

COMMUNITY BENEFIT NARRATIVE GBMC

FY2017 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

BACKGROUND

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

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

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

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

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

- (A) A definition of the community served by the hospital facility and a description of how the community was determined;
- (B) A description of the process and methods used to conduct the CHNA;
- (C) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;
- (D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant; and prioritizing those significant health needs;
- (E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and
- (F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

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

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

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

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

- With respect to each significant health need identified through the CHNA, either—
- (i) Describes how the hospital facility plans to address the health need; or
 - (ii) Identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address it.

HSCRC COMMUNITY BENEFIT REPORTING REQUIREMENTS

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. (For the purposes of this section, “primary services area” means the Maryland postal ZIP code areas from which the first 60 percent of a hospital’s patient discharges originate during the most recent 12-month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).
 - a. Bed Designation – The total number of licensed beds
 - b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;

- c. Primary Service Area (PSA) zip codes;
- d. Listing of all other Maryland hospitals sharing your PSA;
- e. The percentage of the hospital’s uninsured patients by county. (Please provide the source for this data, e.g., “review of hospital discharge data”);
- f. The percentage of the hospital’s patients who are Medicaid recipients. (Please provide the source for this data (e.g., “review of hospital discharge data.”)
- g. The percentage of the hospital’s patients who are Medicare beneficiaries. (Please provide the source for this data (e.g., “review of hospital discharge data.”)

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area zip codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of the Hospital’s Patients who are Uninsured:	f. Percentage of the Hospital’s Patients who are Medicaid Recipients:	g. Percentage of the Hospital’s Patients who are Medicare beneficiaries
Acute Care- 232 Newborn Nursery- 60 NICU- 30 Skilled Nursing- 27	16,195 Med/Surg Acute Care (excludes 3,854 births) 554 Skilled Nursing Facility	21093 21204 21286 21030 21212 21234 21236	St. Joseph Medical Center Sinai Hospital Franklin	Uninsured 5,447 Total 215,277 2.5%	Medicaid 4,303 Total 215,277 2.0%	Medicare 78,076 Total 215,277 36.3

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

- a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):
 - (i) A list of the zip codes included in the organization’s CBSA, and
 - (ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.
 - (iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., individuals with > 3 hospitalizations in the past year). This information may be copied directly from the community definition section of the organization’s federally-required CHNA Report ([26 CFR § 1.501\(r\)-3](#)).

Statistics may be accessed from:

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

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

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

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

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

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

Table II

Demographic Characteristic	Description	Source
Zip codes included in the organization’s CBSA, indicating which include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.	21093- Lutherville Timonium 21204- Towson 21286- Towson 21030- Cockeysville 21212- Baltimore 21234- Parkville 21236- Nottingham	
Median Household Income within the CBSA	21093- \$88,023 21204- \$75,840 21286- \$74,801 21030- \$69,968 21212- \$68,324 21234- \$60,388 21236- \$74,201	2016 American Community Survey Factfinder.census.gov
Percentage of households in the CBSA with household income below the federal poverty guidelines	21093- 2.1% 21204- 5.0% 21286- 5.6% 21030- 3.8% 21212- 9.0% 21234- 6.4% 21236- 5.4%	2016 American Community Survey Factfinder.census.gov
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html ; http://planning.maryland.gov/msdc/American_Community_Survey/2009/ACS.shtml	21093- 4.0% 21204- 6.2% 21286- 6.7% 21030- 9.1% 21212- 7.0% 21234- 10.2% 21236- 6.7%	2014 American Community Survey Factfinder.census.gov
Percentage of Medicaid recipients by County within the CBSA.	Region: Baltimore County Medicaid Enrollment: 13.26%	Overview of Maryland Medicaid Data, 2014 http://www.mhaonline.org/docs/default-source/presentations-and-talking-points/maryland-medicare-landscape.pdf?sfvrsn=2

<p>Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/Pages/Home.aspx</p>	<p>Region: <u>Maryland:</u> All Races: 79.8 White: 80.4 Black: 77.5</p> <p><u>Baltimore County:</u> All Races: 79.4 White: 79.5 Black: 78.4</p>	<p>Maryland Vital Statistics Annual Report 2014 http://dhmh.maryland.gov/</p>
<p>Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx</p>	<p>Region: <u>Maryland:</u> All Races: 764.5 White: 874.2 Black: 672.3 Asian: 251.0 Hispanic: 137.4</p> <p><u>Baltimore County:</u> All Races: 965.4 White: 1201.1 Black: 607.0 Asian: 219.0 Hispanic: 142.5</p>	<p>Maryland Vital Statistics Annual Report 2014 http://dhmh.maryland.gov/</p>
<p>Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)</p> <p>See SHIP website for social and physical environmental data and county profiles for primary service area information:</p> <p>http://ship.md.networkofcare.org/ph/county-indicators.aspx</p>	<p>Baltimore County Social-Emotional Support lacking: Adults 20.3% College Degree: Adults 25+ 35.6% Toxic Chemicals released annually (lbs.) 117,862</p> <p>Healthy Food Outlets 76.5%</p>	<p>Maryland State Health Improvement Process (SHIP)</p>
<p>Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://ship.md.networkofcare.org/ph/county-indicators.aspx</p>	<p>21093 White alone- 31,193 Black of African American alone- 1,378 American Indian and Alaska Native alone- 76 Asian alone- 4,247 Native Hawaiian and other Pacific Islander- 6 Some other race alone- 278 Two or more races- 630 Hispanic or Latino (of any race)- 941</p>	

	<p>White alone, not Hispanic or Latino-30,470</p> <p>21204 White alone- 15,997 Black of African American alone- 2,003 American Indian and Alaska Native alone- 60 Asian alone- 1,119 Native Hawaiian and other Pacific Islander- 0 Some other race alone- 207 Two or more races- 467 Hispanic or Latino (of any race)- 879 White alone, not Hispanic or Latino- 15,997</p> <p>21286 White alone- 16,501 Black of African American alone- 2,196 American Indian and Alaska Native alone- 167 Asian alone- 1,132 Native Hawaiian and other Pacific Islander- 0 Some other race alone- 85 Two or more races- 492 Hispanic or Latino (of any race)- 894 White alone, not Hispanic or Latino- 16,501</p> <p>21030 White alone- 15,273 Black of African American alone- 3,350 American Indian and Alaska Native alone- 154 Asian alone- 3,514 Native Hawaiian and other Pacific Islander- 24 Some other race alone- 32 Two or more races- 362 Hispanic or Latino (of any race)- 1,922 White alone, not Hispanic or Latino- 15,273</p> <p>21212 White alone- 17,695 Black of African American alone- 14,559 American Indian and Alaska Native alone- 21 Asian alone- 1,651 Native Hawaiian and other Pacific Islander- 0 Some other race alone- 331 Two or more races- 915 Hispanic or Latino (of any race)- 1,192 White alone, not Hispanic or Latino- 18,408</p> <p>21234 White alone- 44,442 Black of African American alone- 19,882 American Indian and Alaska Native alone- 486 Asian alone- 4,195 Native Hawaiian and other Pacific Islander- 21 Some other race alone- 737</p>	
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	<p>Two or more races- 1,611 Hispanic or Latino (of any race)- 2,879 White alone, not Hispanic or Latino- 45,720</p> <p>21236 White alone- 27,884 Black of African American alone- 6,486 American Indian and Alaska Native alone- 62 Asian alone- 4,201 Native Hawaiian and other Pacific Islander- 21 Some other race alone- 601 Two or more races- 1,217 Hispanic or Latino (of any race)- 1,307 White alone, not Hispanic or Latino- 26,511</p>	
Other		

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

Yes Provide date approved by the hospital’s governing body or an authorized body thereof here: 6 / 1 / 16 (mm/dd/yy)
 No

