The MARYLAND
HEALTH SERVICES COST REVIEW COMMISSION

University of Maryland

Charles Regional Medical Center

FY 2018 Community Benefit Narrative Report

PART ONE: ORIGINAL NARRATIVE SUBMISSION

Q1.
Introduction:

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) 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 developed a two-part community benefit reporting system that includes an inventory spreadsheet that collects financial and quantitative information and a narrative report to strengthen and supplement the inventory spreadsheet. 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. This reporting tool serves as the narrative report. The instructions and process for completing the inventory spreadsheet remain the same as in prior years. 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.

The Commission moved to an online reporting format beginning with the FY 2018 reports. In this new template, responses are now mandatory unless marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

Q2. Section I - General Info Part 1 - Hospital Identification

Q3. Please confirm the information we have on file about your hospital for FY 2018.

	Is this information correct?		
	Yes	No	If no, please provide the correct information here:
The proper name of your hospital is: UM Charles Regional Medical Center	◉	○	
Your hospital's ID is: 210035	◉	○	
Your hospital is part of the hospital system called University of Maryland Medical System.	◉	○	
Your hospital was licensed for 109 beds during FY 2018.	◉	○	
Your hospital's primary service area includes the following zip codes: 20601, 20602, 20603, 20640, 20646, 20695	◉	○	
Your hospital shares some or all of its primary service area with the following hospitals: None	◉	○	

Q4. The next two questions ask about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

Q5. (Optional) Please describe any other community health statistics that your hospital uses in its community benefit efforts.

The 2017 Maryland Vital Statistics Report is used for birth and death data by race, along with life expectancy data, infant mortality data by race. The Maryland Department of Planning is also a source of population data for Charles County. The Maryland State Health Improvement Process data measures provide information on health disparities and hospitalization/ED visit rates by health condition such as diabetes and heart disease prevalence and mental health and substance use ED visit rates. Additionally, cancer incidence and mortality are available through the 2017 Cigarette Restitution Fund Program's Cancer in Maryland Report. The Maryland Behavioral Risk Factor Surveillance System is used to determine estimates for adult obesity and overweight. The Youth Risk Behavior Survey provides an obesity estimate for youth aged 13-18 years. The Maryland Sexually Transmitted Infections Program at the Maryland Department of Health provides Chlamydia and gonorrhea rates for the county. The Maryland Physician Workforce Study provides information on physician shortages in Southern Maryland. Health Professional Shortage Areas are viewed on the HRSA website. Medicaid data is accessed through the e-health Medicaid database for Maryland.

Q6. (Optional) Please attach any files containing community health statistics that your hospital uses in its community benefit efforts.

Charles County Community Health Statistics.doc
68.5KB
application/msword

Q7. Section I - General Info Part 2 - Community Benefit Service Area

Q8. Please select the county or counties located in your hospital's CBSA.

- ☐ Allegany County
- ☐ Anne Arundel County
- ☐ Baltimore City
- ☐ Baltimore County
- ☑ Charles County
- ☐ Dorchester County
- ☐ Frederick County
- ☐ Garrett County
- ☐ Prince George's County
- ☐ Queen Anne's County
- ☐ Somerset County
- ☐ St. Mary's County

☐ Calvert County ☐ Harford County ☐ Talbot County
☐ Caroline County ☐ Howard County ☐ Washington County
☐ Carroll County ☐ Kent County ☐ Wicomico County
☐ Cecil County ☐ Montgomery County ☐ Worcester County

Q9. Please check all Allegany County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q10. Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q11. Please check all Baltimore City ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q12. Please check all Baltimore County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q13. Please check all Calvert County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q14. Please check all Caroline County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q15. Please check all Carroll County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q16. Please check all Cecil County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q17. Please check all Charles County ZIP codes located in your hospital's CBSA.

☑ 20601 ☑ 20632 ☑ 20662
☑ 20602 ☑ 20637 ☑ 20664
☑ 20603 ☑ 20640 ☑ 20675
☑ 20607 ☑ 20645 ☑ 20677
☑ 20611 ☑ 20646 ☑ 20693
☑ 20616 ☑ 20658 ☑ 20695
☑ 20622 ☑ 20659

Q18. Please check all Dorchester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q19. Please check all Frederick County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q20. Please check all Garrett County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q21. Please check all Harford County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q22. Please check all Howard County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q23. Please check all Kent County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q24. Please check all Montgomery County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q25. Please check all Prince George's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q26. Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q27. Please check all Somerset County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q28. Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q29. Please check all Talbot County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q30. Please check all Washington County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q31. Please check all Wicomico County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q32. Please check all Worcester County ZIP codes located in your hospital's CBSA.

This question was not displayed to the respondent.

Q33. How did your hospital identify its CBSA?

- [ ] Based on ZIP codes in your Financial Assistance Policy. Please describe.
- [ ] Based on ZIP codes in your global budget revenue agreement. Please describe.
- [ ] Based on patterns of utilization. Please describe.
- [x] Other. Please describe.

The Community Benefit Service Area for the University Of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified above as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county.

Q34. (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

The Community Benefit Service Area for the University of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county Zip code level data shows where the most vulnerable populations reside in Charles County. The zip codes of Waldorf (20601, 20602, 20603), White Plains (20695), and Indian Head (20640) represent the geographic areas where the most vulnerable populations reside in Charles County. The lowest average life expectancy is found in 20640, Indian Head, at 74.7 years. The highest Medicaid enrollment rate was in 20602, Waldorf. The highest percentage of low birth weight babies was in 20695, White Plains. The highest WIC participation rate was in 20602, Waldorf. The WIC participation rate was also high in Indian Head, 20640. The 2006-2011 All-cause mortality for Indian Head was 942.6 per 100,000, above the Maryland state rate. The 2006-2010 heart disease mortality for Indian Head was 232.3, also above the Maryland state rate.

Q35. Section I - General Info Part 3 - Other Hospital Info

Q36. Provide a link to your hospital's mission statement.

https://www.umms.org/charles/about-us/mission-values

Q37. Is your hospital an academic medical center?

- ◯ Yes
- ◉ No

Q38. (Optional) Is there any other information about your hospital that you would like to provide?

Q39. (Optional) Please upload any supplemental information that you would like to provide.

Q40. Section II - CHNA Part 1 - Timing & Format

Q41.
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- ◉ Yes
- ◯ No

Q42. Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

This question was not displayed to the respondent.

Q43. When was your hospital's first-ever CHNA completed? (MM/DD/YYYY)

01/01/1994

Q44. When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/30/2015

Q45. Please provide a link to your hospital's most recently completed CHNA.

https://www.umms.org/charles/community/assessment-implementation-plan

Q46. Did you make your CHNA available in other formats, languages, or media?

- ◉ Yes
- ◯ No

Q47. Please describe the other formats in which you made your CHNA available.

The executive summary and health improvement plan are available in paper form. Additionally, the results of the CHNA were presented to the local health improvement coalition with a PowerPoin
presentation. The report is available on the Charles County Department of Health website at charlescountyhealth.org.

Q48. Section II - CHNA Part 2 - Participants

Q49. Please use the table below to tell us about the internal participants involved in your most recent CHNA.

	CHNA Activities	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	Manager of Population Health is the role at the facility level, no Director position exist.
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/ Population Health Director (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	Senior Vice President of Gov't, Regulatory Affairs and Community Health
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (facility level)	☐	☐	☐	☑	☑	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (facility level)	☐	☐	☑	☐	☑	☐	☑	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (facility level)	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Community Benefit staff (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☐	☐	
Physician(s)	☐	☐	☐	☐	☑	☐	☑	☐	☐	☐	
Nurse(s)	☐	☐	☐	☐	☐	☐	☑	☑	☐	☐	
Social Workers	☐	☐	☐	☐	☐	☑	☑	☑	☐	☐	
Community Benefit Task Force	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Hospital Advisory Board	☐	☐	☐	☑	☑	☐	☑	☐	☐	☐	
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Member of CHNA Committee	Participated in development of CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q50. Section II - CHNA Part 2 - Participants (continued)

Q51. Please use the table below to tell us about the external participants involved in your most recent CHNA.

	CHNA Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Department -- Please list the Local Health Departments here: Charles County Department of Health	[ ]	[x]	[x]	[x]	[x]	[x]	[x]	[x]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here: Partnerships for a Healthier Charles County	[ ]	[x]	[x]	[x]	[x]	[x]	[x]	[x]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	[ ]	[ ]	[ ]	[x]	[ ]	[ ]	[ ]	[x]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of the Environment	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[x]	[ ]	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[x]	[ ]	
Maryland Department of Education	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[x]	[ ]	
Area Agency on Aging -- Please list the agencies here: Charles County Department of Community Services	[ ]	[ ]	[ ]	[ ]	[x]	[ ]	[x]	[x]	[ ]	
Local Govt. Organizations -- Please list the organizations here: Charles County Government	[ ]	[ ]	[ ]	[ ]	[x]	[ ]	[x]	[x]	[ ]	
Faith-Based Organizations	[ ]	[ ]	[ ]	[ ]	[x]	[ ]	[x]	[ ]	[ ]	
School - K-12 -- Please list the schools here: Charles County Public Schools	[ ]	[x]	[x]	[ ]	[x]	[x]	[x]	[x]	[ ]	
School - Colleges and/or Universities -- Please list the schools here: College of Southern Maryland	[ ]	[x]	[x]	[x]	[x]	[x]	[x]	[x]	[ ]	
School of Public Health -- Please list the schools here:	[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	
School - Medical School -- Please list the schools here:	[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	
School - Nursing School -- Please list the schools here:	[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	

	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here: Charles County Department of Health's Substance Use and Mental Health Clinics, Charles County Local Behavioral Health Authority, Center for Children	☐	☐	☐	☐	☑	☐	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here: Charles County Department of Social Services	☐	☐	☐	☐	☑	☐	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Post-Acute Care Facilities -- please list the facilities here: Sagepoint, Fenwick Landing, The Charleston Senior Community, Genesis, Restore Health, Morningside, Hospice of Charles County	☐	☐	☐	☐	☑	☐	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here: United Way of Charles County, Health Partners Inc., local extension service, Lifelong Learning Center	☐	☑	☑	☑	☑	☑	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here: Lifestyles of Maryland, Inc. , Charles County Service and Advocacy Council	☐	☐	☐	☐	☑	☐	☑	☑	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here: White Plains Primary Care	☐	☐	☐	☐	☑	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Member of CHNA Committee	Participated int he development of the CHNA process	Advised on CHNA best practices	Participated in primary data collection	Participated in identifying priority health needs	Participated in identifying community resources to meet health needs	Provided secondary health data	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q52. Section II - CHNA Part 3 - Follow-up

Q53. Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

Q54. Please enter the date on which the implementation strategy was approved by your hospital's governing body.

05/26/2015

Q55. Please provide a link to your hospital's CHNA implementation strategy.

https://www.umms.org/charles/community/assessment-implementation-plan

Q56. Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

This question was not displayed to the respondent.

Q57. Please select the health needs identified in your most recent CHNA. Select all that apply even if a need was not addressed by a reported initiative.

- [ ] Access to Health Services: Health Insurance
- [x] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Blood Disorders and Blood Safety
- [x] Cancer
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [x] Health Communication and Health Information Technology
- [ ] Health-Related Quality of Life & Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [x] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal & Infant Health
- [x] Mental Health and Mental Disorders
- [x] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [x] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [x] Social Determinants of Health
- [x] Substance Abuse
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [x] Other (specify): Unnecessary Hospital Utilization

Q58. Please describe how the needs and priorities identified in your most recent CHNA compare with those identified in your previous CHNA.

After the 2012 Charles County Community Health Needs Assessment Report, 11 health priorities were identified to address the health needs of Charles County. While honorable, this level of community initiatives was too great to make a large or lasting impact on the county. Therefore, in 2015, the Charles County Community Health Needs Assessment Committee used the Hanlon Method as a way to prioritize the most critical health needs and become more focused on community wide initiatives. Three priorities were chosen: Chronic Disease Prevention and Management, Behavioral Health, and Access to Care. Within Chronic Disease Prevention and Management, health topics include Diabetes, Cancer, Heart Disease, Educational and Cancer, using educational and community-based programs that are evidence-based. Under Access to Care, the topics include Physician Recruitment and Retention, Social Determinants of Health, and Unnecessary Hospital Utilization. Finally, the Behavioral Health priority includes Substance use disorders and Mental Health disorders.

