I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. The licensed bed designation of Mt Washington Pediatric Hospital (MWPH) is 102, which includes pediatric specialty, pediatric chronic illness, and neonatal transitional care. Inpatient admissions for FY17 were 636 admissions.

   Table 1 describes general characteristics of MWPH such as percentages of Medicaid recipients and uninsured persons delineated by primary service area zip code. The primary service areas listed below are ordered from largest to smallest number of discharges during the most recent 12-month period available (i.e. FY17), as defined by the Health Services Cost Review Commission (HSCRC). Medicaid patients accounted for 80.6% of the total MWPH admissions in FY17 and 5% of these Medicaid patients live in the 21215 zip code which is a target area of the hospital's community benefit service area (CBSA). The socioeconomic criteria of this zip code will be discussed in greater detail in Table II.

Table I

Bed Designation:	**Inpatient Admissions:**	**Primary Service Area Zip Codes:**	**All other Maryland Hospitals Sharing Primary Service Area:**	**Percentage of Uninsured Patients, by County:**	**Percentage of Patients who are Medicaid Recipients, by County:**
102 ***Type*** **86**- Pediatric Specialty **16**-CARF Accredited Rehabilitation ***Location*** **84**-West Rogers(Baltimore) Campus **15**- Prince George's Hospital Center	636	21222 21220 21206 21215 21213 21061 21221 21205 21217 21224 21227 21225 21037	UMD St. Joseph's Mercy Johns Hopkins St. Agnes Union Memorial UMD Midtown Northwest GBMC Kennedy Krieger UM Capital Regional Hospital Sinai	0% Uninsured Patients	**81% of all Patients were Medicaid recipients** Baltimore City 56% Baltimore County 19% Prince Georges County 9% Anne Arundel County 8 % Harford County 4% Howard County 2% St. Mary's County 2%

2. Community Description:

a. MWPH located in the northwest quadrant of Baltimore City, serving both its immediate neighbors and others from throughout Baltimore City, County and several other counties in the region. There are approximately 1.3 million children in Maryland and the Healthcare provider market has largely consolidated into three major systems, UMMS, Johns Hopkins Medicine, and Medstar. We are presently experiencing a unique regulatory environment, with almost 70,000 neonatology discharges (<25% to Hopkins and UMMS) and almost 25,000 pediatric discharges (>50% to Hopkins and UMMS). The neighborhoods surrounding MWPH are identified by the Baltimore Neighborhood Indicators Alliance (BNIA) as Southern Park Heights (SPH) AND Pimlico/Arlington/Hiltop (PAH)[1].

The primary service area zip codes do not necessarily determine eligibility for community benefit services, because MWPH is a specialty pediatric facility, our patient's residence span the state of Maryland and many more from out of state. MWPH determined that the specific zip codes of 21215 & 21216 define the hospital's Community Benefit Service Area (CBSA) and constitute an area that is predominantly African American with below average median family income, but above average rates for unemployment, and other social determinants of poor health.

Relying on data from the American Community Survey[2], SPH's median household income was $26,015 and PAH's median household was $32,410. This is compared to Baltimore City's median household income of $41,819 in 2014. The percentage of families with incomes below the federal poverty guidelines[3] in SPH was 46.4%, in PAH, 28.4% of rates for SPH and PAH, were 23.6% and 17.1% respectively while the Baltimore City unemployment rate recorded in 2014 was 13.1%.[4]

The racial composition and income distribution of the zip codes described below reflect the segregation and income disparity characteristic of the Baltimore metropolitan region. As indicated above, those zip codes that have a predominantly African American population, including 21215, reflect the racial segregation and poverty representative of Baltimore City. This is in contrast to neighboring Baltimore County zip codes (21208 &21209) in which the hospital is located, the median household income is much higher, and in which the population is predominately white.

The Baltimore City Health Department uses the Community Statistical Areas (CSA) when analyzing health outcomes and risk factors. The CSAs represent clusters of neighborhoods based on census track data rather than zip code and were developed by Baltimore City Planning Department based on recognizable city neighborhood perimeters. In the chart below, we present the community benefit activities at MWPH. Two zip codes (21207 & 21222) span city and county lines (see footnote below chart). At the time of this report, Baltimore County did not provide CSAs

[1] Baltimore Neighborhood Indicators Alliance (BNIA), 2014 (1-year estimates)
[2] American Community Survey, (2011-2015, 5 year estimates)
[3] Baltimore City Health Department, Neighborhood Health Profiles, 2017
[4] American Community Survey (ACS), (2011-2015, 5 year estimates)

Table II

Community Benefit Service Area(CBSA)[5] ***Target Population (by sex, race, ethnicity, and average age)***			
CBSA Zip Codes	21215 21206 21216 21213 21222		
Total Population within the CBSA	144,744		
Sex	*Male*		66,766
	Female		77,977
Age	*0-17 yrs.*	43,423	30%
	18-24 yrs.	62,830	4.3%
	25-44 yrs.	38,024	10.6%
	45-64 yrs.	38,625	15.9%
	65+yrs.	20,471	13.4%
Race/Ethnicity	*White Non-Hispanic*	5,604	3.9%
	Black Non-Hispanic	135,480	93.6%
	Hispanic	1,530	1.05%
	Asian and Pacific Islander non-Hispanic	703	0.5%
	All others	2,150	1.5%

CBSA Community Characteristics ***Socioeconomic***				
Baltimore City Neighborhood	**Zip Code**	**Median Household Income**	**% of households with incomes below federal poverty**	**Unemployment**
Baltimore City		$41,819	28.8%	13.1%
Pimlico/Arlington/Hilltop	21215	$32,410	28.4%	17.1%
Southern Park Heights	21215	$26,015	46.4%	23.6%
Clifton Berea	21206	$25,738	30.2%	17.4%
Upton /Druid Heights	21217	$15,950	60.1%	22.3%
Dorchester/ Ashburton	21216	$36,870	31.6%	21.9%
Greater Mondawmin	21216	$38,655	28.4%	19.0%
Dundalk	21222	$30,597	16.5%	19.0%
Belair-Edison	21213	$38,906	29.1%	16.2%

[5] Baltimore Neighborhood Health Profiles 2017

(Table II Cont.) Education				
Baltimore City Neighborhood	**Zip Code**	**% of Kindergartners "ready to learn**	**% of High School Students missing 20+ days**	**% of residents with a high school diploma or less**
Baltimore City		77.6%	38.7%	47.2%
Pimlico/Arlington/Hilltop	21215	80.9%	46.4%	66.2%
Southern Park Heights	21215	63.2%	43.6%	69.0%
Clifton Berea	21206	79.0%	46.9%	63.3%
Upton /Druid Heights	21217	74.0%	46.0%	60.3%
Dorchester/ Ashburton	21216	58.9%	32.6%	55.6%
Greater Mondawmin	21216	83.6%	34.7%	57.9%
Dundalk	21222	93.8%	44.9%	61.0%
Belair/Edison	21213	75.3%	37.5%	5.7%

Access to Healthy Foods			
Baltimore City Neighborhood	**Zip Code**	**Corner Store Density (# of corner stores per 10,000 residents)**	**Carryout Density (# of carryouts per 10,000 residents)**
Baltimore City		14.1	11.4
Pimlico/Arlington/Hilltop	21215	18.6	14.4
Southern Park Heights	21215	11.3	6.0
Clifton-Berea	21206	20.3	12.2
Upton/Druid Heights	21217	23.2	16.4
Dorchester/Ashburton	21216	11.9	9.3
Greater Mondawmin	21216	15.0	12.9
Dundalk	21222	14.4	12.8
Belair Edison	21213	11.5	6.9

Housing				
Baltimore City Neighborhood	**Zip Code**	**Vacant Building Density (# vacant buildings/10,000 units)**	**Hardship Index* (*Description Below*)**	**Lead Paint Violation Rate (# of violations per year/10,000 residents)**
Baltimore City		562.4	51	9.8
Pimlico/Arlington/Hilltop	21215	1,097.3	61	12.8
Southern Park Heights	21215	1,374.5	73	20.9
Clifton-Berea	21206	2,649.3	61	48.7
Dorchester/ Ashburton	21216	224.1	61	10.7
Greater Mondawmin	21216	1039.8	62	17.9
Upton/ Druid Heights	21217	1136.1	82	16.2
Dundalk	21222	105.6	69	1.2
Belair-Edison	21213	276.8	55	9.9

**The Hardship Index combines indicators of public health significance from six socioeconomic indicators- housing, poverty, unemployment, education, income, and dependency. The Index ranges from 100=most hardship to 1= least hardship. This composite score of socioeconomic hardship within a CSA, relative to other CSAs and to Baltimore City.*

(Table II Cont.)		*Community Built and Social Environment*		
Baltimore City Neighborhood	**Zip Code**	**Liquor Store Density Rate (# stores/10,000 residents)**	**Youth Homicide Incidence Rate (#homicides/ 100,000 residents <25 years old**	**Infant Mortality Rate (# reported incidents/10,000 residents)**
Baltimore City		3.8	31.3	10.4
Pimlico/Arlington/Hilltop	21215	1.7	56.8	20.0
Southern Park Heights	21215	4.5	48.9	15.5
Clifton-Berea	21206	6.1	107.0	14.8
Dorchester/ Ashburton	21216	1.7	70.7	6.4
Greater Mondawmin	21216	3.2	46.7	5.2
Upton/Druid Heights	21217	2.1	27.9	49.6
Dundalk	21222	3.2	9.5	8.9
Belair-Edison	21213	2.3	42.3	10.1

