COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2016 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

MedStar Franklin Square Medical Center

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.

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), 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), as provided in the ACA, 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 obtains input from persons who represent the broad interests of the community served by the hospital facility (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions (LHICs) schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. 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.

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 (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; and
(15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (http://www.cdc.gov/chinav/)
(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 meet the health needs identified by the CHNA by the end of the same taxable year.

The IMPLEMENTATION STRATEGY, as provided in the ACA, 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, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and
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.

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 number of licensed Beds;
    b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
    c. Primary Service Area Zip Codes;
    d. List all other Maryland hospitals sharing your primary service area;

e. The percentage of the hospital's uninsured patients by county. (please provide the source for this data, i.e. review of hospital discharge data);
f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data, i.e. review of hospital discharge data, etc.).
g. The percentage of the Hospital's patients who are Medicare Beneficiaries. (Please provide the source for this data, i.e. review of hospital discharge data, etc.)

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 Hospital's Uninsured Patients,:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
Current licensed acute care bed capacity: 364 Source: MFSMC Finance	23,525 Source: MFSMC Finance	21221 21220 21222 21237 21234 21236 21027 Source: Acute Hospital PSA 2016	University of MD Mercy Medical Center, Inc. Johns Hopkins Union Memorial Johns Hopkins Bayview Medical Center Union of Cecil County Greater Baltimore Medical Center Good Samaritan St. Joseph Source: Acute Hospital PSA 2016	1.35% Source: MFSMC Quality Department	31.96% Source: MFSMC Quality Department	40.78% Source: MFSMC Quality Department

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 reside.

(iii) Describe how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. 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).

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/). the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.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 ChartBook 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 reside.	CBISA includes residents living in zip codes 21206, 21219, 21220, 21221, 21222, 21224 * Focus area : 21221 This geographic area was selected as MedStar Franklin Square Medical Center's CBSA as a result of the longstanding collaborative partnership with the Baltimore County Southeast Area Network (Southeast Network) for its community benefit efforts. *Zip Code designation was listed incorrectly in the CHNA. Programming and reporting reflect correct zip codes.	MedStar Health 2015 Community Health Needs Assessment http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf
Median Household Income within the CBSA	Baltimore County - $66,940 CBSA Range: $48,390 - $58,738 Focus Area (21221) - $51,540	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Baltimore County – 6.2% CBSA Range: 8.9% - 16.3% Focus Area (21221) – 9.3%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table

For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Baltimore County – 9.0%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table
Percentage of Medicaid recipients by County within the CBSA.	Baltimore County – 17.0%	2016 Maryland Medicaid e Health Statistics http://www.chpdm-ehealth.org/mco/index.cfm
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	MD 2017 Ship Goal -79.8 Baltimore County – 79.4 African American – 78.4 White – 79.5	2014 Maryland State's Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/Pages/home.aspx
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	<u>Baltimore County</u> Mortality Rates (per 100,000 residents) All Races - 965.4 White – 1201.1 Black – 607.0 Asian or Pacific Islander - 219.0 Hispanic – 142.5 Infant Mortality Rates (per 1,000 live births) Total - 6.9 White – 3.1 Black – 14.6 Neonatal Mortality Rates (per 1,000 live births) Total – 5.0 White – 1.9 Black – 11.2 Postnatal Mortality Rates (per 1,000 live births) Total – 1.9 White – 1.2 Black – 3.4	Maryland Vital Statistics Administration 2014 Report Card http://dhmh.maryland.gov/vsa/Documents/14annual_revised.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) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	**By County within the CBSA** Liquor Store Density (per 10,000) Baltimore County – 3.90 State of Maryland – 2.00 Percentage of Adults (25+) who have a College Degree: Baltimore County – 27.5% State of Maryland – 37.1% Number of days with maximum ozone concentration over the National Ambient Air Quality Standard: Baltimore County - 20 State of Maryland – 11.7 Percent of renters who are paying 30% or more on their household income in rent: Baltimore County – 45.43% State – 48% National – 49.3%	Maryland State's Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/Pages/home.aspx
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	**Demographics** Baltimore County Total Population – 817,720 White - 522,396 Black or African American – 219,268 Hispanic – 37,830 Asian – 44,399 Native Hawaiian and Other Pacific Islander – 375 Two or more races – 19,319 **Language** Speak only English – 86.9% Speak a language other than English – 13.1% CBSA Total Population – 244,132 White – 145,468 Black or African American – 33,327 Hispanic – 15,733 Asian – 4,125 Native Hawaiian and Other Pacific Islander – 375 Two or more races – 5,367 Focus Area (21221) Total Population – 40,187 White – 27,847	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table