Q59. (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

Q60. (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

Q61. Section III - CB Administration Part 1 - Participants

Q62. Please use the table below to tell us about how internal staff members were involved in your hospital's community benefit activities during the fiscal year.

Activities

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
CB/ Community Health/Population Health Director (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	Manager of Population Health Management
CB/ Community Health/ Population Health Director (system level)	☐	☐	☑	☑	☑	☐	☐	☐	☐	☐	
Senior Executives (CEO, CFO, VP, etc.) (facility level)	☐	☐	☑	☑	☐	☑	☐	☐	☑	☐	
Senior Executives (CEO, CFO, VP, etc.) (system level)	☐	☐	☐	☐	☑	☐	☐	☐	☑	☐	Senior Vice President Government, Regulatory Affairs and Community Health
Board of Directors or Board Committee (facility level)	☐	☐	☑	☑	☐	☐	☐	☐	☑	☐	
Board of Directors or Board Committee (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Clinical Leadership (facility level)	☐	☐	☐	☑	☐	☑	☑	☑	☑	☐	
Clinical Leadership (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Population Health Staff (facility level)	☐	☐	☑	☐	☐	☐	☐	☑	☑	☐	
Population Health Staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Community Benefit staff (facility level)	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	

	N/A - Person or Organization was not Involved	N/A - Position or Department does not exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiativves	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community Benefit staff (system level)	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Physician(s)	☐	☐	☑	☑	☐	☐	☐	☑	☑	☐	
Nurse(s)	☐	☐	☐	☑	☐	☐	☐	☑	☐	☐	
Social Workers	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐	
Community Benefit Task Force	☐	☐	☑	☑	☑	☑	☑	☑	☑	☐	
Hospital Advisory Board	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Q63. Section III - CB Administration Part 1 - Participants (continued)

Q64. Please use the table below to tell us about the external participants involved in your hospital's community benefit activities during the fiscal year.

	Activities									Click to write Column 2
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other Hospitals -- Please list the hospitals here:	☑	☐	☐	☐	☐	☐	☐	☐	☐	
Local Health Department -- Please list the Local Health Departments here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Health Improvement Coalition -- Please list the LHICs here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Health	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Human Resources	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Natural Resources	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of the Environment	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Transportation	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Maryland Department of Education	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Area Agency on Aging -- Please list the agencies here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Local Govt. Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Faith-Based Organizations	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - K-12 -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Colleges and/or Universities -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School of Public Health -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Medical School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Nursing School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Dental School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
School - Pharmacy School -- Please list the schools here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Behavioral Health Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Social Service Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Post-Acute Care Facilities -- please list the facilities here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Community/Neighborhood Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Consumer/Public Advocacy Organizations -- Please list the organizations here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:
Other -- If any other people or organizations were involved, please list them here:	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	N/A - Person or Organization was not involved	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing funding for CB activities	Allocating budgets for individual initiatives	Delivering CB initiatives	Evaluating the outcome of CB initiatives	Other (explain)	Other - If you selected "Other (explain)," please type your explanation below:

Q65. Section III - CB Administration Part 2 - Process & Governance

Q66. Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- ☑ Yes, by the hospital's staff
- ☐ Yes, by the hospital system's staff
- ☐ Yes, by a third-party auditor
- ☐ No

Q67. Does your hospital conduct an internal audit of the community benefit narrative?

- ◉ Yes
- ○ No

Q68. Please describe the community benefit narrative review process.

Community Benefits Narrative Review process: CFO, Erik Boas: Oversees all HSCRC and 990 Reporting; internally audits Community Benefit reports; Allocates resources for CB operations. The CFO reviews the report (narrative and spreadsheet) and presents the final report to the Finance Committee of the Board of Directors for approval.The Finance Committee of the Board conducts the review and approval of the report and a summary of key points are presented to the full Board. Vice President, Planning, Clive Savory: Administers CB reporting operations including plan implementation, collaborates with strategic community partners; Oversees data collection and reporting; provides management for LHIC; Compiles reports Decision Support Analysts (2) Jermaine Page, Senior Manager, Jim Clague: Inputs financial data into CB data collection tool for reporting; assists with internal auditing Revenue Integrity Analyst, Ruth Case: Inputs salary data into CB data collection tool. Community Outreach Specialist, Amy Zimmerman: Implements community benefit qualifying activities and community outreach programs; collaborates with strategic community partners; Trains departmental CB reporters and manages data collection tool; provides management for LHIC Epidemiologist, Amber Starn, MPH: Provides data and reporting for CB planning; monitors and reports outcomes of CB Strategic Plan, Reports SHIP data to CCDOH

Q69. Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- ◉ Yes
- ○ No

Q70. Please explain:

This question was not displayed to the respondent.

Q71. Does the hospital's board review and approve the annual community benefit narrative report?

- ◉ Yes
- ○ No

Q72. Please explain:

This question was not displayed to the respondent.

Q73. Does your hospital include community benefit planning and investments in its internal strategic plan?

- ○ Yes
- ○ No

Q74. Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

This question was not displayed to the respondent.

Q75. (Optional) If available, please provide a link to your hospital's strategic plan.

This question was not displayed to the respondent.

Q76. (Optional) Is there any other information about your hospital's community benefit administration and external collaboration that you would like to provide?

Q77. (Optional) Please attach any files containing information regarding your hospital's community benefit administration and external collaboration.

Q78. Based on the implementation strategy developed through the CHNA process, please describe *three* ongoing, multi-year programs and initiatives undertaken by your hospital to address community health needs during the fiscal year.

Q79. Section IV - CB Initiatives Part 1 - Initiative 1

Q80. Name of initiative.

Charles County Mobile Integrated Healthcare

Q81. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q82. Select the CHNA need(s) that apply.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Blood Disorders and Blood Safety
- [x] Cancer
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [x] Health Communication and Health Information Technology
- [ ] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [x] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [x] Mental Health and Mental Disorders
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [x] Social Determinants of Health
- [x] Substance Abuse
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [x] Other. Please specify. Unnecessary Hospital Utilization

Q83. When did this initiative begin?

August 28, 2017

Q84. Does this initiative have an anticipated end date?

- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.

( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

( ) The initiative will end when external grant money to support the initiative runs out. Please explain.

(•) The initiative will end when a contract or agreement with a partner expires. Please explain.

The Memorandum of Understanding between the University of Maryland Charles Regional Medical Center, the Charles County Department of Health, and the Charles County Department of Emergency Services will end on April 30, 2020. However, it is anticipated that the program will continue even once grant funding has been exhausted due to its success in the community.

( ) Other. Please explain.

Q85. Enter the number of people in the population that this initiative targets.

105

Q86. Describe the characteristics of the target population.

An analysis of ED utilization was conducted in December 2015 using the time frame January 1-November 30, 2015. The criteria for inclusion were any patient with 20 or more visits to the emergency department during the specified time period. The data was queried by the transition nurse case manager using the HSCRC database. From January 1, 2015 through November 30,2015, a total of 20 patients made at least 20 visits or more to the University of Maryland Charles Regional Medical Center Emergency Department. They accounted for a total of 643 visits. That is an average of 32 visits per patient. Visit counts ranged from 20 visits to 124 visits per patient in the 11 month time frame. The majority of the patients had either Medicaid (55%) or Medicare (35%) as their primary health insurance. The average number of visits among patients with Medicaid was 25 visits per patient. The average number of visits among patients with Medicare was 82 visits per patient. Managing their conditions in the primary care and home setting could lead to a reduction in hospital visits and a needed reduction in the 30-day readmissions rate to avoid penalties. Most of the high utilizers were discharged to their homes for self care after they have been treated in the acute hospital setting. The most commonly reported reasons for their visits included pain, shortness of breath/trouble breathing, chest pain, and behavioral health conditions. These patients could greatly benefit from community resources to help them self manage their disease processes and how changes to the home can improve their health.

Q87. How many people did this initiative reach during the fiscal year?

71

Q88. What category(ies) of intervention best fits this initiative? Select all that apply.

- [ ] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention
- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [x] Social determinants of health intervention
- [ ] Community engagement intervention
- [ ] Other. Please specify.

Q89. Did you work with other individuals, groups, or organizations to deliver this initiative?

(•) Yes. Please describe who was involved in this initiative.

The Charles County Department of Health, the University of Maryland Charles Regional Medical Center, and the Charles County Department of Emergency Services, collectively implement the Charles County Mobile Integrated Healthcare project to address the health/social determinants leading to repeated use of emergent care.
The Mobile Integrated Healthcare (MIH) Team includes a paramedic employed by Emergency Services and a registered nurse and community health worker, employed by the health department. The MIH team is housed at the Charles County Department of Health. During the initial visit, the MIH team assesses the patient's vital signs, reviews discharge paperwork, evaluates compliance with discharge instructions, completes a medication evaluation/reconciliation, conducts an environmental scan of the home for safety issues, and provides health education and chronic disease self management information when appropriate. After the initial visit, the community health worker provides the high touch needed to keep the patients engaging in this program and out of the emergency department.
Additionally, grant funding for this project has been secured by the Charles County Department of Health.
Another source of referral to MIH includes Health Partners Inc. a charitable clinic in the county.

No.

Q90. Please describe the primary objective of the initiative.

Reduce Emergency Department (ED) utilization and Emergency Medical Services (EMS) transports among high utilizers by linking them with care coordination and community health services.

Q91. Please describe how the initiative is delivered.

Enrollment: • Must be: ◦ 18 years of age, or older (and) ◦ Charles County resident (and) ◦ 1 or more chronic health condition *ALL 3 MUST APPLY* Criteria for Hospital and Emergency Medical Services Inclusion: • 6 or more visits to the ED in 3 months or LACE score greater than 12 • 6 or more calls to EMS in 3 months Criteria for Primary Care Clinic Inclusion: Must display one or more • 2 missed appointments/no-show's to scheduled appointments (and/or) • Have not followed up with recommended specialists/agencies pertaining to health needs (and/or) • Poor medication adherence Initial Visits: • Medical history review • Individual concerns regarding health conditions • Social and Emotional Health Questionnaire • Physical Assessment ◦ Vital signs ◦ Respiratory/Neuro/Integumentary/GI/GU Cardiovascular/Musculoskeletal/Pain Assessments • Immunization history review • Assessment of ADL's • Medication reconciliation ◦ Ability to safely dispose of unused/unwanted medications ◦ Carbon copied lists for convenience • Thorough Home Safety Assessments ◦ Ability to address safety needs with little to no cost to patient Smoke detectors / Carbon Monoxide detectors • Individualized "To-Do" lists for patients • Recognize needs for IDT discussions where applicable • File of Life • Personalized binders with accessible educational materials/references for clients health conditions ◦ Zone Sheets; BP, FSBS, weight charts Follow-up after Initial Visit: • Make contact with appropriate resources ◦ Maryland Access Point line, dental, mental health ◦ Schedule appointments • Arrange transportation when necessary ◦ Contact staff for MA Transportation Forms to be completed • Send "needs list" to providers offices regarding needs of patient ◦ Refill requests, referrals, requests, etc. • Insurance companies ◦ Coverage specifications ◦ Case Manager access • Schedule for home safety modifications when applicable Discharge Process: • First month: ◦ MIH is "hands-on," doing tasks for clients/family and informing them before and after tasks are completed (i.e.- appointment scheduling, etc.) • Second month: ◦ Clients/family are encouraged to take initiative in completing necessary tasks to manage healthcare needs, reflecting level of involvement from MIH in first month • Third month - onward: ◦ MIH monitors ability of client/family to manage healthcare needs independently and provides assistance/guidance when needed ◦ Discharge (successful/unsuccessful) Self-manages, or remains non-compliant

Q92. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: Number of participants referred from hospital, Number of participants referred from EMS, number of participants referred from community agencies, number of patient encounters
- [x] Other process/implementation measures (e.g. number of items distributed): Number of home visits, number of environmental scans, number of phone calls/emails to patients, number of phone calls/emails to outside resources, number of referrals to community services, number of referrals to primary care, number of referrals to specialists, number of people given health education, number of people with contact 48 hours after discharge or referral, number of successful discharges, number of discharges due to non-compliance
- [x] Surveys of participants: Customer satisfaction surveys are completed at discharge from program
- [x] Biophysical health indicators: Blood pressure readings, weight, blood glucose logs
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [x]

Effects on healthcare utilization or cost: Changes in ED utilization, Changes in inpatient admissions, changes in 30 day readmissions, changes in EMS utilization, cost savings due to reductions in ED, inpatient, 30 day admissions, and EMS utilization

- [ ] Assessment of workforce development
- [ ] Other

Q93. Please describe the outcome(s) of the initiative.

