Community Benefit Report

Fiscal Year 2017

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

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

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

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

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

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

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

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

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

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

identifying certain health needs as significant; and prioritizing those significant health needs;

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

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

Examples of sources of data available to develop a CHNA include, but are not limited to:

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) the Maryland Chartbook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(3) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(4) Local Health Departments;
(5) County Health Rankings & Roadmaps (http://www.countyhealthrankings.org);
(6) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(7) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(8) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(9) CDC Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(10) CDC Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx);
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents;
(15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/); and
(16) CRISP Reporting Services.

In order to meet the requirement of the CHNA for any taxable year, the hospital facility must make the CHNA widely available to the public and adopt an implementation strategy to address health needs identified by the CHNA.

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

With respect to each significant health need identified through the CHNA, either—

(i) Describes how the hospital facility plans to address the health need; or
(ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address it.

HSCRC COMMUNITY BENEFIT REPORTING REQUIREMENTS

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. (For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12-month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

   a. Bed Designation – The total number of licensed beds

   b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;

   c. Primary Service Area (PSA) zip codes;

   d. Listing of all other Maryland hospitals sharing your PSA;

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

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

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

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area zip codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of the Hospital's Patients who are Uninsured:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
UMMC University Campus 767 Beds	28,727	21740 21122 21215 21207 21157 21061 21060 21228	UM Upper Chesapeake Health Howard County General Hospital UM BWMC UM Harford Memorial	0.7%	36.9%	31.5%

		21201 21217 21230 21136 21213 21224 21206 21133 21921 21222 21045 21144 21401 21117 21043 21234 21784 21613 21009 21229 21216 21078 21239 21237 21040 21218 21202 21225	Northwest Hospital Carroll Hospital Center UM Midtown Mercy Medical Center UMROI Levindale Hebrew Geriatric Hospital Sinai Hospital of Baltimore The Johns Hopkins Hospital MedStar Union Memorial Hospital Bon Secours Baltimore Health System Johns Hopkins Bayview Medical Center MedStar Harbor Hospital Saint Agnes Hospital MedStar Good Samaritan Hospital			

		21208 21227 21001 21014 21221 21220 21601 21212 21205 21223 21244	UM SMC at Dorchester UM SMC at Easton Anne Arundel Medical Center Franklin Square Greater Baltimore Medical Center Meritus Medical Center UM SJMC Union of Cecil Hospital			

Data Sources: UMMS Administration data (Bed Designation and Inpatient Admissions), HSCRC Semi-Confidential Database (Primary Service Area Zip Codes, Maryland Hospitals Sharing Primary Service Area, Percentage of Hospital's Uninsured, Medicaid Recipients and Medicare beneficiaries)

2. For purposes of reporting on your community benefit activities, please provide the following information:

    a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):

        (i) A list of the zip codes included in the organization's CBSA, and

        (ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.

        (iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., individuals with > 3 hospitalizations in the past year). This information may be copied directly

from the community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Statistics may be accessed from:

The Maryland State Health Improvement Process (http://dhmh.maryland.gov/ship/);

The Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/Pages/home.aspx);

The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf);

The Maryland Chart Book of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf);

The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)

Table II

Demographic Characteristic	Description	Source
Zip codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.	21201, 21215, 21216, 21217, 21218, 21223, 21229, 21230 (Vulnerable population defined as ZIP Codes containing census tract with 20% population below poverty level and 25% population less than high school education)	American Community Survey, 2011-2015, 5-Year Estimates data from http://assessment.communitycommons.org/Footprint/
Median Household Income within the CBSA	CBSA $ 39,043	American Community Survey, 2011-2015, 5-Year Estimates, U.S. Census Bureau
Percentage of households in the CBSA with household income below the federal poverty guidelines	CBSA 21.7 %	American Community Survey, 2011-2015, 5-Year Estimates, U.S. Census Bureau
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Baltimore City 7.6%	American Community Survey, 2015, 1-Year Estimates, U.S. Census Bureau
Percentage of Medicaid recipients by County within the CBSA.	Baltimore City 25.4 %	American Community Survey, 2015, 1-Year Estimates, U.S. Census Bureau
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/Pages/Home.aspx	**Baltimore City** All races/ethnicity: 73.9 years White: 76.9 years Black: 72.0 years	Maryland Vital Statistics Annual Report, 2015

Additional Disparity Information for Baltimore and Targeted CBSA

County Ranking (Out of 24 Counties in Maryland, including Baltimore City)*

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx	**Baltimore City** 987.7 per 100,000 population **Crude Death Rates by Race and Ethnicity:** White: 1,034.1 per 100,000 population Black: 1,145.2 per 100,000 population Asian: 271.5 per 100,000 population Hispanic: 146.9 per 100,000 population	Maryland Vital Statistics Annual Report, 2015
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://ship.md.networkofcare.org/ph/county-indicators.aspx	**Baltimore City** % Households with Severe Problems[1]: 24% % Food Insecure: 24% % Adult Smokers: 24% Violent crime per 100,000 population: 1,389 % Unemployed: 13.1% % Less than High School Education (age 25 and over) : 17.5% % Without vehicle (Age 16 and over): 16.2%	Comprehensive Housing Affordability Strategy (CHAS), 2013 data from http://www.countyhealthrankings.org/ USDA Food Environment Atlas, Map the Meal Gap from Feeding America data from http://www.countyhealthrankings.org/ Behavioral Risk Factor Surveillance System, 2015 data from http://www.countyhealthrankings.org/ American Community Survey, 2011-2015, 5-Year Estimates, U.S. Census Bureau
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://ship.md.networkofcare.org/ph/county-indicators.aspx	CBSA Total population: 350,714 *White: 22.4%* *Black or African American: 69.5%* *Asian: 2.6%* *Hispanic, Any Race: 2.9%* *Others: 2.6%* Total housing units: 170,855 Language Spoken: *English: 92.2%* *Spanish or Spanish Creole: 2.6%* *Indo-European languages: 2.8%* *Asian and Pacific Island languages: 1.5%* *Other languages:1%*	American Community Survey, 2011-2015, 5-Year Estimates, U.S. Census Bureau