	Black or African American – 9,783 Hispanic – 1,977 Asian – 772 Two or more races – 990 **Language** Speak only English – 83.1% Speak a language other than English – 16.9%	

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. Has your hospital conducted a Community Health Needs Assessment that conforms to the IRS definition detailed on pages 1-2 within the past three fiscal years?

   __X__Yes
   ____No

   Provide date here. 6/30/2015

   If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).
   http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf

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

   __X_Yes 4/7/2015
   ___No

   If you answered yes to this question, provide the link to the document here.
   http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf (pg. 17-19)

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? **(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b.)**

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

      _X__Yes
      ___No

      If yes, please provide a description of how the CB **planning** fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

      MedStar Health's vision is *to be the trusted leader in caring for people and advancing health.* In the fiscal year 2013-2017 MedStar Health Strategic Plan, community health and community benefit initiatives and tactics are organized under the implementation strategy of "Develop coordinated care/population health management capabilities." At the hospital-level, community health and community benefit initiatives and tactics are organized under the "Market Leadership" focus area.

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 describe the role each plays in the planning process (additional positions may be added as necessary)

i. Senior Leadership

1. _X_ CEO
2. ___CFO
3. ___Other (please specify)

Describe the role of Senior Leadership.

MedStar Franklin Square Medical Center's Board of Directors, CEO and the organization's operations leadership team work thoroughly to ensure that the hospitals strategic and clinical goals are aligned with unmet community needs through the planning, monitoring and evaluation of its community benefit activities

ii. Clinical Leadership

1. _X_ Physician
2. _X_ Nurse
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

The Community Medicine Service Director (Physician) is on the Board Community Health Improvement Committee which oversees the planning, implementation and evaluation of community benefit activities, supervises the Community Health department and participates in the Community Health Needs Assessment Advisory Task Force.

The Administrative Director, Population Health is on the Board Community Health Improvement Committee which oversees the planning, implementation and evaluation of community benefit activities and facilitates the CHNA and the CHNA Advisory Task Force.

iii. Population Health Leadership and Staff

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

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

The Administrative Director of Population Health (new position 2/1/16) is on the Board Community Health Improvement Committee which oversees the planning, implementation and

evaluation of community benefit activities and supports population health strategy, design, implementation and evaluation.

iv. Community Benefit Operations

1. _X_ Individual (please specify FTE)
    a. Financial Services Manger (1FTE)
    b. Community Health Advocate (1FTE)
    c. Administrative Director of Population Health (1FTE)
2. _X_ Committee (please list members)
3. _X_ Department (please list staff)
4. _X_ Tak 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.

The Financial Services Manager assists with budget, grant revenue and other finance reporting functions of community benefit.

Health Advocate gathers information and enters it into the reporting database.

The Administrative Director of Population Health compiles the report.

Committee Members:

The Community Health Improvement Committee provides oversight and direction to ensure a coordinated and comprehensive approach to identifying, developing, implementing, and evaluating programs that address the health needs of MedStar Franklin Square Medical Center's community. Membership includes:

- Chair: Board member
- Hospital President
- Community Service line Director
- Community Health Manager
- Population Health Administrative Director
- Board members
- Physicians
- Baltimore County Government representative
- Non board member community business representatives
- Non board member community representatives
- Finance Representative
- Vice President of the Philanthropy

Population and Community Health Department:

The department plans, coordinates, implements, evaluates and reports community benefit activities, including the CHNA process. Staff includes:

- Administrative Director, Population Health
- Education Specialists
- Community Health Advocates

CHNA Advisory Task Force:

The ATF participates in the development and implementation of the strategic community benefit plan. Membership:

Name	Organization	Title
Nick D'Alesandro	BC Social Services	Social Worker
Megan Doty	MSFSMC	Marketing Specialist
Tricia Isennock	MSFSMC	Administrative Director, Population Health
Christopher King	MedStar Health	AVP Community Health
Terri Kingeter	Planning Office	Sector Coordinator
Scott Krugman	MSFSMC	Community Medicine Service Line Director
Patricia Norman	MSFSMC	Board Member
Sally Rixey	MSFSMC	FHC Chief of Family Practice
Don Schlimm	BC Local Mgt. Bd.	Acting Executive Director
Tobie-lynn Smith	HCHBC	Medical Director
Rene Youngfellow	BCDH	Division Chief, Clinical Services-Center Based Services

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

Spreadsheet __X___yes _____no
Narrative __X___yes _____no

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

The internal review of the Community Benefit Report is performed by the Administrative Director, Population Health, the Financial Services Manager, and the CFO. The CFO provides oversight of the CBISA reporting function, auditing process and approval of Community Benefit funding. The CEO's signature is obtained through an attestation letter supporting their approval of the Community Benefit Report. The MedStar Health Corporate Office also conducts a review/audit of the hospital's Community Benefit Report annually

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

Spreadsheet __X___yes _____no
Narrative __X___yes _____no

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

_X___Other hospital organizations
_X___ Local Health Department
_X___ Local health improvement coalitions (LHICs)
_X___ Schools
_X___ Behavioral health organizations
_X___ Faith based community organizations
_X___ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative

activities with each partner (please add as many rows to the table as necessary to be complete)

Organization	Name of Key Collaborator	Title	Collaboration Description
Baltimore County Social Services	Nick D'Alesandro	Social Worker	CHNA Advisory Task Force Member Survey Distribution Focus Group
Baltimore County Department of Aging	Donna Bilz	Healthscope Coordinator	Survey Distribution Focus Group
Baltimore County Department of Health	Rene Youngfellow	Division Chief, Clinical Services-Center Based Services	CHNA Advisory Task Force Member
Baltimore County Local Management Board	Don Schlimm	Acting Executive Director	CHNA Advisory Task Force Member
Baltimore County Planning Office	Terri Kingeter	Sector Coordinator	CHNA Advisory Task Force Member Survey Distribution Focus Group
Baltimore County Public Schools	Sue Hahn	Parent Support Services	Survey Distribution Focus Group
Creative Kids	Juanita Ignacio	Director	Survey Distribution Focus Group
Health Care for the Homeless - Baltimore County	Tobie-Lynn Smith	Medical Director	CHNA Advisory Task Force Member Survey Distribution
St. Stephens AME Church	Cassandra Umoh	Program Manager	Survey Distribution Focus Group

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

_____yes __X__no

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

__X__yes _____no

- Administrative Director for Population Health
- Family Practice Faculty Member
- Community Health Clinical Nurse Specialist

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, 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. Please see attached example of how to report.

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

a. 1. 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. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.
2. Please indicate whether the need was identified through the most recent CHNA process.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/)
(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 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, and the metrics that will be used to evaluate the results.

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.

h. Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.

- What were the measurable results of the initiative?
- For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

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? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.

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? 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, or grants associated with the fiscal year being reported.
B. of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

Table III – Initiative I

Identified Need	Access to Mainstream Resources Of the 2,778 patients who accessed MFSMC charity care funds, 44% were self-pay and 37% were Medicaid recipients (FY13 Hospital Charity Care Usage Report). Twenty-eight percent of CHNA respondents (n=570) stated poverty affected the quality of life in the community (MedStar Franklin Square Medical Center Community Health Needs Assessment, 2015). The welfare focus group advised welfare/social service eligibility assessment and referral prior to hospital discharge (MedStar Franklin Square Medical Center Advisory Task Force Welfare Focus Group, 2015).
Hospital Initiative	Access to Mainstream Resources
Primary Objectives	Primary Goal: To improve health outcomes for Medicaid and self-pay patients by providing access to mainstream resources. Objective 1: To assess patients for mainstream service needs prior to discharge. Objective 2: To identify local mainstream service resources. Objective 3: To partner with identified resources for a direct point of contact. Objective 4: To provide mainstream services support assistant to assist with resource eligibility and enrollment. Objective 5: To partner with MD Food Bank for food supplies and nutrition education. Objective 6: To provide eligibility education and enrollment assistance for patients in need of mainstream services.
Single or Multi-Year Initiative Time Period	Program began in 2015 and is planned to continue indefinitely.
Key Partners in Development and/or Implementation	Southeast Area Network Faith Communities Community Assistance Network Baltimore County Department of Health Department of Planning Department of Social Services Health Coalition Local Management Board