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

<https://www.gbmc.org/workfiles/our-community/chna/2016-chna-informant.pdf>

<https://www.gbmc.org/workfiles/our-community/chna/2016-chna-secondary.pdf>

<https://www.gbmc.org/workfiles/our-community/chna/2016-chna-strategy.pdf>

<https://www.gbmc.org/workfiles/our-community/chna/2016-chna-final-summary.pdf>

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

Yes Enter date approved by governing body/authorized body thereof here:
06/01/16 (mm/dd/yy)
 No

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

<https://www.gbmc.org/workfiles/our-community/chna/2016-chna-strategy.pdf>

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

Yes
 No

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

GBMC is transforming delivery of healthcare which will include building relationships between patients and their healthcare team, comprised of physicians, nurse practitioners, and healthcare navigators. This team will focus on a patient’s wellness and long term care, rather than the traditional model of episodic care (i.e. waiting until an individual has a problem and then “fixing” that problem). In order to help us meet these objectives, we will implement the latest

healthcare information technology tools such as Electronic Medical Records (EMR) and Computerized Physician Order Entry (CPOE); reduce waste and improve operational performance using LEAN tools; promote improved clinical outcomes through evidence-based medicine and continue educating system leaders; develop a network of community-based and GBMC employed clinical providers – Greater Baltimore Health Alliance (GBHA) – that will offer high quality and convenient healthcare. The future of healthcare is about integrating care and access and addressing the overall wellness of the community.” (excerpt from Strategic Plan document)

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

i. Senior Leadership

1. CEO
2. CFO
3. Other (please specify) – COO, CMO, CNO, VP Post-Acute Services, VP Quality

Describe the role of Senior Leadership.

The executive team is primarily responsible for the strategic development of community outreach programs within GBMC. Needs identified through the Community Health Needs Assessment are discussed and prioritized by leadership, where planning follows on how to address those needs. Leadership is responsible for conveying these and leading implementation through partnering with clinical leadership and teams.

ii. Clinical Leadership

1. Physician
2. Nurse
3. Social Worker
4. Other (please specify)

Describe the role of Clinical Leadership

Clinical leadership is primarily responsible for the implementation of clinical programs designed for improvements in patient care and long-term health of the patient community.

iii. Population Health Leadership and Staff

1. Population health VP or equivalent (please list)
2. Other population health staff (please list staff)

Megan Priolo, Chief Operating Officer of GBHA (Administrative Leader)

Dr. Robin Motter-Mast, Medical Director of Primary Care (Clinical Leader)

Ahmed Elsayed-Ahmed, Director of Population Health & Payer Analytics

- 2 Population Health Data Analysts on Ahmed's team

Taylor Nasby – Manager of Population Health Clinical Services

- 11 PCMH RN Care Managers on Taylor's team

Melanie Miller – Manager of Population Health Coordination Services

- 11 PCMH Care Coordinators on Melanie's team

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

They inform about issues that need to be addressed and participate in all community benefit meetings.

iv. Community Benefit Operations

1. ___ the Title of Individual(s) (please specify FTE)
2. Committee (please list members)
3. ___ Department (please list staff)
4. ___ Task Force (please list members)
5. ___ Other (please describe)

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

Meghan Chan- Data compilation and reporting

George Bayless- Vice President of Finance

Kim Davenport- Community Outreach Manager

Laura Schein- Community Outreach Oncology Services

Carolyn Candiello- Vice President of Quality and Patient Safety

Cathy Hamel – Vice President Continuing Care

Gregory Schaffer- Community Publications

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

Spreadsheet yes no

Narrative yes no

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

The Community Benefit report is reviewed for accuracy by the Internal Audit Department. The report is subsequently provided to the Audit Committee, a Board sub-committee for approval within the IRS-990 filing process.

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

Spreadsheet yes no

Narrative yes no

If no, please explain why.

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

Yes No

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

The Community Benefit investments in senior low income housing and behavioral health in our PCMH allow us to provide more care for senior consistent with our Gilchrist serious illness and end of life work and adding Behavioral Health services expands the care for our patients in our PCMH further reducing unnecessary costly utilization.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

Other hospital organizations

Local Health Department

Local health improvement coalitions (LHICs)

Schools

Behavioral health organizations

Faith based community organizations

X Social service organizations

 X Post-acute care facilities

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

Organization	Name of Key Collaborator	Collaboration Description
Holleran	Mallory McCloskey	Community Engagement & Research
Baltimore County Health Department	Gregory Branch	Key Informant
Life Bridge Health	Shino Brown	Key Informant
Baltimore City Health Department	Camille Burke	Key Informant
Baltimore County Department of	Jacquelyn Cornish	Key Informant
Towson University	Donna Cox, Phd.	Key Informant
Baltimore City Health Department	Shonda DeShields	Key Informant
Community Law Center	Kristine Dunkerton	Key Informant
Towson University	Cyrus Engineer	Key Informant
Baltimore City Health Department	Emilie Gilde	Key Informant
Veterans Affairs(Baltimore)	Stacy Heinze	Key Informant
Community Law Center	Robin Jacobs	Key Informant
Bykota Senior Center	Julie Lynn	Key Informant
Towson University	Mary McSweeney-Field	Key Informant
Holly Hill Nursing	Colleen Mercier	Key Informant
Behavioral Health Administration	Barry Page	Key Informant
Baltimore County School System	Michelle Proser	Key Informant
Behavioral Health System Baltimore	Kathleen Westcoat	Key Informant

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

yes no

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

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

yes no

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

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

- a. 1. Identified need: This may have been identified through a CHNA, a documented request from a public health agency or community group, or other generally accepted practice for developing community benefit programs. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include a description of the collaborative process used to identify common priority areas and alignment with other public and private organizations.
2. Please indicate how the community's need for the initiative was identified.
- b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based community health improvement initiatives may be found on the CDC's website using the following links: <http://www.thecommunityguide.org/> or <http://www.cdc.gov/chinav/>), or from the County Health Rankings and Roadmaps website, here: <http://tinyurl.com/mmea7nw>. (Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)
- c. Total number of people within the target population (how many people in the target area are affected by the particular disease or other negative health factor being addressed by the initiative)?
- d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?
- e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need,
- f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)
- g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.
- h. Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.

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

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

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

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

- i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)
- j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? If not, why? What is the mechanism to scale up successful initiatives for a greater impact in the community?
- k. Expense:
 - A. what were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, and grants associated with the fiscal year being reported.
 - B. Of the total costs associated with the initiative, what amount, if any, was provided through a restricted grant or donation?

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

The key health issues identified in the CHNA were Overweight/Obesity/Diabetes, Substance Abuse/Alcohol Abuse, Mental Health and Access to Care. At this time, there are no primary needs that are not being addressed.

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

GBMC's community benefit operations and activities work toward Maryland's State Health Improvement Process (SHIP) in several ways. GBMC's population health programming has direct ties to the SHIP.

Related to Health Beginnings, significant effort is placed by the obstetrics, pediatrics and family medicine practices along with the hospital units to ensure patients receive appropriate prenatal care, screenings and appropriate education to achieve the best possible health outcomes.

Related to Healthy Living, screening and follow up for patients with a body mass index (BMI) outside of normal parameters is a key metric of focus, especially in the Patient Centered Medical Home (PCMH) setting. Care Coordinators, RN Care Managers and Behavioral Health Consultants work together with the patient and PCP to develop care plans to help maintain healthy weight and lifestyles for patients. Significant effort is also placed on screening and follow up for tobacco use.

Related to Health Communities, the integration of behavioral health services into the PCMH practices also aims to make improvement with mental health including suicide rates. Efforts to improve behavioral health care are also made in

all setting across the GBMC system. GBMC works to prevent and treat domestic violence through its Sexual Assault Forensic Examination (SAFE) program.