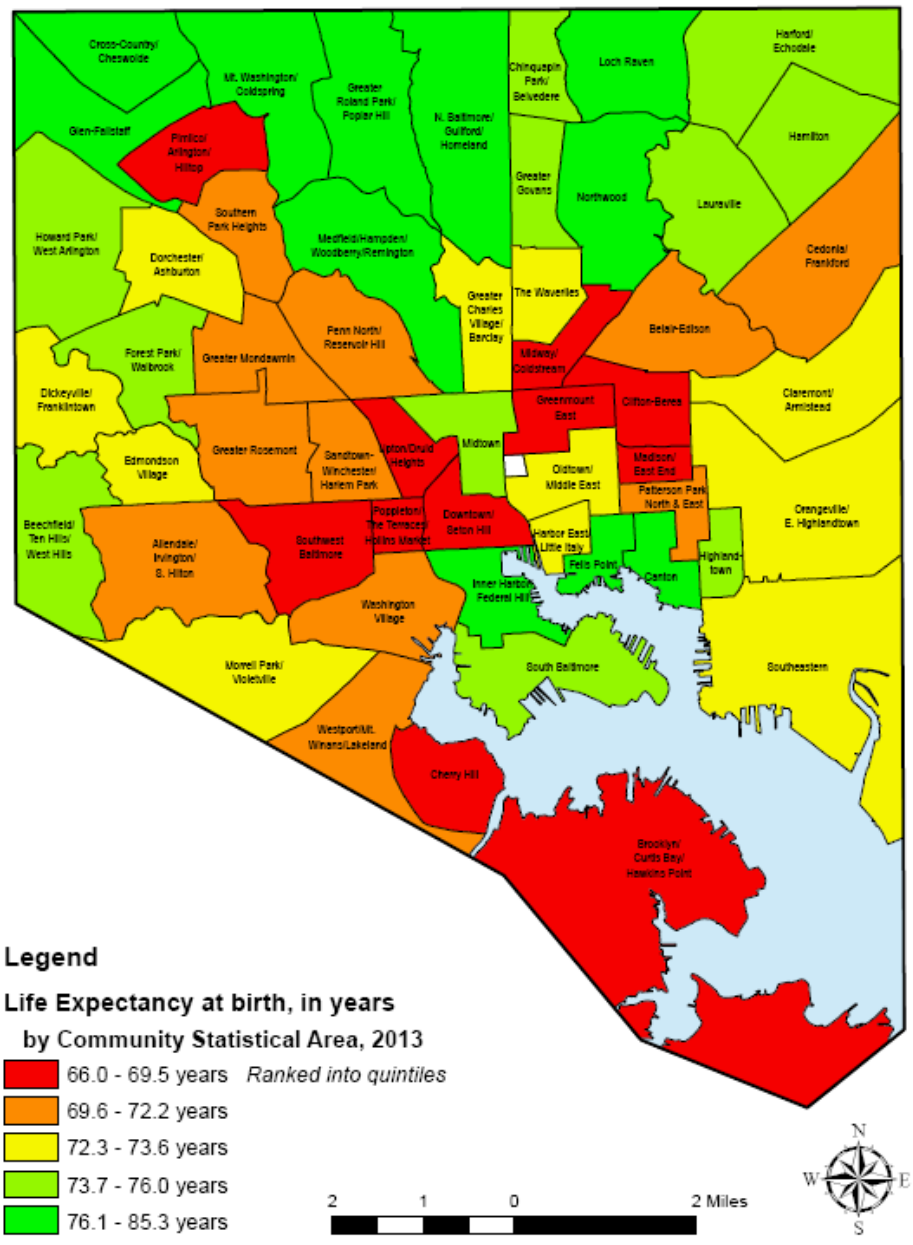
Other	**Baltimore City** All races/ethnicity: 8.4 per 1,000 live births White: 4.4 per 1,000 live births Black: 9.7 per 1,000 live births Hispanic: 8.7 per 1,000 live births Baltimore City: 13.2%	Maryland Vital Statistics Annual Report, 2015 Maryland Behavioral Risk Factor Surveillance System http://www.marylandbrfss.org

	Length of Life	Quality of Life	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Baltimore City	24	24	24	20	24	12

*Ranking key – Higher number is worse
Source – Robert Wood Johnson Foundation, County Health Rankings, 2017
http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_MD.pdf

As evident in the Table above using the County Health Rankings, Baltimore is the lowest ranked area in Maryland in 4 out of 6 categories. Within the City of Baltimore, there are further health disparities. In the following Life Expectancy Map, there is a 20 year difference in the life expectancy between many of the CBSA targeted zips (Southwest Baltimore, Upton, Pimlico, Poppleton, etc.) and other zips which include Roland Park. In some areas of targeted CBSA, the life expectancy is equivalent to the life expectancy in Nepal and India. Many social determinants (i.e. literacy, poverty, food deserts, unsafe environments, and violence to name a few) have a large impact on the overall health outcomes in these communities. The Medical Center has initiatives (as seen later in Table 3) addressing all of these above social determinants in an effort to positively impact the health outcomes in the targeted CBSA.