Life Expectancy & Mortality			
Baltimore City Neighborhood	**Zip Code**	**Life Expectancy at birth (in years)**	**Percentage of Live Births Occurring Preterm (less than 37 wks gestation)**
Baltimore City		73.6	12.4%
Pimlico /Arlington/Hilltop	21215	68.2	15.0%
Southern Park Heights	21215	70.1	13.4%
Clifton-Berea	21206	66.9	14.7%
Dorchester/ Ashburton	21216	73.4	14.5%
Greater Mondawmin	21216	70.4	15.1%
Upton/Druid Heights	21217	68.1	13.5%
Dundalk	21222	72.7	11.3%
Belair-Edison	21213	72.0	16.1%

Percentage of Uninsured people by County within the CBSA (Baltimore City)				
Health Insurance Coverage	**Estimate**	**Margin of Error (+/-)**	**Percent**	**Margin of Error (+/-)**
With health insurance coverage	646,300	10,414	90.6%	0.8
With private health insurance coverage	564,262	11,439	79.1%	1.2
With public health coverage	186,337	7,005	26.1%	1
No health insurance coverage	66,699	6,013	9.4%	0.8

Life Expectancy, Infant Deaths, Low Birth Weights, Sudden Infant Death, Child Maltreatment, by County within the CBSA (Baltimore City[6])					
Measure Description	**Baltimore City Baseline**	**Baltimore City Update**	**Maryland Update**	**Race/Ethnicity City Update**	**Race/Ethnicity State Update**
Life Expectancy (at birth)	72.9	73.6	79.3	Black-- 71.5 White-- 76.5	Black-- 76.4 White-- 80.2
Infant Mortality (per 1,000 births)	12.3	10.4	6.7	Black-- 15.8 Non-Hispanic (NH) White-- 5.3	Black-- 11.8 Hispanic-- 4.1 NH White-- 4.2
Low Birth Weight (percentage)	12.3%	12.4%	8.8%	API-- 8.9%* Black-- 14.8% Hispanic-- 6.4% White—8.0%	API-- 8.9% Black-- 12.1% Hispanic-- 7.0% NH White-- 6.9%
Sudden Infant Death Syndrome (per 1,000 births)	2.07	2.10	0.93	***	NH Black—1.68 NH White—0.69
Child Maltreatment (per 1,000 children <18 yrs. With cases reported to social services)	13.8	13.8	5.3	N/A	4.8

The presence of health disparities as well as social determinants of health are a major key factor in determining what the target population for our CBSA and how MWPH might serve it best as a pediatric specialty hospital. Unlike most other hospitals that share one or more of our primary service area zip codes and because of the specialty services we provide, patients come to MWPH from all over the state of Maryland and Pennsylvania. MWPH is also located within the 21209 zip code that is a part of Mt Washington /Coldspring CSA that is one of the most wealthy and healthy neighborhoods in the city of Baltimore. Interestingly enough, MWPH is within walking distance from the 21215 zip code and Pimlico/Arlington /Hilltop neighborhood which as the aforementioned data demonstrate had several health disparities: poverty and vulnerable populations.

MWPH realizes that population health improvement requires focusing beyond the healthcare clinical space and moving into the innovative non-medical healthcare space to comprehensively address all factors that determine health. This is exemplified through MWPH community benefit programs such as the Healthy Living Academy, Bullying Prevention Program, Telepsychology, Weigh Smart, Abilities Adventures, and Injury Prevention programming that will be discussed in Table III.

[6] Maryland Health Improvement Process 2015

*Asian Pacific Islander

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

   X Yes
   ____No

   MWPH completed its second Community Health Needs Assessment in conjunction with other University of Maryland Medical Systems hospitals in June 2015. It is available for viewing at this link:

   Provide date here. 06/28/15 (mm/dd/yy)

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

   http://www.mwph.org/about/community-advocacy

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

   X Yes 06/26/15 Enter date approved by governing body here: 11/07/16
   ____ No

   The MWPH implementation strategy is at the end of the CHNA document and can be viewed using the same link

   http://www.mwph.org/about/community-advocacy

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. Is Community Benefits planning part of your hospital's strategic plan?
   X Yes

   The MWPH Community Advocacy & Injury Prevention Program which includes two full time employees, whose primary responsibility includes the operation, administration, reporting, record-keeping, and overall management of all community benefit activity and initiatives. This department develops a 3 year strategic plan to guide their work. One of the 3 goals was to develop strong partnerships, build upon community awareness of the hospital's services, and capitalize upon existing community relationships to further the hospital's mission as it relates to eliminating health disparities. In addition, the plan cites a need for infrastructure for community benefit resource distribution, which will ensure that identified needs are matched with appropriate community benefit programming and that resources are leveraged and honed to strengthen community impact in areas of need.

   In 2015, the MWPH hospital wide strategic plan identified four priorities for fiscal years 2015-2020. These priorities included:

1) Innovation- Industry leadership in the use of transitional settings.
2) Integration- Integral part of the pediatric continuums of UMMS and Hopkins
3) Impact- Viewed as a high value resource for medically complex children
4) Involvement-Engaged with others in advocacy, education and reform.

As MWPH continues to engage with a broad array of stakeholders to help to build sustainable solutions for medically complex children, we will actively transfer knowledge and best practices in core areas of expertise to providers locally and regionally. We are actively participating in advocacy efforts for medically complex children which includes but is not limited to, prevention and/or health education, family education and training, innovative funding approaches, and community outreach. This will build awareness about the care of medically complex children in the state and regional pediatric health care delivery system.

Our metrics include community benefit contributions, participation in advocacy efforts (nationally, regionally, and locally), percent of children managed through a medical home or similar models, transfers to/from community-based settings, and the number or students, residents, and fellows involved in care.

b. What stakeholders in the hospital are involved in your hospital community benefit process/structure to implement and deliver community benefit activities? (Please place a check next to any individual/group involved in the structure of the CB process and provide additional information if necessary):

i. Senior Leadership
_X_ CEO (Sheldon Stein, CEO, President of Mt Washington Pediatric Hospital) acts as a liaison to governing bodies, both foundation and hospital boards
_X_ CFO (Mary Miller, CFO, Vice President of Finance & Business Development) fiscal oversight and management.
_X_ Other Vice President Development & External Relations Jill Feinberg-identifies external, private, and public resources to promote sustainability of community benefit programs

Vice President Outpatient Services Justina Starobin- provides data and resources to ensure that community benefit programming meets the needs of our patients/community

Vice President of Human Resources Tom Ellis- assist with managing community benefit programming human resources ensuring that participants meet human resource guidelines.

Jeneba Fofana, Fiscal Analyst- primary fiscal resource for community benefit financial reporting

Senior Leadership works very closely with the Community Advocacy Manager at all levels of the Community Benefit Operations, Community Benefit Reporting Process, and Community Health Needs Assessment.

All of the aforementioned participate in focus groups during the Community Health Needs Assessment process, as well as volunteering their time at various outreach events to the community. Our VP of Human Resources advocated for proper reimbursement of staff who participated in weekend and night activities outside of standard business hours

ii. Clinical Leadership

_X_ Physician (Vice President of Medical Affairs Dr. Richard Katz, Dr. Ajoke Akintade, Dr. Tamara Burgunder, Dr. Monica Satpute, Dr. Julia Rosenstock, Dr. Elizabeth Testa-Getzoff)

_X_ Nurse (Director of Nursing Education Sharon Meadows, Chief Nurse Executive Jenny Bowie, Nurse Educator Linda Morrison, Joan Geckle, MSN,)

_X_ Social Worker (Denise Pudinski, Ilene Devereux, Clarissa Whitaker, Rhea McDonald,Tamara Aviles)

_X_ Other (Susan Dubroff, Director Rehab Services, Child Life Specialists, Recreational Therapists, Rehabilitation Therapists, Michele Demeule (Weigh Smart Program Manager), Angie Wenman Volunteer Coor., Michelle Hanover Patient & Family Liaison)

Clinical Leadership participates in the MWPH Community Advocacy Coalition to ensure that the program stays on target with regard to implementation and strategy of Community Benefit Programming. They are also the facilitators of many of the Community Benefit Programs and Services at MWPH.

iii. Population Health Leadership and Staff/Community Benefit Operations:

1. _X_ Department

Melissa S. Beasley (Community Advocacy & Injury Prevention Manager)
Michelle Hanover (Patient Family Liaison)
Lauren Brown (Community Advocacy Program Assistant and Child Passenger Safety Program Coordinator)

Community Advocacy Manager is responsible for the overall reporting, operations, and implementation at MWPH. Provides necessary training on CBISA, the community benefit monitoring software, completes the CHNA to identify needs of the community and then creates strategic impactful programming to rectify to problems.

Patient Family Liaison, trained as a Clinical social workers acts as the eyes and ears of patients we serve, effectively communicates their needs to other staff and then facilitates many of those programs to meet their needs.

