



***FY '13 Community Benefit Report
University of Maryland St. Joseph Medical Center
7601 Osler Drive
Towson, MD 21204***

COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2013 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 regulated 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, and (3) hospital community benefit administration.

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 hospitals by the HSCRC.

Table I: General Hospital Demographics and Characteristics

FY ’13 Bed Designation:	247		
FY ’13 Inpatient Admissions	17,111		
FY ’13 Primary Service Area Zip codes	21234, 21030, 21236, 21117, 21222, 21014,	21093, 21286, 21239, 21220, 21214, 21136,	21204, 21212, 21206, 21221, 21237, 21208
Other Maryland Hospitals Sharing Primary Service Area	Greater Baltimore Medical Center, Franklin Square Hospital, Good Samaritan Hospital, Sinai Hospital		
Percentage of Uninsured Patients by County	Baltimore County	Maryland	
	12%	13.2%	

Percentage of Patients who are Medicaid Recipients	Baltimore County	Maryland
	12.5%	15%

When the zip codes of the Primary Service Area (purple) and Secondary Service Area (orange) of UM-St. Joseph Medical Center are plotted on a map, the results appear thus:

UM-SJMC Primary and Secondary Service Areas

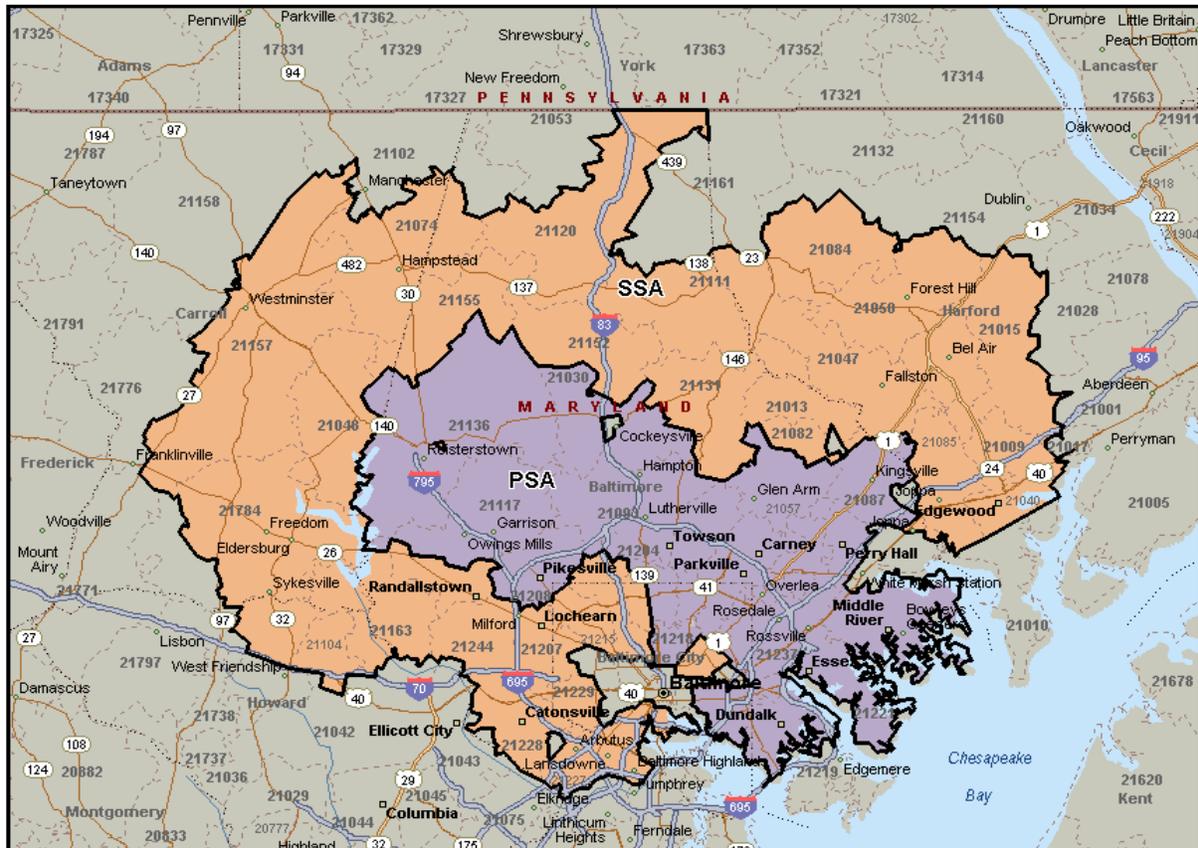


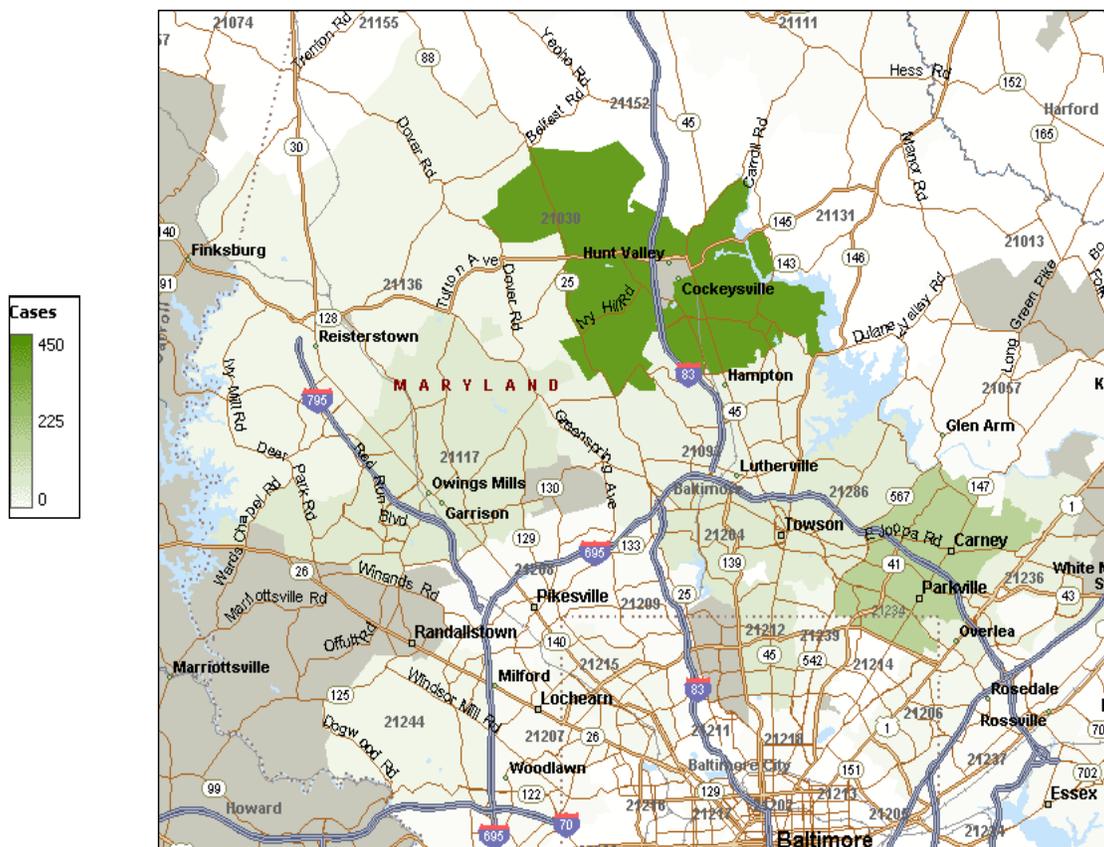
Table I

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

The Community Benefit Service Area of UM-St. Joseph Medical Center is constituted by the zip codes in which patients reside who have received charity care. These zip codes are:

- 17361, 20011, 20724, 21001, 21014, 21030, 21050, 21057, 21078, 21082, 21093, 21094, 21111, 21117, 21120, 21136, 21161, 21202, 21204, 21206, 21207, 21209, 21211, 21212, 21214, 21215, 21216, 21217, 21218, 21221, 21222, 21227, 21228, 21229, 21234, 21236, 21237, 21239, 21244, 21286, 30062

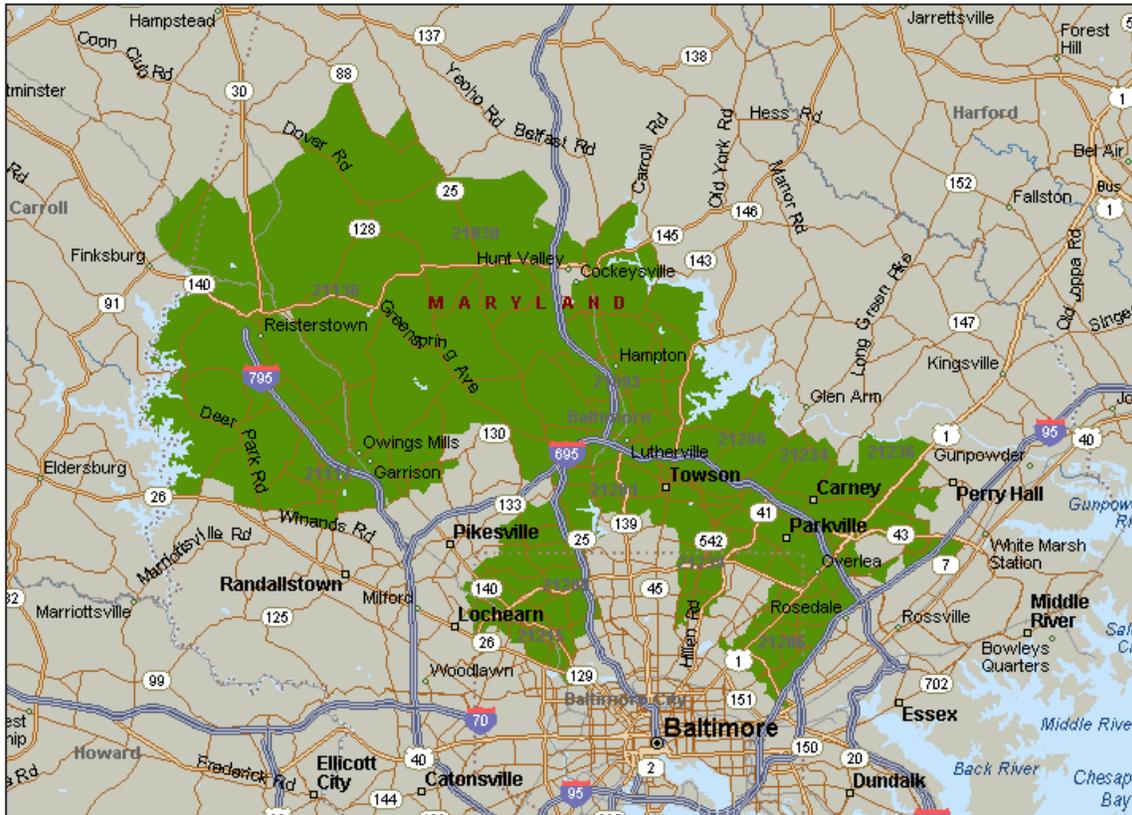
UMSJMC FY 2013 Charity Care Patient Origin



The CBSA for St. Joseph Medical Center (SJMC) has been identified by plotting the zip codes of recipients of financial assistance/charity care in FY '12. St. Joseph Medical Center's CBSA falls primarily within Baltimore County with a few outlying areas in, Harford County. When illustrated in this way, it becomes clear that a significant portion of our the charity care cases for FY '12 are concentrated in two areas, i.e., the northern segment of Baltimore County around Hunt Valley and Cockeysville, and the Eastern segment in the Carney/Parkville area. We feel this confirms several things we've known already: The immediate geographic area in which SJMC is located is predominantly a middle-class/upper middle-class population. While there are, indeed, people from the area proximate to SJMC who receive charity care, this is not where the greatest need for charity care exist for us. The "hidden" population receiving a significant amount of charity care is a growing Hispanic immigrant population in the Hunt Valley/Cockeysville area. This has created a pocket of financially challenged people in an area that is usually viewed as fairly affluent.

When the all the recipients of charity care are plotted, no matter what the concentration of charity care received, our CBSA appears below.