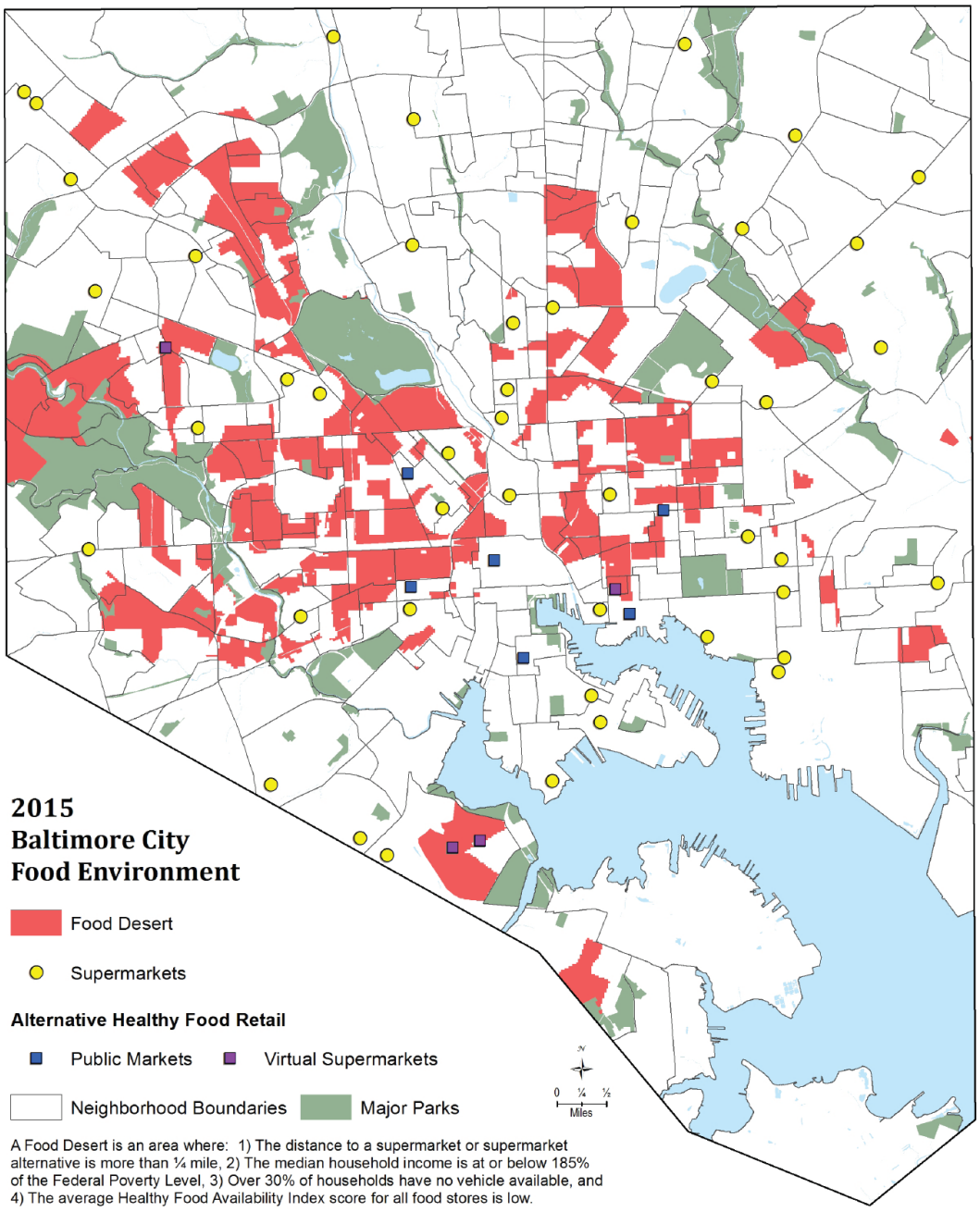
Baltimore City Life Expectancy Map



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

Food Environment Map of Baltimore

#BmoreFoodMap



JOHNS HOPKINS
CENTER for A LIVABLE FUTURE

HEALTH DEPARTMENT
BALTIMORE MARYLAND

CITY OF BALTIMORE

STEPHANIE
RAWLINGS-BLAKE
MAYOR

BALTIMORE
DEVELOPMENT CORPORATION

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

__X__Yes Provide date approved by the hospital's governing body or an authorized body thereof here**: 6/18 /15** (mm/dd/yy)

____No

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

http://www.umm.edu/-/media/umm/pdfs/about-us/community-outreach/ummc-chna-executive-report-fy2015.pdf?la=en&hash=F20CB4AD0B70F0725D7400F7B42BEC5BC8FBCA83

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

_X_Yes Enter date approved by governing body/authorized body thereof here: **6/18/15** (mm/dd/yy)

___No

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

http://www.umm.edu/-/media/umm/pdfs/about-us/community-outreach/ummc-chna-executive-report-fy2015.pdf?la=en&hash=F20CB4AD0B70F0725D7400F7B42BEC5BC8FBCA83

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

_X_Yes
___No

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

Elements of the CHNA are integrated into the Strategic Plan within the following sections - Environmental Assumptions, Strategic Plan Guiding Principles, which lead to the Strategic Goals and Strategies. Specifically, the community benefit planning and findings of the CHNA are embedded within the Population Health Strategy to….."implement evidence-based community interventions targeting the West Baltimore community, to improve the health status

of primary service residents". This Strategic Plan covers both campuses – University of Maryland Medical Center and UMMC Midtown Campus.

The Strategic Plan supports our Mission, and the Community Health Improvement initiatives outlined in this document support the one of the key strategies of Stewardship & Community Engagement.

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

i. Senior Leadership

1. _X_CEO
2. ___CFO
3. _X_Other (please specify) Senior Vice President, Strategy, Community & Business Development

Describe the role of Senior Leadership

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

ii. Clinical Leadership

1. _X_Physician
2. _X_Nurse
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

- Provides clinical knowledge/context for needs assessment and programming
- Develops/approves protocols for health screenings
- Provides oversight to health screenings program
- Insures regulatory compliance
- Collaborates with UMB Professional Schools (Medicine, Nursing, Social Work)

iii. Population Health Leadership and Staff

1. __X__ Population health VP or equivalent (please list) Dr. Charles Callahan, VP, Population Health
2. ____ Other population health staff (please list staff)

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

- Leads organization with value-based care and population health initiatives
    - Works with medical staff to reduce PAUs and readmissions, works with new Coordinated Care Center for high utilizer patients to prevent readmissions
- Partners with the University of Maryland School of Medicine
- Partners with the University of Maryland Baltimore Campus

iv. Community Benefit Operations

1. _X__the Title of Individual(s) (please specify 3.5 FTEs) – see below
2. ___Committee (please list members)
3. _X__Department (please list staff)
4. ___Task Force (please list members)
5. ___Other (please describe)

Anne D. Williams, DNP, RN – Director, Community Health Improvement
Mariellen Synan – Community Outreach Manager
Asunta Henry, MA – Community Health Specialist
Lauren Davis, BA – Administrative Coordinator (.5 FTE)

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

Anne Williams, Director – Leads CHNA process and CB reporting process; Collaborates with numerous internal departments and Finance to produce annual reports/filings; Prepares Board summary

Mariellen Synan, Manager – Manages day-day operations and programming of community health improvement initiatives; Data entry into CBSA

Asunta Henry, CH Specialist – Manages Hypertension program and assists Manager with community events, Data entry into CBSA

Lauren Davis, Administrative Coordinator – Data entry into CBSA, Assists with event scheduling

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

Spreadsheet __X__yes _____no

Narrative __X__yes _____no

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

After completion, the Narrative is reviewed by the UMMS Director, Community Health Improvement, and UMMC Senior VP of Strategy, Community & Business Development. After their approval, it is then reviewed by the UMMS SVP for Government & Regulatory Affairs. After completion, the Spreadsheet is reviewed by the UMMS Director, Community Health Improvement, UMMC Senior VP of Strategy, Community & Business Development, and UMMS SVP for Government & Regulatory Affairs, and the UMMS Vice President of Reimbursement & Revenue. A high level overview of both reports are reviewed and approved at the UMMC Community Benefits Committee of the Board at a meeting in early December.

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

Spreadsheet __X__yes _____no

Narrative __X__yes _____no

If no, please explain why.

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

___X___Yes _____No

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

Examples of some strategies include efforts to increase health equity and decrease health disparities by increasing screenings in the community to underserved populations (for example, African American men for hypertension screening and education)

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

__X__Other hospital organizations

__X__Local Health Department

__X__Local health improvement coalitions (LHICs)

__X__ Schools

__X__Behavioral health organizations

__X__Faith based community organizations

__X__Social service organizations

__X__Post-acute care facilities

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

Organization	Name of Key Collaborator	Title	Collaboration Description
University of Maryland Medical Center – Midtown Campus	**Don Ray** **Multiple other staff**	**Vice President, Operations** **Mgr, Supervisor, Clinical Nutritionist**	**Strategic Leadership** **Members of joint CHI Team**
University of Maryland Medical System	**Donna Jacobs**	**Senior Vice President**	**Hosted community partner focus group**
University of Maryland – Professional Schools	**Dr. Russell Lewis, Dr. Pat Maclaine Bronwyn Mayden**	**School of Medicine School of Nursing School of Social Work**	**Attended strategic retreat; Provided insight into UMB comm. initiatives**
Mt Washington Pediatric Hospital	**Melissa Beasley**	**Community Outreach Coordinator**	**Co-hosted community partner focus group; Attended strategic retreat**
Baltimore City Health Dept	**Laura Fox**	**Director, Chronic Disease Prevention**	**Provided City's & Mayor's health priorities**
University of Maryland Baltimore	**Ashley Valis**	**Director, Community Initiatives**	**Attended strategic retreat; Provided insight into UMB community initiatives**
Union Baptist Church	**Rev. Dr. Al Hathaway**	**Senior Pastor**	**Provided input re: community faith leaders'**

			perspectives on community health priorities

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

_____yes __X__no (Baltimore City Health Dept staff chairs the LHIC)

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

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

_X___yes _____no

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

Baltimore City – the Baltimore City Health Department leads the LHIC, but our representative is Donna Jacobs, Senior Vice President, UMMS who attends the meetings; Anne Williams to begin attending as well in FY2018.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

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

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

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

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

e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need,

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

g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.