Referrals: July '17 Aug. '17 Sept. '17 Oct. '17 Period #1 1a) EMS 0 0 0 0 0 1b) UMCRMC 0 2 8 12 22 1c) Health Dept. 0 0 0 0 0 1d) Other, specify 0 0 0 0 0 1e) Total: 0 2 8 12 22 Support delivered by: 2a) Home Visits 0 1 11 18 30 2b) Public Locations 0 0 1 6 7 2c) Phone/Email (to patient) 0 4 28 63 95 2d) Phone/Email (outside resources) 0 1 13 38 52 2e) Total: 0 6 53 125 184 Linking participants to outside resources: 3a) 48h post hospital d/c contact 0 2 8 12 22 3b) Home Environment Scans 0 1 6 10 17 3c) Health Education 0 2 8 12 22 3d) Primary Care (new/old) 0 0 1 1 2 3e) Social/Comm. Svc (new/old) 0 1 5 10 16 3f) Specialty Care (new/old) 0 4 4 8 16 3g) Total: 0 10 32 53 95 Reducing Hospital/EMS utilization (program participants): 4a) # of EMS calls 4 4b) # of ED visits 30 4c) # of hospital admissions 5 4d) # of 30 day readmissions 1 4e) Total: 40 Referrals: May '18 June '18 July '18 1a) EMS 2 0 1 1b) Emergency Dept. 5 1 4 1c) Health Dept. 0 0 0 1d) Other, specify 0 0 0 1e) Total: 7 1 5 Support delivered by: 2a) Home Visits 11 7 15 2b) Public Locations 27 31 32 2c) Phone/Email (patient) 82 84 100 2d) Phone/Email (to resources) 69 37 63 2e) Total: 189 159 210 Linking/re-establishing participants to outside resources: 3a) 48h post referral contact 7 1 5 3b) Home Environment Scans 7 2 4 3c) Health Education 8 2 10 3d) Primary Care 0 1 0 3e) Social Services 5 1 7 3f) Specialty Care 2 3 0 3g) Total: 22 10 26 Reducing Hospital/EMS utilization (program participants): 4a) # of EMS calls 12 10 13 4b) # of ED visits 11 NA NA 4c) # of hospital admissions 4 NA NA 4d) # of 30 day readmissions 0 NA NA 4e) Total: 27 NA NA NA: Data not yet available for these time periods. Looking at 3 month pre and post MIH data for the first 50 participants: ▫ ED utilization dropped by 60% ▫ Inpatient admissions dropped 57% from a total of 37 inpatient admissions 3 months prior to MIH to 16 inpatient admissions. ▫ 30 day readmissions dropped by 86%. ▫ There was a 48% reduction in EMS utilization among participants. ▫ 63% of participants reduced their EMS utilization after MIH enrollment ▫ 68% with hypertension and 38% with diabetes saw improvement after MIH enrollment

Q94. Please describe how the outcome(s) of the initiative addresses community health needs.

The outcomes of this initiative directly impact the Access to Care priority and its focus on unnecessary hospital utilization by addressing social determinants of health.

Q95. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

The University of Maryland Charles Regional Medical Center contributed $50,000 to this initiative in Fiscal Year 2018.

Q96. (Optional) Supplemental information for this initiative.

Q97. Section IV - CB Initiatives Part 2 - Initiative 2

Q98. Name of initiative.

Living Well: Chronic Disease Self Management Program

Q99. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q100. Select the CHNA need(s) that apply.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Blood Disorders and Blood Safety
- [x] Cancer
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [x] Diabetes
- [ ] Disability and Health
- [x] Educational and Community-Based Programs
- [x] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [x] Mental Health and Mental Disorders
- [x] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [x] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases

- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [ ] Sleep Health
- [ ] Social Determinants of Health
- [x] Substance Abuse
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Other. Please specify.

Q101. When did this initiative begin?

January 2016

Q102. Does this initiative have an anticipated end date?

- ( ) The initiative will end on a specific end date. Please specify the date.
- ( ) The initiative will end when a community or population health measure reaches a target value. Please describe.
- ( ) The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.
- ( ) The initiative will end when external grant money to support the initiative runs out. Please explain.
- ( ) The initiative will end when a contract or agreement with a partner expires. Please explain.
- (•) Other. Please explain. No, this initiative will continue to be implemented in the community due to the commitment by the University of Maryland Charles Regional Medical Center and its community partners.

Q103. Enter the number of people in the population that this initiative targets.

Approximately 35% of the county population has either hypertension or diabetes. They are our target population for this initiative. Target population: 54641

Q104. Describe the characteristics of the target population.

Heart disease is the leading cause of death for Charles County residents. Heart disease accounts for approximately 1/4 of the county deaths each year (2015 Maryland Vital Statistics Report). The 2014 rate of ED visits for hypertension per 100,000 population is higher in blacks (349.2) than whites (109.0). This is a priority measure with the Maryland State Health Improvement Process. The 2013-2015 death rate for people in Charles County with diabetes mellitus 25.3 per 100,000 people. This is highest among the other SoMD counties and higher than the state average of 19.0 per 100,000. (2015 MD Vital Statistics Report). Approximately 13.3% of CC adults report having diabetes (2014 MD BRFSS). Emergency Department visit rates due to diabetes show a disparity among Charles County African Americans: 201.9 per 100,000 for African Americans and 71.5 for Whites. The same is true for Maryland African Americans. Therefore, this priority has been established by the Maryland State Health Improvement Process.

Q105. How many people did this initiative reach during the fiscal year?

39

Q106. What category(ies) of intervention best fits this initiative? Select all that apply.

- [x] Chronic condition-based intervention: treatment intervention
- [x] Chronic condition-based intervention: prevention intervention

- [ ] Acute condition-based intervention: treatment intervention
- [ ] Acute condition-based intervention: prevention intervention
- [ ] Condition-agnostic treatment intervention
- [ ] Social determinants of health intervention
- [ ] Community engagement intervention
- [ ] Other. Please specify.

Q107. Did you work with other individuals, groups, or organizations to deliver this initiative?

- (•) Yes. Please describe who was involved in this initiative.

  Yes, this project is implemented with the Charles County Department of Health, the Charles County Parks and Recreation Division, the Charles County Office on Aging, and Health Partners Inc.

- ( ) No.

Q108. Please describe the primary objective of the initiative.

Increase evidence based chronic disease self management by hospitals and primary care providers. Link health care-based efforts to increase participation in community prevention activities.

Q109. Please describe how the initiative is delivered.

Living Well is a chronic disease self management program developed by Stanford University. It is a 6-week program for people with chronic conditions and the people who love them. Participants make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program. Throughout the program, participants will learn: Techniques to deal with problems such as frustration, fatigue, pain and isolation, Appropriate exercise for maintaining and improving strength, flexibility, and endurance Appropriate use of medications Communicating effectively with family, friends, and health professionals Nutrition Decision making How to evaluate new treatments

Q110. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: Number of participants who successfully completed the course (4 or more out of 6 classes attended)
- [x] Other process/implementation measures (e.g. number of items distributed): Race, ethnicity, gender, chronic conditions
- [x] Surveys of participants: Participant pre and post evaluations with satisfaction questions and self confidence questions
- [ ] Biophysical health indicators
- [ ] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ] Other

Q111. Please describe the outcome(s) of the initiative.

Charles County Number of workshops: 4 Average participants per workshop: 9.8 Number of participants: 39 Participants with attendance data: 39 Completers: 28 of 39 (72%) Number who are caregivers: 10 of 35 (29%) Age Count Percent 0-44 3 9% 44-49 2 6% 50-54 3 9% 55-59 2 6% 60-64 3 9% 65-69 4 11% 70-74 13 37% 75-79 3 9% 80-84 1 3% 90+ 1 3% Unknown 4 Can Manage Condition Count Percent 10 5 71% 8 1 14% 9 1 14% Unknown 32 Caregiver Count Percent No 25 71% Yes 10 29% Unknown 4 Chronic Condition Count Percent Hypertension 26 79% Arthritis 16 48% Diabetes 15 45% Obesity 13 39% Depression or Mental Illness 11 33% Chronic Pain 9 27% Lung Disease 8 24% Osteoporosis 8 24% Heart Disease 4 12% Cancer 3 9% Kidney Disease 2 6% Stroke 2 6% Other 9 27% Unknown 2 Completers Count Percent Yes 28 72% No 11 28% Condition Count Count Percent Multiple chronic conditions 30 81% No chronic conditions 4 11% One chronic condition 3 8% Unknown 2 Disabilities Count Percent Limited Phy/Men/Emotial 11 28% Diff. walking or climbing stairs 10 26% Diff. concentrating, remembering, making decisions 9 23% Diff. running errands 6 15% Hearing impaired 5 13% Diff. dressing or bathing 5 13% Visually impaired 3 8% Education Count Percent Completed High School 10 36% Some College 10 36% Completed College 7 25% Some High School 1 4% Unknown 11 Ethnicity/Race Count Percent White/Caucasian 19 53% Black or African American 17 47% American Indian or AK Native 2 6% Unknown 3 Gender Count Percent Female 28 80% Male 7 20% Unknown 4 Health Count Percent Good 17 49% Fair 14 40% Very Good 3 9% Poor 1 3% Unknown 4 How Did You Hear Count Percent Not reported 39 100% Insurance Count Percent Medicare 10 71% Medicaid 7 50% United 4 29% BC/BS 3 21% Unknown 25 Lives Alone Count Percent No 31 86% Yes 5 14% Unknown 3 Organization Count Percent Charles County Department of Health 39 100% Referred Count Percent No 39 100% My peer leaders made me feel welcome and a part of the group Count Percent Strongly Agree (1) 18 95% Agree (2) 1 5% Average Value 1.1 My peer leaders shared teaching responsibilities Count Percent Strongly Agree (1) 18 95% Agree (2) 1 5% Average Value 1.1 The peer leaders were prepared when they came to class Count Percent Strongly Agree (1) 17 94% Agree (2) 1 6% Average Value 1.1 I have more self-confidence in my ability to manage my health than I did before taking this workshop Count Percent Strongly Agree (1) 14 74% Agree (2) 5 26% Average Value 1.3 The book that we used for the workshop was very helpful Count Percent Strongly Agree (1) 14 74% Agree (2) 5 26% Average Value 1.3 I learned how to set an action plan and follow it Count Percent Strongly Agree (1) 16 84% Agree (2) 3 16% Average Value 1.2 I now have a better understanding of how to manage the symptoms of my chronic health conditions Count Percent Strongly Agree (1) 11 58% Agree (2) 8 42% Average Value 1.4 The site used for the workshop was conducive to learning Count Percent Strongly Agree (1) 17 89% Agree (2) 2 11% Average Value 1.1 I felt my opinions and contributions to the group were valued by the other participants Count Percent Strongly Agree (1) 15 79% Agree (2) 4 21% Average Value 1.2 The peer leaders were able to manage the group very well Count Percent Strongly Agree (1) 18 95% Agree (2) 1 5% Average Value 1.1 I felt my opinions and contributions to the group were valued by the peer leaders Count Percent Strongly Agree (1) 15 83% Agree (2) 3 17% Average Value 1.2 My peer leaders got along well together Count Percent Strongly Agree (1) 18 95% Agree (2) 1 5% Average Value 1.1 I valued the time to talk to other participants at break time Count Percent Strongly Agree (1) 13 68% Agree (2) 6 32% Average Value 1.3 I noticed that some participants did not come back to the workshop after the first week Count Percent Strongly Agree (1) 3 17% Agree (2) 7 39% Disagree (3) 1 6% Strongly Disagree (4) 7 39% Average Value 2.7 I feel more motivated to take care of my health since I took this workshop Count Percent Strongly Agree (1) 16 84% Agree (2) 3 16% Average Value 1.2

Q112. Please describe how the outcome(s) of the initiative addresses community health needs.