UM-SJMC CBSA



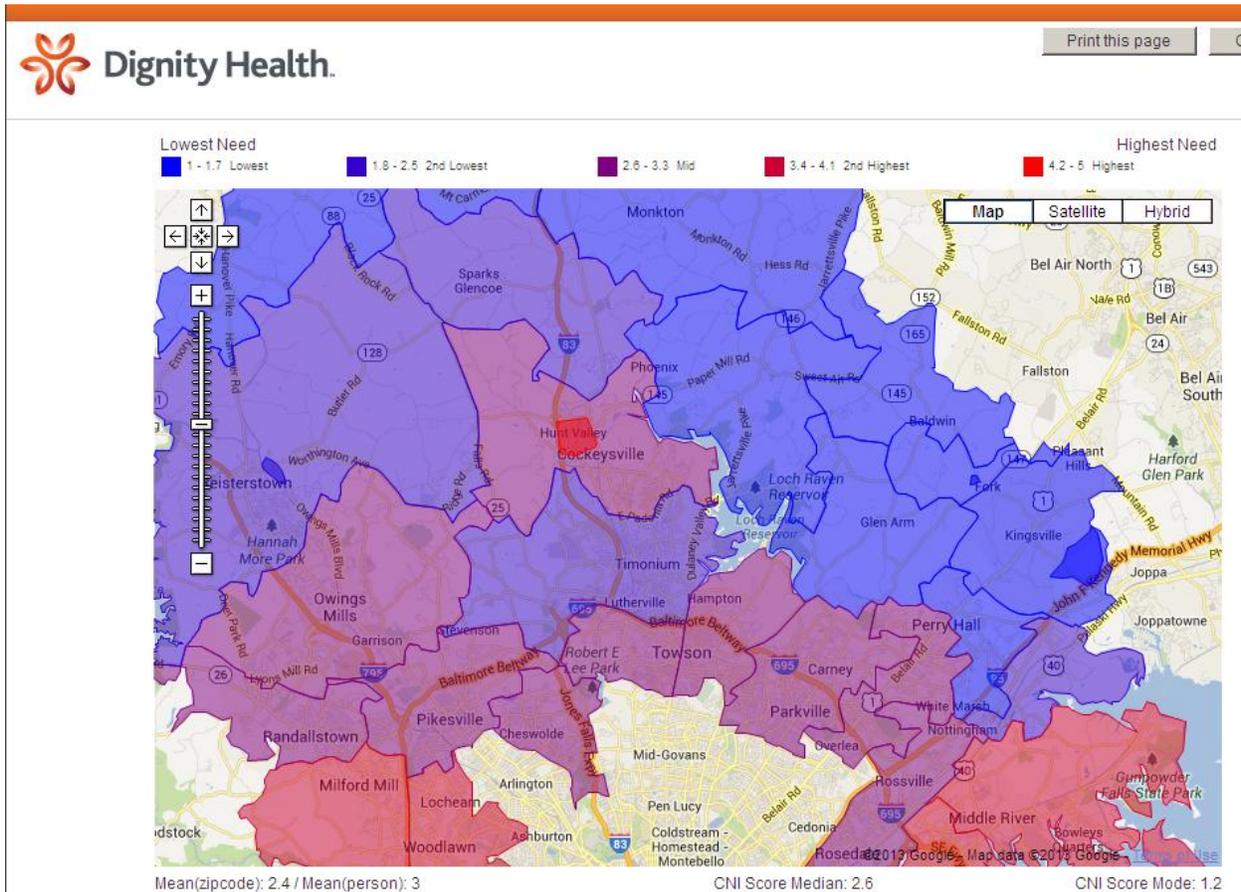
b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the information in each response.

Table II

The University of Maryland – St. Joseph Medical Center is located in a northern suburb of Baltimore City, and as shown on the map detailing our Primary and Secondary Service areas, draws patients from Franklinville, Westminster in the West, Aberdeen and Eastern Shore to the East, to the Pennsylvania line up the I-81 corridor including and Hanover, PA and as far south as Landsdowne. This is an area distinctive in the very broad range of populations it contains in terms of economic, ethnic/racial, and urban/rural considerations.

The map below also illustrates that our CBSA overlaps with some areas of significant unmet health needs in Baltimore County. On this map, blue indicates an area where health needs are

well met, while the more red an area is colored the more it contains unmet health needs. Surprisingly, the red dot in the middle of the Hunt Valley area is a pocket of severely unmet health needs that corresponds with the presence of the Hispanic population in that same area. This is an area from which many patients of our St. Clare Medical Outreach clinic (a free clinic for those who have no health insurance at all) come from.

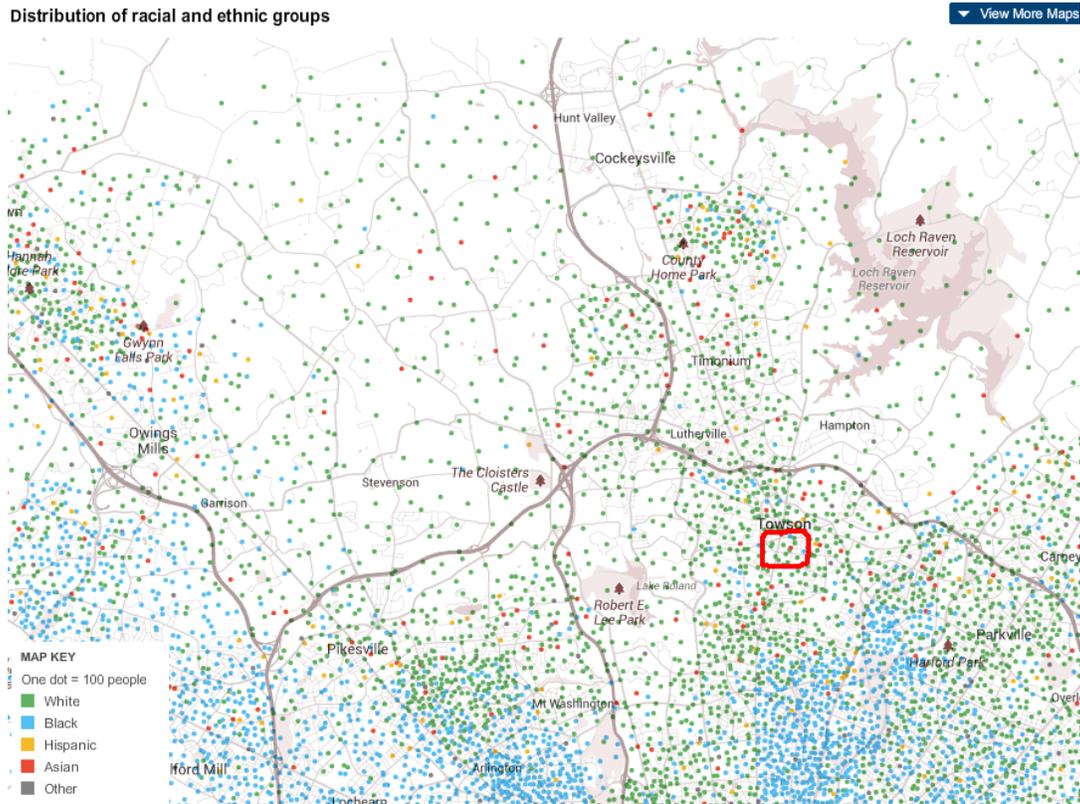


Map from Dignity Health interactive website: <http://cni.chw-interactive.org>

The ethnic/racial characteristics of our primary and secondary service areas, which include our CBSA, are illustrated in the map below. The red circle indicates the location of UM-St. Joseph Medical Center:

Mapping America: Every City, Every Block

Browse local data from the Census Bureau's American Community Survey, based on samples from 2005 to 2009. Because these figures are based on samples, they are subject to a margin of error, particularly in places with a low population, and are best regarded as estimates.



Map: <http://projects.nytimes.com/census/2010/explorer>

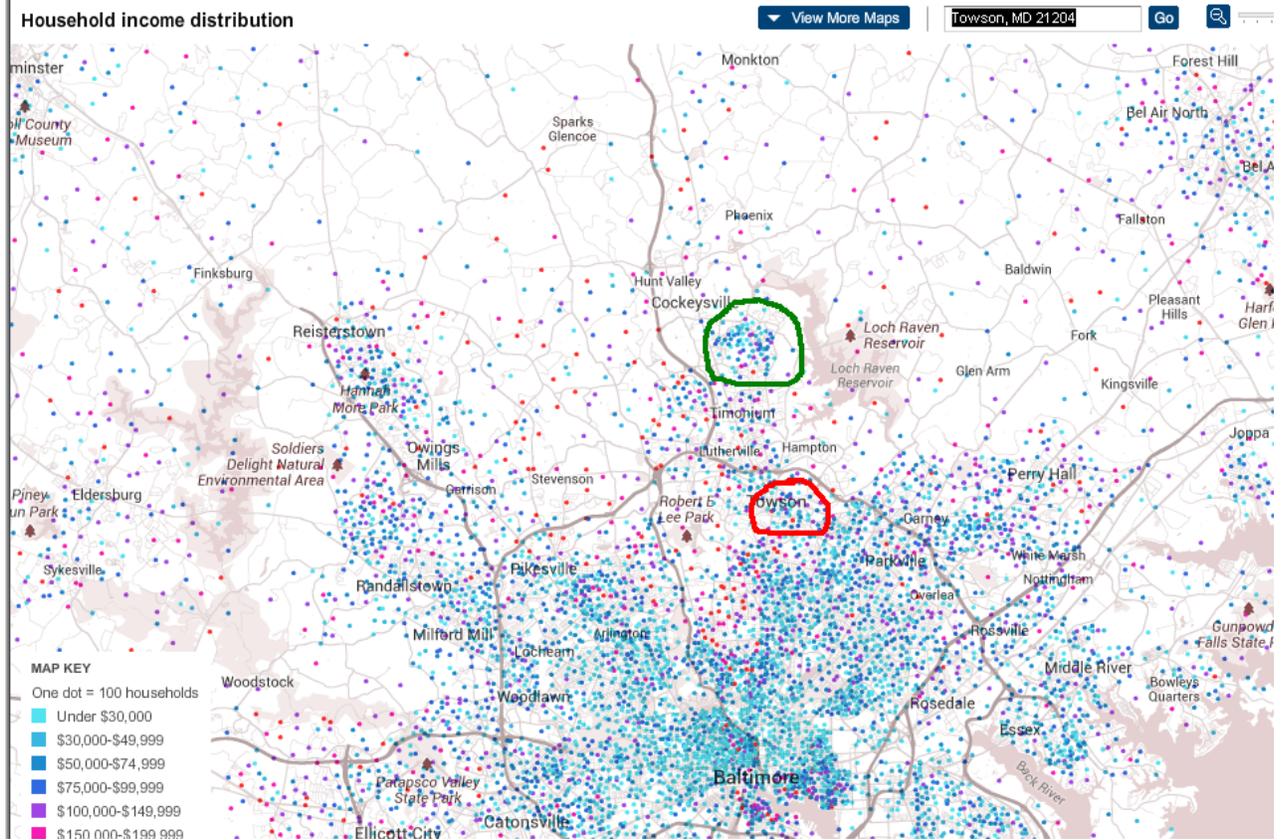
This map and the legend in the lower left-hand corner confirm the data from the DHHS and Maryland Bureau of Vital Statics which indicates that our primary and secondary service area is largely white, with a lesser presence of a black population in that area. Just south and east of Cockeysville, the gold dots indicate the presence of the Hispanic population in the area.

Finally, the map below illustrates the income range in our PSA/SSA and our CBSA. It is useful to note the presence of lighter blue dots in the southeastern Cockeysville area and in the area just north of Towson. These three maps illustrate the complex demographic mix of our PSSA/SSA and CBSA which include households with comfortable economic means alongside households where economic realities are difficult. The red circle indicates the location of UM-St. Joseph Medical Center. The green circle indicates the location of a pocket of people in the Cockeysville area whose income is under \$30,00 per year – an unexpected pocket of low-income residents in an area that is usually considered upper middle class to affluent. This indicates how important it is to do careful demographic research to find these hidden pockets of poverty in a presumed advantaged area.

Mapping America: Every City, Every Block

Find something interesting? Share this view on [Twitter](#)

Browse local data from the Census Bureau's American Community Survey, based on samples from 2005 to 2009. Because these figures are based on samples, they are subject to a margin of error, particularly in places with a low population, and are best regarded as estimates. [View R](#)



Map: <http://projects.nytimes.com/census/2010/explorer>

Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, ethnicity, and average age)

Total Population: 817,455

Persons Under 18: 21.7%

Persons Over 65: 15.1%

Female: 52.7%

Median age: 39 years

Median Household Income within the CBSA - \$65,411

Percentage of households within the CBSA with incomes below the federal poverty guidelines within the CBSA - 5.4%

Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links:

Total Baltimore County uninsured -
NH black—17.5%
Hispanic—44.7%
NH white—10.4%
Percentage of Medicaid recipients by County within the CBSA.