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

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

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

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

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

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

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)

j. Continuation of Initiative:
What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? If not, why? What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:
A. what were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, and grants associated with the fiscal year being reported.
B. Of the total costs associated with the initiative, what amount, if any, was provided through a restricted grant or donation?

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

Analysis of all quantitative and qualitative data during the CHNA FY15 process identified the following top five areas of need within Baltimore City. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths

and mission. These priorities were identified and approved by the UMMC/Midtown CHI Team and validated with the health experts from the UMB Campus Panel:

1. **Cardiovascular Disease**
2. **Workforce Development (as a shared component of literacy and SDoH)**
3. **Maternal & Child Health**
4. **Violence Prevention (related to behavioral/mental health)**

- **Health Literacy (shared UMMS priority)**

Several additional topic areas were identified by the Community Health Improvement Team during the CHNA process including: Behavioral/mental health, safe housing, transportation, and substance abuse. While UMMC & Midtown Campuses will focus the majority of our efforts on the identified strategic priorities outlined earlier, 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 either existing clinical programs (i.e. Methadone clinics, Residential Psychiatric program) or through collaboration with other health care organizations as needed (Baltimore City Health Department, Johns Hopkins, Medstar, St Agnes, Mercy, and others for health literacy and other issues). Additionally, substance abuse programming is already integrated into either existing clinical programs or community health programs, like – Stork's Nest and Violence Prevention programs. The additional unmet needs not addressed by UMMC/Midtown will also continue to be addressed by key Baltimore City governmental agencies and existing community-based organizations.

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

The Population Health Strategy and Implementation Plan was finalized and submitted to the State on 12/7/15. This plan covers both the University of Maryland Medical Center and Midtown Campuses. The Community Health Needs Assessments and Community Benefits Reports are integrated into the Plan to provide a context of the community for planning purposes. Two of the five goals within the plan directly reflect the work already conducted by the Community Benefits Team. The two goals which are most closely linked to current community health improvement work are:

Goal 2: Improve patient outcomes and quality of care for patients suffering from chronic disease

Goal 3: Promote health and well-being through enhanced screening, prevention and health promotion

Initiatives specifically for high utilizers were started in FY16. Additionally, the Living Well/Chronic Disease Self Management Program and the CDC's Diabetes Prevention Program was fully integrated into the community health improvement programming. These current programs led by the Community Health Improvement Department augment both above population health goals.

In addition, there are six workgroups which are tasked with specific elements of the overall strategy. The Social Determinants of Health (SDoH)/Community Partnership Workgroup is led by the Senior Vice President, Strategy, Business, and Community Engagement along with the VP of Population Health. The Director of Community Health Improvement staffs this group. Several initiatives are currently in pilot phase or were implemented which address the SDoH which are barriers (transportation and literacy) in the targeted West Baltimore population.

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

PHYSICIANS

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

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

Table IV – Physician Subsidies – **Not Applicable**

Category of Subsidy	**Explanation of Need for Service**
Hospital-Based physicians	
Non-Resident House Staff and Hospitalists	
Coverage of Emergency Department Call	
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):

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

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

   - Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
     - in a culturally sensitive manner,
     - at a reading comprehension level appropriate to the CBSA's population, and
     - in non-English languages that are prevalent in the CBSA.
   - Posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
   - Provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
   - Provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
   - Includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills;
   - Besides English, in what language(s) is the Patient Information sheet available;
   - Discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

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

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

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

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

Attachment A

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

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

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	Cardiovascular Disease Prevention A.1.Baltimore City Data: County Health Rankings reports that Baltimore City is ranked the lowest of all counties within Maryland on 6 of 8 major categories. 68% of Baltimore City adults are either overweight or obese. 34% of Baltimore adults report a BMI of > 30. Heart Disease is the number one leading cause of death, and stroke is the third leading cause of death in Baltimore City. Baltimore City's Hypertension ED visit rate is 658.9/100,000 as compared to 252/100,000 for Maryland. Significant health disparities exist among African Americans in Baltimore City. Food deserts exist in half of the targeted CBSA zips. Thirty five percent of Baltimore high school students are obese or overweight compared with 26% statewide. http://health.baltimorecity.gov/sites/default/files/HealthyBaltimore2015_Final_Web.pdf http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship30 A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Cardiovascular Disease Prevention. This need was identified both years and was based on the high prevalence of heart disease, hypertension, and obesity in the CBSA targeted zip codes as stated above.
B: Name of hospital initiative	To combat the high prevalence of obesity and heart disease in the targeted CBSA area, UMMC has several initiatives to address the above identified need: **Know Your Numbers Initiative**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; Estimated that 119,243 individuals are obese in the targeted CBSA using the obesity prevalence rate of 34%.
D: Total number of people reached by the initiative:	2,714 Individuals educated in the community
E: Primary objective of initiative:	**Know Your Numbers Initiative** 1) Increase the proportion of adults who are at a healthy weight 2) Reduce the proportion of youth who are obese Long-Term Goal: 1) Increase the proportion of adults who are at a healthy weight
F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
G: Key collaborators in delivery:	UMMC Dept of Family Medicine, Dept of Cardiology, Dept of Clinical Nutrition, University of Maryland Baltimore Campus, Baltimore City Health Department, American Heart Association, MAC, Inc.
H: Impact of hospital initiative:	Description: Provide education and information on heart-healthy lifestyle through engaging, evidence-based programs in the community • Metrics:

	• # of people attending health events receiving info on heart healthy lifestyle through health fairs and events • # of Living Well with High Blood Pressure Classes	
I: Evaluation of outcome:	• 2,629 People attending health events who received info/education on heart-healthy lifestyle through health fairs and community events • 85 People completed the Living Well with Hypertension class	
J: Continuation of initiative:	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. $130,506	b. $0