Related to Access to Care, pediatrics and family medicine practices work to ensure adolescent patients receive proper well care. Additionally, efforts are made across the system of care at GBMC to ensure that patients have a primary care provider (PCP). Care Coordinators in the PCMH practices work to refer patients to community resources and establish relationships with community partners to assist in providing access for patients related to nonmedical barriers to care.

Related to Quality Preventive Care, there are a multitude of efforts to work toward these goals. The RN Care Managers in the PCMH practices work individually with patients to provide education on management of chronic disease and prevention of unnecessary hospital or emergency department (ED) utilization. These conditions include but are not limited to diabetes and hypertension. Certified Diabetic Educators are also available to support patients with diabetes through individual visits and group sessions. A substance use consultant is also available in the PCMH practices that works together with the care team and the patient to assist patients with issues related to substance use and/or addiction. The care teams in the PCMH practices are also proactive in out for reach and encouragement for patients related to necessary immunizations including influenza.

Beyond SHIP, GBMC is a participant in the Complex and Chronic Care Improvement Program (CCIP) under Maryland's care redesign amendment. GBMC is an active partner with other CCIP programs in the state, HSCRC, and CRISP in its efforts to redesign care in alignment with population health goals. The journey toward care delivery redesign for GBMC began several years ago through the participating in the Medicare Shared Savings Program (MSSP) as an Accountable Care Organization (ACO) in July 2012. GBMC is committed to improving population health for our community and providing the best care possible for our patients.

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

Initiative 1- Access to Care for Low Income Seniors

<p>a. 1. Identified Need</p> <p>2. Was this identified through the CHNA process?</p>	<p>As identified by both the Key Informant and Secondary data profile portion of the Community Health Needs Assessment, access to care is one of the most significant barriers to satisfying the health needs of the community. Finding access to appropriate care can prove to be a difficulty particularly for low income seniors within our service area.</p>
<p>b. Hospital Initiative</p>	<p>In order to address the largest need identified by the Community Health Needs Assessment, GBMC has made an effort to improve access to care wherever possible. The organization has dedicated a full time geriatric nurse practitioner to go out into the community and service the healthcare needs of low income seniors within its service area.</p>
<p>c. Total Number of People Within the Target Population</p>	<p>1,433 people</p>
<p>d. Total Number of People Reached by the Initiative Within the Target Population</p>	<p>Patient visits- 1,433 Vaccinations- 250 Referrals- 50 Glucose screenings- 48</p>
<p>e. Primary Objective of the Initiative</p>	<p>GBMC employs a nurse practitioner whose sole responsibility is to provide education and primary care services within Towson’s low income senior living facilities. This was a service that had at one time been provided by Baltimore County, but has since been discontinued, allowing GBMC to make an impact on our community health. The primary objective of the initiative is to coordinate care and provide guidance to finding and receiving the appropriate healthcare resources for the targeted low income senior population. In addition to helping the target population locate appropriate resources, direct care is provided to patients on a temporary basis until they have been able to establish a primary care provider.</p>
<p>f. Single or Multi-Year Initiative –Time Period</p>	<p>Multi year</p>
<p>g. Key Collaborators in Delivery of the Initiative</p>	<p>The facilities service includes: Tabco Towers, Virginia Towers, Trinity House, Parkview/Timothy House, Village Crossroads (I & II), Mission Helpers, Gallagher House, Aigburth Vale, ACTC</p> <p>Key Partners:</p> <ul style="list-style-type: none"> - Catholic Charities: partnered on a grant to improve Aging in Place - St. Ambrose Housing - Inspirit Counseling Services: partnered in a grant to provide in home counseling services - Aigburth Vale - Mission Helpers of the Sacred Heart

<p>h. Impact/Outcome of Hospital Initiative?</p>	<p>Throughout FY17 our nurse practitioner was able to make 1,433 visits to seniors throughout the community. During these visits she was able to provide vaccinations and glucose screenings as a measure for preventative health.</p> <p>Providing these low income seniors with information regarding their health allows them to make better healthcare decisions. In turn, providing these resources has allowed for better health outcomes including less frequent hospital stays with the reduction in length of stay, resources, and waste.</p>	
<p>i. Evaluation of Outcomes:</p>	<p>The effectiveness of the initiative is evaluated by the quantity of visits made to patients. The number of at risk seniors who receive vaccinations and glucose screenings as a result of education is another example of evaluation criteria. In addition, a patient satisfaction survey is conducted to allow GBMC to measure satisfaction amongst patients served.</p>	
<p>j. Continuation of Initiative?</p>	<p>Yes.</p>	
<p>k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue</p>	<p>Direct expense- \$160,329</p>	<p>Offsetting revenue- \$6,877</p>

Initiative 2- SAFE Program

<p>a. 1. Identified Need</p> <p>2. Was this identified through the CHNA process?</p>	<p>The <i>Maryland 2012 Uniform Crime Report</i> documents 17,615 domestic violence (DV) crimes in the State with 21% originating where GBMC is located--Baltimore County.</p> <p>Many victims do not report or reach out to available services on their own, but may avail themselves of services offered through a hospital. Hospital-based programs also have heightened ability to reach the following underserved groups: high risk victims, including the elderly, victims with disabilities, pregnant victims, victims with injuries, and victims in felony cases who may be brought to the hospital for a forensic examination; underserved populations including minorities, the under-insured and uninsured. Additionally, the SAFE program provides forensic evaluation for both sexual and intimate partner violence victims that is critical for law enforcement investigation and prosecution.</p>
<p>b. Hospital Initiative</p>	<p>Maintain 24/7, 365 days a year Forensic Nurse examiner coverage for victims of all ages. In particular, this year GBMC SAFE has worked to bolster available forensic capacity for the pediatric population. Maintain 24/7, 365 days per year Advocate coverage for DV and SA victims providing crisis counseling, safety planning, service referral, information on victim's rights, and follow-up services. Initiate community awareness events such as the Walk-a-Mile, grassroots fundraisers, and school/college/community partner presentations.</p>
<p>c. Total Number of People Within the Target Population</p>	<p>GBMC has strong institutional capacity to serve our patient demographic, which is primarily women from Baltimore County, but also Baltimore City, Harford County and Howard County. Annually GBMC sees almost 27,000 in-patient cases, 60,000 Emergency Room visits and has over 1,500 affiliated physicians. GBMC's 40 physician practices reach 250,000 people. GBMC was founded by the Hospital for the Women of Maryland, Baltimore City and we are the hospital women in our communities trust for their care.</p>
<p>d. Total Number of People Reached by the Initiative Within the Target Population</p>	<p>The SAFE Program saw approximately 185 patients in the last fiscal year and will be exceeding that going forward. The SAFE DV Program provided advocacy and crisis intervention to 340 individuals. The Walk-a-mile event had over 250 participants and volunteers, and community outreach exceeded 1400 students, EMS, Police and other organizations which received information regarding the SAFE Program and the services offered. The grassroots bull roast was attended by 440 members of the community.</p>
<p>e. Primary Objective of the Initiative</p>	<p>The primary objective is to maintain 24/7 coverage for victims, where we provide early forensic examinations and connect victims with any resources they may need such as continued medical care or psychological counseling. We also strive to raise awareness in the community about the services we provide, while we are the only hospital in all of Baltimore County, Baltimore City, and Harford County to provide comprehensive forensic services to victims of all ages and one of only two to offer hospital-based advocacy.</p>
<p>f. Single or Multi-Year Initiative –Time Period</p>	<p>Multi Year – ongoing and continual</p>