Those with the tools to self manage their own chronic conditions are less likely to have emergent situations that lead to visits to the emergency department or lead to inpatient admissions. Since our long term objectives are to reduce ED visit rates for hypertension, diabetes, mental health, and substance use, programs to manage their own health are critical.

Q113. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Q114. (Optional) Supplemental information for this initiative.

Q115. Section IV - CB Initiatives Part 3 - Initiative 3

Q116. Name of initiative.

Charles County Efforts to Reduce the Incidence and Mortality of Cancer

Q117. Does this initiative address a need identified in your CHNA?

- (•) Yes
- ( ) No

Q118. Select the CHNA need(s) that apply.

- [ ] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [ ] Access to Health Services: ED Wait Times
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Blood Disorders and Blood Safety
- [x] Cancer
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, Including Alzheimer's Disease
- [ ] Diabetes
- [ ] Disability and Health
- [ ] Educational and Community-Based Programs
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Genomics
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health-Related Quality of Life and Well-Being
- [ ] Hearing and Other Sensory or Communication Disorders
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Mental Health and Mental Disorders
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [ ] Oral Health
- [ ] Physical Activity
- [ ] Preparedness
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health
- [ ] Social Determinants of Health
- [ ] Substance Abuse
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [ ] Other. Please specify.

Q119. When did this initiative begin?

7/1/2015

Q120. Does this initiative have an anticipated end date?

- ( ) The initiative will end on a specific end date. Please specify the date.
- (•) The initiative will end when a community or population health measure reaches a target value. Please describe.

This initiative toward the reduction of incidence and mortality of cancer, specifically colorectal cancer, will be completed on June 30, 2018. Rates of colorectal cancer incidence and mortality are now below the state rates and disparities by race for many sites, including prostate, colorectal, and breast cancers are diminishing. It was not identified as a priority in the 2018 community

- ○ The initiative will end when a clinical measure in the hospital reaches a target value. Please describe.

- ○ The initiative will end when external grant money to support the initiative runs out. Please explain.

- ○ The initiative will end when a contract or agreement with a partner expires. Please explain.

- ○ Other. Please explain.

Q121. Enter the number of people in the population that this initiative targets.

Because our focus is on the prevention of the disease and not just the treatment and survival after disease onset, we choose to target the whole county. The 2015 Charles County population was 156,118.

Q122. Describe the characteristics of the target population.

Cancer is the leading cause of death in Charles County. In 2015, a total of 222 deaths occurred in Charles County from cancer, representing 22% of the total county deaths. Source: 2015 Maryland Vital Statistics Report Charles County had a 2010-14 Colon and Rectal Cancer incidence rate of 35.9 per 100,000. This was slightly lower than the Maryland state average rate of 36.7. Incidence rates were higher for Charles County men than Charles County women (38.2 vs. 34.0). Charles County Whites had a similar colon and rectal cancer incidence rate to Charles County African Americans (37.5 vs. 30.9). Source: 2017 CRF Cancer Report The 2010-2014 Charles County colon and rectal cancer mortality rate of 17.2 per 100,000 is higher than the Maryland state average rate of 14.5 and the other Southern Maryland counties (15.6 for Calvert and 13.0 for St Mary's County). Charles County males were more likely to die from colon and rectal cancer than Charles County females (19.7 vs. 15.3). 2010-2014 Charles County colon and rectal cancer mortality rates for African Americans were higher than the rates for Charles County Whites (24.2 vs. 14.3).

Q123. How many people did this initiative reach during the fiscal year?

1,430

Q124. What category(ies) of intervention best fits this initiative? Select all that apply.

- ☐ Chronic condition-based intervention: treatment intervention
- ☑ Chronic condition-based intervention: prevention intervention
- ☐ Acute condition-based intervention: treatment intervention
- ☐ Acute condition-based intervention: prevention intervention
- ☐ Condition-agnostic treatment intervention
- ☐ Social determinants of health intervention
- ☑ Community engagement intervention
- ☐ Other. Please specify.

Q125. Did you work with other individuals, groups, or organizations to deliver this initiative?

- ◉ Yes. Please describe who was involved in this initiative.

  Charles County Department of Health, American Cancer Society, the Partnerships for a Healthier Charles County, Sisters at Heart, Health Partners Inc. all played an active role in the implementation of this initiative.

- ○ No.

Q126. Please describe the primary objective of the initiative.

1. Increase Community Outreach & Education surrounding cancer and overall health 2. Establish a referral system with county providers and other county agencies to community resources and programs for Colorectal Cancer screening and follow-up.

Q127. Please describe how the initiative is delivered.

Community Outreach and Education: Education at the Charles County Fair The Cancer Team used the Charles County Fair Friday as the location for a colorectal cancer education and awareness event. The Charles County Department of Health brought the inflatable colon (funded by UM Charles Regional Medical Center in 2014) and set up in the center of the fairgrounds. People had the opportunity to walk through the colon and talk with Cancer Team members about colon and rectal health and colonoscopies for screening. The team also designed and printed out signs on the importance of colon and rectal cancer screening. Team members walked around the fair that day with their signs. There were a total of 1000 encounters at this community event. Relay for Life Each year, the University of Maryland Charles Regional Medical Center plays an active role in the Charles County Relay for Life event. The hospital is the sponsor for the Survivors Event before Relay for Life begins. Health education is available at the event. Breast Cancer Luncheon The University of Maryland Charles Regional Medical Center in collaboration with the Sisters at Heart hosts an Annual Breast Cancer Luncheon in October. This event educates the community on breast cancer and the innovations and treatments currently available in the community. 2. Establishing Partnerships through Community-Clinical Linkages to Increase Cancer Screening The Charles County Department of Health was awarded a grant to work with a local health system to develop and implement a referral system for colorectal cancer screening. The goal of the program was to increase colorectal cancer referral and screening rates among the practice. The LHIC Chronic Disease and Cancer Team provided planning and support for the project. It was established that the CRC screening rate at the practice was 7%. The practice was given models to use when educating their patients on colorectal cancer and the need for screening. System level changes were made to increase referrals to those aged 51-75. A patient educator/navigator was hired to help eliminate barriers to screening and to educate people on the importance of screening. The practice developed a process map and formalized a policy on colorectal cancer screening. The practice added a provider reminder system into their EHR to prompt the provider to educate and refer eligible patients for screening.

Q128. Based on what kind of evidence is the success or effectiveness of this initiative evaluated? Explain all that apply.

- [x] Count of participants/encounters: Number of people in attendance at Relay for Life and number of people in attendance at breast cancer luncheon, number of encounters at county fair
- [x] Other process/implementation measures (e.g. number of items distributed): Colorectal cancer screening rate, Colorectal cancer referral rate at health system, number of people assisted by patient navigator, number of people educated on importance of CRC screening, number of educational materials distributed, number of phone calls made to patients, number of follow ups to patients, number of reminders to patients about screening
- [ ] Surveys of participants
- [ ] Biophysical health indicators
- [x] Assessment of environmental change
- [ ] Impact on policy change
- [ ] Effects on healthcare utilization or cost
- [ ] Assessment of workforce development
- [ ] Other

Q129. Please describe the outcome(s) of the initiative.

Community Education and Outreach: A total of 1000 encounters occurred at the Charles County Fair. People were able to walk through the inflatable colon and learn about polyps and how they can be removed and thereby remove the risk of colon cancer. The Relay for Life event raises awareness of cancer incidence and mortality. It is a hopeful event to rally a community around action and research to end cancer. A total of 200 participated in this event. The Annual Breast Cancer Luncheon had 230 in attendance. A panel discussion was lead, and participants were educated on the newest techniques for diagnosis and treatment of breast cancer. Collaboration with Health Systems to Increase Colorectal Cancer Screening Number of patients assisted by the patient navigator: 6 Number of educational sessions: 5 Number of phone calls made: 10 Number of referrals made: 26 Number of appointments scheduled: 0 Number of reminders provided: 3 Number of follow-up calls made: 2 Number of patients who were assisted by the patient navigator who successfully completed their CRC screening: 2 Number of educational materials disseminated: 240 Colorectal cancer referral rate: 6.7% Colorectal cancer screening rate: 23%

Q130. Please describe how the outcome(s) of the initiative addresses community health needs.

When people are educated on the importance of early screening, detection, and treatment, there is an improved chance of cancer survival. Charles County has seen decreases in colorectal cancer mortality due to programs that educate on preventive screenings and increase screening and referral rates.

Q131. What was the total cost to the hospital of this initiative in FY 2018? Please list hospital funds and grant funds separately.

Total cost of hospital initiative in FY 2018- $ 9,096.00

Q132. (Optional) Supplemental information for this initiative.

Q133. Section IV - CB Initiatives Part 4 - Other Initiative Info

Q134. Additional information about initiatives.

Q135. (Optional) If you wish, you may upload a document describing your community benefit initiatives in more detail, or provide descriptions of additional initiatives your hospital undertook during the fiscal year. These need not be multi-year, ongoing initiatives.

Q136. Were all the needs identified in your CHNA addressed by an initiative of your hospital?

- (•) Yes
- ( ) No

Q137. Please check all of the needs that were NOT addressed by your community benefit initiatives.

This question was not displayed to the respondent.

Q138. How do the hospital's community benefit operations/activities align with the State Health Improvement Process (SHIP)? The State Health Improvement Process (SHIP) seeks to provide a framework for accountability, local action, and public engagement to advance the health of Maryland residents. The SHIP measures represent what it means for Maryland to be healthy. Website: http://ship.md.networkofcare.org/ph/index.aspx. To the extent applicable, please explain how the hospital's community benefit activities align with the goal in each selected measure.

Enter details in the text box next to any SHIP goals that apply.

SHIP goal	Details
Reduce infant mortality	Participation on the county's fetal and infant mortality review team, support for the March of Dimes efforts including the March for Babies
Reduce rate of sudden unexpected infant deaths (SUIDs)	Safe sleeping campaigns with the fetal and infant mortality review team and the Charles County Department of Health's maternal and child health program
Reduce the teen birth rate (ages 15-19)	
Increase the % of pregnancies starting care in the 1st trimester	
Increase the proportion of children who receive blood lead screenings	
Increase the % of students entering kindergarten ready to learn	
Increase the %of students who graduate high school	
Increase the % of adults who are physically active	Health education on physical activity and healthy eating at many community events.
Increase the % of adults who are at a healthy weight	Health education on physical activity and healthy eating at many community events.
Reduce the % of children who are considered obese (high school only)	Support for the county youth triathlon, health education at the county fair
Reduce the % of adults who are current smokers	Quit to assist fax program with the health department cessation program
Reduce the % of youths using any kind of tobacco product (high school only)	
Reduce HIV infection rate (per 100,000 population)	
Reduce Chlamydia infection rate	
Increase life expectancy	
Reduce child maltreatment (per 1,000 population)	
Reduce suicide rate (per 100,000)	Support for the Southern Maryland Out of the Darkness Walk and the American Foundation for Suicide Prevention's trainings in county
Reduce domestic violence (per 100,000)	
Reduce the % of young children with high blood lead levels	
Decrease fall-related mortality (per 100,000)	
Reduce pedestrian injuries on public roads (per 100,000 population)	
Increase the % of affordable housing options	
Increase the % of adolescents receiving an annual wellness checkup	
Increase the % of adults with a usual primary care provider	Campaigns on appropriate use of primary, urgent, and emergent care; Opened a primary care practice to increase county providers
Increase the % of children receiving dental care	
Reduce % uninsured ED visits	Charitable care for those who are uninsured, Work with Health Partners Inc to ensure follow up care for uninsured, work with SeedCo to get individuals signed up for insurance through the exchange
Reduce heart disease mortality (per 100,000)	Heart Healthy Eating, Stroke Support Group, Chronic Disease Self Management Program
Reduce cancer mortality (per 100,000)	Relay for Life, Annual Breast Cancer Luncheon, Health Education on cancer prevention, Chronic Disease Self Management Classes
Reduce diabetes-related emergency department visit rate (per 100,000)	Center for Diabetes, Diabetes Support Group, Diabetes Self Management Program
Reduce hypertension-related emergency department visit rate (per 100,000)	Hypertension Module to the Chronic Disease Self Management Program
Reduce drug induced mortality (per 100,000)	Participation in the county Overdose Fatality Review Team and Overdose Intervention Team, Referral to health department peer recovery specialist program
Reduce mental health-related emergency department visit rate (per 100,000)	Provide access to University of Maryland Medical System webinars on mental health
Reduce addictions-related emergency department visit rate (per 100,000)	Participation in the county Overdose Fatality Review Team and Overdose Intervention Team, Referral to health department peer recovery specialist program, Distribute Narcan
Reduce Alzheimer's disease and other dementias-related hospitalizations (per 100,000)	
Reduce dental-related emergency department visit rate (per 100,000)	

Increase the % of children with recommended vaccinations	
Increase the % vaccinated annually for seasonal influenza	
Reduce asthma-related emergency department visit rate (per 10,000)	

Q139. (Optional) Did your hospital's initiatives in FY 2018 address other, non-SHIP, state health goals? If so, tell us about them below.