107,294 recipients or 13.13%
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).

General life expectancy: 78.1 years
Black life expectancy: 75.4 years
White: 78.6 years.

Data from: http://eh.dhmd.gov/ship/SHIP_Profile_Baltimore.pdf

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).

Heart Disease Mortality – Deaths per 100,000 people:

Average – 198.1
Black—238.6
White--197.4

Statistics for Hispanic/Latino population not available

Data from: http://eh.dhmd.gov/ship/SHIP_Profile_Baltimore.pdf

Cancer Mortality – Deaths per 100,000 people:

API--98.5
Black--218.8
Hispanic--65.3
White--191.7

Data taken from: http://eh.dhmd.gov/ship/SHIP_Profile_Baltimore.pdf

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)

As was the case last year, within our CBSA the USDA Economic Research Service provides tools to identify food deserts in our CBSA. On the map below, the red dot in the center of the image locates UM-St. Joseph Medical Center. Just to our north and east is a low vehicle access area which creates significant hardships for residents to access supermarkets easily. The green area highlighted to the north of that area indicates both a low vehicle access area and low income area, compounding the problem of access to supermarkets and nutritious food

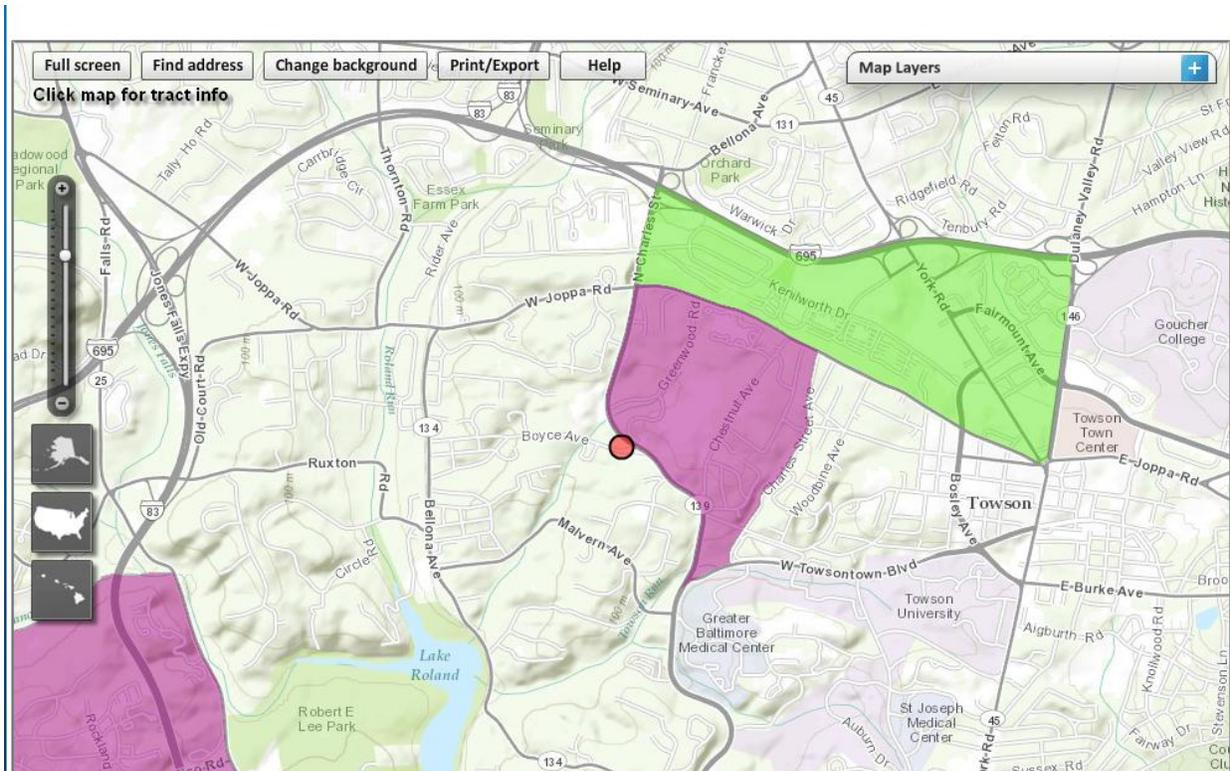


Image created on the U.S. Department of Agriculture website: <http://www.ers.usda.gov/data-products/food-access-research-atlas.aspx>

Available detail on race, ethnicity, and language within CBSA.

- White: 64.8%
- Black/African American: 27.0%
- Hispanic/Latino: 4.6%
- Asian alone: 5.4%
- Two or more races: 2.2%
- Language other than English spoken at home: 12.6%

Our CHNA that was completed and published by UM-SJMC in June, 2013, provided the following information on health needs in our CBSA obtained through interviews with key stakeholders and residents of the CBSA.

Ranking of key health issues

Rank	Health Issue	% Respondents who selected this issue	% Respondents who selected this as most significant issue
1	Access to health care	72%	33%
2	Overweight/Obesity	56%	22%
3	Mental Health/Suicide	44%	22%
4.	Diabetes	33%	6%
5	Substance Abuse/Alcohol Abuse	22%	6%
6	Heart Disease	17%	0%
7	Maternal/Infant Health	17%	6%
8	Aging/Chronic Disease Disability	17%	0%
9	Cancer	11%	6%
10	Tobacco	11%	0%

II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act (“ACA”), hospitals must perform a Community Health Needs Assessment (CHNA) either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and perform an assessment at least every three years. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report, the IRS defines a CHNA as a:

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

The written document (CHNA) must include the following:

A description of the community served by the hospital and how it was determined;

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

A description of how the hospital organization took into account input from persons who represent the broad interests of the community served by the hospital facility, including a description of when and how the hospital consulted with these persons (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.). If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual’s special knowledge or expertise. The report must identify any individual providing input who is a “leader” or “representative” of

**certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);
A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and
A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.**

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 meet the health needs identified by the CHNA by the end of the same taxable year.