g. Key Collaborators in Delivery of the Initiative	GBMC SAFE & Domestic Violence Program staff Volunteers within the hospital Baltimore County Police Department Baltimore County Child Advocacy Center Baltimore County States Attorney Office	
h. Impact/Outcome of Hospital Initiative?	<p>Over 185 Patients were seen in the SAFE Program, and the program successfully expanded its service to care for pediatric sexual abuse victims, an underserved population in Baltimore County. Additionally, 340 victims of abuse benefitted from advocacy and safety planning. We primarily serve patients whose assault occurred in Baltimore County but often care for victims of surrounding jurisdictions and other states. Patients that presented to the Emergency Department without the presence of law enforcement received counseling by a Forensic Nurse Examiner to assist these patients in their decision to either notify police of their assault and have a forensic examination; have a forensic examination without reporting the assault to the police (the evidence will be stored at the Baltimore County Crime Lab for at least 20 years) or receive medical services only where they are offered antibiotics to prevent infections and emergency contraception.</p> <p>Additionally, the Walk-a-mile event had over 250 participants and volunteers, and community outreach exceeded 1400 students, EMS, Police and other organizations which received information regarding the SAFE Program. The grassroots bull roast was attended by 440 members of the community.</p>	
i. Evaluation of Outcomes:	The Outcomes of this initiative are evaluated by the number of victims who receive forensic exams as well as attendance numbers for community outreach and engagements. Baltimore County police SVU are continuing to utilize the SAFE Program as the Baltimore County SAFE Center. Baltimore County Crimes Against Children Unit is now regularly utilizing the SAFE Program for the 12 and under population.	
j. Continuation of Initiative?	Yes.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	\$387,624	\$284,204

Initiative 3- Run GBMC Obesity Program

<p>1. a. Identified Need</p> <p>2. Was this identified through the CHNA process?</p>	<p>Obesity is an important health issue that has become increasingly prevalent in today’s society. Obesity is a serious concern as it can be a contributing factor to a variety of other health conditions such as diabetes and heart disease. Data from the Maryland Behavioral Risk Factor Surveillance System (BRFSS) demonstrated that the GBMC Service Area has a higher percentage of residents that are overweight/obese (68.1%) when compared to the state and the nation (both 64.9%).</p>	
<p>b. Hospital Initiative</p>	<p>In order to address the growing need of weight management, GBMC made an effort to continue a successful running program for the hospitals bariatric patients. The hospital dedicated employee volunteers to engage patients 2 Saturday’s per month in a running program along-side the targeted patient population.</p>	
<p>c. Total Number of People Within the Target Population</p>	<p>3,901</p>	
<p>d. Total Number of People Reached by the Initiative Within the Target Population</p>	<p>100 patients</p>	
<p>e. Primary Objective of the Initiative</p>	<p>The goal of Run GBMC was to get patients engaged in starting a healthier lifestyle, with the goal of completing GBMC’s annual Father’s Day 5k. Giving patients the opportunity to gain necessary tools and education on physical activity allowed for these patients to start a journey to lose weight and gain a better health status in general.</p>	
<p>f. Single or Multi-Year Initiative –Time Period</p>	<p>January 2nd 2016 – present Multi year</p>	
<p>g. Key Collaborators in Delivery of the Initiative</p>	<p>Employee volunteers including physicians and nurses</p>	
<p>h. Impact/Outcome of Hospital Initiative?</p>	<p>2 Saturdays per month the group of volunteers and patients would practice for 1.5 hours walking or jogging various routes in preparation for the GBMC Father’s Day 5K and/or Baltimore Running Festival as part of team RUN GBMC. Patients are now successfully completing multiple races and several have completed half marathons and even a full marathon.</p>	
<p>i. Evaluation of Outcomes:</p>	<p>The effectiveness of the initiative is evaluated by the number of participants to complete the Father’s Day 5K and/or the Baltimore Running Festival.</p>	
<p>j. Continuation of Initiative?</p>	<p>Yes</p>	
<p>k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue</p>	<p>\$10,040</p>	

Initiative 4- Yoga for Stroke Survivors

<p>1. a. Identified Need</p> <p>2. Was this identified through the CHNA process?</p>	<p>As identified by the Community Health Needs Assessment, the management of chronic health issues is a serious need in the community. There are many stroke survivors throughout the community who have exhausted their compensated rehabilitation, creating an opportunity for GBMC to assist survivors regain mobility lost as a result of a stroke.</p>
<p>a. Hospital Initiative</p>	<p>GBMC is offering a yoga class for stroke survivors in an effort to help the survivors regain lost mobility and function. Prior to the beginning of the program, all participants are screened by a Physical Therapist. The Physical Therapist screens for past medical and surgical history, range of motion, strength, balance and functional mobility to ensure the patient is able to safely participate in the class. Participants are also asked to list their goals for the yoga program.</p>
<p>b. Total Number of People Within the Target Population</p>	<p>386</p>
<p>c. Total Number of People Reached by the Initiative Within the Target Population</p>	<p>Classes were held on Mondays and Fridays for 37 weeks during FY16. The average class size on Monday was 14 Clients while Fridays had an average of 8.</p>
<p>d. Primary Objective of the Initiative</p>	<p>The Yoga for Stroke Survivors program is designed to address the disabilities that result from a stroke and provide a network of social support from others having similar experiences.</p>
<p>e. Single or Multi-Year Initiative –Time Period</p>	<p>Multi-year</p>
<p>f. Key Collaborators in Delivery of the Initiative</p>	<p>Body Harmony</p>
<p>g. Impact/Outcome of Hospital Initiative?</p>	<p>The yoga class has had a positive impact on many of the participants. The staff have reported seeing changes in decreased flexed posture, decrease tone, improved strength and flexibility, improved transfers, improved mood, and body awareness.</p> <p>As well as the staff reporting improvements, feedback from participants was also positive. They reported better movement, increased strength, improved breath control, decreased tone, improved functional mobility, posture, speaking quality, weight loss, decreased stress and anxiety, and improved concentration.</p>
<p>h. Evaluation of Outcomes:</p>	<p>The primary evaluation of this program is based on the number of stroke survivors, retention of participants, and feedback from participants themselves.</p>

i. Continuation of Initiative?	yes	
j. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	\$720	

PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.
2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please use Table IV to indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

Table IV – Physician Subsidies

Category of Subsidy	Explanation of Need for Service
Hospital-Based physicians	GBMC employs select hospital based physician groups (i.e. Neurology, Infectious Disease, Genetics) to better serve the clinical needs of the region that may not be available or as easily accessible through community based physicians.
Non-Resident House Staff and Hospitalists	GBMC employs select hospitalist groups (OB, NICU, Medicine & Intensivist) to serve the inpatient clinical needs through in-house 24/7 coverage.
Coverage of Emergency Department Call	GBMC employs emergency medicine providers to meet the emergent clinical needs of the community that cannot be met by community physicians and urgent care facilities based on clinical need and/ or hours of operation.
Physician Provision of Financial Assistance	GBMA recognizes its obligation to the communities it serves to provide medically necessary care to individuals who are unable to pay for medical services regardless of race, color, creed, religion, gender, national origin, age, marital status, family status,

	handicap, military status, or other discriminatory factors.
Physician Recruitment to Meet Community Need	GBMC employs select hospital based physician groups (i.e. Neurology, Infectious Disease, Genetics) to better serve the clinical needs of the region that may not be available or as easily accessible through community based physicians. Given the sub-specialization of these training programs, GBMC frequently engages with physician recruitment firms to address this need.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):

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

For example, state whether the hospital:

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

- Includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills;
 - Besides English, in what language(s) is the Patient Information sheet available;
 - Discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.
- b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).
- i. GBMC's Financial Assistance policy was modified in August 2014 in response to the ACA. The policy attached highlights those modifications.
- c. Include a copy of your hospital's FAP (label appendix III).
- d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions:
http://www.hsrcr.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospitalPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).
<https://www.gbmc.org/workfiles/patientrightsbrochure.pdf>
2. Attach the hospital's mission, vision, and value statement(s) (label appendix V).