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	Cardiovascular Disease Prevention A.1.Baltimore City Data: County Health Rankings reports that Baltimore City is ranked the lowest of all counties within Maryland on 6 of 8 major categories. 68% of Baltimore City adults are either overweight or obese. 34% of Baltimore adults report a BMI of > 30. Heart Disease is the number one leading cause of death, and stroke is the third leading cause of death in Baltimore City. Baltimore City's Hypertension ED visit rate is 658.9/100,000 as compared to 252/100,000 for Maryland. Significant health disparities exist among African Americans in Baltimore City. Food deserts exist in half of the targeted CBSA zips. Thirty five percent of Baltimore high school students are obese or overweight compared with 26% statewide. http://health.baltimorecity.gov/sites/default/files/HealthyBaltimore2015_Final_Web.pdf http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship28 A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Cardiovascular Disease Prevention. This need was identified both years and was based on the high prevalence of heart disease, hypertension, and obesity in the CBSA targeted zip codes as stated above.
B: Name of hospital initiative	To combat the high prevalence of hypertension in the targeted CBSA area, UMMC has several initiatives to address the above identified need: **Maryland Healthy Men (Hypertension) Initiative**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; Estimated that 122,750 individuals likely have hypertension in the targeted CBSA using the hypertension prevalence rate of 35%.
D: Total number of people reached by the initiative:	1,063 Individuals screened in the community; 337 African American men educated on hypertension
E: Primary objective of initiative:	**Maryland Healthy Men (Hypertension) Initiative** 1) Engage at least 440 African American men with hypertension education after identifying them with BP reading > 139/89 Long-Term Goal: 1) Decrease the ED visit rate due to hypertension (Maryland SHIP)
F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
G: Key collaborators in delivery:	UMMC Dept of Family Medicine, Dept of Cardiology, Dept of Clinical Nutrition, University of Maryland Baltimore Campus, Local Farmers, American Heart Association, Shopper's Food Warehouse, Druid Hill YMCA, MAC (Maintaining Active Citizens), Inc., and Baltimore City Health Department

H: Impact of hospital initiative:	Description: Provide education and information on heart-healthy lifestyle and blood pressure management to African American men with hypertension through engaging, evidence-based programs in the community Metrics: • # of BP screenings (all races, both genders) • # of AA men with hypertension • # of AA men educated • # of AA men in program • BP after program • Self-reported behaviors after the program	
I: Evaluation of outcome:	• 1,063 people received BP screenings (all races, both genders) • 337 African American men identified with hypertension >139/89 • 337 AA men received education (risk factors, exercise, tobacco use, fast food, and salt intake) • 35 men participated and completed the program • 35% of the men participating in the program decrease their BP, 42% had same BP, and 23% stayed the same • 95% of men reported they now take their BP regularly at home as a result of the program • 95% of men reported they now know their BP as a result of this program	
J: Continuation of initiative:	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. $89,850	b. $40,000

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	Cardiovascular Disease Prevention A.1.Baltimore City Data: County Health Rankings reports that Baltimore City is ranked the lowest of all counties within Maryland on 6 of 8 major categories. 68% of Baltimore City adults are either overweight or obese. 34% of Baltimore adults report a BMI of > 30. Heart Disease is the number one leading cause of death, and stroke is the third leading cause of death in Baltimore City. Significant health disparities exist among African Americans in Baltimore City. Food deserts exist in half of the targeted CBSA zips. Thirty five percent of Baltimore high school students are obese or overweight compared with 26% statewide. http://health.baltimorecity.gov/sites/default/files/HealthyBaltimore2015_Final_Web.pdf http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship28 A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Cardiovascular Disease Prevention. This need was identified both years and was based on the high prevalence of heart disease, hypertension, and obesity in the CBSA targeted zip codes as stated above.
B: Name of hospital initiative	To combat the high prevalence of obesity and food insecurity in the targeted CBSA area, UMMC has several initiatives to address the above identified need: **Farmers' Market**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; Estimated that 119,243 individuals are obese in the targeted CBSA using the obesity prevalence rate of 34%.
D: Total number of people reached by the initiative:	Approximately 2,800 individuals
E: Primary objective of initiative:	**Farmers' Market Initiative** 1)Increase healthy food access 2)Increase the variety of fruits and vegetables to the diets of the population aged 2 years and older Long-Term Goal: 1) Increase the proportion of adults who are at a healthy weight (Maryland SHIP)
F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
G: Key collaborators in delivery:	UMMC Dept of Family Medicine, Dept of Community Health Improvement, Dept of Clinical Nutrition, University of Maryland Baltimore Campus, Local Farmers

H: Impact of hospital initiative:	Description: Provide a Farmers' Market in the heart of the CBSA which sells healthy, local produce (SNAP EBT accepted along with purchasing bonuses); Provide free BP screenings and health education at the market as well Metrics: • # of Farmers' Markets held • # of people attending Farmers' Markets	
I: Evaluation of outcome:	• 28 Farmers' Markets held (from May through November) • 2,800 people attending (based on estimate of 100 attending at each weekly market) •	
J: Continuation of initiative:	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. $28,288	b. $0

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	Cardiovascular Disease Prevention A.1.Baltimore City Data: County Health Rankings reports that Baltimore City is ranked the lowest of all counties within Maryland on 6 of 8 major categories. 68% of Baltimore City adults are either overweight or obese. 34% of Baltimore adults report a BMI of > 30. Heart Disease is the number one leading cause of death, and stroke is the third leading cause of death in Baltimore City. Significant health disparities exist among African Americans in Baltimore City. Food deserts exist in half of the targeted CBSA zips. Thirty five percent of Baltimore high school students are obese or overweight compared with 26% statewide. http://health.baltimorecity.gov/sites/default/files/HealthyBaltimore2015_Final_Web.pdf http://ship.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship30 A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Cardiovascular Disease Prevention. This need was identified both years and was based on the high prevalence of heart disease, hypertension, and obesity in the CBSA targeted zip codes as stated above.
B: Name of hospital initiative	To combat the high prevalence of obesity and food insecurity in the targeted CBSA area, UMMC has several initiatives to address the above identified need: **Fresh Farmacy Pilot**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; Estimated that 119,243 individuals are obese in the targeted CBSA using the obesity prevalence rate of 34%.
D: Total number of people reached by the initiative:	20 individuals directly with an additional 60 family members of participants
E: Primary objective of initiative:	**Fresh Farmacy Pilot** 1) Increase healthy food access 2) Increase the daily consumption of fruits and vegetables to the diets of an identified at-risk population Long-Term Goal: 1) Increase the proportion of adults who are at a healthy weight (Maryland SHIP)
F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
G: Key collaborators in delivery:	UMMC Dept of Family Medicine, Dept of Community Health Improvement, Dept of Clinical Nutrition, Local Farmers