Community Advocacy Program Assistant acts as a community benefit reporting coordinator, collecting data throughout the year and monitoring expenditures. Also provides education and outreach as needed (this is part time employee)

2. _X_ Committees

MWPH is an active participant in many committees and coalitions that support vast community benefits initiatives throughout the city of Baltimore. This includes but is not limited to:

UMMS Community Benefits Team- This group meets periodically to plan major Community Benefit Activities in the West Baltimore City neighborhoods.

Members include:

Donna L. Jacobs, Senior Vice President Government and Regulatory Affairs and Community Health, UMMS
Mary Jo Adams, Nurse Coordinator, St. Joseph Medical Center
Kristen Artes Health Educator, St Joseph Medical Center
Karen Warmkessel, Media Relations Manager, UMMS

Angela Ginn-Meadows, Education Coordinator, University of Maryland Midtown Campus
Mariellan Synan, Community Outreach Manager, UM Medical Center
Anne D. Williams, DNP, RN, Director, Community Empowerment & Health Education, UMMC, UMROI, UM Midtown
Jo-Ann Williams, Manager, Career Development Programs

UMMS Community Needs Assessment Team- This group meets monthly to collaborate and identify best practices in Community Benefit programming and implementation. Members include representatives of each of the University of Maryland Medical System hospitals who have the primary responsibility of administration in community benefits.

Donna L. Jacobs, Senior Vice President Government and Regulatory Affairs and Community Health, UMMS
Mary Jo Adams, Nurse Coordinator, St. Joseph Medical Center
Kristen Artes Health Educator, St Joseph Medical Center
Laurie Fetterman, Planning & Business Development Analyst UM BWMC
Kathleen McGrath, Regional Director Outreach and Business Development Shore Regional Health
Becky Paesch, Sr. Director Strategic Planning and Enterprise UM BWMC
Vickie Ensor Bands, Dir. Community Outreach UM UCH
Kimberly Theis, Community Benefits & CHI Manager UM UCH
Anne D. Williams, DNP, RN, Director, Community Empowerment & Health Education, UMMC, UMROI, UM Midtown
Asunta Henry, Community Health Specialist, UMMS
Mariellen Synan, Community Outreach Manager UMMS

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

As we are a part of the University of Maryland Medical System (UMMS), an internal audit is completed by Donna Jacobs, Senior Vice President Government, Regulatory Affairs and Community Health.

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 you answered no to this question, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

a.)_X_Other hospital organizations (co-affiliated with University of Maryland Medical Systems and Johns Hopkins Medicine
b.)_X_Local Health Department (Baltimore City Department of Health, several offices at the state level (Department of Mental Health and Hygiene)
c.)_X_Local Health Improvement Coalitions (Baltimore City)

d.) _X_Schools (Arlington Elementary Middle, Mt.Washington School, Rosemount Elementary, Medfield Heights Elementary to name a few)
e) _X__ Behavioral Health Organizations (Family Tree, Autism Speaks)
f) _X__Faith Based Community Organizations
g.) _X__Social Service organizations.

Organization	Name of Collaborator	Title	Collaboration Description
University of MD Medical Systems	Anne Williams	Director, Community Health Improvement	CHNA Surveys/Focus Groups/ Outreach Activities
Park Heights Renaissance Baltimore City Public Schools	Jimmy Mitchell	Community Coordinator Arlington Elementary Middle	Focus Groups/ Healthy Living Academy/ Success For All Program/ Violence-Prevention Youth Program
Medfield Heights Elementary School	Amber Kilcoyne	Principal	Bullying Prevention Project
B'more for Healthy Babies	Stacey Stephens	Director	Safety Baby Showers/ Focus Groups/ Pass It On Initiatives
MD Department of Health	Shantell Roberts	Public Health Analyst	CHNA Focus Group, Implementation and Strategy Planning, Maternal/Child Health
MWPH Foundation Board	Matthew L. Cohen,	Chairmen/President	MWPH Community Advocacy Coalition
Safe Kids Baltimore	Karen Hardingham	Coordinator	Injury Prevention Initiatives
Traumatic Brain Injury Society	Susan Dubroff	Advisor	Injury Prevention Initiatives
Dayspring Head Start	Malika Joyner	Family Services Supervisor	Precious Cargo
MD Department of Health	Courtney Lewis	Director	Health Literacy Initiative
Catholic Charities Head Start	Mary Gunning	Director	Precious Cargo and Parents who are at-risk for violence sessions
The Family Tree	Patricia Ross	Supervisor	Support Groups (Space, Baby's 1st year
The Community Engagement Department of the Baltimore City Police Department NW District	Officer Chantell English Major Charles Gibson	Baltimore City Police Department Officers	MENTOR Program
Green & Healthy Homes Initiative	Marche Templeton	Analyst	Lead poisoning and asthma prevention
Holistic Life Foundation	Ali and Atman Smith	Founders/Instructors	MENTOR Program
BCHD Local Health Improvement Committee	Kelleigh Eastman	Special Projects Director	CHNA/LHIC/Population Health Improvement

c. Is there a member of the hospital organization that is co-chairing the Local Health Improvement Coalition (LHIC) in the jurisdictions where the hospital organization is targeting community benefit dollars? ___yes __X_ no

d. Is there a member of the hospital organization that attends or is a member of the LHIC in the jurisdictions where the hospital organization is targeting community benefit dollars?
X yes ____ no

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INTIATIVES

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

1. Please see Table III

Table III

Identified Need	<u>Encourage safe physical environments for children</u> During the CHNA conducted in FY15, Mt Washington Pediatric Hospital (MWPH) met with community partners to determine that community health problems and were greatest issues concerning infant mortality. The number one killer of children in the United States and locally is preventable injuries. This includes substantially reducing child maltreatment by providing parents with proper techniques in behavior management. Baltimore City Data: • The death rate from unintentional injuries declined by 60% from 1987 to 2012. • In 1987, 16,501 children ages 19 and under died from unintentional injuries, and the death rate was 23.39 per 100,000 children. • In 2013, 7,645 children ages 19 and under died from unintentional injuries, and the death rate was 9.3 per 100,000 children. • The number of unintentional injury deaths fell by 53.7% during this time period. <u>Reduce the percentage of births that are low birth-weight(LBW) in West Baltimore</u> During the CHNA conducted in FY17, another need that was identified for the same population was reducing low-birth weight babies in Baltimore. By extending the Safety Baby Shower to expecting moms in the Belly Buddies program of Healthy Start MWPH was able to provide education and materials to provide support to expecting mothers who met the demographic. Baltimore City Data: • In 2015, a total of 73 infants died, resulting in an infant mortality rate of 8.4 infant deaths per 1,000 live births • Sleep-related infant deaths in Baltimore City have decreased by more than 50% since 2009 (from 27 deaths in 2009 to 13 deaths in 2015), which has greatly contributed to the decrease in the IMR • In 2015, a black infant was almost 2 times more likely to die than a white infant, resulting in 23 excess black infant deaths* • In 2015, Baltimore City's infant mortality rate was 1.3 times greater than Maryland's rate, resulting in 15 excess infant deaths*
Hospital Initiative	<u>Initiative</u>: Safety Baby Showers. MWPH decided to support evidenced-based Innovative Pre-natal programs that reduce LBW in West Baltimore Communities by utilizing an injury prevention based curriculum
Primary Objectives	1) Provide safety baby showers to women and/or their families to educate them about injury prevention topics such as choking, poisoning, child passenger safety, burning/scalding, infant sleep safety and falls and other residential injuries. a) <u>Description</u>: Safety Baby Showers are monthly at MWPH on the 3rd Thursday of every month. Consistency in scheduling promoted increased participation and engagement. Because we are a specialty facility many patients are in the hospital for many months at a time, they would often attend more than one shower but bring another family member with them that had not attended

	because they wanted to make sure that everyone who that came in contact with the child had proper training in preventing injuries. b) Metrics: Attendance sheet/Pre and Post Tests. 2) Provide materials on proper nutrition, physical activity, and stress management to encourage healthy full-term pregnancies Description: Baby's 1st Year is a health literacy program that helps pregnant moms read, understand, and act upon pregnancy information. The program has the following goals: a) Provide comprehensive and easy-to-read prenatal materials that are not only beautiful but also serve as a catalyst for learning and health literacy. b) Empower underserved parents to be active participants and effectively navigate the healthcare system, advocating on their own behalf and on behalf of their children and families. c) Teach healthcare providers to think about health literacy and cultural competency with their patients, integrating tools into daily practice to improve patient communication and compliance. d) Build community initiatives so families receive consistent, comprehensive, integrated, prenatal care information.
	3) Provide talks on behavior management, medication administration, lead poisoning safety, appropriate toys/play, baby signing, and a resource guide to parents of free resources in the community to provide parents with skills and tools required to be better and more engaged parents a) Description: During the Safety Baby Shower supplemental information is provided by clinical staff such as nurses, child life specialists, rehabilitation therapists, and outside community agency partners to provide parents with as many of the tools as possible to get them on the right foot for being well informed and safer parents. b) Metrics: In order to properly discharge a patient, clinical staff must provide training on safe sleep, medication administration, developmentally appropriate play and toys, child passenger safety among other topics. Many clinical staff felt that the training is often rushed and that parents weren't retaining the information as well as they would like. The Safety Baby Shower gives the parent more time with clinical staff and an opportunity to "teach back" what was learned. After completing assignment, that staff signs off on the training and it is recorded as completed training in the Meditech system for documentation. This has assisted with nursing staff feeling less overwhelmed on the unit as well.
Single or Multi-Year Initiative Time Period	Multi-Year – MWPH is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.