How were the outcomes evaluated?	Baseline assessment of services and responsibilities for mainstream resources Coordination of mainstream resource services MFSMC hospital readmission data (CRISP) Decreased readmission rates among clients who receive mainstream assistance.	
Outcomes (Include process and impact measures)	Outcome 1: MFSMC is participating in a pilot of Aunt Bertha for this assessment. Population health is working with Quality, Clinical Informatics, and MI2 for additional tools. Case conferences with Case Managers, Transitional Care Nurses and BCDH Nurses were conducted to assess possible mainstream resource availability for patients identified with complex non-medial healthcare needs. Outcome 2: A directory of local mainstream service resources is maintained by Healthy Babies Collaborative and by Family Health Center Care Coordination and is being shared with Aunt Bertha. United Way 211, MDCSL (MD Community Service Locater) and BCPL are also used. Faith community partner meetings are being held to assess potential collaborative efforts. Outcome 3: HBC and FHC are developing partnerships and compiling direct points of contact in the directory. Outcome 4: Assessment of partnerships and resources have been conducted to provide mainstream services support assistant to assist with resource eligibility and enrollment Outcome 5: Obtained partnership with local Giant food store for free nutrition education. MedStar corporate Community Health has partnered with MD Food Bank for food supplies and nutrition education. Outcome 6: Financial Services, Case Management and Care Coordination are providing eligibility education and enrollment assistance for patients in need of mainstream services.	
Continuation of Initiative	Mainstream Resource Networking will continue through assessment of patient non-medical health needs, and partnering with social service providers. Mainstream resource needs screening tools will be piloted in 2017.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $11,217	B. Direct offsetting revenue from Restricted Grants

		N/A

Table III – Initiative II

Identified Need	Birth outcomes Fifty-two percent of women in the 21221 zip code (Essex) who had a birth in the past 12 months are eligible for Medicaid, demonstrating an underserved population (American Community Survey (ACS), 2013; Center for Medicaid and CHIP Services (CMS)). According to the Women, Infants and Children Program (WIC), 72% of (participating) infants in Baltimore County are being "Fully Formula-Fed," and infants in Essex contributed largely to this population. The Maryland State Agency reports that 67% of participating WIC infants are "Fully Formula-Fed," and the lowest rate in the state is 45%, achieved by a large, diverse population in Montgomery County. A lower rate of "Fully Formula-Fed" is desirable. The Baltimore County Local Management Board identified, within the Essex zip code, a small community (3 Census block groups) that annually produced the most negative birth outcomes, including infant mortality, babies born of low birth weight, and births to adolescents. Babies born with a low birth weight (2500 grams or less) are at increased risk for serious health consequences including disabilities and death. Maryland's LBW percentage is higher than the national average. Percentage of live births that are a low birth weight (2500 grams or less). MD SHIP 2017 Goal -8 MD -8.6 Baltimore County – 8.8 MD Non-Hispanic Blacks - 12.1 Baltimore County Non-Hispanic Blacks - 12.4 MD SHIP http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship3 10-7-16
Hospital Initiative	Healthy Babies Collaborative Healthy Babies Collaborative (HBC) unites local organizations who have a common interest in promoting positive birth outcomes for mothers and their families with mutually reinforcing activities.
Primary Objectives	Primary Goal: Support babies being born healthy and being raised in safe and stable families and communities in southeast Baltimore County. Objective 1: To serve in a leadership role in the Healthy Babies Collaborative. Objective 2: To provide a weekly breastfeeding support group in Essex at Creative Kids Center.