Q140. Section V - Physician Gaps & Subsidies

Q141. As required under HG §19-303, please select all of the gaps in physician availability in your hospital's CBSA. Select all that apply.

- [ ] No gaps
- [x] Primary care
- [x] Mental health
- [ ] Substance abuse/detoxification
- [ ] Internal medicine
- [ ] Dermatology
- [ ] Dental
- [ ] Neurosurgery/neurology
- [x] General surgery
- [ ] Orthopedic specialties
- [ ] Obstetrics
- [ ] Otolaryngology
- [ ] Other. Please specify.

Q142. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand.

Hospital-Based Physicians	Due to the significant physician shortage in the Southern region, UM CRMC does not have adequate pool of community physicians to provide 24 hour professional and administrative services for many required specialties. Contracts with these physicians and groups are needed to provide 24 hour services for patients regardless of their insurance status or ability to pay and make it necessary for UM CRMC to assure that Contractor receives fair market value compensation for the services it is rendering to or for the benefit of Hospital.
Non-Resident House Staff and Hospitalists	N/A
Coverage of Emergency Department Call	As a result of the prevailing physician shortage (southern Maryland has the highest number of physician specialty shortages in the state); the University of Maryland Charles Regional Medical Center has an insufficient number of specialists within the medical staff. In all of these areas there are not enough physicians to care for patients including uninsured and underinsured in the hospital. Therefore, subsidies are paid to the physicians to provide on call coverage for the Emergency Department and patient care departments.
Physician Provision of Financial Assistance	N/A
Physician Recruitment to Meet Community Need	Southern Maryland had the highest percentage of physician shortages of all of the regions in Maryland (89.9%). To address the shortage, the University of Maryland Charles Regional Medical Center hired both a Chief Medical Officer and Physician Recruiter and Liaison who are working to successfully attract and retain physicians to the community. Private practice within the community is preferred, but the hospital will employ those physicians when necessary.
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	
Other (provide detail of any subsidy not listed above)	

Q143. (Optional) Is there any other information about physician gaps that you would like to provide?

Q144. (Optional) Please attach any files containing further information regarding physician gaps at your hospital.

Data on Physician Gaps for Charles County.doc
1.8MB
application/msword

Q145. Section VI - Financial Assistance Policy (FAP)

Q146. Upload a copy of your hospital's financial assistance policy.

AD-0150-Guidelines for the Financial Assistance Program - 03-18.docx
89.2KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q147. Upload a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e).

Patient Information brochureCRMC.pub
392KB
application/octet-stream

Q148. What is your hospital's household income threshold for medically necessary free care? Please respond with ranges as a percentage of the federal poverty level (FPL).

100% Financial Assistance for medically necessary care provided to uninsured patients with household income between 0% and 300% of the FPL

Q149. What is your hospital's household income threshold for medically necessary reduced cost care? Please respond with ranges as a percentage of the FPL.

Partial Financial Assistance for medically necessary care provided to uninsured patients with household income between 200% and 500% of the FPL

Q150. What are your hospital's criteria for reduced cost medically necessary care for cases of financial hardship? Please respond with ranges as a percentage of the FPL and household income. For example, household income between 301-500% of the FPL and a medical debt incurred over a 12-month period that exceeds 25 percent of household income.

Q151. Provide a brief description of how your hospital's FAP has changed since the ACA Expansion became effective on January 1, 2014.

There has been an increase in quality and affordability of healthcare since ACA's Health Care Coverage Expansion Option became effective on January 1, 2014. It has changed FAP substantially with a decrease in having patient present to the hospital uninsured and/or self-pay status. The status change decreased the uncompensated care for straight self-pay. Another affect of the ACA Health Care Coverage Expansion Option was discontinuing the primary adult care (PAC), substantial impact on the hospital causing additional reduction in uncompensated care since January 1, 2014. During the intake or discharge process or when there is contact regarding a billing matter, if a patient discloses financial difficulty or concern with payment of the bill, the patient is provided with FAP information. A packet with the application, criteria, and a documentation checklist is provided. Assistance completing the application is available. Additionally, assistance is provided for patients or their families in qualification and application of government benefits, Medicaid, and other state programs. Once an application is processed and if it is deemed incomplete, a letter is sent to the patient requesting the missing or incomplete items. Patients may call 301-609-4400 or visit the Call Center for assistance or to drop off their application

Q152. (Optional) Is there any other information about your hospital's FAP that you would like to provide?

Q153. (Optional) Please attach any files containing further information about your hospital's FAP.

10. Appendix II ACA Expansion Option FINAL.docx
13.1KB
application/vnd.openxmlformats-officedocument.wordprocessingml.document

Q154. Summary & Report Submission

Q155.

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Once you proceed to the next screen using the right arrow button below, you cannot go backward. For that reason, we strongly recommend that you use the Table of Contents to return to the beginning and double-check your answers.

When you click the right arrow button below, you will see a page with all of your answers together. You will see a link to download a pdf document of your answers, near the top of the page. You can download your answers to share with your leadership, board, or others as required by your internal processes.

Location Data

Location: (39.285598754883, -76.689903259277)

Source: GeoIP Estimation

PART TWO: ATTACHMENTS

Charles County Community Health Statistics

The Community Benefit Service Area for the University Of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified above as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county.

Geography

Charles County is located 23 miles south of Washington, D.C. It is one of five Maryland counties, which are part of the Washington, DC-MD-VA metropolitan area. At 458 square miles, Charles County is the eighth largest of Maryland's twenty-four counties and accounts for about 5 percent of Maryland's total landmass. The northern part of the county is the "development district" where commercial, residential, and business growth is focused. The major communities of Charles County are La Plata (the county seat), Port Tobacco, Indian Head, and St Charles, and the main commercial cluster of Hughesville-Waldorf-White Plains. Approximately 60 percent of the county's residents live in the greater Waldorf-La Plata area. By contrast, the southern (Cobb Neck area) and western (Nanjemoy, Indian Head, Marbury) areas of the region still remain very rural with smaller populations.

Population

Charles County has experienced rapid growth since 1970, expanding its population from 47,678 in 1970 to 120,546 in the 2000 census and 146,551 in the 2010 census. The current 2017 Census Bureau estimates the population at 159,700. The magnitude of growth can be seen in the changes in population density. The 1990 census showed that there were 219.4 individuals per square mile, which increased to 261.5 individuals per square mile by 2000, an increase of 19.2%, and to 320.2 individuals per square mile by 2010, an increase of 22.5%.

Source: 2012-2016 US Census Bureau's American Community Survey 5 year estimates and 2017 one-year estimate

Transportation

The percent change in the population growth for Charles County has been slightly greater than the change seen in the Maryland population growth. This growth has created transportation issues for the County, in particular for the "development district" in the northern part of the county where many residents commute to Washington D.C. to work. The average work commute time for a Charles County resident is 42.9 minutes which is higher than the Maryland average of 32.4 minutes (Source US Census Bureau's 2012-2016 American Community Survey 5 year estimates). Public transportation consists of commuter buses for out-of-county travel and the county-run Van Go bus service for in-county transportation.

Source: 2012-2016 US Census Bureau's American Community Survey 5 year estimates

Diversity

As the population of the county changes, the diversity of the county also increases. The African American population has experienced the greatest increase. In 2000, African Americans made up 26% of

the total Charles County population; by 2017, they comprise 47.5% of the total county population. As of 2017, minorities comprise roughly 59.7% of the Charles County population. The Hispanic community has also seen increases over the past few years. They now comprise 5.8% of the total county population. This is the one of the highest percentages among the 24 Maryland jurisdictions. Charles County also has one of the largest American Indian/Native American populations in the state of Maryland at 0.8% of the total county population.

The 2017 Charles County gender breakdown is approximately 50/50. Males make up 48.2% of the population, and females make up 51.8% of the county population.
Source: 2017 US Census Bureau's American Community Survey 1 year estimate

Economy

Employment and economic indicators for the county are fairly strong. The 2012-2016 US Census American Community Survey estimates that 67.7% of the Charles County population is currently in the labor work force. The 2012-2016 5-year estimate for Charles County found that approximately 7.4% of Charles County individuals are living below the poverty level; however, this is lower than the Maryland rate of 9.3%. The Charles County median household income was $91,373, well above the Maryland median household income of $76,067.The diversity of the county is also represented in the business community with 46% of all Charles County businesses being minority-owned firms. This is higher than the State of Maryland at 38%.
Source: 2012-2016 US Census Bureau's American Community Survey 5 year estimates

Education

Charles County has a larger percentage of high school graduates than Maryland (92.8% vs. 89.6%); however, Charles County has a smaller percentage than Maryland of individuals with a bachelor's degree or higher (27.4% vs. 38.4%).
Source: 2012-2016 US Census Bureau's American Community Survey 5 year estimates

Housing

There is a high level of home ownership in Charles County (77.4%); however, this is slightly down from the 2010 level (81.8%). The median value of a housing unit in Charles County is similar to the Maryland average ($287,600 vs. $290,400). Home values across Maryland have decreased and Charles County showed a similar downward trend. The average household size in Charles County is 2.81 persons.
Source: 2012-2016 US Census Bureau's American Community Survey 5 year estimates

Life Expectancy

The life expectancy for a Charles County resident, as calculated for 2017, was 78.9 years. This is slightly below the state average life expectancy of 79.2 years.

Source: 2017 Maryland Vital Statistics Report

Births

There were 1,837 births in Charles County in 2017. Charles County represents 45% of the births in Southern Maryland and 2.6% of the total births in Maryland for 2017.

Minorities made up just over half of the babies born in Charles County in 2017 (64%).

Source: 2017 Maryland Vital Statistics Report

Health Disparities

Health topics where health disparities are seen for the minority population in Charles County:

Health Topic	Indicator	Rate	Source
Heart Disease Prevalence and Mortality	Rate of ED visits for hypertension per 100,000 population Age-adjusted heart disease mortality rate	White: 228.6 Black: 634.2 White: 178.7 Black: 151.1	Maryland SHIP (Prevalence: HSCRC 2016 and Mortality: 2014-2016 Maryland Vital Statistics Report)
Colon and Rectal Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 37.5 Black: 30.9 White: 14.3 Black: 24.2	2017 Cigarette Restitution Fund Program Cancer Report (2010-2014 rates)
Breast Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 124.4 Black: 130.4 White: 24.8 Black: 29.4	2017 Cigarette Restitution Fund Program Cancer Report (2010-2014 rates)
Prostate Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per	White: 103.4 Black: 190.7 White: 14.3	2017 Cigarette Restitution Fund Program Cancer Report (2010-2014 rates)

	100,000	Black: 43.9	
Diabetes Prevalence	Unadjusted Diabetes ED Visit Rates by Black or White Race	White: 152.7 Black: 335.9	Maryland 2016 HSCRC per SHIP site
Obesity	Unadjusted % Adults at Healthy Weight	Overall: 26.7 White: 25.4 Black: 28.7	Maryland 2016 BRFSS per SHIP site
STD	Rate of Chlamydia infection for all ages per 100,000 (all ages)	Overall: 514.8 Data not available by race and ethnicity	Maryland STD Prevention Program Level data 2016
Asthma	Rate of ED visits for asthma per 10,000	White-54.6 Black-109.1	HSCRC 2016 Per SHIP Site
Infant Mortality	Infant Mortality Rate per 1,000 births	County Overall: 10.89 White/Not Hispanic: 12.2 Black-10.0	2017 Maryland Infant Mortality Report, Vital Statistics Admin.