FY 2017 Community Benefit Report Filing
Description of Financial Assistance Policy

GBMC has designed its Financial Assistance Policy with the intention of ensuring free and/or reduced care is available to patients. In administering its Financial Assistance Policy, GBMC utilizes an automated resource for scanning a patient's financial profile and/or an application process. Because GBMC's application process allows for a net asset test (i.e., a patient's necessary living expenses are taken into account), patients at or above 300% of the Federal Poverty Guidelines will typically qualify for free and/or reduced care.

In addition, GBMC has taken significant measures to ensure that its Financial Assistance Policy is both visible and accessible to patients by enacting the following measures:

1. Availability of Applications & Brochures

- Via website
- All hospital patient registration areas; including admitting, emergency department, laboratory stations, clinics and radiology services
- GBMC owned physician offices
- Billing Office
- Included in each billing statement to patient

In addition, to the availability of applications and brochures, signs describing the existence of a Financial Assistance Policy and opportunity for financial assistance are also prominently displayed throughout the hospital.

2. Direct Assistance

Utilizing the admitting and insurance verification process, prior to discharge, the Patient Financial Services department attempts to assist many patients with financial evaluations in order to determine the availability for financial assistance and/or qualifying insurance coverage. In addition, during the account resolution process, staff is also trained to evaluate a patient's unique circumstances and attempt to direct patients to financial assistance when appropriate.

GBMC will also assist patients in enrolling for State Medical Assistance coverage.

3. Education

To ensure that employees are qualified to direct patients in accessing financial assistance, new employees and volunteers are specifically educated during new-hire orientation programs on how to obtain financial assistance applications and brochures.

Appendix II

Greater Baltimore Medical Center's Financial Assistance Policy has not changed in response to the Affordable Care Act.

GBMC
PATIENT FINANCIAL SERVICES POLICY

FINANCIAL ASSISTANCE POLICY

APPROVAL:

Signature on File

Executive Vice-President and Chief Financial Officer

I. PURPOSE

To establish guidelines assuring consistency in the implementation of the Financial Assistance Program.

II. POLICY

GBMC recognizes its obligation to the communities it serves to provide medically necessary care to individuals who are unable to pay for medical services regardless of race, color, creed, religion, gender, national origin, age, marital status, family status, handicap, military status, or other discriminatory factors.

The Financial Assistance procedures are designed to assist uninsured individuals or individuals who qualify for less than full coverage under federal, state or local programs, or individuals whose patient balances after insurance exceed their ability to pay.

While flexibility in applying guidelines to an individual patient's situation is clearly needed, certain objective criteria are essential to assure consistency in the implementation of the Financial Assistance Program.

A. Eligible/Ineligible Services

1. Services considered medically necessary are covered under the program
2. Services considered elective (i.e. cosmetic) are not covered under the program unless directly to related or part of a medically necessary procedure
3. Self pay patients who are scheduled for non-emergency surgery must complete the Financial Assistance application prior to the scheduled procedure or they will be required to pay a deposit prior to the surgery

4. Patients who incur additional out-of-pocket by going out of the network specified by their insurance carrier, are not eligible for consideration
5. Applicants meeting eligibility criteria for Federal Medicaid must apply and be determined ineligible prior to Financial Assistance consideration

B. Referral Sources

1. Financial Assistance referrals will generally originate in the Insurance Verification, Advocacy and Collection/Insurance departments accompanied with a **Financial Evaluation** (Attachment #1) and **Medical Assistance Eligibility Check List** (Attachment #1a)
2. Other referral sources include social services, physician offices, administration, etc.
3. GBMC recognizes the importance of communicating the availability of the Financial Assistance Program to all patients
 - a. The Financial Assistance Application and brochures explaining the program are located on the GBMC website
 - b. Brochures and applications are available in all GBMC owned physician offices and in all hospital registration areas
 - c. All new employees and volunteers are educated during their orientation programs with regard to the Financial Assistance Program and how to assist patients in obtaining applications and brochures

C. Financial Eligibility Criteria

1. Eligibility is based on gross household income
 - a. The IRS guidelines are followed in order to determine the number of family members that qualify to be counted as dependents
2. Gross household income is defined as wages and salaries from all sources before deductions
3. Other financial information such as liquid assets and liabilities are Considered

4. Annual household income criteria is 300% of the current poverty guidelines published in the Federal Register
5. Applicants that exceed established household income levels may still be eligible when additional factors such as disposable net income are considered (See “Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines”)

D. Household Income

1. Household Income to be considered
 - a. All wages and salaries
 - b. Social Security, veteran’s benefits, pension plans, unemployment and worker’s compensation, trust payments, child support, alimony, public assistance, strike benefits, union funds, income from rent, interest and dividends or other regular support from any person living in the home
 - c. Generally, the availability of liquid assets including cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, etc. exceeding 2 months of living expenses will be considered (referred to in the policy as Liquid Assets)
 - d. Based on individual circumstances, allowances can be made to have liquid assets exceed the two month test up to \$25,000
2. Proof of Household Income (Attachment #2)

One or more of the following items may be requested from the applicant to verify income for each income producing member of the household. Monthly household income is prorated to determine annual household income level.

- a. Two recent pay stubs reflecting year-to-date earnings for each family member who is a guarantor or could be deemed responsible for the account.
- b. Most recent income tax return(s) with W2s
- c. Social Security Award Letter(s)
- d. Most recent unemployment insurance stub

Patient Financial Services Policy – Patient Financial Assistance

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- e. Two most recent checking and savings account statements
- f. Two most recent investment statements (money market, CD, stocks, etc.)
- g. Letter from federal, state or local agency verifying the amount of assistance awarded
- h. Applicants claiming zero household income must supply proof of how their living expenses are paid with a notarized letter of support. Cancelled checks and/or receipts may also be required if another individual is paying patient's bills
- i. Medical Assistance denial or spend-down determination letter
- j. Identified asset transfers within a 12 month period of application may be factored into determining eligibility.
- k. Other pertinent household income verification documentation as required

E. Expenses

1. Expenses to be considered (also see “Questionable Expenses” under “Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines”)

2. All reasonable living expenses (mortgage/rent, utilities and loan/credit card payments)
 - a. Either land-line telephone or cell phone bill will be considered (not both)

 - b. A monthly car payment of up to \$450 for one car is allowed
The maximum allowance per family (2 adults) is \$900
Any amount over the above allowance will be considered within the miscellaneous allowance

 - c. Payments for recreational items such as boats, motorcycles, etc. are not allowable expenses Exception: if motorcycle is only source of transportation

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- d. Expenses for Cable TV, Dish TV and/or Internet are considered within the miscellaneous allowance

- e. Expenses for second homes are not allowable expenses (however, income from rental properties will be counted as Household Income)

- f. \$150 food allowance will be given for patient; and \$75 food allowance for each additional family member
- g. \$300 miscellaneous allowance will be given for ancillary living expenses (i.e.: gas for automobile, grooming items, automobile maintenance, tuition and tithing)

3. Medical expenses

- a. Up to \$100 in prescription expenses per person will be considered without receipts
- b. Prescription expenses that exceed \$100 per person cannot be considered unless patient provides receipts for the two prior months
- c. Medical expenses are considered upon proof from patient of active payment arrangements

III. PROCEDURES

A. Application Process

- 1. Patients may request Financial Assistance prior to treatment or after billing
 - a. A new application must be completed for each new course of treatment with the following exceptions:

Inpatient and outpatient Medicare patients are certified for one year (see “Medicare Patients”)

Inpatient and outpatient non-Medicare patients are certified for 6 months. However, if it is determined during the course of that period that the patient meets Medical Assistance eligibility criteria they are required to pursue Medicaid prior to receiving additional Financial Assistance

Mitigating circumstances impacting eligibility period are identified. (examples include favorable changes in the applicants income, winning a lottery, receiving notable inheritance, etc..)

