rate (Deaths per 10,000) for Baltimore City – 3%</p> <p>https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports</p>
<p>A. 2. How was the need identified:</p>	
<p>B: Name of hospital initiative</p>	<p>Stanford University's “Living Well: Diabetes Self Management Program”</p>
<p>C: Total number of people within target population</p>	<p>Diabetes: Age-adjusted Mortality Rate (Deaths per 10,000) for Baltimore City for 2017 – 3.0</p> <p>https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports</p>
<p>D: Total number of people reached by the initiative</p>	<p>14 persons served</p>
<p>E: Primary objective of initiative:</p>	<p>Seven week evidenced-based workshop with the goal of</p>

	empowering participants to become better managers of their diabetes. Topics include nutrition (carbohydrate counting), exercise, medications, monitoring blood sugar, foot care, managing emotions, better communication, pain management, decision making and goal setting for better health.	
F: Single or multi-year plan:	Multi- year (2007 and ongoing)	
G: Key collaborators in delivery:	MAC - Wendy Farthing MedStar Good Samaritan Hospital Joy Wellness Center – Kerry Martinez, Director	
H: Impact of hospital initiative:	<p>14 participants attended the workshop 7 were screened for blood pressure, weight, BMI and body fat at the start of the program 6 were rescreened at the end of the program 6 participants had lower blood pressure readings 6 participants had weight loss</p> <p>6 participants completed a survey on the last day Survey results</p> <p>1. I have a better understanding of how to Manage the symptoms of my health condition Strongly Agree - 5 Agree - 1</p> <p>2. I learned how to set goal and action plan and follow it. Strongly Agree - 6</p> <p>3. I have more self-confidence in my ability to manage my health than I did before taking the workshop. Strongly Agree - 5 Agree - 1</p> <p>4. I feel more motivated to take care of my health since I took this workshop. Strongly Agree - 6</p>	
I: Evaluation of outcome	Diabetes: Age-adjusted Mortality Rate (Deaths per 10,000) for Baltimore City decreased from 3.2% to 3.0% between the years of 2011 and 2017 https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports	
J: Continuation of initiative:	Yes	
K: Expense:	a. \$1,200	b. \$0

Table III – Initiative IV – Diabetes Prevention

<p>A. 1. Identified Need:</p>	<p>Diabetes Prevention: The need for chronic disease programs, such as diabetes management/prevention, was identified during the FY15 CHNA process. The Advisory Task Force members compiled BCHD data and survey responses from the local community and identified this need. MUMH and Shepherd’s Clinic have had a longstanding relationship to address this community need. MUMH continues to support Shepherd’s Clinic and Joy Wellness Center as a site for community wellness and prevention programs.</p> <p>86 million Americans have prediabetes and only 9 million of the 86 million people with prediabetes know they have it. 15% to 30% of those people with prediabetes will develop type 2 diabetes within 5 years. Type 2 diabetes can be prevented if caught in the stage of prediabetes. By developing and maintaining healthy lifestyle changes prediabetes can be reversed. Type 2 diabetes is the most common form of diabetes. Currently, diabetes affects more than 29 million people. https://health.baltimorecity.gov/chronic-disease-prevention/diabetes-prevention</p> <p>Adult Obesity Rate in Maryland:29.9% https://stateofobesity.org/adult-obesity/</p> <p>Obesity Rate for adults over 18 in Baltimore 33.6% https://www.opendatanetwork.com/entity/0500000US24510/Baltimore_city_MD/health.health_behaviors.adult_smoking_valu_e?year=2015</p>
<p>A. 2. How was the need identified:</p>	
<p>B: Name of hospital initiative</p>	<p>Life Balance/Weight Management (National Diabetes Prevention Program)</p>
<p>C: Total number of people within target population</p>	<p>Adult Obesity Rate in Maryland:29.9% https://stateofobesity.org/adult-obesity/</p> <p>Obesity Rate for adults over 18 in Baltimore 33.6% https://www.opendatanetwork.com/entity/0500000US24510/Baltimore_city_MD/health.health_behaviors.adult_smoking_valu_e?year=2015</p>
<p>D: Total number of people reached by the initiative</p>	<p>65 people</p>
<p>E: Primary objective of initiative:</p>	<p>A CDC-recognized lifestyle change program developed specifically to prevent type 2 diabetes. It is designed for people who have prediabetes or are at risk for type 2 diabetes. A trained</p>