1. 2017 Charles County Current Population Survey Data. United States Census Bureau. Available at: www.census.gov.

2. 2017 Maryland Vital Statistics Report. Charles County Demographic and Population Data. Maryland Department of Health. Available at www.vsa.maryland.gov.

3. 2012-2016 US Census Bureau, American Community Survey 5 year estimates, Charles County and Maryland. Available at www.census.gov.

4. Maryland State Health Improvement Process Measures. Accessed on October 2018. Available at: http://charles.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship17.

5. 2017 Maryland Cigarette Restitution Fund Program's Cancer Report. Maryland Department of Health. Available at: https://phpa.health.maryland.gov/cancer/SiteAssets/Pages/surv_data-reports/2017_CRF_Cancer_Report_(20170827).pdf.

6. 2016 Chlamydia Infection Rates by Race. Maryland Department of Health. Center for Sexually Transmitted Infection Prevention. Accessed through the Maryland State Health Improvement Process. Available at: http://charles.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship17.

7. 2017 Maryland Infant Mortality Report. Maryland Vital Statistics Administration. Available at: https://health.maryland.gov/vsa/Pages/reports.aspx.

Table II: Service Area Demographic Characteristics and Social Determinants:

Demographic Characteristic	Description	Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	The Community Benefit Service Area for the University of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the seven zip codes identified as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county. The zip codes of Waldorf (20601, 20602, 20603), White Plains (20695), and Indian Head (20640) represent the geographic areas where the most vulnerable populations reside in Charles County. The lowest average life expectancy is found in 20640, Indian Head, at 74.7 years. The highest Medicaid enrollment rate was in 20602, Waldorf. The highest percentage of low birth weight babies was in 20695, White Plains. The highest WIC participation rate was in 20602, Waldorf. The WIC participation rate was also high in Indian Head, 20640. The 2006-2011 All-cause mortality for Indian Head was 942.6 per 100,000, above the Maryland state rate. The 2006-2010 heart disease mortality for Indian Head was 232.3, also above the Maryland state rate.	2006-2010 Maryland Vital Statistics 2007-2011 MD Medicaid Program 2006-2010 Maryland Vital Statistics 2007-2011 MD WIC Program 2006-2011 Maryland Vital Statistics 2006-2010 Maryland Vital Statistics
Median Household Income within the CBSA	$91,373	2012-2016 US Census *American Community Survey*

		5 year estimate
Percentage of households with incomes below the federal poverty guidelines within the CBSA	5.8%	2012-2016 US Census American Community Survey 5 year estimate
For counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://census.gov/hhes/www/hlthins/data/acs/aff.html http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	4.4%	2012-2016 American Community Survey 5-Year Estimate
Percentage of Medicaid recipients by County within the CBSA.	15.7%	Fiscal Year 2016 Maryland Medicaid e-Health Statistics: Medicaid Enrollment Rates
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	The life expectancy from birth for a Charles County resident as calculated for 2015-2017 was 78.9 years. This is slightly below the state average life expectancy of 79.7 years. White: 78.2 Black: 79.5	2017 Maryland Vita Statistics Report. Charles County Demographic and Population Data. MDH
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	All-cause death rate for Charles County for 2017 is 683.8 per 100,000 population. This is below the Maryland state average death rate of 826.3 per 100,000. White: 1024.1 Black: 489.8 Asian/PI: 261.1 American Indian: 407.5 Hispanic: 161.6 The rate among the White population is greater than the other races because they make up the majority of the aging population in the county. Two-thirds of the 65+ population in Charles County (66%) are White. The minority populations are moving into Charles County and are a younger	2017 Charles Co. Death data, 2017 Maryland Vital Statistics Report

	population; therefore, they have lower mortality rates. The median age in Charles County is 34 years.	

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)	**Access to healthy food**:
	• 3 Census tracts with low income and low access to food: 2 in Indian Head and 1 in Waldorf (Both primary service area zip codes)
	
	Transportation:
	• Mean travel time to work: 42.9 min
	
	Environmental Factors:
	• # of days Air Quality Index exceeds 100: 1.7
	• % of children tested who have blood lead levels ≥ 10 mg/dl: 0.10% (2015)(Goal: .288)
	
	Housing:
	• Home ownership: 77.4%
	• Renter occupied housing: 22.6%
	• Affordable housing: the % of houses sold that are affordable on a median teacher's salary: 35.8%
	
	Access to Care:
	• 70% of Charles County residents travel outside of the county for medical care at some point.
	• % Mothers who received prenatal care 1st trimester ; 63.2%
	  ○ White/NH: 69.3%
	  ○ Black: 64.4%
	  ○ Hispanic: 40.6%
	  ○ Asian/Pacific Islander: 54.5%
		USDA 2016,
		Food Access Research Maps
		
		2012-2016 US Census ACS
		
		2016 MD Department of Planning from Maryland SHIP
		
		2012-2016 US Census Data, *American Community Survey* 5 year estimates,
		2016 Maryland Department of Planning from Maryland SHIP
		
		2015 Charles County Health Needs Assessment
		2017 Maryland Vital Statistics Report

	○ American Indian: 62.5% • Infant Mortality Rate: 10.9 per 1000 live births ○ White/NH: 12.2 ○ Black: 10.0 • Number of federally designated medically underserved areas in Charles County: 6 ○ Brandywine ○ Allens Fresh ○ Thompkinsville ○ Hughesville ○ Marbury ○ Nanjemoy • Number of physician shortage specialties in Southern Maryland: 28 Physician-to-population ratios in Southern Maryland below the HRSA benchmark for all types of physician **Education:** • 92.8% persons 25+ high school graduates • 27.4% persons 25+ bachelor's degree or higher	2017 Maryland Vital Statistics Report HPSA MUS/MUP Designations as of November 7, 2018 2007 Maryland Physician Workforce Study 2011 MD workforce Study Health Resources and Services 2012-2016 US Census Bureau's American Community Survey 5 year estimates
Available detail on race, ethnicity, and language within CBSA	**Population**: 159,700 **Sex**: • Female 51.8% • Male: 48.2%	2011-2015 US Census , *American Community Survey* 5 year estimate and 2016 1 year estimates

	Race and Ethnicity: • White 44.3% • Black 47.5% • American Indian and Alaska native 0.8% • Asian alone 3.4% • Native Hawaiian and Other Pacific Islanders 0.1% • Person reporting 2 or more races 3.9% • Hispanic or Latino 5.8% • White not Hispanic 40.3% **Age:** • Persons under 5 years 6.1% • Persons under 18 years 24.2% • Persons 65 years and over 12.1% **Language:** • Language other than English spoken at home: 7.7%	

Data on Physician Gaps for Charles County:

2011 Maryland Health Care Workforce Study:

2011 Maryland Health Care Commission (MHCC)'s Physician Workforce Study highlighted the physician workforce in Maryland. This study looked at the HRSA Area Health Resource File for 2009 and 2010 to determine the supply of physicians in Maryland and its regions. Charles County has been included in the Southern Maryland region with Calvert and St Mary's Counties.

As illustrated by the table below, Southern Maryland has physician to population ratios significantly below the HRSA benchmark for all types of physicians.

Table 10: Maryland Supply by Type of Physician and Region, 2009/2010

	Total	Primary Care	Medical Specialties	Surgical Specialties	All Other
Maryland physicians per 1000, residents excluded, with all adjustments					
Baltimore Metro	2.85	0.86	0.48	0.61	0.90
Eastern Shore	1.86	0.62	0.27	0.39	0.57
National Capital	2.25	0.72	0.41	0.48	0.64
Western	2.17	0.73	0.39	0.42	0.63
Southern	1.34	0.53	0.25	0.26	0.30
Total	2.44	0.77	0.42	0.52	0.74
Memo: HRSA baseline, interns excluded, with all adjustments	1.93	0.69	0.27	0.43	0.53
Percent difference from HRSA baseline					
Baltimore Metro	48%	24%	76%	41%	70%
Eastern Shore	-4%	-10%	0%	-11%	8%
National Capital	17%	4%	49%	11%	21%
Western	12%	5%	41%	-4%	19%
Southern	-31%	-24%	-8%	-40%	-43%
Total	27%	11%	54%	19%	39%

Source: Analysis of Maryland 2009/2010 license renewal database, calculations from HRSA 2008, population counts from U.S. Bureau of the Census

The Maryland physician supply ratios were adjusted to account for variation in average patient-care hours. Even with the adjustment, Southern Maryland continued to see low

physician to population ratios. Southern Maryland region had a 26% total physician deficiency versus the HRSA standard. This was the only region in Maryland to have such a significant deficiency. The Southern Maryland region also had physician supply deficiencies for primary care (19%), medical specialties (7%), surgical specialties (34%), and all other physicians (39%). Four out of the five physician supply deficiencies are greater than 10% below the HRSA standard.

Maryland Physician Supply Versus HRSA Standard, All Adjustments					
Region	**Total**	**Primary Care**	**Medical Specialties**	**Surgical Specialties**	**All Other**
Entire State	27%	11%	54%	19%	39%
Baltimore Metro	44%	21%	69%	40%	66%
Eastern Shore	4%	0%	8%	-2%	13%
National Capital	18%	4%	56%	8%	23%
Western	20%	12%	48%	3%	29%
Southern	-26%	-19%	-7%	-34%	-39%
Key: Green = >10%, Yellow = -10% to 10%, Red = <-10%					

Note: Positive percentage indicates supply in excess of HRSA Standard, and negative percent indicates a supply deficit compared to the HRSA Standard. Southern: Charles, Calvert, and St Mary's Counties

Study implications for Southern Maryland from the 2011 Maryland Physician Workforce Study include:

Residents are likely to travel out of area for care:

- Physicians in Southern Maryland provide about 67% of Medicare beneficiary's total Medicare physician care. Residents receive 14% of physician care in Mont/PG counties and 12% in out-of-state (probably DC)

Table 14: Intrastate Travel for Care, Medicare Fee-for-Service Part B Beneficiaries, 2009								
Maryland Residents, Physician Services Spending Per Capita								
			Physician Location					
Beneficiary Residence	Baltimore Metro	Eastern Shore	National Capital	Western	Southern	Out of state	Total	% of spending in own region
Baltimore Metro	$ 2,503	$ 12	$ 56	$ 23	$ 7	$ 74	$ 2,675	94%
Eastern Shore	$ 299	$ 1,712	$ 26	$ 6	$ 2	$ 318	$ 2,362	72%
National Capital	$ 159	$ 4	$ 2,335	$ 15	$ 73	$ 595	$ 3,181	73%
Western	$ 121	$ 8	$ 101	$ 1,834	$ 3	$ 224	$ 2,290	80%
Southern	$ 182	$ 4	$ 378	$ 6	$ 1,806	$ 316	$ 2,692	67%
Source: Analysis of Medicare 5% sample limited data set standard analytic files and denominator file, 2009								

- Southern Maryland physicians are as likely as physicians overall to participate in Medicaid/Medicare and to accept new patients.