The IMPLEMENTATION STRATEGY must:

- a. Be approved by an authorized governing body of the hospital organization;**
- b. Describe how the hospital facility plans to meet the health need; or**
- c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.**

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

XX Yes
___ No

Provide date here. _6_/_15_/_13_– Date published

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

<http://www.stjosephtowson.com/Community-Health-Needs-Assessment.aspx>

2. Has your hospital adopted an implementation strategy that conforms to the definition detailed on page 5?

XX Yes
___ No

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

<http://www.stjosephtowson.com/Community-Health-Needs-Assessment.aspx>

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

Yes

No

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

i. Senior Leadership

1. CEO

2. CFO

3. Other (please specify) -

- Vice President, Mission Integration

ii. Clinical Leadership

1. Physician – Chief Medical Officer

2. Nurse -- Chief Nursing Officer

3. Social Worker – Supervisor of Case Management

4. Other (please specify)

iii. Community Benefit Department/Team

1. .3 FTE Individual (please specify FTE)

2. Committee (please list members)

3. Other (please describe)

- Oncology outreach program coordinator
- Community health specialist (two)
- Nurse manager of our free clinic
- Director of Revenue Cycle/Managed Care
- Decision Support Analyst
- Diabetes educator

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

Spreadsheet XX - Yes _____no
 Narrative XX - Yes _____no

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

Spreadsheet XX yes _____no
 Narrative XX yes _____no

If you answered no to this question, please explain why.

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

- 1. Please use Table III (see attachment) to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each initiative and how the results will be measured, 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. Please see attached examples of how to report.**

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

- a. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups.**
- b. Name of Initiative: insert name of initiative.**
- c. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results (Use several pages if necessary)**
- d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?**
- e. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the**

initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.

- f. How were the outcomes of the initiative evaluated?**
- g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data to support the outcomes reported). How are these outcomes tied to the objectives identified in item C?**
- h. Continuation of Initiative: Will the initiative be continued based on the outcome?**
- i. Expense: What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.**

Initiative 1
Access to Health Care Services

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Access to health care services	Bring health care services to populations who previously did not receive basic services.	<p>Bring screenings, vaccinations and health education to people who otherwise would not receive any health care interventions.</p> <p>Increase the number of patients receiving health screenings and follow-up</p>	Multi-year	<p>Baltimore County Senior Centers</p> <p>Catholic Charities locations, especially senior citizen residences for low-income seniors</p> <p>Catholic school system, Archdiocese of Baltimore</p>	Comparing the number of patients seen in each initiative year over year.	<p>In FY '12 this initiative we:</p> <ul style="list-style-type: none"> • Gave 6120flu shots • Bone density screenings to 200 people • Breast cancer screenings to 255 women • Cervical cancer screenings for 48 women • Peripheral vascular screenings to 85 people • Substance abuse and violent relationship seminars for 17,00 student athletes and coaches • Prostate cancer screenings for 85 men • Stroke screenings for 225 people • Pediatric vision screenings for 215 children 	While these initiatives are single year initiatives, they address issues that are constant and warrant annual commitments	<ul style="list-style-type: none"> • \$44,086 • \$5205 • \$18,933 • \$1555 • \$3845 • \$152,698 • \$5432 • \$6057 • \$855

Initiative 2
Reduction in Undiagnosed and Uncontrolled Diabetes

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Reduction in undiagnosed and uncontrolled Diabetes	Provide diagnosis of diabetes and diabetes education	<p>Diagnose and treat diabetes in patients who previously were undiagnosed.</p> <p>Educate on factors influencing diabetes, glucose monitoring, diet and nutrition education for diabetes-healthy lifestyle.</p> <p>Tailor diabetes education to cultural needs of populations and learning limits of populations (some patient groups do not read Spanish or English).</p>	Multi-year	<p>American Heart Association</p> <p>American Diabetes Association</p>	<p>Used clinical benchmark to track improvement in the number of patients with uncontrolled diabetes.</p> <p>Reduce the number of patients with complications of undiagnosed and uncontrolled diabetes.</p>	<p>1. Increased the number of patients served by Diabetes Education/Outreach (free clinic providing primary care for those with no health insurance, especially Hispanic population)</p> <p>2. Increased the emphasis in Diabetes Education on obesity education and high blood pressure awareness as a consequence of diabetes</p> <p>3. Maintained and enhance diabetes education for Hispanic patients at St. Clare Medical Outreach. Developed education tools for Hispanic</p>	<p>Initiative will be continued</p> <p>Initiative will continue</p> <p>This initiative will continue as it is embedded in patient education at St. Clare Medical Outreach.</p>	<p>Cost captured in salaries of our Health Outreach specialists.</p> <p>Cost captured in salary of diabetes educator</p> <p>Cost is part of St. Clare's budget</p>

					<p>patients who don't read Spanish or English.</p> <p>4. Educated re the connection between diabetes and resulting complications, especially high blood pressure for patients receiving diabetes education</p> <p>5. Increased diabetes compliance by patients at St. Clare Medical Outreach</p> <p>6. Offered 4-part public education using <i>Weight of the Nation</i> HBO video. 300 attended. Education from cardiac physicians, bariatric surgeons, and other clinical specialists.</p>	<p>T</p> <p>This will continue. This education occurs in our outpatient diabetes education office and through in-patient consultations with patients newly diagnosed with diabetes.</p> <p>The initiatives being used at St. Clare Medical Outreach will continue and hopefully will continue to result in reduced A1C levels.</p> <p>This was a one-time initiative using the HBO video. However, other similar initiatives are being explored</p>	<p>This education occurs in an ambulatory clinic in the hospital</p> <p>Cost captured as part of St. Clare Outreach budget</p> <p>\$10,625</p>
--	--	--	--	--	--	---	--

Initiative 3
Reduction in Undiagnosed and Untreated Cancers in Minority and Uninsured Populations

Identified Need	Hospital Initiative	Primary Objective of the Initiative/Metrics that will be used to evaluate the results	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	How were the outcomes evaluated?	Outcome (Include process and impact measures)	Continuation of Initiative	Cost of initiative for current FY? (See Instructions)
Reduction in undiagnosed and untreated cancers in minority and uninsured population	Offer cancer screenings and education for minority & uninsured populations .	Increase the number of minority patients and uninsured patients who receive cancer screenings.	Multi-year	American Cancer Society	Number of patients screened	2 Community Screenings offered in partnership with UM-SJMC's Community Health.	Yes	\$18,933
	Move into treatment the number of patients diagnosed w/cancer	Increase the number of minority and uninsured patients who move to treatment.		Nueva Vida	Number of cancers diagnosed	Continuation of monthly 100 Free Screening Mammogram program with our original One Voice partner, Nueva Vida, thru April 2014. Self-breast exam education included in monthly screening s. 255 women.	Pending funding	
	When screened patients are identified with cancer, the patient's treatment occurs in St. Joseph Medical Center, usually at no cost to the patient.			Baltimore City Cancer/Health Equity Coalition	Number of patients who moved into treatment after diagnosis	Participated in the University of Maryland Medical Center's Springtime Community Fair, on Friday, June 7, 2013, from 10:00 am- 3:00 PM	Yes	
				Johns Hopkins Center to Reduce Cancer Disparities Community Advisory Group		Collaborated with the University of Maryland	TBD	
				Maryland Cancer Collaborative State Coalition				
				3				