Key Partners in Development and/or Implementation	B'More Healthy Babies, Baltimore Healthy Start Programs, St. Vincent De Paul, Catholic Charities and the Central Y of MD Head Start programs.	
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above.	
Outcomes (Include process and impact measures)	Objective 1-3: Provide talks on behavior management, medication administration, lead poisoning safety, appropriate toys/play, baby signing, and a resource guide to parents of free resources in the community to provide parents with skills and tools required to be better and more engaged parents Metric: Participants took Pre and Post test that focused on various injury prevention topics which also included safe sleep and shaken baby syndrome. The B'More Healthy program provided parents with a 15 min. video about sleep safety and a talk about nutrition physical activity and stress management. • Outcomes A total of eighteen 2-hour talks were conducted with a total of 356 participants. • On the pre-talk test, 197 of the participants answered at least one of the 12 questions wrong. 116 of the participants answered enough questions correctly to earn a passing score on the post-talk survey. Forty-three (43) of the participants answered four or fewer questions correctly. • On the post-talk test 343 of the participants answered all 12 questions correctly and 13 participants answered 11 of 12 correctly All participants earned a passing score on the post test. • Safety Baskets were provided with prevention materials (latches, bath hot water thermometers, poisoning control magnets) and educational materials on how to safety proof home provided to 326 participants **please note ALL family members are encouraged to attend, many just come for education and not a gift. i.e. grandparents, spouses, siblings)	
Continuation of Initiative	Yes. This program is one of the very well-received programs at MWPH. Both community partners and parents have requested the program to expand and we are consistently looking for additional financial support to increase the outreach of the program.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A.$20,000	B. $10,000

Identified Need	<u>Reduce the proportion of youth who are obese and thus increase the proportion of adults who are at a healthy weight (LBW)</u> During the CHNA conducted in FY17, Mt Washington Pediatric Hospital (MWPH) met with community partners to determine that community health problems and were greatest poor health outcomes locally and nationally. Obesity, as well as the co-morbidities of obesity (diabetes, hypertension, cardiovascular disease, high cholesterol) continue to cause health disparities in the MWPH community benefit service area (CBSA) as well as nationally and locally Baltimore City Data: Long-Term Goals: Healthy People 2020 NWS 9 (LHI)– Reduce the proportion of adults who are obese Healthy People 2020 NWS 10 (LHI) - Reduce the proportion of children and adolescents who are obese Healthy People 2020 NWS 14 & 15 – Increase the variety & contribution of fruits & vegetables to the diets of the population aged 2 yrs and older Healthy People 2020 PA 2.4 – Increase the proportion of adults who meet the objectives for aerobic physical activity and for muscle- strengthening activity 1) Maryland SHIP # 30 – Increase the proportion of adults who are at a healthy weight (Balto City Baseline: 33.1% » 2017MD Target: 35.7%) 2) Maryland SHIP #31 – Reduce the proportion of youth (ages 12-19) who are obese (Balto City Baseline: 17.4% » 2017 MD Target: 11.3%) 3) Maryland SHIP #25 – Reduce deaths from heart disease (Deaths/100,000 age-adjusted) (Balto City Baseline: 259.7 » 173.4) 4) Maryland SHIP #27 – Reduce diabetes-related emergency department visits (Balto City Baseline: 823.7 » 2017 MD Target: 330.0) who met the demographic.
Hospital Initiative	<u>Initiative</u>: Weigh Smart/Weigh Smart Jr. and Healthy Living Academy. Educate & engage community on the importance of daily physical activity guidelines using evidence- based research & programs
Primary Objectives	1) Investigating diet quality before and after participation in a pediatric weight management program. 2) Identifying poor diet quality that is associated with obesity such as inadequate fruit and vegetable intake, excessive sugar-sweetened beverages (SSB) and fast food intake. 3) Provide an inter-professional psycho-educational weight management program involving medicine, nutrition, physical therapy, and psychology 4) Establish a coordinated holistic approach to management of diagnoses that have a nutritional component. 5) Engage targeted communities on healthy lifestyles: - Sponsor community meetings - Advocacy - Food Label Sessions - Cooking Demos/Tastings 6) Develop & distribute healthy food information at various health fairs.
Single or Multi-Year Initiative	Multi-Year – MWPH is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.

Key Partners in Development and/or Implementation	YWCA Baltimore, The League for People with Disabilities, Mt Washington School, Arlington Elementary Middle School
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the "Primary Objectives" section above.
Outcomes (Include process and impact measures)	Objective 1-3: Provide talks on behavior management, medication administration, lead poisoning safety, appropriate toys/play, baby signing, and a resource guide to parents of free resources in the community to provide parents with skills and tools required to be better and more engaged parents Metric: Children's Dietary Questionnaire (CDQ) was administered to caregivers of patients ages 2-17 years during initial consultation. Change in body composition- weight, height, BMI, body fatness. Change in quality of life by parent and child self-report, change in dietary quality, change in behaviors by child and parent report • Outcomes A total of 3395 participants, 78% show decreased Body Mass Index z score at 1 yr 21% ↓ mean insulin levels 4% ↓ mean cholesterol level 14% ↓ mean triglyceride level • Diet changes French fries • ↓ from 1.06 to 0.49 (p=0.023) over last 7 days Fast food ↓ from 1.55 to 0.75 (p=0.000) over last 7 days Fruit juice/fruit drink ↓ from 2.15 to 1.53 (p=0.021) in the past 24 hours Soft drink/sweet tea/koolaid/lemonade (not diet) ↓ 1.77 to 1.23 per wk (p=0.073) Potato chips, other chips (e.g. Fritos, Doritos) or crackers ↓ 1.49 to 1.05 per wk (p=0.096) Ice-cream/Popsicles ↓ 1.14 to 0.69 per wk (p=0.069) • Also statistically significant improvements in quality of life measurements. • Attended 56 health fairs and distributed materials as well as provided demonstration of proper food portions with food models. **HEALTHY LIVING ACADEMY** Mt. Washington Pediatric Hospital Healthy Living Academy (HLA), a wellness program for children enrolled in kindergarten through grade three at the Mt Washington School (MWS) and Arlington Elementary Middle School (AEMS). HLA utilizes a health curriculum called the OrganWise Guys (OWG) which uses characters shaped like organs of the body to teach that lifestyle choices can have either a positive or negative effect on the body. The goals of the project are 1) to increase healthy behaviors in enrolled children and therefore decrease the risk of developing obesity and associated illnesses, and 2) to increase visibility of MWPH in the community. HLA sessions included **267** students in ten classes of kindergarten through third grade students. Classes were taught by the psychologist, psychology post-doctoral student, physical therapy assistant, and dietitian who work within MWPH's Weigh Smart® program. The program also utilized Yuba, the hospital's therapy dog, during sessions. Materials including folders, pedometers, water bottles and healthy snacks were provided to the children. Feedback from school administration and teachers was very positive, and the children were very excited to see MWPH staff return this year. Comparison of scores for a pre/post test administered showed an average 11 percent increase on test scores.

JUMPSTART

In 2015, the groundbreaking Weigh Smart® program at Mt. Washington Pediatric Hospital, Clinicians added a new program designed to get severely obese children and their families in for treatment as quickly as possible.

The Weigh Smart® Jump Start program lasts for 4-weeks and offers both educational and group exercise sessions for children and their families. The goal of Jump Start is to get families in quickly for that initial education that is so important, and then offer additional services tailored to each family's individual needs. Under Jump Start, after their initial assessment, the patient can join the next Jump Start class, instead of waiting perhaps several weeks for the next group session.

In 2009, MWPH added Weigh Smart® Jr., a program targeting children in the two to seven-year-old range, when clinicians noticed younger siblings of patients with obesity were also overweight or obese.

The typical Weigh Smart Jr. patient who now comes to us is 5 years old and weighs about 100 lbs., according to Michelle Demeule-Hayes, Weigh Smart® Program Director; "We need to treat children earlier than ever before."

Mt. Washington Pediatric Hospital is one of 118 children's hospitals in the U.S. that contributed to a recent Children's Hospital Association report on the evolving field of obesity treatment in children's hospitals. The report, "2015 Survey Findings of Children's Hospitals Obesity Services," outlines why such programs are critical for tackling the nationwide health epidemic.

In Baltimore City, the problem is widespread. The City Health Department released statistics on a random sample of 2,143 students assessed for BMI by BCHD School Health staff-- more than a quarter (26%) of the children in the study were considered obese. Furthermore, for Pre-K and K students, the rates were significantly higher for obesity than for all other grades (31%).

Nationwide, more than one-third of children are overweight or obese, making it the most widespread public health issue facing children. Over the last 30 years, obesity rates have more than doubled in young children and quadrupled in teens. Childhood obesity was been identified as an issue of community need in the hospital's most recent community health needs assessment.

In 2005, Mt. Washington Pediatric Hospital started one of the earliest programs with a comprehensive approach that also addressed the psychological components involved in being a child with a weight issue.