These determinations are made at the discretion of the Collection Manager and/or Director of Patient Financial Services.

2. At the time of application all open accounts are eligible for consideration with the potential exception of patients who are in bad debt status and did not respond to collection activity or statements prior to write-off of account(s)

3. The signed/completed **Financial Evaluation** is referred to the Financial Assistance Department
 - a. Combined account balance(s) greater than \$2,500
 - i. Completed **Financial Evaluation**
 - ii. Proof of household income
 - iii. Credit bureau report obtained and reviewed to verify information, develop additional sources for funds and utilized as a collection tool found

 - b. Combined account balance(s) less than \$2,500 but greater than \$500
 - i. Completed **Financial Evaluation**
 - ii. Proof of household income

- iii. Credit bureau report may be obtained and reviewed if household income and/or household expense discrepancies are found
- c. Combined account balance(s) less than \$500
 - i. Completed **Financial Evaluation**
 - ii. Proof of household income

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- iii. Application and proof of household income are tested to insure that liquid assets do not exceed the allowed amount
- iv. Applications that meet the liquid asset test are screened through TransUnion to determine income eligibility (Refer to IV. Assumptive Financial Assistance)
- v. Applications that do not meet the liquid asset test continue through the processes outlined below in section B
- d. Accounts are approved or denied based on household income criteria and applicant cooperation

B. Household Income Criteria for Financial Assistance Approval/ Denial

1. Combined gross household income less than 300% of the poverty guidelines

a. Applicants are eligible for 100% Financial Assistance

b. However, applicants with assets including cash,

checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, etc., not exceeding \$25,000, who meet the income eligibility requirements, will be considered for assistance at the discretion of the Director of Patient Financial Services and/or the Financial Assistance Committee. Inability to replenish the resource and/or current usage of the resource to cover allowed living expenses may qualify the applicant for assistance.

c. Applicants with assets (described above) exceeding \$25,000, may not qualify for assistance. However, at the discretion of the Chief Financial Officer, inability to replenish the resource and/or current usage of the resource to cover allowed living expenses may qualify the applicant for full or partial assistance

d. Applicants who own property in addition to their primary residence (residential or business), will not be considered for Financial Assistance

2. Combined gross household income greater than 300% of the poverty guidelines and the patient is still unable to make acceptable payment arrangements (minimum \$25 per month)

a. Applicants are reviewed on a case-by-case basis (see “Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines”)

C. Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guidelines

1. Applicants whose gross household income exceeds 300% of the poverty guidelines but state they are still unable to pay all or part of their account balance(s) may be further evaluated for Financial Assistance
2. In these cases, consideration is given to expenses, disposable net household income, total liquid assets and account balance(s)
3. Disposable net income is defined as gross household income less deductions and expenses (Program allows \$250 disposable income for one person and \$75 for each additional family member.) Disposable income (exceeding \$250 for one person and \$75 for each additional family member) will be used to determine patient's ability to pay)
 - a. The applicant is required to supply proof of "questionable" expenses
 - i. "Questionable" expenses are defined as any expense item that appears to be overstated/understated and/or not reasonable or customary
 - b. A credit bureau report is required to evaluate the application (regardless of account balance)
 - c. Patients whose disposable income is within the limits stated above and whose liquid assets do not exceed the standard (See Household Income); are eligible for 100% Financial Assistance
 - d. Patients who exceed the asset standard (See Household Income) are ineligible for Financial Assistance and need to make payment

arrangements (See Resource Payment Arrangements)

- e. Eligibility for patients who have excess disposable income is determined based on ability to satisfy outstanding balance(s) within timeframe defined (See Financial Assistance With Resource) All exceptions will be reviewed by the Director of Patient Financial Services

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4. Applicants approved for 100% Financial Assistance (See “Processing Approved Applications”)

D. Financial Assistance With Resource

1. Resource amounts are determined based on the applicant’s ability to pay a portion of their account balance(s) without causing undue financial hardship \ using the following guidelines
2. Outstanding balance(s) owed to GBMC are divided by excess disposable income to determine the number of months needed to pay the outstanding balance(s) in full
3. Excess disposable income determines the amount of the monthly payment (See Resource Payment Arrangements for standards)
4. Outstanding balance(s) that cannot be satisfied within 24 months will be reduced by the difference between the total outstanding balance(s) and the total required patient payment amount (excess disposable income multiplied times 24 months)
5. All resource amounts are reviewed and approved by the Director and Collection Manager
6. Approval process
 - a. The completed **Financial Evaluation** (including resource recommendation), **Authorization Form** (Attachment #3) and documentation is forwarded to the Collection Manager

- b. The Collection Manager will ensure that all required authorization signatures are obtained

- 7. When authorization is obtained the patient is mailed a **Financial Assistance Reduction Letter** (Attachment #6) and a **Financial Assistance Promissory Note** (Attachment #6A) outlining the terms and conditions of the agreement

- 8. The **Financial Assistance Promissory Note** must be returned within 14 days. Failure to do so may result in the patient's ineligibility for Financial Assistance
 - a. Signed promissory notes are forwarded to the Collection Manager (see "Processing Approved Applications")

Patient Financial Services Policy – Patient Financial Assistance

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E. Resource Payment Arrangements

- 1. Resource payment arrangements will not exceed 24 months
 - a. Every effort is made to liquidate the resource amount within the earliest possible time frame

- 2. The minimum monthly payment amount is \$25
 - a. Patient is set up under a contract in Meditech with an alert on Patient Overview screen (alert is set to remind collector that partial write-off occurred in the event of patient default on resource

payments)

- b. Patients are automatically sent monthly statements through Meditech indicating their monthly payment amount, due date and account balance(s)
3. If a patient qualifies for Financial Assistance with a resource and has multiple account balances, all account balances are allowed leaving only one open account (if possible) for the resource amount
- a. A weekly Meditech work list is reviewed to determine if patients are delinquent with their payments
 - b. Failure to pay as agreed will result in the patient being responsible for both the allowance amount and the unpaid resource balance
 - c. Forward the delinquent account to the Collection Manager
 - d. The Collection Manager/ or designee reverses the Financial Assistance allowance
 - e. Patient is sent a final demand letter

F. Authorization For Financial Assistance

\$1 - 2,499 - Coordinator

\$2,500 - 5,000 - Collection Manager

\$5,001 - 10,000 - Director of Patient Financial Services

GT \$10,000 - EVP/CFO

G. Incomplete / Uncooperative

1. Failure to supply required information or to communicate reason for delay within 10 days may result in the applicant's ineligibility for Financial Assistance

H. Processing Approved Applications

1. Completed applications are forwarded to the Collection Manager with all appropriate supporting documentation
2. The Collection Manager will ensure that each applicant has met household income requirements, supplied appropriate supporting documentation and that proper authorization signatures are obtained
 - a. The Collection Manager or designee applies the Financial Assistance adjustment and files the **Financial Evaluation, Authorization Form** and related documentation
3. The patient is sent a Financial Assistance Award Letter (Attachment #4)

I. Processing Denied Applications

1. Applicants that are determined to be ineligible based on household income and/or asset criteria are sent a Financial Assistance Denial Letter Attachment #5)
2. Patients have the right to appeal denials. Final appeal decisions are

at the sole discretion of the next level of required signature authority.
(Example – Director of Patient Financial Services to review appeal for
Collection Manager level denial)