		Participate with other community agencies to reduce cancer diagnosis and outcome disparities				<p>Medical Center on June 22 at the New Psalmist Baptist Mega Church teaching self-breast exams</p> <p>Participated in the Baltimore City Cancer/Health Equity Coalition, Baltimore County Cancer Coalition and Johns Hopkins Center to Reduce Cancer Disparities Community Advisory Group, Maryland Cancer Collaborative State Coalition</p> <p>2 Cervical Cancer Screenings scheduled in partnership with UM-SJMC's Community Health</p> <p>1 Prostate Screening scheduled in partnership with Community Health. 84 men screened.</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>\$4337</p> <p>\$1555</p> <p>\$5432</p>
--	--	--	--	--	--	---	----------------------------------	---

						The Breast Center sponsored an educational program in June, <i>Navigating the BRCA Gene Maze</i> , in response to numerous questions about genetic testing for over 85 women.	No	
--	--	--	--	--	--	---	----	--

2. Were there any primary community health needs that were identified through the CHNA that were not addressed by the hospital? If so, why not?

A priority identified in the Key Informant interviews in the CHNA that UM-SJMC has not pursued is dental health since we do not have dental resources at UM-SJMC. We have not developed a response to the Baltimore County Health Coalition priority of obesity in children and adolescents because we have a very small pediatric service at UM-SJMC and no on-going relationships with pediatricians in the area which is the appropriate entry point for addressing this priority. We have not developed a response to the Maryland SHIP priority concerning infectious diseases, i.e., HIV/AIDS, tuberculosis and Hepatitis A and B, because after consultation with our Senior Infection Prevention Coordinator, these infectious diseases are not felt to be present in the populations we serve to the degree that would make a concerted effort addressing them an appropriate use of our resources.

V. 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.**

St. Joseph Medical Center provides care to meet the health care needs of underserved populations in several areas. One area is care for Hispanic/Latino patients who have no health insurance at all, particularly those who are undocumented and are not eligible for government health care programs. To meet the needs of this population UM-SJMC initiated the dedicated primary care practice of St. Clare Medical Outreach about twelve years ago working in conjunction with the Hispanic ministry of the Archdiocese of Baltimore in the Fells Point area. This outreach service is subsidized 100% by the hospital. It charges nothing for any of its health care services. It has been staffed by various volunteer physicians but also by one bilingual Hispanic physician who is an employee of UM-SJMC.

Initially St. Clare Medical Outreach was housed in a renovated recreational vehicle that parked outside the Hispanic Apostolate (now called the Esperanza Center) in Fells Point, Baltimore. Four years ago St. Clare Medical Outreach was moved to the campus of St. Joseph Medical Center and housed in the adjoining medical building. Two years ago St. Clare Medical Outreach was moved to a location on the main north-south bus line serving the City of Baltimore and Baltimore County. It continues to provide primary health care to those with no health insurance at all, and 95% of its patients are Hispanic/Latino.

Women's Health Associated is an obstetrical/gynecological practice providing high quality ob/gyn health care services to women of very low economic means. Staffed by four physicians and six certified nurse midwives, it provides obstetrical and gynecological care to adolescent, adult and geriatric women. It serves both insured and underserved women and teens in the community. It is a combined physician and nurse-midwife UM-SJMC practice delivering about 5000 babies each year at UM-SJMC. If a patient from Women's Health Associates needs more specialized care during her

pregnancy, she is referred to the Perinatal Center at UM-SJMC, staffed by four high-risk pregnancy obstetricians.

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

The following physician subsidies are paid by UM-SJMC to insure that these services are available to all patients who come to the hospital, regardless of their ability to pay for the services received or whether they have any insurance. Without these subsidies, these services would not be available to our patients on a 24/7 basis:

Anesthesia, Specialty Care (including NICU (On Call), MSICU (On Call), Radiology (On Call), Clinical Surgical Support, Pediatric House Staff, OB/GYN, Cardiac Surgery Support), Emergency Department, Mental Health, Primary Care and Women's Health Associates (noted above) for a total physician subsidy of \$9,087,021.

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; and/or
 - 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. Include a copy of your hospital's FAP (label appendix II).
 - c. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) (label appendix III).
2. Attach the hospital's mission, vision, and value statement(s) (label appendix IV).

Appendix I – Description of Financial Assistance Policy

Our financial assistance policy and the communication about our financial assistance policy is regularly reviewed to make sure it is available to our patients in a variety of formats and that it is available in culturally/linguistically sensitive manner and at a reading comprehensive level appropriate to the population of our CBSA.

The availability of financial assistance for patients who would otherwise be billed for services about their eligibility for assistance under federal, state or local government programs is communicated to patients in multiple ways:

At all our points of registration in the hospital (general registration, Emergency Department) and in our specialized service areas (Perinatal Center, Cancer Institute, etc.) large signs are posted informing the patient that if they face problems in paying for their care, they may apply for financial assistance. The phone number is posted for them to contact one of our financial counselors.

When patients are registering in the hospital for inpatient treatment or outpatient treatment, they are given the Patient Financial Information Sheet (Appendix III) that is printed on two sides in English and Spanish. This Patient Financial Information Sheet is available at every point of entrance to the hospital and every point of service delivery. It is also included in the patient information packet given to each patient.

When patients are inpatients and do not have any health insurance, one of our financial counselors visits them in their room and discusses with them availability of various government benefits such as Medicaid or state programs offering health care assistance and assists the patients with appropriate qualifications to apply.

When patients receive outpatient services and do not have any health insurance, the financial counselor sends them information about their potential eligibility for various government benefits such as Medicaid or state programs offering health care assistance, and invites them to call (Spanish and English-speaking financial counselors are available) to discuss applying for these programs.