Through Weigh Smart®, Weigh Smart® Jr., Jump Start and the Adolescent Bariatric Surgery Evaluation and Management program that partners with Johns Hopkins Bayview Medical Center, MWPH is working to meet the growing health needs of our community and to improve the current and future health of our children.

In fiscal year 2017, MWPH clinical staff evaluated 134 new patients. The evaluation is a comprehensive, 90 minute visit which includes a thorough assessment by the team. Staff saw 133 patients for follow up this fiscal year for a total of 267 annual visits.

Continuation of Initiative	Yes. This program is one of the very well-received programs at MWPH. Both community partners and parents have requested the program to expand and we are consistently looking for additional financial support to increase the outreach of the program.	
Expense: A) Total Cost of Initiative for Current Fiscal Year B) What amount is Restricted Grants/Direct offsetting revenue	A.$1,099,227	B. $454,488

Identified Need	During the CHNA conducted in 2015, MWPH met with community partners to determine that community health problems and it was determined by both the Family Advisory Committee and many of our clinical and public health professionals, that a large portion of the patients that were receiving long term rehabilitative care were admitted due to preventable injuries . Through further exploration, it was determined that the number one killer of all children in the U.S. was preventable injuries as well. Baltimore City Data: • Overview of Childhood Injury Morbidity and Mortality in the U.S. Fact Sheet (2015) Fatalities • The death rate from unintentional injuries declined by 60% from 1987 to 2012. • In 1987, 16,501 children ages 19 and under died from unintentional injuries, and the death rate was 23.39 per 100,000 children. • In 2013, 7,645 children ages 19 and under died from unintentional injuries, and the death rate was 9.3 per 100,000 children. • The number of unintentional injury deaths fell by 53.7% during this time period.1 The five leading causes and number of unintentional injury-related deaths, by age group, United States, 20132 Rank Age
Hospital Initiative	Initiative: Community Outreach and Advocacy Program to reduce the rate of recidivism due to child maltreatment
Primary Objectives	3) Provide talks on behavior management, appropriate toys/play, baby signing, and a resource guide to parents of free resources in the community to provide parents with skills and tools required to be better and more engaged parents c) Description: MWPH will focus on 3 strategies: 1) Offer pamphlets to patients at discharge, highlighting injury prevention methods from Safe Kids Worldwide, the Baltimore City Health Department and Johns Hopkins School of Public Health; 2) Provide the current Injury Prevention information on MWPH website and social media outlets; and 3) Emphasize utilization of tools provided in safety kits given at safety baby showers resources. d) Metrics:

	• *Strategy 1:* Community Advocacy Manager and/or Program Assistant will track the # of pamphlets distributed each Fiscal Year. • *Strategy 2:* MWPH Parent Education Task Force will evaluate all materials for literacy and efficacy and ensure that resources webpage is user-friendly on MWPH's website and tack # of users per Fiscal Year. • *Strategy 3:* Community Benefits will track # of referrals made to Safety Baskets given in the hospital and in the community. • 4) Educate community youth in Northwest Baltimore zip code 21215 on the importance of violence prevention. 5) Provide anti-bullying talks twice a month as a community benefit. Print resource guide. 6) Present Healthy Self Image Curriculum to program at Baltimore City middle and high schools that is focused of positive self-esteem and identifying bullying behaviors 7) Attend community events.
Outcomes	Partnership was established with the schools in the CSA zip codes (Arlington Elementary, Rosemont, Windsor Hill, and Grove Park). Each school was requested to select 10 students who excelled academically and would be willing to meet twice a month to provide input in the Healthy Self Image Curriculum and to start an Anti-Bullying group at their schools. Community Outreach Coordinator acted as a facilitator and then provided a summary of the information to the Education Team. Currently there are 65 active participants. 200 copies of materials distributed and a little over 40 events attended.
Single or Multi-Year Initiative Time Period	Multi-Year – MWPH is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	Medfield Heights Elementary School, Arlington Elementary School, Recreational Therapy, Rehabilitation Therapy, Psychology and Community Advocacy.
How were the outcomes evaluated?	The MWPH Education Team developed materials for the resource guide. The inter-professional group of educators, clinicians, and administrators met to ensure that the materials were appropriate and met literacy standards Edit and evaluate after 6 months to ensure accuracy.

Identified Need	**Increase the number of minority allied health care professionals (specifically pediatric nurses).** When comparing measures of income, employment, poverty, housing, incarceration and overall health, the city's black residents are living in a very different city than their wealthier white neighbors. Just over 63% of Baltimore's population is black and here are some of the stunning disparities they face. Baltimore is located in the richest state in the country, Maryland, which makes comparing the incomes of blacks in Baltimore to the median income of the state overall particularly stark, with an almost $40,000 a year a difference in earnings. But even if you compare the incomes of blacks versus whites living within the city of Baltimore, a large chasm still exists. White residents in the city make almost twice as much as black residents. The gross disparity in income has a lot to do with jobs. Decades of decline in the manufacturing and shipping industries and a shrinking population have left large sections of the city in economic despair. Meanwhile, there's been an influx of jobs in fields that are seeking white collar, college-educated workers, such as cyber security, life sciences and information technology. For young black men between the ages of 20 and 24, the unemployment rate was an astounding 37% in 2013, according to the most recent data available from the U.S. Census Bureau. That's compared with 10% for white men of the same age. Racial and ethnic minorities are woefully underrepresented in the health professions. In the 2000 U.S. Census, African Americans accounted for nearly 12.7 percent and Hispanics accounted for nearly 12.6 percent of the U.S. population. This diversity is not reflected in the health-professions workforce. African Americans and Hispanics are underrepresented in both the nation's health professions and among those currently training to work in the health professions. Diversity improves access to health care for underserved patients: • African-American, Hispanic, and Native-American physicians are much more likely than are white physicians to practice in underserved communities and to treat larger numbers of minority patients, irrespective of income.[7] • African-American and Hispanic physicians, as well as women, are more likely to provide care to the poor and those on Medicaid.[8] Diversity leads to increased racial and ethnic minority patient choice and satisfaction: • Racial and ethnic minority patients who have a choice are more likely to select healthcare professionals of their own racial or ethnic background.[9]

[7] Kington R, Tisnado D, Carlisle DM. Increasing racial and ethnic diversity among physicians: an intervention to address health disparities? In Smedley BD, Stith AY, Colburn L, Evans CH, (eds.). The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions. Washington, DC: National Academy Press, 2001.

[8] Cantor JC, Miles EL, Baker LC, Barker DC. Physician service to the underserved: implications for affirmative action in medical education. Inquiry. 1996; 33: 167-180.

[9] Saha S, Taggart SH, Komaromy M, Bindman AB. Do patients choose physicians of their own race? Health Affairs. 2000; 19: 76-83.

	• Racial and ethnic minority patients are generally more satisfied with their care, and are more likely to report receiving higher-quality care, when treated by a health professional of their own racial or ethnic background.[1011] Increasing diversity will also lead to improving the ability of the health care workforce to effectively address the health care needs of all Americans. Diversity in education environments improves the quality of education for health professionals, which, in turn, improves their ability to treat patients from a wide range of cultural and social backgrounds: • By encountering and interacting with individuals from a variety of racial and ethnic backgrounds during their training, health professionals are better able to serve the nation's diverse society by having broadened perspectives of racial, ethnic, and cultural similarities and differences.[12] • Growing evidence shows that diversity in education environments can improve learning outcomes for all students, improving such skills as active thinking, intellectual engagement, and motivation, as well as certain social and civic skills, such as the ability to empathize and have racial and cultural understanding.[13] Even though hiring has picked up in Baltimore since 2013, the trend continues. And overall, unemployment is still much higher in Baltimore than it is nationwide. To address the disparity in workforce development, CAMP NOAH was created. A program structured to give inner-city Baltimore Students an opportunity to learn of the health professions available in a pediatric specialty hospital setting.
Hospital Initiative	**CAMP NOAH (Nursing and Other Allied Health Sciences)**
Primary Objectives	CAMP NOAH to spark interest in nursing and Allied Health in the high school students of Baltimore City. <u>Description</u>: 1. Increase the number of college graduates from Northwest Baltimore City who enter into professions in Nursing or other Allied Health Sciences. 2. Increase potential career opportunities for underserved residents of Northwest Baltimore.

[10] Cooper-Patrick L, Gallo JJ, Gonzales JJ, Vu HT, Powe NR, Nelson C, Ford DE. Race, gender, and partnership in the patient-physician relationship. JAMA. 1999; 282: 583-589.

[11] Cooper LA, Powe NR. Disparities in patient esperiences, health care processes, and outcomes: the role of patient-provider racial, ethnic, and language concordance. Washington DC: The Commonwealth Fund, 2004.

[12] Whitla DK, Orfield G, Silen W, Teperow C, Howard C, Reede J. Educational benefits of diversity in medical school: a survey of students. Acad Med. 2003; 78: 460-6.

[13] Gurin P, Dey EL, Hurtado S, Gurin G. Diversity and higher education: theory and impact on educational outcomes. Harvard Education Review. 2002; 72: 330-366.

	3. Provide training, coaching and employment for program participants 4. Provide participants with experience and the opportunity to observe care practices working directly with premature infants, toddlers & adolescents, under the guidance of respiratory therapists, and child life specialists. Metrics: 16 "campers" annually participate in week long program. MWPH had student campers from 5 different area Baltimore City high schools.