	<p>lifestyle coach leads the program to help individuals change certain aspects of their lifestyle, like eating healthier, reducing stress, and getting more physical activity. The program also includes group support from others who share the same goals and struggles. This is a year-long program is focused on long-term changes and lasting results.</p> <p>Goals:</p> <ol style="list-style-type: none"> 1. Lose 5%-& 7% of body weight 2. Exercise for at least 150 minutes per week 				
F: Single or multi-year plan:	Multi-year (2015-ongoing)				
G: Key collaborators in delivery:	<p>Center for Chronic Disease Prevention and Control Maryland DHMH Prevention and Health Promotion Administration Sue Vaeth, Diabetes Program Coordinator, DHMH MedStar Good Samaritan Hospital Shepherd's Clinic/Joy Wellness</p>				
H: Impact of hospital initiative:	<p>Class 1 Shepherd's Clinic/Joy Wellness location Total # participants that started - 40 Total # completing program -19 Total with at least 5% body weight loss at this point - 10 Total with at least 150 minutes of exercise per week - 12</p> <p>Class 2 Shepherd's Clinic/Joy Wellness location Total # participants that started - 25 Total # currently in program -19 Total with at least 5% body weight loss at this point - 7 Total with at least 150 minutes of exercise per week - 14</p>				
I: Evaluation of outcome	<p>Diabetes: Age-adjusted Mortality Rate (Deaths per 10,000) for Baltimore City decreased from 3.2% to 3.0% between the years of 2011 and 2017</p> <p>https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports</p>				
J: Continuation of initiative:	Yes				
K: Expense:	<table border="0"> <tr> <td>1.</td> <td>\$4,500</td> <td>c.</td> <td>\$0</td> </tr> </table>	1.	\$4,500	c.	\$0
1.	\$4,500	c.	\$0		

D: Total number of people reached by the initiative	14 persons served
E: Primary objective of initiative:	This program is a seven week evidenced-based workshops with the goal of helping participants become better managers of their chronic disease (improving heart health and managing hypertension). Topics include nutrition, exercise, medications, managing emotions, better communication, pain management, decision making and goal setting for better health
F: Single or multi-year plan:	Multi-year (2007 – ongoing)
G: Key collaborators in delivery:	Baltimore City Health Department - Crystal Pope, Community Health Educator MAC - Wendy Farthing Director of Evidence Based Integration CDSME/FALLS MedStar Good Samaritan Shepherd's Clinic/Joy Wellness Center
H: Impact of hospital initiative:	Results of surveys given to 8 participants at end of program 1. I have more confidence in my ability to manage my health than I did before taking this workshop Strongly Agree – 4 Agree - 4 2. I now have a better understanding of how to manage symptoms of my chronic health condition. Strongly Agree - 5 Agree – 3 3. I learned how to set an action plan and follow it Strongly Agree - 8 4. I feel more motivated to take care of my health since I took this workshop. Strongly Agree - 8
I: Evaluation of outcome	Heart Disease: Age-adjusted Mortality Rate (Deaths per 10,000) for Baltimore City decreased from 25.8% to 24.4% between the years of 2011 and 2017 https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports
J: Continuation of initiative:	Yes
K: Expense:	a. \$2,000 b. \$0

Table III – Initiative VI – Heart Disease/ Chronic Disease Prevention and Management