H: Impact of hospital initiative:	Description: Pilot a fruit/vegetable prescription program based through our existing Farmers' Market in the heart of the CBSA. Twenty at-risk individuals were identified through the UM Dept of Family/Community Medicine and were given "prescriptions" for healthy produce ($5/prescription) weekly that could be turned in at the UMMC Farmers' Market. Additional prescriptions were given up to 4 /week or $20/week for healthy produce for a family of four. Metrics: • # of individuals who received produce "prescriptions" • # of family members who benefitted from the pilot • # of "prescriptions" turned into the Farmers' Market • $ of fresh produce provided through the pilot • Pre-and post-pilot servings of fruits and vegetables consumed by participants (using a participant survey)	
I: Evaluation of outcome:	• 20 individuals identified as at-risk through the University of Maryland Department of Family/Community Medicine received weekly "prescriptions" for produce • Nearly 60 additional family members of the 20 participants benefitted from the infusion of healthy produce • 737 "prescriptions" (vouchers) were cashed in at the Farmers' Market over 4 months • $3,685 of fresh produce was purchased as a result of the "prescriptions" • Average number of servings of fruits/vegetables increased from 2.5 to 5.2 servings/day. This change was statistically significant ($p < 0.0001$).	
J: Continuation of initiative:	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. $8,412	b. $0

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	<u>Maternal and Child Health</u> A.1.Baltimore City Data: Pediatric asthma prevalence (20%) within Baltimore City is much higher than the State with a rate of 9.4%. According to the Maryland State Health Improvement Plan (SHIP), the ED visit rate for Baltimore City is 224.8 per 10,000 as compared to 63.8 per 10,000 for Maryland. The ED visit rate for African Americans is 100.8 per 10,000. All of these significant disparities in prevalence in Baltimore City speaks to the identified need, and subsequently, the UMMC priority of Maternal and Child Health with an emphasis on pediatric asthma. A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Maternal and Child Health. This need was identified both years and was based on the high rates of prematurity, low birth weights, low breastfeeding rates, high pediatric asthma rates and unintentional injury rates in the CBSA . Specifically, the Source: https://health.baltimorecity.gov/node/454
B: Name of hospital initiative	**Breathmobile**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; It is estimated that 14,870 children within the CBSA total population is diagnosed with asthma – based on 20% prevalence of pediatric asthma within 21.2% of the population being under 17 years old. (Baltimore City Health Department Statistics)
D: Total number of people reached by the initiative:	505 patients over 818 encounters
E: Primary objective of initiative:	**Breathmobile Program** 1) Decrease the ED visit rate due to (pediatric) asthma 2) Decrease hospitalizations due to pediatric asthma 3) Decrease missed school days due pediatric asthma
F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.

G: Key collaborators in delivery:	UMMC Dept of Pediatrics, UMMC Dept of Family Medicine, Baltimore City Public Schools, Baltimore City Health Department, Kohls Cares Foundation	
H: Impact of hospital initiative:	Description: Provide mobile primary treatment and health education to school-age children with asthma in Baltimore City using the Breathmobile. • Metrics: • # of site visits • # of individual students seen • # of total visits • % of ED visits • % of hospitalizations • %of missed school days	
I: Evaluation of outcome:	Metrics: • 505 individual students seen • 818 total visits • 50.5% students with any ED visits • 30.4% students with >2 ED visits • 11.8% students hospitalized • 50.5% students missing any school days • 30.7% students missing > 5 school days	
J: Continuation of initiative:	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. $181,702	b. $159,808

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	Maternal and Child Health A.1.Baltimore City Data: The pedestrian injury rate in Baltimore City is 113.8 (per 100,000 population) as compared to 42.5 in the State. Motor vehicle crashes are the number 1 reason for unintentional death in children 0-19 years. Contributing to this statistic, there is a high misuse rate of car seats. One CDC study found that, in one year, more than 618,000 children ages 0-12 rode in vehicles without the use of a child safety seat or booster seat or a seat belt at least some of the time. Of the children ages 12 years and younger who died in a crash in 2014, 34% were not buckled up. All of these significant health disparities in Baltimore City children speaks to the identified need, and subsequently, the UMMC priority of Maternal and Child Health. A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Maternal and Child Health. This need was identified both years and was based on the high rates of prematurity, low birth weights, low breastfeeding rates, high pediatric asthma rates and unintentional injury rates in the CBSA . Specifically, the Source: https://health.baltimorecity.gov/node/454
B: Name of hospital initiative	**Safe Kids**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; It is estimated that are 70,844 children under 17 years old within the CBSA total population. (Baltimore City Health Department Statistics)
D: Total number of people reached by the initiative:	3,919 children from 23 Baltimore City Elementary Schools 13 Car safety seat inspections
E: Primary objective of initiative:	**Safe Kids Program** 1)Decrease number of fire-related deaths to children under 14 years of age 2) Decrease the pedestrian injury rate on public roads 3) Increase the percentage of correctly installed child safety seats 4) Increase in participants' knowledge and awareness of fire safety, pedestrian safety, and child passenger seat safety

F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.	
G: Key collaborators in delivery:	Safe Kids Worldwide, UMMC Dept of Pediatrics, Baltimore City Public Schools, Baltimore City Health Department, Baltimore City Fire and Police Departments, DHMH, MIEMSS Child Passenger Programs	
H: Impact of hospital initiative:	Description: Provide education and information on child passenger safety, fire safety, pedestrian safety, and distracted pedestrian awareness to children and families Metric: • # of encounters with children and/or families • # of fire-related deaths under 14 yrs in Balto City • # of child passenger safety seat errors identified and corrected • Increase in knowledge using pre/post-tests for: fire safety, pedestrian safety, child passenger seat safety	
I: Evaluation of outcome:	Metrics: • 13 Car safety seat inspections • 3,919 children educated on fire safety in 23 Baltimore City elementary schools • 190 car seats out of a total of 235 were incorrectly installed (81% misuse rate) • 100% of incorrect car seats were corrected	
J: Continuation of initiative:	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. $95,472	b. $1,750

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	<u>Maternal and Child Health</u> A.1.Baltimore City Data: Baltimore City's infant mortality rate was 10.4 (deaths/1,000 live births) for the entire city in 2014. However, within the targeted CBSA zip codes, the infant mortality rate ranges from 10.3 to 21. These rates are far higher than the State of Maryland average of 6.5. Contributing to this high infant mortality rate is low birth weight infants (LBW < 5 lbs, 8 oz). Baltimore City's rate is 12.8 overall with rates in the targeted CBSA from 13.8 – 18. All of these significant health disparities in Baltimore City children speaks to the identified need, and subsequently, the UMMC priority of Maternal and Child Health. A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Maternal and Child Health. This need was identified both years and was based on the high rates of prematurity, low birth weights, low breastfeeding rates, high pediatric asthma rates and unintentional injury rates in the CBSA . Specifically, the infant mortality rate has been above the state goal and state average of 6.5/1,000 live births.
B: Name of hospital initiative	**Stork's Nest**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; 14 live births per 1,000 women in Baltimore City annually, so approximately 4,909 births in this CBSA last year
D: Total number of people reached by the initiative:	153 pregnant women
E: Primary objective of initiative:	**Stork's Nest Program** 1) Increase the percentage of babies born >37 weeks gestation 2) Reduce the percentage of births that are low birth weight 3) Increase the percentage of women breastfeeding at discharge/after delivery Long-Term Goal: 1)Decrease infant mortality