Table 13: Acceptance of Medicaid and Medicare Patients, by Region				
	Medicaid		Medicare	
Region	% of practices accepting Medicaid	Of those, % accepting new Medicaid patients	% of practices accepting Medicare	Of those, % accepting new Medicare
Percent of physicians				
Baltimore Metro	80%	88%	85%	94%
Eastern Shore	89%	90%	91%	94%
National Capital	61%	85%	79%	93%
Western	80%	85%	86%	91%
Southern	86%	86%	89%	93%
Total	75%	87%	84%	94%
Percent difference from state average				
Baltimore Metro	6%	1%	2%	1%
Eastern Shore	18%	4%	8%	1%
National Capital	-19%	-2%	-6%	-1%
Western	6%	-3%	2%	-3%
Southern	15%	-1%	6%	0%
Total	0%	0%	0%	0%
Source: Maryland license renewal survey, 2009/2010				

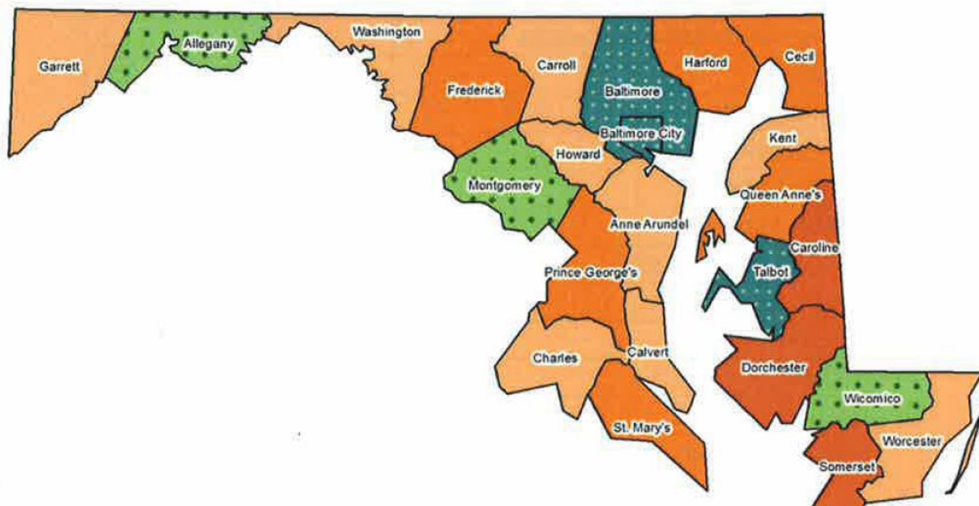
***Maryland Health Workforce Study Phase 2 Report, January 2014*:**

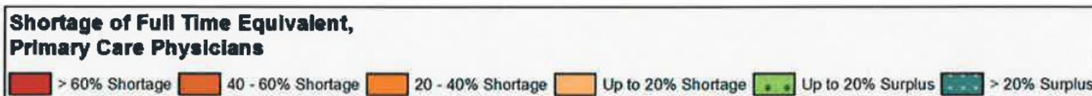
In January 2014, the Maryland Health Care Commission (MHCC) released a second report detailing Phase 2 of the Maryland Health Workforce Study. This study assessed health workforce distribution and the adequacy of supply. Using funding from the Robert Wood Johnson Foundation, the MHCC was able to study the Maryland healthcare workforce on the state and jurisdictional level. Phase II presents estimates of current supply and demand for health professions designated by MHCC as high priority in supporting Maryland's transition to health reform, and for which data were readily available for estimating supply and demand. These professions included primary care specialties and psychiatrists. Current supply estimates were also presented for

psychologists, social workers, counselors, physician assistants, pharmacists, registered nurses, and dentists.
Demand modeling: Estimates of the current demand for healthcare providers were developed using the IHS Healthcare Demand Micro-simulation Model. The major components of this model include: 1. A population database that contains characteristics and health risk factors for a representative sample of the population in each Maryland count; 2. Equations that relate a person's characteristics to his or her demand for healthcare services by care delivery setting; and 3. Staffing patterns that convert demand for healthcare services to demand for full time equivalent (FTE) providers.

In Charles County, the primary care physician FTE demand is greater than the primary care FTE supply (7.4 vs. 6.1). There is an 18% shortfall in the primary care services supply to fulfill the current demand. Charles County falls in the “Up to 20% Shortage Area” for primary care physician supply. See Map 1 below.

Map 1: Maryland County-Level Adequacy of FTE Primary Care Physician Supply

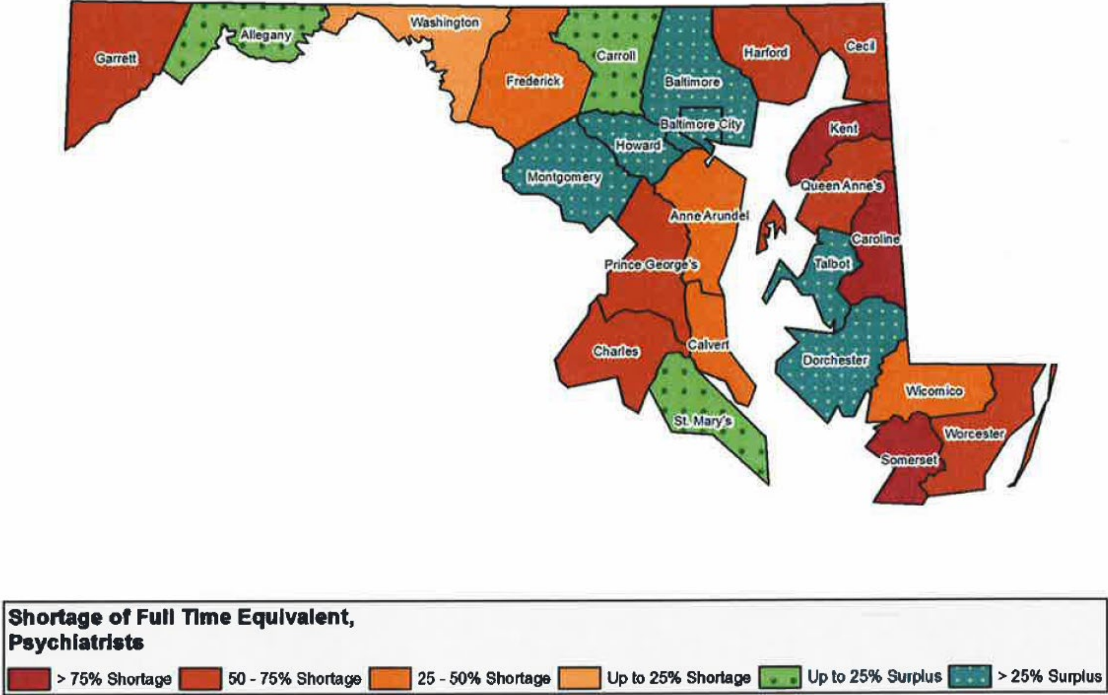




The FTE per 10,000 supply rates for professional counselors, social workers, and psychologists in Charles County is much lower than the rates for Maryland. The Charles County FTE rate for physician assistants is the only rate that came close to the Maryland state supply rate.

The demand for psychiatrists in Charles County is much higher than the county supply for psychiatry. Charles County has a shortage between 50-75% of full time equivalent psychiatrists. See Map 2 below.

Map 2: Maryland county-Level Adequacy of FTE Psychiatrist Supply



2011 County Physician/Nurse Specialty Data:

The US Department of Health and Human Services' Health Resources and Services Administration publishes information on the number of physicians and nurses by speciality for each state. 2011 data on the number of pediatricians, nurse practitioners, nurse midwives, general surgeons, general practitioners, OBGYN's, internal medicine physicians, and family medicine practitioners were compiled for Maryland and its jurisdictions. Specialities where Charles County is in lower half of the Maryland jurisdictions include OBGYN, nurse practitioners, and general surgeons.

***Primary Care Physicians Ratio*:**

Access to care requires not only financial coverage, but also access to providers. While high rates of specialist physicians have been shown to be associated with higher, and perhaps unnecessary utilization, sufficient availability of primary care physicians is essential for preventive and primary care, and when needed, referrals to appropriate specialty care. Using data from the Area Health Resource File and the American Medical Association, the

County Health Rankings were able to provide 2012 primary care physician ratios for all United States counties. For 2012, the Charles County primary care physician ratio was 2035:1. Primary Care Physicians (PCP) is defined as the ratio of the population to total primary care physicians. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The 2012 Charles County PCP ratio is almost twice as high as the Maryland state ratio of 1131:1.

TITLE: GUIDELINES FOR THE FINANCIAL ASSISTANCE PROGRAM

POLICY NUMBER: AD-0150

EFFECTIVE: January, 1999 LAST REVISED: March 2018

POLICY:

1. This policy applies to University of Maryland Charles Regional Medical Center (UM CRMC). UM CRMC 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.

2. It is the policy of UM CRMC 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.

3. UM CRMC will publish the availability of Financial Assistance on a yearly basis in the local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office and key patient access areas. A Financial Assistance Information Sheet will be provided to patients receiving inpatient services, and a Financial Assistance Information Sheet will be made available to all patients upon request.

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

5. UM CRMC 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 services, applications to the Financial Assistance Program will be accepted, reviewed, and evaluated retrospectively and will not delay patients from receiving care.

6. Account(s) will be written off to bad debt and assigned to a collection agency generally between 90 - 120 days from the date of discharge and after communication with the customer has failed to produce a plan to liquidate the account(s). With approval from the Patient Accounts Department, Extraordinary Collection Actions (ECAs) may be taken on accounts that have not been disputed or are not on a payment arrangement. These actions will occur no earlier than 120 days from submission of first bill to the patient and will be preceded by notice 30 days prior to commencement of the action. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

7. UM CRMC staff/designee may pursue all collection activities available for the purpose of collecting amounts legally due and owed to include the following:

- Dunning
- Suit
- Exercise of liens
- Wage attachments

PROCEDURE:

I. Program Eligibility

A. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, UM CRMC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. UM CRMC reserves the right to grant Financial Assistance without formal application being made by our patients.

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

1. Services provided by healthcare providers not affiliated with UM CRMC (e.g., home health services)

2. Patients whose insurance denies coverage for services due to patient's noncompliance with insurance restrictions, rules and access (e.g., insurance requires use of capitated facility and patient was non-compliant; therefore claim was denied), 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 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 UM CRMC's financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly

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

1. Refusal to provide requested documentation or providing incomplete information

2. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to UM CRMC 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 UM CRMC
5. Failure to make appropriate arrangements on past payment obligations owed to UM CRMC (including those patients who were referred to an outside collection agency for a previous debt)
6. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program
7. Refusal to divulge information pertaining to legal liability claim

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

D. Patients who indicate they are financially unable to pay an outstanding balance(s) shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance (See Section II below) eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership.

E. Standard financial assistance coverage amounts will be calculated based upon 200-300% of income, and hardship will be calculated based on hardship guidelines, as defined by federal poverty guidelines and follows the sliding scale **(ATTACHMENT I).**

II. Presumptive Financial Assistance

A. Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance form and/or supporting documentation on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with Financial Assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UM CRMC 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. If patient is receiving any of the programs listed below and completed an application for financial assistance, the application may be processed to provide patient with a longer term of assistance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. Active Medical Assistance pharmacy coverage.

2. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums).
3. Homelessness.
4. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs.
5. Maryland Public Health System Emergency Petition patients.
6. Participation in Women, Infants and Children Programs ("WIC")
7. Food Stamp eligibility.
8. Maryland eligibility Family Planning Only.
9. Eligibility for other state or local assistance programs.
10. Patient is deceased with no known estate.
11. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.

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

1. Purely elective procedures (e.g., Cosmetic procedures) are not covered under the program.

III. Medical Hardship

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

1. Medical Hardship criteria is State defined:
   a. Combined household income less than 500% of federal poverty guidelines.
   b. Having incurred collective family hospital medical debt at UM CRMC exceeding 25% of the combined household income during a 12-month period. The eligibility period is 12-month from the date that the Medical Hardship application was approved.
   c. The medical debt includes co-payments, co-insurance, and deductibles.

B. Patient balance after insurance:

1. UM CRMC applies the State established income, medical debt and time frame criteria to patient balance after insurance applications.

C. Coverage amounts will be calculated based on household up to 500% of federal poverty levels and the sliding scale below.