<p>A. 1. Identified Need</p>	<p>Heart Disease/Chronic Disease Prevention and Management</p> <p>The need for chronic disease programs was identified during the FY15 CHNA process. The Advisory Task Force members compiled BCHD data and survey responses from the local community and identified this need. MedStar Union Memorial Hospital has had a longstanding relationship with Hampden Family Center and Action in Maturity. These two community organizations have a common interest to promote good health and wellness within the community.</p> <p>Baltimore City Heart Disease: Age-adjusted Mortality Rate (Deaths per 10,000) 24.4%. Number one cause of death in Baltimore City in 2017. https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports</p> <p>BCHD released a report -- <i>Healthy Baltimore 2015</i> -- that summarized 55 neighborhood health profiles and identified CVD as a leading cause of death, with a 20-year life-expectancy gap between high-income and low-income neighborhoods. https://health.baltimorecity.gov/node/155</p> <p>The majority (76.1%; n=151) of Community Input Survey respondents, who live and/or work in the CBSA, classified the incidence of heart disease as “severe” or “very severe.”</p> <p>There is a Healthy Baltimore 2015 goal of increasing the percent of adults with high blood pressure on medication by 10%. Baltimore City’s emergency department visit rate due to hypertension is 615/100,000 persons, compared to 265/100,000 for the state (MD SHIP, 2013).</p> <p>In 2014, the cardiovascular premature death rate (deaths before 75 years of age) among black residents was about 1.6 times that of white residents. https://health.baltimorecity.gov/sites/default/files/health/attachments/Baltimore%20City%20CHA%20-%20Final%209.20.17.pdf</p> <p>In Maryland, 30% of all deaths were attributed to</p>
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A. 2. How was the need identified:	heart disease and stroke. Heart disease and stroke can be prevented by control of high blood pressure. http://ship.md.networkofcare.org/ph/indicator.aspx?id=2040	
B: Name of hospital initiative	Fitness for 50's Program Action in Maturity Exercise Program for Older Adults	
C: Total number of people within target population	Percentage of deaths in Baltimore City due to heart disease 24.4% Source: 2017 Neighborhood Health Profiles (Baltimore City) http://health.baltimorecity.gov/neighborhood-health-profile-reports In Maryland, 30% of all deaths were attributed to heart disease and stroke. http://ship.md.networkofcare.org/ph/indicator.aspx?id=2040	
D: Total number of people reached by the initiative	Approximately 50 served	
E: Primary objective of initiative:	Improve cardiovascular fitness Prevention/Management of hypertension	
F: Single or multi-year plan:	Multi-year (2002 –ongoing)	
G: Key collaborators in delivery:	Hampden Family Center Action in Maturity MedStar Good Samaritan Hospital	
H: Impact of hospital initiative:	Approximately 50 people attended classes twice a week for aerobic exercise, strength training and stretching	
I: Evaluation of outcome	Heart Disease: Age-adjusted Mortality Rate (Deaths per 10,000) for Baltimore City decreased from 25.8% to 24.4% between the years of 2011 and 2017 https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports	
J: Continuation of initiative:	Yes	
K: Expense:	a. 6,530	b. \$0

Table III – Initiative VII – Heart Disease/ Chronic Disease Prevention and Management

<p>A. 1. Identified Need:</p>	<p>Heart Disease/Chronic Disease Prevention and Management</p> <p>The need for chronic disease programs was identified during the FY15 CHNA process. The Advisory Task Force members compiled BCHD data and survey responses from the local community and identified this need. MUMH and Shepherd’s Clinic have had a longstanding relationship to address this community need. MUMH continues to support Shepherd’s Clinic and Joy Wellness Center as a site for community wellness and prevention programs.</p> <p>Percentage of deaths in Baltimore City due to heart disease 24.4%</p> <p>Source: 2017 Neighborhood Health Profiles (Baltimore City) http://health.baltimorecity.gov/neighborhood-health-profile-reports</p> <p>Adult smokers in Baltimore City – 25.1% http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship32</p>
<p>A. 2. How was the need identified:</p>	
<p>B: Name of hospital initiative:</p>	<p>American Cancer Society's FreshStart Smoking Cessation Program</p>
<p>C: Total number of people within target population:</p>	<p>Percentage of deaths in Baltimore City due to heart disease 24.4%</p> <p>Source: 2017 Neighborhood Health Profiles (Baltimore City) http://health.baltimorecity.gov/neighborhood-health-profile-reports</p> <p>Adult smokers in Baltimore City – 25.1% http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship32</p>
<p>D: Total number of people reached by the initiative:</p>	<p>8 persons served</p>
<p>E: Primary objective of initiative:</p>	<p>Freshstart is designed to help plan a successful quit attempt by providing essential information, skills for coping with cravings, and group support. Participants are also referred to the Maryland Quit line for nicotine patches/gum.</p>
<p>F: Single or multi-year plan</p>	<p>Multi-year (2016 – ongoing)</p>
<p>G: Key collaborators in delivery:</p>	<p>American Cancer Society Shepherd's Clinic/Joy Wellness Center Maryland Quitline MedStar Good Samaritan Hospital</p>
<p>H: Impact of hospital initiative:</p>	<p>Two 4-week workshops were conducted in FY 17</p>

	8 participants 2 reported being smoke free	
I: Evaluation of outcome:	Heart Disease: Age-adjusted Mortality Rate (Deaths per 10,000) for Baltimore City decreased from 25.8% to 24.4% between the years of 2011 and 2017 https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports	
J: Continuation of initiative:	Yes	
K: Expense:	a. \$1,657	b. \$0

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

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

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

MUMH was also awarded a two-year grant from CHRC in efforts to expand access to affordable, high-quality health care services in underserved areas of the state. Awarded funds allowed the hospital to open a new FQHC site operated by Total Health Care on the hospital’s campus. The FQHC serves patients from Baltimore City who are chronically ill and who are frequent users of the hospital ED and inpatient services.

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.