When a patient applies for financial assistance, our bilingual financial assistance counselor works with the patient to gather appropriate documents and submit their application for financial assistance.

Appendix II – Financial Assistance Policy

 UNIVERSITY of MARYLAND MEDICAL SYSTEM	The University of Maryland Medical System Policy & Procedure	<i>Policy #:</i>	TBD
		<i>Effective Date:</i>	02-01-2013
	<u>Subject:</u> FINANCIAL ASSISTANCE	<i>Page #:</i>	4 of 35
		<i>Supersedes:</i>	07-01-2012

POLICY

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

- University of Maryland Medical Center (UMMC)
- James L. Kernan Hospital (JLK)
- University Specialty Hospital (USH)
- University of Maryland St. Joseph Medical Center (UMSJMC)

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

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

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

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

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

PROGRAM ELIGIBILITY

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

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

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

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

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

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

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

Coverage amounts will be calculated based upon 200-300% of income as defined by federal poverty guidelines and follows the sliding scale included in *Attachment A* for a Reduced Cost of Care.

Presumptive Financial Assistance

Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to

support a patient's eligibility for financial assistance, UMMS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% writeoff of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

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

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

- a. Purely elective procedures (example – Cosmetic) are not covered under the program.
- b. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.
2. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
 - a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
 - b. Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.

- c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.
 - d. Upon receipt of the patient's application, they will have twenty (20) days to submit the required documentation to be considered for eligibility. If no data is received within the 20 days, a denial letter will be sent notifying that the case is now closed for inactivity and the account will be referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.
3. There will be one application process for UMMC, JLK, USH and UMSJMC. The patient is required to provide a completed Financial Assistance Application. In addition, the following may be required:
 - a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...
 - b. A copy of their most recent pay stubs (if employed) or other evidence of income.
 - c. A Medical Assistance Notice of Determination (if applicable).
 - d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.
 4. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.
 - a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.
 - i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
 - ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
 - (1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.
 5. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
 6. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination, up to 3 years prior, and up to six (6) calendar months in to the future. However, there are no limitations on the Financial Assistance eligibility period. Each eligibility period will be determined on a case-by-case basis. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department.
 7. If a patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
 8. A letter of final determination will be submitted to each patient who has formally submitted an application.

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

Financial Hardship

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

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

- 1) Their medical debt incurred at our either UMMC, JLK, USH or UMSJMC exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship; and
- 2) who meet the income standards for this level of Assistance.

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

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

Medical Debt is defined as out of pocket expenses for the facility charges incurred here at UMMC, JLK, USH or UMSJMC for medically necessary treatment.

Once a patient is approved for Financial Hardship Assistance, coverage will be effective starting the month of the first qualifying date of service and up to the following twelve (12) calendar months from the application evaluation completion date. Each patient will be evaluated on a case-by-case basis for the eligibility time frame according to their spell of illness/episode of care. It will cover the patient and the immediate family members living in the household for the approved reduced cost and eligibility period for

medically necessary treatment. Coverage shall not apply to elective or cosmetic procedures. However, the patient or guarantor must notify the hospital of their eligibility at the time of registration or admission. In order to continue in the program after the expiration of each eligibility approval period, each patient must reapply to be reconsidered. In addition, patients who have been approved for the program must inform the hospitals of any changes in income, assets, expenses, or family (household) status within 30 days of such change(s).

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

Asset Consideration

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

1. Under the current legislation, the following assets are exempt from consideration:
 - a. The first \$10,000.00 of monetary assets for individuals, and the first \$25,000.00 of monetary assets for household families.
 - b. Up to \$150,000.00 in primary residence equity.
 - c. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement, account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.

Appeals

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

Judgments

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

Appendix III – Patient Financial Information Sheet



FACTS ABOUT

FINANCIAL ASSISTANCE POLICY

St. Joseph Medical Center has a financial assistance policy and under Maryland law must inform you that you may be entitled to receive financial assistance with 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 are low-income.

Patients' Rights

- If you meet the policy criteria you may receive financial assistance from the hospital.
- If you believe you have wrongly been referred to a collection agency, you have the right to contact the hospital to request assistance.
- You may be eligible for Maryland Medical Assistance. This is a joint state and Federal program that pays the full cost of health coverage for low-income individuals who meet certain criteria.

Patients' Obligations

- Those able to pay for their bill, will do so in a timely manner.
- It is your responsibility to provide correct insurance information.
- If you do not have health coverage or cannot afford to pay the bill in full, you should contact the business office promptly, to discuss payment.
- You must provide accurate and complete financial information. If your financial position changes, you have an obligation to promptly contact the business office.

Contacts

- You can download the uniform financial assistance application from the following link: http://hsrsc.state.md.us/consumers_uniform.cfm
- For information on Maryland Medical Assistance contact your local Department of Social Services by phone 1-800-332-6347; TTY 1-800-925-4434; or www.dhr.state.md.us.

Physician Services

Physician services provided during your stay will be billed separately and are not included on your hospital billing statement.

Business Office

410-821-4140

Financial Assistance Office

410-337-3902

Appendix IV – Mission, Vision and Core Values

Mission Statement:

As a proud member of the University of Maryland Medical System, the University of Maryland St. Joseph Medical Center provides the highest quality health care service for our community's medical needs. In close collaboration, our physicians and staff provide a continuum of loving service and compassionate care for all who come to us. As a Catholic hospital observing the *Ethical and Religious Directives*, we are committed to

- Growing our services to become the preferred health partner for patients and providers.
- Serving and advocating for those who are poor and marginalized
- Partnering with others to improve the quality of life in our community.

Vision Statement:

As a partner hospital within the University of Maryland Medical System, the University of Maryland St. Joseph Medical Center aspires to serve the highest ideals of our Catholic health care tradition, our role as an innovative community hospital, and our unique clinical relationship with UMMC and the University School of Medicine. Through loving service and compassionate care, and an enduring focus on quality and integrity, we will exceed expectations to become the health system of choice for providers and patients.

Core Values:

- **Reverence** –respect for all people as God's loved children
- **Integrity** – Coherence between what we say and what we do/how we do it
- **Compassion** – Ability to enter into another's joy and sorrow. Com-passion = to feel with
- **Excellence** – *Always* putting forth our personal and professional best efforts