Outcomes	High school students to interact with health care professionals while gaining real world experiences. All students receive education in First Aid & CPR, nursing observation experiences, and all necessary equipment such as stethoscopes, scrubs, and breakfast and lunch.	
Single or Multi-Year Initiative Time Period	Multi-Year – MWPH is looking at data over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.	
Key Partners in Development and/or Implementation	Baltimore City Public Schools, Baltimore Alliance for Careers in Healthcare Nursing Education Department, Community Advocacy & Outreach Program	
How were the outcomes evaluated?	The MWPH Education Team developed materials for the resource guide. The inter-professional group of educators, clinicians, and administrators met to ensure that the materials were appropriate and met literacy standards Edit and evaluate after 6 months to ensure accuracy. Program evaluation by the "campers" are all very positive. Campers provided feedback that they were grateful and didn't anticipate how "hands-on" the camp was and how much time they actually provided service to patients.	
Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $2,500	B. Direct offsetting revenue from Restricted Grants N/A

Identified Need	<u>Encourage safe physical environments for children</u> During the CHNA conducted in FY15, Mt Washington Pediatric Hospital (MWPH) met with community partners to determine that community health problems and were greatest issues concerning infant mortality. The number one killer of children in the United States and locally is preventable injuries, this includes but is not limited to violence and homicide. MWPH Pediatric psychology has at its foundation the biopsychosocial model, focusing on the ways that biological, psychological, and social factors interact with the health of a child. These principles have been incorporated into core competencies (Palermo, 2014) that address domains including knowledge (*e.g., has knowledge of the effects of socioeconomic factors on health and illness; understands how other systems affect pediatric health and illness and a child's adaptation to illness*) and professionalism (e.g., *works effectively with diverse populations, as well as diverse professionals*). These competencies, and their relevance in the current social climate, anchor and reflect our ideals for a skilled and effective pediatric psychology workforce. They point to the need for us to be knowledgeable and capable of working directly with youth and families in an ever-changing climate which includes racism, xenophobia, and racial trauma. It has been difficult to escape the numerous media reports of ethnic and race-based incidents. This is especially true in light of the vitriolic political discourse leading up to the 2016 US elections. Organizations such as the Southern Poverty Law Center have been documenting what appears to be increased frequency of targeted harassment, intimidation, and crimes committed against various minority groups (Kennedy, 2016). Like other municipal agencies, the City of Philadelphia's Commission on Human Relations reported receiving more complaints about bias and hate crimes in the two months after the election than they received in the preceding 12 months, an unprecedented increase (Allyn, 2017). Young people have been the target of too many of these incidents, and when not directly targeted may be impacted by media representations and awareness of the nature of such events. As adverse events faced by ethnic minority youth and families rise, pediatric psychologists are increasingly working with families to manage the consequences of race-based stress and racial trauma. In hospital and primary-care settings across the country, clinicians and researchers have been anecdotally reporting encounters with children and teenagers where racial stress has contributed significantly to their physical and/or emotional distress. In our primary care clinics, we have seen several children and adolescents presenting with physical (e.g., headache, tension, insomnia, GI distress), emotional (e.g., worry, nightmares, depression), and behavioral (e.g., avoidance, anger, withdrawal) symptoms directly related to racial stress experienced personally or witnessed indirectly. Clinical examples from integrated primary care include Hispanic youth worried about their undocumented relatives being deported, African-American teenagers worried about being harassed, assaulted, or harmed by law enforcement officers or hate-inspired private citizens, and Muslim girls fearing harassment or intimidation while walking in their communities or schools. Psychologists in these settings have been forced to confront the 'social' aspect of the biopsychosocial model with increased frequency.

	In Baltimore where there were riots in April 2015 over the death of Freddie Gray while in police custody, families receiving pediatric psychology services have increasingly started to discuss in therapy sessions their mistrust of the police. For instance, pediatric psychologists in various specialty clinics have confronted the following clinical examples: Parents of children in a weight management program cited increased police presence as a barrier to outdoor physical activity. The families are fearful that they will be harmed or killed by the police. Similarly, a child with Type 1 Diabetes discussed in session which foods he is planning to grow when, as discussed by his pastor, 'black people are no longer accepted to live in society.' Finally, a mother of a young boy with asthma stated she would never call the police despite her son pulling a knife on her and threatening to kill her, as she believed that calling the police would be more likely than her son's gestures to lead to her death. Regrettably, clinical examples of the impact of recent race-based events on youth and families seen in pediatric psychology services are numerous. As a result, pediatric psychology has a unique opportunity to address these issues in clinical practice, research, training, and advocacy. Pediatric psychologists are being called to increase our skill, preparation, knowledge, and comfort in assessing the impact of racial stress and race-based trauma on children and families. To ensure that our interventions are flexible and sufficiently responsive to the particular needs of persons experiencing racial stress. The delivery of clinical care requires a better understanding of how these events and media representation of them (including social media) impact the health of children and families and scholarly efforts to understand the best approaches to support families. These efforts may include innovative methods such as collaborations between pediatric health centers and police community engagement departments dedicated to improving the relationships between law enforcement and the families we serve. Additionally, MWPH has the opportunity to develop new and expand existing competencies used in training pediatric psychologists to include a focus on best practices in assessment, intervention, and self-care for both families and clinicians experiencing racial trauma or race-based stress. Clinicians are not immune to the impact of these events, and developing resources for clinicians' self-care should also be prioritized. Finally, recognizing that our combined voices can be more powerful, MWPH decided to collaborate with our community partners to advocate for social justice issues affecting the families and communities we serve. <u>References</u> Allyn, B. (2017, January 11). Since November election, rate of hate crime reports rising in Philly. WHYY/Newsworks. Retrieved from http://www.newsworks.org/index.php/local/philadelphia/100423-since-november-election-rate-of-hate-crime-reports-rising-in-philly-. Kennedy, M. (2016, November 14). Hundreds of hateful incidents reported after Trump's victory. National Public Radio. Retrieved from http://www.npr.org/sections/thetwo-way/2016/11/14/502013652/hundreds-of-hateful-incidents-reported-in-wake-of-trumps-victory. Palermo, T.M., Janicke, D.M., McQuaid., E.L., Mullins, L.L., Robins, P.M. & Wu, Y.P. (2014). Recommendations for Training in Pediatric Psychology: Defining core competencies across training levels. Journal of Pediatric Psychology 39(9), 965-984

Hospital Initiative	**MENTOR -Mindfulness Engaging N Trusting Open-minded Relationships - ("In each other we TRUST")**
Primary Objectives	Co-sponsored by Mt. Washington Pediatric Hospital (MWPH) and the Baltimore Police Department. Community Partner: Holistic Life Foundation Description: The program agenda is offered 3 hours a month to youth (8-12 years) and their families to increase wellness at home and in the community. Classes were every other week for 90 minutes learning about stress management, team building, increasing community engagement, and mindfulness. Another subtler, but critically important aspect of the program is to increase child and family comfort with police officers. As the program progressed, the officers have increased the outward visual of their profession by wearing more of their uniform each session. We had Holistic Life Foundation provide instruction on yoga and breathing techniques children could use in frustrating situations and guidance on peer mediation techniques. • Participants are children whose parents/teachers kids identified as potentially at risk for negative encounters with the police; lived in similar certain neighborhoods, lower SES of single parents, etc. • To encourage youth and their families to increase wellness at home and in the community. • Enhance knowledge about meal-based structures, stress management, team building and increasing community engagement and comfort with police officers. • Provide information to youth and their families that will help guide and structure a healthy and caring lifestyle.
Outcomes	A 6-session every other week program in the afternoon at MWPH. Pre/post Questionnaires • 5 item Quantitative and Qualitative • Expectations for the program, activities you do as a family, ever practiced mindfulness before • 2 Likert questions - What is your comfort level with the police - What is your comfort level with your neighborhood • Response were low, but favorable to improving community relations with police from participants.
Single or Multi-Year Initiative Time Period	This program was structured as a multi-year initiative, however due to resource limitations the program will not take place in FY18. Instead FY18 will be utilized as a year of evaluation and planning for this initiative so that we are ready to begin again FY19.

Key Partners in Development and/or Implementation	Dr. Elizabeth Getzoff-Testa Pediatric Psychologist, Baltimore City Police Department Office of Community Collaboration Northwest District, Holistic Life Foundation	
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above by virtue pri	
Expense: A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative 5,500	B. Direct offsetting revenue from Restricted Grants N/A

2. Primary community health needs identified through the CHNA that were not addressed by the hospital were during the CHNA are safe housing, transportation, and substance abuse. In table 3.1 below, MWPH outlines its needs assessment priorities & outcomes.