Gaps identified by MedStar Union Memorial Hospital are:

- Timely placement of patients in need of inpatient psychiatry services
- Limited availability of outpatient psychiatry services
- Limited availability of inpatient and outpatient substance abuse treatment
- Medication assistance
- Dentistry

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

Table IV – Physician Subsidies

Category of Subsidy	Explanation of Need for Service
Non-Resident House Staff and Hospitalists	MedStar Union Memorial Hospital is a safety net hospital with a considerable uninsured and underinsured population with no primary care physicians. Subsidy is required to maintain sufficient coverage.
Coverage of Emergency Department Call	MedStar Union Memorial Hospital’s professional services are utilized to support community outreach efforts to local patients and neighboring families.

	Furthermore, MedStar provides call coverage by telephone for the Emergency Department, inpatient Orthopedic, and Hand Surgery pediatric patients.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	The demand for dialysis services in the immediate area surrounding MedStar Union Memorial is high and is expected to increase. The outpatient dialysis center at the hospital is consistently full and maintains a waitlist for services. Renal specialists are in high demand in this market. Subsidy is required to maintain sufficient coverage.

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.hsrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).
2. Attach the hospital's mission, vision, and value statement(s) (label appendix V).

VII. APPENDICES

Appendix I **Description of Financial Assistance Policy**

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

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

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

Appendix II

Financial Assistance Policy Changes

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

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

Appendix III Financial Assistance Policy

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

Policy

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

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

Scope

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

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

Definitions

1. Free Care

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

2. Reduced Cost-Care

Financial assistance for medically necessary care provided to uninsured patients in households between 200% and 400% of the FPL.

3. Medical Hardship

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

4. Maryland State Uniform Financial Assistance Application

A uniform data collection document developed through the joint efforts of Maryland hospitals and the Maryland Hospital Association.

5. Maryland Patient Information Sheet / MedStar Patient Information Sheet (Non-Maryland Hospitals)

A patient education document that provides information about MedStar's Financial Assistance policy, and patient's rights and obligations related to seeking and qualifying for free or reduced cost medically necessary care.

Responsibilities

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

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

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

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

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

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

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

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

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

4. ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE

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

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

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

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

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

Adjusted Percentage of Poverty Level	Financial Assistance Level Free / Reduced-Cost Care	
	HSCRC-Regulated Services ¹	Washington Facilities and non-HSCRC Regulated Services
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

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

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

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

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

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

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

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

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

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

5.6 Medical Hardship Reduced-Care Sliding Scale Levels:

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

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

6.1 Patients may obtain an application for Financial Assistance Application:

6.1.1 On Hospital websites

6.1.2 From Hospital Patient Financial Counselor Advocates

6.1.3 By calling Patient Financial Services Customer Service

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

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

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

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

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

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

7. PRESUMPTIVE ELIGIBILITY

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

7.1.1 Maryland Primary Adult Care Program (PAC)

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

8 MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS

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

9. PAYMENT PLANS

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

10 BAD DEBT RECONSIDERATIONS AND REFUNDS

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

Exceptions

1 PROGRAM EXCLUSION

MedStar Health's financial assistance program excludes the following:

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

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

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

What Constitutes Non-Compliance

Actions or conduct by MedStar Health employee or contract employee in violate of this Policy.

Consequences of Non-Compliance

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

Explanation And Details/Examples

N/A

Requirements And Guidelines For Implementing The Policy

N/A

Related Policies

N/A

Procedures Related To Policy

- Admission and Registration
- Financial Self Pay Screening
- Billing and Collections
- Bad Debt

Legal Reporting Requirements

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

Reference To Laws Or Regulations Of Outside Bodies

- Maryland Senate Bill 328 Chapter 60 – Maryland Hospitals Only
- COMAR 10.37.10 Rate Application and Approval Procedures – Maryland Hospitals Only
- IRS Regulations Section 501(r)

Right To Change Or Terminate Policy

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

Appendix IV Hospital Patient Information Sheet

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

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

Patients' Rights

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

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

Patients' Obligations

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

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

Contacts

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

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

For information about Maryland Medical Assistance

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

Learn more about [Medical Assistance](#) on the Maryland Department of Human Resources website.

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

Appendix V
Hospital's Mission, Vision, Value Statement

MedStar Union Memorial Hospital

Mission

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

Vision

The trusted leader in caring for people and advancing health.

Values

- **Service:** We strive to anticipate and meet the needs of our patients, physicians and co-workers.
- **Patient First:** We strive to deliver the best to every patient every day. The patient is the first priority in everything we do.
- **Integrity:** We communicate openly and honestly, build trust and conduct ourselves according to the highest ethical standards.
- **Respect:** We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.
- **Innovation:** We embrace change and work to improve all we do in a fiscally responsible manner.
- **Teamwork:** 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