F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.	
G: Key collaborators in delivery:	UMMC Dept of Pediatrics, UMMC Dept of OB/GYN, UMMC Dept of Family Medicine, March of Dimes, Zeta Phi Beta Sorority, Faith-based partners, B'more Healthy Babies	

H: Impact of hospital initiative:	• Description: Provide education and information on healthy pregnancies, breastfeeding, and early infant care to pregnant moms and their partners
	• Program Metrics:
	  • # of women enrolled
	  • % of babies born> 37 weeks gestation
	  • % of babies born>2500 grams
	  • % of women breastfeeding	

I: Evaluation of outcome:	• 153 pregnant women enrolled • 90.32% of babies born > 37 weeks gestation! • 85.26% of babies born > 2500 grams • 73.12% of women initiated breastfeeding prior to discharge Infant mortality decreased to 8.4/1,000 live births in 2015 – the lowest rate on record. Source: https://health.baltimorecity.gov/news/press-releases/2016-10-05-baltimore-city-experiences-record-low-infant-mortality-rate-2015 Maryland's SHIP State Goal is 6.3/1,000 births Our initiatives support the city-wide campaign to decrease infant mortality in Baltimore City. By increasing the number of full-term deliveries, babies born > 2500 grams, and the initiation of breastfeeding all support the reduction of infant mortality.	
J: Continuation of initiative:	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. $33,946	b. In-kind donations of infant supplies

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	<u>Violence Prevention</u> A.1.Baltimore City Data: The rate of domestic violence is reported as 677.4 incidences/100,000 population. This is higher than the State average of 510.9 incidences/100,000. The Maryland SHIP 2017 Target is 445/100,000. Additionally, in the CBSA domestic violence rates and homicide rates in general are among the highest in Baltimore City. All of these significant health disparities in Baltimore City speaks to the identified need, and subsequently, the UMMC priority of Violence Prevention. A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Violence Prevention. This need was identified both years and was based on the high rates of homicide and domestic violence prevalence in the CBSA .
B: Name of hospital initiative	**Violence Intervention Program (VIP)**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; 1,031 patients admitted for violence through UM Shock Trauma Center
D: Total number of people reached by the initiative:	232 patients participated from 1,031 total admitted for violence
E: Primary objective of initiative:	**Violence Intervention Program** 1)Increase number of participants in program from admissions for violence 2) Reduce the rate of recidivism due to violent injury Long-Term Goal: 1)Increase life expectancy (Maryland SHIP)
F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.

G: Key collaborators in delivery:	UMMC Shock Trauma Center, Baltimore City Police Department, Baltimore City Public Schools, and Baltimore City Health Department, University of Maryland Baltimore	
H: Impact of hospital initiative:	Description: Provide education, support, and information through evidence-based program – Violence Intervention Program (VIP) • Metrics: ○ 100% of violence victims enrolled in program ○ 100% participant completion ○ Re-injury rate (Recidivism) ○ VPP Survey and program evaluation	
I: Evaluation of outcomes:	○ 232 people participated (out of 1,031 patients admitted for violence) ○ 22.5% enrollment rate – up from 15% enrollment in FY16 ○ 63% Completion rate ○ 0.01 Re-injury rate (Recidivism) ○ 100% of participants screened positive for adverse childhood events (ACES); PTSD experience and symptoms at intake.	
J: Continuation of initiative:	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. Cost $136,000	b. Grants $100,000

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	<u>Violence Prevention</u> A.1.Baltimore City Data: The rate of domestic violence is reported as 677.4 incidences/100,000 population. This is higher than the State average of 510.9 incidences/100,000. The Maryland SHIP 2017 Target is 445/100,000. Additionally, in the CBSA domestic violence rates and homicide rates in general are among the highest in Baltimore City. All of these significant health disparities in Baltimore City speaks to the identified need, and subsequently, the UMMC priority of Violence Prevention, specifically Domestic Violence. A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Violence Prevention. This need was identified both years and was based on the high rates of homicide and domestic violence prevalence in the CBSA .
B: Name of hospital initiative	**Bridge Program (Domestic Violence)**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; Overall City rate of 40.6 domestic violence injuries/1,000. Domestic violence rates within the CBSA are as high as 66.3/1,000 in SW Baltimore. Therefore, the estimated population within the CBSA for potential victims of domestic violence is 3,507.
D: Total number of people reached by the initiative:	369 patients participated averaging 30/month or 1/day
E: Primary objective of initiative:	**Bridge Program** 1)Increase number of participants in program 2) Reduce the rate of recidivism due to domestic violence Long-Term Goal: 1)Increase life expectancy (Maryland SHIP)
F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per

	Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.	
G: Key collaborators in delivery:	UMMC Shock Trauma Center, Baltimore City Public Schools, and Baltimore City Court System, University of Maryland Outpatient Psychiatry, Maryland Network for Domestic Violence, Mayor's Office on Crime Control, University of Maryland Baltimore	
H: Impact of hospital initiative:	Description: Provide education, support, and information through evidence-based program – Bridge Program • Metrics: o 100% of violence victims enrolled in program o Re-injury rate (Recidivism) o % referrals for additional services	
I: Evaluation of outcomes:	o 369 people participated o 1.1% Re-injury rate (4 Clients out of 369 re-injured due to domestic violence, 0 fatal) o 92% of victims were referred to the VINE Protective Order service, 44% of victims registered or received assistance for VINE Protective Orders o 100% of victims were offered direct services in the form of information and referral, personal advocacy/accompaniment, emotional support, safety, shelter/housing, and criminal/civil justice system assistance.	
J: Continuation of initiative:	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. $230,520	b. $169,500 Received as grant from: Violence of Crime Act & BJAG

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	<u>Workforce Development</u> A.1.Baltimore City Data: Baltimore City's unemployment rate is reported as 13.1% for the entire city. However, within the targeted CBSA zip codes, the unemployment rate ranges from 19.2% to 29.9%. These rates are far higher than the State of Maryland average of 5.3% - ranging from 3-4 times higher in the targeted CBSA. The extreme unemployment leads to the high level of poverty. Households below poverty range from 12.2% - 48.8% with the lowest median income of $13,811 in the 21201 zip code. The high unemployment rates are a result of limited literacy, low levels of high school graduates and limited job opportunities in the community. All of these significant health disparities in Baltimore City children speaks to the identified need, and subsequently, the UMMC priority of Workforce Development. https://health.baltimorecity.gov/sites/default/files/NHP%202017%20-%2000%20Baltimore%20City%20(overall)%20(rev%206-22-17).pdf A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Workforce Development based on the above mentioned data.
B: Name of hospital initiative	To combat the high prevalence of unemployment and accompanying poverty, UMMC has several initiatives to address the above identified need: **Workforce Development Programs**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; Estimated potential of 70,143 adults unemployed within the CBSA based on 20% unemployment rates
D: Total number of people reached by the initiative:	711 Adults (employees) and 1,105 Youth from the community 935 tours, visits, or lectures to youth and 170 internships for youth in the community
E: Primary objective of initiative:	**Workforce Development**