Sliding Scale

FINANCIAL ASSISTANCE – INCOME GUIDELINES

		% of Federal Poverty Level Income - 2018												
		Up to 200%	**Up to 210%**	**Up to 220%**	**Up to 230%**	**Up to 240%**	**Up to 250%**	**Up to 260%**	**Up to 270%**	**Up to 280%**	**Up to 300%**		**300% - 500%**	
Size of Family Unit	**FPL Income**	**Standard Financial Assistance - % of Reduction in Charges**											**Medical Hardship**	
		100%	90%	80%	70%	60%	50%	40%	30%	20%	10%		Patient Responsibility is 25% of Income	
1	12,140	24,280	25,494	26,708	27,922	29,136	30,350	31,564	32,778	33,992	35,206		36,420	(3) 60,700
2	16,460	32,920	34,566	36,212	37,858	(2) 39,504	41,150	42,796	44,442	46,088	47,734		49,380	82,300
3	20,780	41,560	43,638	45,716	47,794	49,872	51,950	54,028	56,106	58,184	60,262		62,340	103,900
4	25,100	50,200	52,710	55,220	57,730	60,240	62,750	65,260	67,770	70,280	72,790		75,300	125,500
5	29,420	(1) 58,840	61,782	64,724	67,666	70,608	73,550	76,492	79,434	82,376	85,318		88,260	147,100
6	33,740	67,480	70,854	74,228	77,602	80,976	84,350	87,724	91,098	94,472	97,846		101,220	168,700
7	38,060	76,120	79,926	83,732	87,538	91,344	95,150	98,956	102,752	106,568	110,374		114,180	190,300
8	42,380	84,760	88,998	93,236	97,474	101,712	105,950	110,188	114,426	118,664	122,902		127,140	211,900

For families with more than 8 persons, add $4,320 for each additional person.

Patient Income and Eligibility Examples:

Example #1	**Example #2**	**Example #3**
- Patient earns $59,500 per year - There are 5 people in the patient's family - The % of potential Finance Assistance coverage would equal 90% (they earn more than $58,840 but less than $61,782)	- Patient earns $40,500 per year - There are 2 people in patient's family - The % of potential Financial Assistance coverage would equal 50% (they earn more than $39,504 but less than $41,150)	- Patient earns $60,000 per year - There is 1 person in the family - The balance owed is $20,000 - This patient qualifies for Hardship coverage, ; patient responsibility is $15,000 (25% of $60,000)

FPL = Federal Poverty Levels

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

E. Individual patient situation consideration:

1. UM CRMC reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.
2. The eligibility duration and discount amount is patient-situation specific.
3. Patient balance after insurance accounts may be eligible for consideration.
4. Cases falling into this category require management level review and approval.

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

G. Patient is required to notify UM CRMC of their potential eligibility for this component of the financial assistance program.

IV. Asset Consideration

A. Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient responsibility without causing undue hardship. Individual patient financial situation such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are reviewed.

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

1. The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.
2. Up to $150,000 in primary residence equity.
3. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement, account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.

V. Appeals

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

B. Appeals can be initiated in writing.

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

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

E. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.

F. The escalation can progress up to the Chief Financial Officer who will render a final decision.

G. A letter of final determination will be submitted to each patient who has formally submitted an appeal.

VI. Procedures

A. UM CRMC will provide a trained person or persons who will be responsible for taking Financial Assistance applications in Patient Access and Patient Accounts. These staff can be Financial Counselors, Billing Staff, Customer Service, etc.

B. Every possible effort will be made to provide financial clearance prior to date of service. The financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent. 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.

1. Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.
2. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
3. UM CRMC will not require documentation beyond that necessary to validate the information on the Financial Assistance Application.
4. Applications initiated by the patient will be tracked, worked and eligibility determined within 30 days of receipt of completed application. A letter of final determination will be submitted to each patient that has formally requested financial assistance.
5. Incomplete applications/missing documentation will be noted in patient’s account, and original documents will be returned to patient with instruction to complete and return for processing.

C. In addition to a completed Financial Assistance Application, patients may be required to submit:

1. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable)
2. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses
3. Proof of social security income (if applicable).
4. A Medical Assistance Notice of Determination (if applicable)

5. Proof of U.S. citizenship or lawful permanent residence status (green card)
6. Work permit and copy of Social Security card
7. Reasonable proof of other declared expenses
8. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
9. Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted

D. 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, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UM CRMC guidelines.

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

    a. If the patient does qualify for financial clearance, appropriate personnel will notify scheduling department who may then schedule the patient for the appropriate service
    b. If the patient does not qualify for financial clearance, appropriate personnel will notify the scheduling staff of the determination and the non-emergent/urgent services will not be scheduled
    c. A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request

E. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination up to three (3) years prior and the following three (3) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. Payments made for care received during the financial assistance eligibility window that exceed the patient’s determined responsibility will be refunded if that amount exceeds $5.00.

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

1. Post approval discovery of an ability to pay
2. Changes to the patient’s income, assets, expenses or family status which are expected to be communicated to UM CRMC

G. Patients with three (3) or twelve (12) months certification periods have the responsibility (patient or guarantor) to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

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

UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER

TITLE: **GUIDELINES FOR THE FINANCIAL ASSISTANCE PROGRAM**

FUNCTION: Administrative

POLICY NUMBER: AD-0150

ISSUE DATE: 01/99

REVIEW/REVISED DATE:

Revised: 04/00	Revised: 05/01	Revised: 06/02
Revised: 07/03	Revised: 01/04	Revised: 11/04
Revised: 04/06	Revised: 05/07	Revised: 05/08
Revised: 04/10	Revised: 03/11	Revised: 02/12
Revised: 02/13	Name Change: 07/13	Revised: 03/14
Revised: 02/15	Revised: 02/16	Revised: 05/16
Revised: 02/17	Revised: 03/18	

APPROVED BY:

____________________________ ____________________________
Shelley Culhane — Date
Chair, Board of Directors

____________________________ ____________________________
Noel Cervino — Date
President & CEO

____________________________ ____________________________
Erik Boas — Date
Sr. Vice President, Finance/CFO

NOTE: This policy was previously LD-004 (as of 04/10).

Disclosure Statement

Effective July 1, 2013, the name of Civista Health, Inc. was changed to University of Maryland Charles Regional Health, Inc. and the name of Civista Medical Center, Inc. was changed to University of Maryland Charles Regional Medical Center. For purposes of all Policies and Procedures, these new names are now operational and any inadvertent mention of Civista Health, Inc. or Civista Medical Center is now incorrect.

The shared drive is the official location for Organizational Policies and Procedures for University of Maryland Charles Regional Medical Center. The original of this Organizational Policy and Procedure document with required signature is available for review during regular business hours by contacting the Information Technology Department at 301-609-4495. University of Maryland Charles Regional Medical Center reserves the right to update or modify all policies, procedures, and forms at any time and without prior notice, by posting the revised version on this drive. **NOTE:** To ensure the integrity of these documents, each page is either scanned or converted and placed on this drive as a duplicate of the original.

Contact Information

If you feel your rights have been violated in any way, please contact Performance Improvement immediately by calling 301-609-4715

Contact & Phone Numbers:
For customer Service in Billing, the hours of operation are 8:30am—4:00pm., Monday through Friday. We can be reached at 301-609-4400

Patient Financial services:
301-609-4400

Maryland Medical Assistance
800-284-4510

Department of Labor, Licensing and Regulation:
301-645-8712

5 Garrett Ave.
PO Box 1070
La Plata, MD 20646
Phone: 301-609-4000
www.charlesregional.org

PATIENT INFORMATION

Patient's Rights & Obligations

You have the right to:

1. Receive care and treatment at this hospital despite the ability to pay.
2. Receive consideration and respect by the staff during every phase of your care.
3. Be treated with dignity, respecting your spiritual, cultural, and personal values and beliefs.
4. Have respect for your privacy and for the confidentiality of information about you and your medical condition.
5. Be involved in decisions affecting your health care and well-being.
6. Know the name of the physician responsible for directing and coordinating your care as well as the names of other hospital caregivers.
7. Be informed about procedures and treatment and to refuse treatment as permitted by law.
8. Have questions answered about your condition and course of treatment.
9. Expect the health care professionals will accept and act upon your reports of pain and will provide education and resources available relating to pain management.
10. Be informed of available resources for resolving disputes, grievances, and conflicts.
11. Receive a written bill stating the Medical Center's charges.

You have the responsibility to:

1. Provide, to the best of your ability, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
2. Ask questions and request clear explanations of your care treatments and service in order to make informed decisions.
3. Follow the care, treatment, and service plan developed.
4. Be responsible for the outcomes if you do not follow the care, treatment and service plan provided to you.
5. Provide a copy of your advance directives power of attorney or domestic partnership affidavit if you have created such documents, to those responsible for your care while you are in the hospital.
6. Know and follow hospital rules and regulation, showing respect and consideration for other patients and individuals providing your health care.
7. Meet the financial commitments made with Civista Medical Center.
8. Inform Civista Medical Center as soon as possible if you believe that any of your rights have been or may be violated. You may do this at any time by calling the Office of the President at 301-609-4265 or Performance Improvement at 301-609-4715.

Hospital billing can be confusing. We hope that this brochure answers some of the questions that you may have regarding billing.

Physician Billing

You will receive multiple bills for your visit to the emergency room; as well as multiple bills for outpatient/inpatient services. Charles Regional Medical Center will submit a bill to you or your insurance company for our facility charges and/or the "technical" portion of the services. Your physician, surgeon, anesthesiologist, pathologist, radiologist, cardiologist, and Emergency Department physician will bill you separately for their professional services. Please contact them directly with your billing questions.

Emergency Medical Associates
240-686-2310

University of Maryland Faculty Physicisans, Inc.
888-243-8890

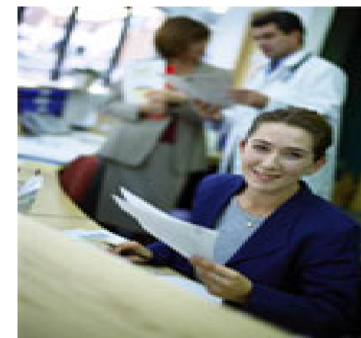
New Bridge Anesthesia
Anesthesia
301-638-4400

ABEO (Pathology Billing).
240-566-1603

Charles Regional Medical Center understands that patients may be faced with a difficult financial situation when they incur medical bills that are not covered by insurance. We encourage every patient and family to pursue all available programs that may be offered through the local Department of Social Services.

Financial Assistant

Charles Regional Medical Center can offer financial assistance to our patients who are denied state assistance. Please speak with a Customer Service Representative to determine if you may be eligible for either full or discounted services under this program. You may also contact a Customer Service Representative at 301-609-4400 for further information. Our financial aid programs will only apply to your hospital bills, and again, we encourage you to contact the Department of Social Services for assistance in paying your medical bills.



5 Garrett Ave.
PO Box 1070
La Plata, MD 20646

Phone: 301-609-4000
www.charlesregional.org

New Financial Assistance Policy Changes Pursuant to the ACA

ACA Health Care Coverage Expansion Description

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

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

1. LANGUAGE TRANSLATIONS

a. Requirement: The new 501(r) regulations lowered the language translation threshold for limited English proficient (LEP) populations to the lower of 5% of LEP individuals in the community served/1000-LEP individuals. University of Maryland Charles Regional Medical Center translated its financial assistance policy into the following languages: Spanish

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 Charles Regional 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 Charles Regional Medical Center maintains that list which is available for review.

Hospital	FAP Language Translations
UM Baltimore Washington Medical Center	English; Spanish; Korean
UM Charles Regional Medical Center	English; Spanish
Mt. Washington Pediatric Hospital	English; Spanish; French; Chinese
UM Shore Regional Health	English; Spanish
UM St. Joseph Medical Center	English; Spanish; French; Russian; Chinese; Korean; Vietnamese; Tagalog
University of Maryland Medical Center	English; Spanish; French; Chinese
UMMC-Midtown Campus	English; Spanish; French; Chinese
UM Rehabilitation & Orthopaedic Institute	English; Spanish; French; Russian; Chinese; Korean; Vietnamese; Tagalog
UM Upper Chesapeake Health	English; Spanish