J. Medicare Patients

1. Medicare patients are required to supply a copy of their Social Security Award Letter on a yearly basis
2. Medicare patients are certified for 1 year. However, if it is determined during the course of that year that the patient meets Medical Assistance eligibility criteria they will be required to pursue Medicaid prior to receiving additional Financial Assistance

3. The Financial Assistance Department will refer Medicare patients

Patient Financial Services Policy – Patient Financial Assistance

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meeting Medicaid eligibility criteria to the Advocacy Department for processing

K. Medicaid Resources

1. Medicaid resources are automatically reviewed for Financial Assistance when a copy of the Department of Social Services (DSS) **0102 Form** (Attachment #7) is supplied to the Financial Assistance Department
2. DSS income calculations and Financial Assistance program allowances are used to calculate patient's disposable income (see "Gross Household Income Is Greater Than 300% Poverty Guidelines")

L. Recurring Accounts

1. Patients are certified 6 months for Non Medicare and 1 year for Medicare. Based on each unique situation, these periods may be extended at the discretion of the Director of Patient Financial Services.
2. If patients are admitted or start a new course of treatment, they are screened for Medicaid and/or reevaluated for Financial Assistance

M. Financial Assistance Statistical Reporting

1. The Collection Manager or designee is responsible for completing all monthly and year-to-date statistical analysis as required.

III. ASSUMPTIVE FINANCIAL ASSISTANCE

Assumptive Financial Assistance is a program run in partnership with TransUnion credit reporting agency. **Self pay accounts for Maryland residents** are referred to TransUnion, who utilizes a proprietary credit scoring system to determine likelihood of ability to pay based on estimated income and family size. The results from the TransUnion credit scoring are compared to GBMC's Financial Assistance eligibility criteria and a decision is made to write off or to pursue collection.

Patient Financial Services Policy – Patient Financial Assistance

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A. Eligible/Ineligible Services

1. Only bills for uninsured patients are eligible for Assumptive Financial Assistance screening at this time (exception balances after insurance under \$500 that meet liquid asset test as spelled out under III. A. 4. c.)
2. Patients seen as the result of a motor vehicle accident or for which any third party liability may exist will not be considered under the Assumptive

Financial Assistance program

3. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the Assumptive Financial Assistance program until the **Mental Health Insurance** has been billed
4. **Uninsured patients who incur bills for elective surgical procedures will not be considered under the Assumptive Financial Assistance program (these patients may apply for consideration under our regular Financial Assistance program)**
5. **Self pay patients who are denied by Medical Assistance as over-scale in income are screened through the Assumptive Program**
6. **Self pay patients who are denied by Medical Assistance as over-scale in resources, must go through the regular Financial Assistance application process**

V. PROCESSES UTILIZED BY TRANSUNION TO DETERMINE ELIGIBILITY STATUS

- A. TransUnion accesses credit data, via the Healthcare Revenue Cycle Platform (HRCP). TransUnion built and maintains a proprietary matching Algorithm to select consumer credit files, including data like; name, address, SSN, Soundex and other criteria to match input inquiries to the correct credit file. This algorithm is used to match hundreds of millions of credit inquiry requests each year. It is constantly reviewed and maintained to provide accurate credit data to tens of thousands of customers. The minimum customer input requirement is name and \ address. TransUnion also accepts, SSN, previous address and date of birth input as part of its matching algorithm. HRCP then employs proprietary algorithms and expert business rules to match each hospital's own charitable, regulatory guidelines and policies to patient qualifications.

Patient Financial Services Policy – Patient Financial Assistance

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B. HRCP employs a proprietary algorithm to estimate minimum family income and size. The algorithm uses information like debt to income ratios, current financial obligations that are being met, residual income for household members and cost of living calculations to estimate the minimum monthly income. HRCP also estimates family size based upon data such as, joint credit accounts, authorized users of credit cards, etc. The algorithm calculates FPL based upon these data. Customers may evaluate and

configure certain parts of the algorithm like residual income to level the

estimates for cost of living differences in geographic areas.

C. Under the Fair Credit Reporting Act (FCRA) and other privacy regulations,

TransUnion cannot disclose financial information regarding individual

consumers to anyone without satisfying permissible purpose requirements.

D. The HRCP proprietary algorithm used for estimating FPL (minimum

estimated family income and size) uses both credit data and other calculations like residual income and cost of living. In the absence of credit data, other calculations are used and can be configured to consider certain geographic cost of living differences as stated above. In such instances where credit data is absent, it is recommended to further qualify FPL if possible through documentation or patient interviews.

VI. ASSUMPTIVE FINANCIAL ASSISTANCE PROCEDURES

A. Identifying Patients For Assumptive Financial Assistance Write-offs

1. Up to three invoices per Emergency Room visit will be sent to each uninsured patient for hospital charges incurred. In addition, at least one phone call will be generated to the patient by the Patient Liability Staff.
2. Patient Financial Services may accelerate the screening process based on individual patient experience or accumulated historical data.
3. The invoices will be generated at the time of final billing of the patient's account and then 30 days from initial billing and then 60 days from initial billing
4. Within 10 days after the final invoice has generated, a file will be created to identify all accounts that have remained in a self pay status (excluding

motor vehicle accidents, emergency petitions, and other third party liability)

Patient Financial Services Policy – Patient Financial Assistance

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- a. Patients who have failed to respond to invoices or telephone attempts in order to confirm self pay status will not be processed under the Assumptive Program
 - b. Patients screened at time of service by the Advocacy Co-ordinator to confirm self pay status may be considered without need for additional patient contact
5. The file will be sent to TransUnion for credit scoring (see VI. on page 12 for Processes Used By TranUnion To Determine Eligibility Status)
6. TransUnion will return the file with the credit scoring for each individual
- a. **Meets Charity Guidelines** means the patient income is below 300% of the Federal Poverty Guidelines and the patient does not have the ability to pay. The patient qualifies for a write off of their hospital bill under the Assumptive Financial Assistance write off code (CHARASSUMP) in Meditech.
 - b. **Collect Hospital Charges, Pursue Payment Arrangement or Question Household Income** means the patient appears to have the ability to pay and the Patient Liability staff will pursue a payment plan or offer Financial Assistance Screening through our non-assumptive program
 - c. **No Credit Found** means the patient demographic information did not

match any information in the TransUnion data bank. The Patient Liability staff will pursue the patient and if additional or corrected demographic information is uncovered, they will have the patient rescreened through TransUnion.

d. Social Security Number not issued by Social Security

Administration or Social Security Number used in death benefits requires that we pursue patient. If the Patient Liability staff uncovers a data entry error with regard to Social Security Number they will have the patient rescreened through Trans Union.

B. Reversal Of Assumptive Financial Assistance Write-offs

1. If verifiable insurance is uncovered at anytime after the Assumptive Financial Assistance write-off, the write-off will be reversed and the patient's insurance billed

C. Assumptive Financial Assistance Statistical Reporting

1. The Collection Manager or designee is responsible for completing all monthly and year-to-date statistical analysis as required.

Responsible for Review:

CFO

Date Reviewed:

August 2014

GBMC
6701 North Charles Street
Baltimore, MD 21204

PERMISSIONS / ACKNOWLEDGEMENTS – Page 1 of 4

USE AND DISCLOSURE OF HEALTH INFORMATION – I authorize GBMC Healthcare and independent physicians or other practitioners providing services by or in the Health System to disclose any health information related to this hospitalization for my treatment as well as use of routine Health System operations and payment for services and associate care. I further authorize release of health information pertaining to this hospitalization to other health care providers for continuing care and treatment.