Table 3.1 MWPH Community Needs Assessment Priorities & Outcomes FYs '15-18

Maryland SHIP Vision Area	MWPH Priorities (in order of priority)	SHIP Outcome Objectives
Healthy Beginnings	**Maternal/Child Health** **Lead Poisoning**	1) Reduce low birth weight (LBW) & very low birth weight (VLBW) 2) Reduce sudden unexpected infant deaths (SUIDS) 3) Increase the proportion of pregnant women starting prenatal care in the first trimester. 4) Increase the proportion of children who receive blood lead screenings
Healthy Social Environments Healthy Living	**Childhood Obesity/Chronic Disease/CVD/Diabetes** **Injury/Trauma/Violence Prevention**	1) Reduce the % of children who considered obese 2) Increase life expectancy 3) Decrease rate of alcohol-impaired driving fatalities 4) Decrease rate of distracted driving fatalities 5) Reduce rate of recidivism due to violent injury
Safe Physical Environments Healthy Communities	**Injury/Trauma/Violence Prevention** **Lead Poisoning** **Childhood Obesity/Chronic Disease/CVD/Diabetes**	1) Decrease fall-related deaths 2) Reduce pedestrian injuries on public roads 3) Increase access to healthy foods (See below: Obesity) 4) Reduce child maltreatment 5) Reduce the % of young children with high blood levels 6) Decrease fall related deaths
Access to Health Care	**Health Literacy /Education/Outreach** **Access to Health Care**	1) Increase the proportion of persons with health insurance 2) Increase general health literacy and the general populations ability to navigate the healthcare system
Chronic Disease	**Obesity/Heart Disease/ Diabetes**	1) Increase the proportion of adults who are at a healthy weight 2) Reduce the proportion of children & who are considered obese 3) Increase access to healthy foods 4) Reduce deaths from heart disease 5) Reduce diabetes-related emergency room visits

Based on the above assessment, findings, and priorities, the MWPH agreed to incorporate our identified priorities with Maryland's State Health Improvement Plan (SHIP). Using the SHIP as a framework, the

following matrix was created to show the integration of our identified priorities and their alignment with the SHIP's Vision Areas. MWPH will also track the progress with long-term outcome objectives measured through the Maryland's Department of Health & Mental Hygiene (DHMH).

Short-term programmatic objectives, including process and outcome measures will be measured annually by MWPH for each priority areas through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

In addition to the identified strategic priorities from the CHNA, MWPH employs the following prioritization framework which is stated in the MWPH Community Outreach Plan. Because MWPH, serves the region and state, priorities may need to be adjusted rapidly to address an urgent or emergent need in the community, (i.e. disaster response or infectious disease issue). The CHNA prioritized needs for the Sustained and Strategic Response Categories and the Rapid and Urgent Response Categories' needs will be determined on an as-needed basis.

MWPH will provide leadership and support within the communities served at a variety of response levels. Rapid and Urgent response levels will receive priority over sustained and strategic initiatives as warranted.

While the MWPH will focus the majority of our efforts on the identified priorities outlined in the table above, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through other health care organizations with our assistance as available.

The unmet needs not addressed by MWPH will also continue to be addressed by key Baltimore City governmental agencies and existing community- based organizations. The MWPH identified core priorities target the intersection of the identified community needs and the organization's key strengths and mission.

3. The Community Health Needs Assessments and Community Benefits Reports are integrated into the MWPH Strategic Implementation Plan to provide a context of the community for population health planning. One of the four goals within the plan directly reflect the work already conducted by the Community Advocacy Program.

   Enhancing the knowledge of specialty pediatric clinical care providers and focusing outreach and prevention efforts on programming that reduces preventable readmissions is the intent that is driving most of our population health efforts. Programs led by the Community Health Advocacy Department and Hospital Education will augment our goals. As we continue to evaluate our programming, initiatives will be further developed to address the SDoH that are primary health concerns in targeted West Baltimore population.

   STATE INNOVATION MODEL (SIM) http://hsia.dhmh.maryland.gov/SitePages/sim.aspx
   MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
   http://dhmh.maryland.gov/ship/SitePages/Home.aspx
   HEALTH CARE INNOVATIONS IN MARYLAND
   http://www.dhmh.maryland.gov/innovations/SitePages/Home.aspx
   MARYLAND ALL-PAYER MODEL http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/
   COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

VI. PHYSICIANS

1. MWPH received no physician subsidies and there are no gaps in the provision of care because we are a specialty hospital.

VII. APPENDICES

APPENDICES

APPENDIX I

a.) **Description of Patient Charity Care Policy**

The Patient Financial Assistance Policy at Mt. Washington Pediatric Hospital is a comprehensive policy designed to assess the needs of patients and families that have expressed concerns about their ability to pay for needed medical services.

Mt. Washington Pediatric Hospital makes every effort to make financial assistance information available to our patients/families. These efforts include signage at our outpatient desks and inpatient welcome areas, notices on patient bills and admissions documents, and information on our web site.

Description of how MWPH informs Patients of the Charity Care Policy

Notices informing the patient about the availability of financial assistance have been posted in certain locations within the Hospital. Notices were posted on the outpatient registration desk at Rogers Avenue, the outpatient registration desk at PG Hospital, the inpatient family welcome room at Rogers Avenue, and the inpatient nurse's station at PG Hospital. The posted notices state the following:

"Mount Washington Pediatric Hospital has a Patient Financial Assistance Program established to help patients obtain financial aid when it is beyond their ability to pay for services. An application and further information is available from the financial counselor in the admissions office."

Other means of informing the patients of availability of financial assistance include handouts, notification by the admissions office, social work staff, and patient accounting representatives, and/or billing company staff.

Also, an information sheet is provided to the patients, the patient's family, or the patient's authorized representative before discharge, with hospital bill, or on request.

The information sheet included the following items:

a. A description of the Hospital's financial assistance policy;
b. A description of the patient's rights and obligations with regard to Hospital billing and collection;
c. Contact information for the individual or office at the Hospital that is available to assist the patient or the patient representative in understanding the hospital bill and how to apply for free and reduced cost care;
d. Contact information for the Maryland Medical Assistance Program;
e. A statement that physician charges are not included in the Hospital bill and are billed separately.

APPENDIX II

b.) New Financial Assistance Policy Changes Pursuant to the ACA

ACA Health Care Coverage Expansion Description

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

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

1. **LANGUAGE TRANSLATIONS**
    a. Requirement: The new 501(r) regulations lowered the language translation threshold for limited English proficient (LEP) populations to the lower of 5% of LEP individuals in the community served/1000-LEP individuals. Mt Washington Pediatric Hospital translated its financial assistance policy into the following languages: English, French, Spanish, and Chinese

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

3. **PROVIDER LISTS**

Requirement: The new 501(r) regulations require each hospital to create and maintain a list of all health care providers (either attached to the FAP or maintained as a separate appendix) and identify which providers on that list are covered under the hospital's FAP and which providers are not. Mt Washington Pediatric Hospital maintains that list which is available for review

APPENDIX III

FINANCIAL ASSISTANCE POLICY

1. **POLICY**

   a. This policy applies to Mt. Washington Pediatric Hospital ("MWPH"). MWPH is committed to providing financial assistance to children who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual and family financial situation.

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

   c. MWPH will publish the availability of Financial Assistance on its website and will post notices of availability at appropriate intake locations as well as the Inpatient Welcome Center. Notice of availability will also be sent to patients on patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided to patients/families receiving inpatient services with their welcome packet and made available to all patients/families upon request.

   d. Financial Assistance may be extended when a review of a patient's individual and family financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

   e. MWPH retains the right in its sole discretion to determine a patient's or family's ability to pay.

2. **PROGRAM ELIGIBILITY**

   a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for children, MWPH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

   b. Physician charges related to dates of service are included in MWPH's financial assistance policy. Both hospital and physician charges will be considered during the application process.

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

      i. Services provided by healthcare providers not affiliated with MWPH (e.g., home health services)

      ii. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, Workers Compensation, or Medicaid), are not eligible for the Financial Assistance Program without approval of senior leadership.

         1. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made considering medical and programmatic implications.

      iii. Unpaid balances resulting from non-medically necessary services

   d. Patients may become ineligible for Financial Assistance for the following reasons:

i. Refusal of family to provide requested documentation or providing incomplete information.

ii. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to MWPH due to insurance plan restrictions/limits.

iii. Failure of parent/guardian/guarantor to pay co-payments as required by the Financial Assistance Program.

iv. Failure of parent/guardian/guarantor to keep current on existing payment arrangements with MWPH.

v. Failure of parent/guardian/guarantor to make appropriate arrangements on past payment obligations owed to MWPH (including those patients who were referred to an outside collection agency for a previous debt).

vi. Refusal of parent/guardian/guarantor to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.

e. Parent/guardian/guarantor of patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

f. Parents/guardians/guarantors who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance (See Section 3 below) eligibility criteria. If patient qualifies for COBRA coverage, parent's/guardian's/guarantor's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership. Families with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

g. Coverage amounts will be calculated based upon 200-300% of income as defined by federal poverty guidelines and will generally follow the sliding scale included in Attachment A, with MWPH reserving the right to increase aid where it is deemed necessary.

3. **PRESUMPTIVE FINANCIAL ASSISTANCE**

a. Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance form and/or supporting documentation on file. Often there is adequate information provided by the patient family or through other sources, which could provide sufficient evidence to provide the patient with Financial Assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, MWPH reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining Financial Assistance eligibility and potential reduced care rates. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

i. Medical Assistance coverage

ii. Homelessness

iii. Family participation in Women, Infants and Children Programs ("WIC")

iv. Family food Stamp eligibility

v. Eligibility for other state or local assistance programs

vi. Patient is deceased with no known estate

vii. Family members unavailable to provide information

4. **MEDICAL HARDSHIP**

a. Patients falling outside of conventional income or presumptive Financial Assistance criteria are potentially eligible for bill reduction through the Medical Hardship program.

i. Uninsured Medical Hardship criteria is State defined:

1. Combined household income less than 500% of federal poverty guidelines

2. Having incurred collective family hospital medical debt at MWPH exceeding 25% of the combined household income during a 12 month period. The 12 month period begins with the date the Medical Hardship application was submitted.