	1) Increase the number of people gainfully employed 2) Improve/enhance individuals' level of employment skills Long Term Goal: 1) Decrease unemployment	
F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.	
G: Key collaborators in delivery:	Mayor's Office of Employment Development, University of Maryland Baltimore Campus, Department of Social Services, Center for Urban Families, Helping Up Mission, Catholic Charities, Sinai Hospital VSP, HSCRC, BAHEC, BACH	
H: Impact of hospital initiative:	<u>Description:</u> Provide training, coaching, and employment for program participants through 6 key programs. • BACH • Project Search • Youthworks • Career Coaching • Essential Skills Training • Financial Literacy <u>Program Metrics:</u> • # of Students enrolled in programs •# of Individuals hired as a result of programs	
I: Evaluation of outcome:	# of Students enrolled in programs: • BACH – 10 • Project Search – 5 • Youthworks – 75 • Career Coaching – 321 • Essential Skills Training – 311 • Financial Literacy – 42 • # of individuals hired as a result of programs – 137	
	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. $174,687	b. $0

Table III – FY 2017 Community Benefits Narrative Report

A. 1. Identified Need: A. 2. How was the need identified:	<u>Workforce Development</u> A.1.Baltimore City Data: Baltimore City's unemployment rate is reported as 13.1% for the entire city. However, within the targeted CBSA zip codes, the unemployment rate ranges from 19.2% to 29.9%. These rates are far higher than the State of Maryland average of 5.3% - ranging from 3-4 times higher in the targeted CBSA. The extreme unemployment leads to the high level of poverty. Households below poverty range from 12.2% - 48.8% with the lowest median income of $13,811 in the 21201 zip code. The high unemployment rates are a result of limited literacy, low levels of high school graduates and limited job opportunities in the community. All of these significant health disparities in Baltimore City children speaks to the identified need, and subsequently, the UMMC priority of Workforce Development. https://health.baltimorecity.gov/sites/default/files/NHP%202017%20-%2000%20Baltimore%20City%20(overall)%20(rev%206-22-17).pdf A.2. During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Workforce Development based on the above mentioned data.
B: Name of hospital initiative	To combat the high prevalence of unemployment and accompanying poverty, UMMC has several initiatives to address the above identified need: **Live Near Your Work Program**
C: Total number of people within target population	350,714 in the CBSA within Baltimore City; Estimated potential of 70,143 adults unemployed within the CBSA based on 20% unemployment rates
D: Total number of people reached by the initiative:	8 UMMC employees (Baltimore City residents)
E: Primary objective of initiative:	**Live Near Your Work Program**

	1) Increase number of employees able to purchase a home in Baltimore City	
F: Single or multi-year plan:	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.	
G: Key collaborators in delivery:	Mayor's Office of Employment Development, University of Maryland Baltimore Campus	
H: Impact of hospital initiative:	Description: Provide $2,500 to employees to assist with closing costs toward purchase of home in Baltimore City Program Metrics: • # of Individuals who are able to purchase a home in Baltimore City as a result of the program	
I: Evaluation of outcome:	• 8 employees were able to purchase a home in Baltimore City as a result of this program (Each participant received $2,500 toward closing costs)	
	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA is completed.	
K: Expense:	a. $28,560	b. $0

Appendix 1

Financial Assistance Policy Description

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

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

UMMC makes every effort to make financial assistance information available to our patients including, but not limited to:

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

Appendix 2

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. University of Maryland Medical Center translated its financial assistance policy into the following languages: English, Spanish, French, 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. University of

Maryland Medical Center created a new plain language summary of its financial assistance policy in addition to its already-existing patient information sheet.

3. PROVIDER LISTS

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

Appendix 3

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

POLICY

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

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

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

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

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

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

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

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

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

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

PROGRAM ELIGIBILITY

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

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

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

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

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

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

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

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

Presumptive Financial Assistance

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

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

n. St. Clare Outreach Program eligible patients

o. UMSJMC Maternity Program eligible patients

p. UMSJMC Hernia Program eligible patients

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

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

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

PROCEDURES

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

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

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

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

4. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.
   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.
      i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
      ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
         (1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.
5. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
6. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination, up to 3 years prior, and up to six (6) calendar months in to the future. However, there are no limitations on the Financial Assistance eligibility period. Each eligibility period will be determined on a case-by-case basis. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

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

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

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

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

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

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

Financial Hardship

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

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

1) Their medical debt incurred at our either UMMC, MTC, UMROI, UMSJMC and UMBWMC exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship; and

2) meet the income standards for this level of Assistance.

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

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

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

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

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

Appeals

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

Judgments

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

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

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

Effective 7/1/16

Appendix 4

Financial Help for Patients to Pay Hospital Care Costs

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

PLEASE NOTE:

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

HOW THE PROCESS WORKS:

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

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

HOW WE REVIEW YOUR APPLICATION:

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

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

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

HOW TO APPLY FOR FINANCIAL HELP:

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

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

OTHER HELPFUL INFORMATION:

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

Revised 6/2016

Appendix 5

Our Mission

University of Maryland Medical Center is the academic flagship of the University of Maryland Medical System. Its mission is to provide health care services on its two campuses for the Baltimore community, the State of Maryland and the nation. In partnership with the University of Maryland School of Medicine and the University of Maryland health professional schools, we are committed to:

- Delivering superior health care
- Training the next generation of health professionals
- Discovering ways to improve health outcomes worldwide

Source: Vision, Mission and Values - University of Maryland Medical Center http://umm.edu/about/mission-and-vision#ixzz3cUw0vRnF

Our Vision:

UMMC will be known for providing high value and compassionate care, improving health in Maryland and beyond, educating future health care leaders and discovering innovative ways to advance medicine worldwide.

Source: Vision, Mission and Values - University of Maryland Medical Center http://umm.edu/about/mission-and-vision#ixzz3cUwFj4UW

Our Community Health Improvement Mission: To empower and build healthy communities

People & Culture

UMMC will be an "employer of choice" and a leader in staff recruitment, retention, satisfaction and ongoing leadership development.

Safety & Quality

UMMC will provide safe high quality care, maintain a safe and secure environment for patients and staff, and become a recognized leader in achieving optimal clinical outcomes.

Service

UMMC will provide compassionate care and outstanding service in a culturally sensitive manner to all patients and families, exceeding expectations.

Stewardship

UMMC will achieve revenue growth and manage operating expenses to achieve financial results allowing investment in our strategic priorities, while meeting our mission to provide services to all.

Innovation

UMMC will develop innovative programs and services to improve the health status and quality of life for residents of communities served while fulfilling our academic mission to educate and advance knowledge.

Community

Enhance our community engagement efforts and bolster our community health improvement initiatives to better meet the health, wellness and social needs of those we serve as well as those we hope to serve.