HEALTH INFORMATION EXCHANGES – We participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a state-wide health information exchange. As permitted by law, your health information will be shared among several health care providers or other health care entities in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. This means we may share information we obtain or create about you with outside entities (such as doctors' offices, labs, or pharmacies) or we may receive information they create or obtain about you (such as medical history or billing information) so each of us can provide better treatment and coordination of your healthcare services. You may "opt-out" and prevent searching of your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at www.crisphealth.org. Even if you opt-out, a certain amount of your information will be retained by CRISP and your ordering or referring physicians, if participating in CRISP, may access diagnostic information about you, such as reports of imaging and lab results.

ASSIGNMENTS OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS – I hereby authorize payment directly to GBMC Healthcare of hospital benefits otherwise payable to me, including major medical insurance benefits, PIP benefits, sick benefits, or injury benefits due because of any insurance policy and the proceeds of all claims resulting from the liability of the third party payable by any person, employer, or insurance company to or for the patient unless the account is paid in full upon discharge. I also authorize payment of surgical or medical, including major medical benefits, directly to attending physicians, but not to exceed charges for these services. I understand that I am financially responsible to the hospital and physicians for charges, whether or not covered by this assignment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts may bear interest at the legal rate. I further authorize refund of overpaid insurance benefits in accordance with my policy conditions where my coverages are subject to coordination of benefits clause. I understand that I am responsible for any deductibles, coinsurance, or co-payments associated with my policy to include Point of Service (POS), Preferred Provider Organization (PPO), "opt-out" plan, "out-of-network" preferred, and indemnity benefits and for payment of services not covered under my policy or those services I

elect to receive if denied for coverage by my insurer. I will contact my insurer or Health Advocacy Unit of the Attorney General's Office to learn how to appeal adverse decisions made by my insurer.

PERMISSIONS / ACKNOWLEDGEMENTS – Page 2 of 4

MEDICARE/MEDICAID PATIENT CERTIFICATION (for Medicare/Medicaid patients only) –

I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

I understand that I have been instructed to leave all valuables at home, give such valuables to a friend or family member, or if that is not possible, to deposit such valuables with the GBMC Security Office. I understand that I am responsible for safekeeping such items as eyeglasses, dentures, or hearing aides, or any of my property while it is in my possession or under my control. I release the hospital from any responsibility for loss of any item not deposited with the Security Office.

Has the patient received the Notice of Privacy Practices?

- Yes
 No

Reason no NOPP given:

- Newborn
 Patient Unable to Accept

PATIENT FINANCIAL POLICY

We are committed to providing you with quality and affordable health care. You are receiving this information because under Maryland law, GBMC must have a financial assistance policy and must inform you that you may be entitled to receive financial assistance for the cost of medically necessary hospital services if you have a low income, do not have insurance or your insurance does not cover your medically necessary hospital care and you have a low income.

Hospital Financial Assistance Policy:

- GBMC provides emergency and urgent care to all patients regardless of ability to pay.
- GBMC offers several programs to assist patients who are experiencing difficulty paying their hospital bills.
- GBMC complies with Maryland's legal requirement to provide financial assistance based on income level and family size.
- GBMC Patient Representatives are available to assist you with the application process (see contact information on page 4), or you may access an application by going to <http://www.gbmc.org/> (go to the Patient & Visitors Tab and then click Financial Support).

PERMISSIONS / ACKNOWLEDGEMENTS – Page 3 of 4

Patient Rights:

- Those patients that meet the financial assistance policy criteria described above may receive assistance from the hospital in paying their bill.
- If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance (see contact information on page 4).
- You may be eligible for Maryland Medical Assistance a program funded jointly by the state and federal governments (see contact information on page 4).

Patients' Obligations:

- For those patients with the ability to pay their hospital bill, it is the obligation of the patient to pay the hospital in a timely manner.
- GBMC makes every effort to see that patient accounts are properly billed. It is your responsibility to provide correct insurance information.
- If you do not have health coverage, we expect you to pay the bill in a timely manner. If you believe that you may be eligible under GBMC's financial assistance policy, or if you cannot afford to pay the bill in full you should contact the Patient Financial Services department promptly to discuss this matter (**see contact information on page 4**).
- If you fail to meet your financial obligations for services received, you may be referred to a collection agency. In determining whether a patient is eligible for free, reduced cost care, or a payment plan, it is the obligation of the patient to provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact Patient Financial Services to provide update/corrected information (**see contact information on page 4**).

Insurance: We participate in most insurance plans, including Medicare. Please remember to always bring your insurance card with you when you come for a visit.

- **Co-payments and deductibles** - All co-payments and deductibles must be paid at the time of service. This arrangement may be part of your contractual agreement with your insurance company. Please assist us by being prepared to submit your co-payment for each visit.
- **Referrals/Authorizations/Pre-certifications** -You may be responsible for obtaining precertification, submitting a referral and/or authorization prior to being seen, if required by your insurance carrier (except Medicare). Please obtain your pre-certification, referral and/or authorization from your primary care physician and submit at the time of service.
- You may also be responsible for tracking your referrals (number of remaining visits and expiration date). Please obtain additional or new referrals as necessary.
- **Non-covered services** – Some, and perhaps all of the services you receive may be noncovered or not considered reasonable or necessary by your insurance company. Please contact your insurance company with any questions you may have regarding coverage. If your insurance does not cover the service it does not necessarily mean that you do not need the service. Your physician will explain why he or she thinks that you can benefit from a service or procedure. If you elect to receive the non-covered service, you will be financially responsible.

PERMISSIONS / ACKNOWLEDGEMENTS – Page 4 of 4

- **Medicare patients** – If we believe you are receiving a service that Medicare considers not reasonable or necessary for your condition, you will be notified in writing on a form called an Advance Beneficiary Notice of Non-coverage (ABN). This will provide you with the opportunity to decide if you will proceed with the service ordered. This process is required by Medicare and preserves your right to appeal Medicare's decision.
- **Claims submission** – We will submit your claim(s) and assist in any way we reasonably can to ensure claim payment. Your insurance company may require you to supply certain information directly. The balance of your claim is your responsibility regardless of your insurance company payment and GBMC is not party to that contract.
- **Coverage changes** – Please notify us before your next visit of any coverage changes so that we may assist you in maximizing your benefits.
- **Acceptable forms of payment** – We accept personal checks, money orders, Visa, MasterCard, Discover, American Express and we offer payment plans.

Physician Services:

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement. Depending upon your treatment plan, you may receive separate bills for all services rendered including but not limited to, GBMC, the physician treating you, Charles Emergency Physicians, Advanced Radiology,

Physicians Anesthesia Associates, Radiation Oncology Healthcare, Greater Baltimore Pathology Associates, Pediatric Physicians, etc.

Contact Information:

· **GBMC Patient Representatives are available Monday through Friday, from 8:00 a.m. to 6:00 p.m., at (443) 849-2450, option 1, or at 1-800-626-7766, option 1.**

· Our representatives can assist you with applying for Maryland Medical Assistance or you may also obtain information about or apply for Maryland Medical Assistance by contacting your local Department of Social Services by phone at 1-800-332-6347; TTY: 1-800-925-4434; or on the Internet at www.dhr.state.md.us.

I have read and understand in its entirety the information provided in this document and agree to follow its guidelines.

Signature of Patient or Responsible Party Date

Relationship to Patient
(if signed by person other than the patient)

Appendix V



FY 2015 Community Benefit Report Filing
Mission, Vision & Values Statement

MISSION

Health. Healing. Hope.

The mission of GBMC is to provide medical care and service of the highest quality to each patient leading to health, healing and hope.

VISION

To every patient, every time, we will provide the care that we would want for our own loved ones. GBMC also dedicates itself to the guiding principle that *“the patient always comes first.”*

GREATER VALUES

The values of GBMC are our GREATER Values of Respect, Excellence, Accountability, Teamwork, Ethical Behavior and Results.

Attachment A

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

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

- Reduce hospital ED visits related to addictions
- Reduce Fall-related death rate