3. The medical debt excludes co-payments, co-insurance and deductibles

b. Patient balance after insurance

i. MWPH applies the same criteria to patient balance after insurance applications as it does to self-pay applications

c. Coverage amounts will be calculated based upon 0 - 500% of income as defined by federal poverty guidelines and follow the sliding scale included in Attachment A , with MWPH reserving the right to increase aid where it is deemed necessary.

d. If determined eligible, patients and their immediate family are certified for a 12 month period effective with the date on which the reduced cost medically necessary care was initially received

e. Individual patient situation consideration:

i. MWPH reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.

ii. The eligibility duration and discount amount is patient-situation specific.

iii. Patient balance after insurance accounts may be eligible for consideration.

iv. Cases falling into this category require management level review and approval.

f. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance programs, MWPH is to apply the greater of the two discounts.

g. Parent/guardian/guarantor is required to notify MWPH of their potential eligibility for this component of the financial assistance program.

5. **ASSET CONSIDERATION**

a. Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient/family responsibility without causing undue

hardship. Individual patient/family financial situation such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are reviewed.

b. Under current legislation, the following assets are exempt from consideration:

   i. The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.

   ii. Up to $150,000 in primary residence equity.

   iii. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

6. **APPEALS**

   a. Patients whose financial assistance applications are denied have the option to appeal the decision.

   b. Appeals can be initiated verbally or in writing.

   c. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

   d. Appeals are documented. They are then reviewed by the next level of management above the representative who denied the original application.

   e. The escalation can progress up to the V.P. of Finance who will render a final decision.

   f. A letter or email (according to family preference) of final determination will be submitted to each patient who has formally submitted an appeal.

7. **PATIENT REFUND**

   a. Patients applying for Financial Assistance up to 2 years after the service date who have made account payment(s) greater than $5 are eligible for refund consideration

   b. Collector notes, and any other relevant information, are deliberated as part of the final refund decision. In general, refunds are issued based on when the patient was determined unable to pay compared to when the payments were made.

   c. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for refund.

8. **JUDGEMENTS and EXTRAORDINARY COLLECTION ACTIONS**

   a. With approval from the Director of Patient Accounting or CFO, Extraordinary Collection Actions (ECAs) may be taken on accounts that have not been disputed or are not on a payment arrangement. These actions will occur no earlier than 120 days from submission of first bill to the patient and will be preceded by notice 30 days prior to commencement of the action. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

      i. Legal action may be initiated in order to collect on the debt:

a. If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained, MWPH shall seek to vacate the judgment.

Financial Assistance may be withdrawn if:

. Parent/guardian/guarantor fails to pay co-payments as required by the Financial Assistance Program.

a. Parent/guardian/guarantor fails to keep current on existing payment arrangements with MWPH. iii. Parent/guardian/guarantor fails to make appropriate arrangements on past payment obligations owed to MWPH (including those patients who were referred to an outside collection agency for a previous debt).

PROCEDURES

a. MWPH admissions staff, outpatient registrars, authorization specialists, patient accounting staff and social workers are trained to offer Financial Assistance applications to those who express concern regarding their ability to pay. Applications should be submitted to the Director of Patient Accounting, the Manager of Patient Accounting, or to the V.P. of Finance.

b. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

i. Each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility (Attachment B).

ii. MWPH will not require documentation beyond that necessary to validate the information on the Maryland State Uniform Financial Assistance Application.

iii. A letter or email (according to family preference) of final determination will be submitted to each patient that has formally requested financial assistance.

iv. Patients/families will have thirty (30) days to submit required documentation to be considered for eligibility. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.

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

c. In addition to a completed Maryland State Uniform Financial Assistance Application, patient families may be required to submit:

i. A copy of parent/guardians/guarantor' most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable).

ii. A copy of parent/guardians/guarantors' most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.

iii. Proof of social security income (if applicable)

iv. A Medical Assistance Notice of Determination (if applicable).

v. Proof of U.S. citizenship or lawful permanent residence status (green card).

vi. Reasonable proof of other declared expenses.

vii. If parents/guardians/guarantors are unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...

viii. Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted.

d. A patient family can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient family has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Accounting or Finance Department for final determination of eligibility based on MWPH guidelines.

i. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.

1. If the patient does qualify for financial clearance, appropriate personnel will notify the treating department who may then schedule the patient for the appropriate service.
2. If the patient does not qualify for financial clearance, appropriate personnel will notify the clinical staff of the determination and the non-emergent/urgent services will not be scheduled.

a. A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.

e. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.

f. The following may result in the reconsideration of Financial Assistance approval:

i. Post approval discovery of an ability to pay

ii. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to MWPH

g. MWPH will track patients with 6 or 12 month certification periods. However, it is ultimately the responsibility of the patient or guarantor to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

h. If patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

Help for Patients to Pay Hospital Care Costs

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

When you visit us for your child's care, we can help explain how much of the cost is covered by insurance and how much of the cost you will have to pay. You must give us all of the information about your health insurance, and we will do our best to help you. You may still need to talk to your insurance company directly about the health care services they cover. Only your insurance company can confirm what is covered *for you*. You need to be certain you *completely* understand your child's insurance coverage. *The hospital cannot make any promises about what your insurance company covers.* If your health insurance changes, you must give us the new information as soon as possible.

You will receive one bill for hospital services and a second bill for doctor services. We can offer patient financial help for hospital bills and doctor services. If you do not have insurance, we will not charge you more for hospital services than we charge people with health insurance. Usually, we will ask you to pay 1/2 of any expected costs on the first day of care, then we will divide up the rest to be paid while your child is being treated.

If you cannot pay what you owe for the health care costs of your child's care, you can apply to Mt. Washington for financial help with those costs. We will:

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

HOW WE REVIEW YOUR APPLICATION:

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

1. Your income or your family's total income is low for the area where you live, or

2. Your income falls below the federal poverty level if you had to pay for the full cost of your hospital care, minus any health insurance payments.

We offer free care if your/your family income is below a certain amount and lower cost care if your income is a little bit higher. We also give cost discounts based on special family factors. You may receive help in the following ways:

1. Payment Plan: You pay the full cost of care, but this option lets you make smaller payments over a longer period of time; or
2. Patient Financial Assistance: You will not pay any costs or you will pay less than the full cost of care.

PLEASE NOTE: If you can get financial help, we will tell you just how much you can get. If you are not able to get financial help, we will tell you why not. The hospital must check all patients to see if they can get Medicaid before giving their own financial help.

HOW TO APPLY FOR FINANCIAL HELP:

1. Fill out a **Financial Assistance Application Form**.
2. Give us all of the information we need to understand your financial situation.
    a. We will need information from each responsible parent/guardian of the child, including:
        i. Your last two pay stubs, and
        ii. Your most recent bank statement from any/all of your bank accounts.
3. Turn the Application Form into us at 1708 W. Rogers Ave, Baltimore, MD 21209.

OTHER HELPFUL INFORMATION:

1. You can get a **free copy** of our Financial Assistance Policy and Application Form:
    - *Online* at www.mwph.org
    - *In person* at:
        i. The Admissions Office or Outpatient Registration desk at our main location at 1708 W. Rogers Avenue, Baltimore, MD 21209 or
        ii. The Nursing Station or Outpatient Registration desk at our unit in Prince George's Hospital Center, located at 3001 Hospital Drive, Cheverly, MD 20785.
    - *By mail* (by sending a request to: Patient Accounting Office, MWPH, 1708 W. Rogers Avenue, Baltimore, MD 21209.

2. You can call the **following resources** if you have questions or need help applying. You can also call if you need help in another language.

Mary Miller, Vice President of Finance, 410-578-5163
Linda Ryder, Manager of Patient Accounting, 410-578-5206
Denise Pudinski, Director of Collaborative Care, 410-578-2669 (inpatient only).
Debbie Fike, Credentialing & Payer Relations, 410-578-5334
Joanne Carper, Outpatient Manager, 410-578-5281
Sidney Williams, Outpatient Financial Counselor, 410-578-2689

If you have questions about your bills or payment, please call our Patient Accounting office at 410-578-2614. To apply for health care coverage, visit www.marylandhealthconnection.gov or call 1-855-642-8572; TTY 1-855-642-8573.

APPENDIX V

MISSION

Mt. Washington Pediatric Hospital is dedicated to maximizing the health and independence of the children we serve.

VISION

Mt. Washington Pediatric Hospital will be a premier leader in providing specialty health care for children, as distinguished by our:

- Quality of care
- Service excellence
- Innovation
- Multidisciplinary approach
- Family focus
- Outstanding workforce

VALUES STATEMENT

Mt. Washington Pediatric Hospital will act in a manner consistent with these values:

- Quality - Adhere to the highest standards of care in a safe environment
- Integrity - Act with honesty and truthfulness in all patient care and business activities
- Respect - Treat all individuals with compassion, dignity and courtesy
- Education - Promote lifelong learning