	Objective 3: Assess community factors associated with poor birth outcomes in Essex. Objective 4: Identify evidence based programming (EBP) to address identified risk factors. Objective 5: Provide health education and services to support Southeast Network partner initiatives to address identified risk factors.
Single or Multi-Year Initiative Time Period	Multi-Year – Founding partners began assessment of poor birth outcomes in specific census block areas in 2012. Additional partners with similar interests were added to the core group to form the Healthy Babies Collaborative in May 2014 with a common vision of "Healthy Babies born and raised in safe and stable families and communities." United Way of Central Maryland began to provide support for MFSMC as the backbone organization in October 2016 by funding a HBC Project Coordinator.
Key Partners in Development and/or Implementation	Abilities Network— Healthy Families Southeast Area Network United Way of Central Maryland National Association of City and County Health Organizations Young Parent Support Center Baltimore County Department of Health Department of Planning Department of Social Services Health Coalition Local Management Board
How were the outcomes evaluated?	Breastfeeding Moms Lunch MD SHIP Babies with low birth weight, infant death rate, teen birth rate
Outcomes (Include process and impact measures)	Outcome 1: MFSMC has been designated as the backbone organization for HBC, using the Collective Impact model. Funding from United Way of Central MD supports the Project Coordinator who facilitates communication and logistics. This has resulted in documentation of regular meetings of HBC and the Steering Committee, as well as business plan and logic model development. Data has been shared by member organizations to assist in determining root causes of and best practices for affecting the high rate of low birth weight in the area. Outcome 2: MFSMC participated in Reducing Disparities in Breastfeeding through Peer and Professional Support (The Breastfeeding Project), a program supported by NACCHO to promote breastfeeding amongst mothers in the HBC target population. The weekly Breastfeeding Moms Lunch is facilitated by a MFSMC certified Lactation Specialist and includes peer and professional support, resource information and contacts, a monthly baby story time and lunch, free of charge for all participants. The final grant report is attached. Below are Breastfeeding Support Luncheon stats for FY16:

	# unique participants- 36 # total attendees – 250 # mom initiating breastfeeding- 10 # mom achieving 3 months breastfeeding- 12 # mom achieving 6 months breastfeeding- 6 # mom achieving 12 months breastfeeding- 4 Note: the # of moms reaching intervals is only reflective of mom attended the group at the time of the interval. Outcome 3: Data has been shared by member organizations to assist in determining root causes of and best practices for affecting the high rate of low birth weight in the area. Results indicate a disparity for African American women in their thirties despite educational, income, working status. Teen pregnancy, though higher than desired, were not a major contributor to low birth weight in this population. Outcome 4: Housing instability is a challenge in this population. The Family Stability Initiative has been identified as an evidence based program which may assist. FSI is a program supported by UWCM with whom we are working to access funding. Outcome 5: As a longtime member of SE Network, MFSMC continues to participate in monthly meetings and to support initiatives, i.e., DunFest resource fair, Creative Kids Baby Showers, Young Parent Support Center educational series. The Healthy Babies Collaborative has been analyzing data to assess the demographic and root causes of the poor low birth weight (LBW) rate in the target population. Early results indicate that mothers who delivered LBW infants were Black, ages 20-24, utilizers of WIC services, of lower education level. Focus groups and surveys are planned to access the perspective of the target population. Evidence-based programs are being assessed to address possible root causes.	
Continuation of Initiative	Healthy Babies Collaborative is planned to continue indefinitely. The Breastfeeding Moms Lunch will be sustained by in-kind donations from MFSMC, Abilities Network and the Baltimore County Department of Health. MFSMC's role as a backbone organization is supported by continued funding United Way of Central Maryland for a Project Coordinator.	
C. Total Cost of Initiative for Current Fiscal Year D. What amount is Restricted Grants/Direct offsetting revenue	B. Total Cost of Initiative $63,925	B. Direct offsetting revenue from Restricted Grants $35,975

Table III – Initiative III

Identified Need	Heart Disease The age adjusted rate of heart disease deaths per 100,000 population in Baltimore County is 198.1, compared to 182.0 in MD. The 2014 MD Target is 173.4 The rate of ED visits for hypertension per 100,000 population in Baltimore County is 226.2 compared to 222.2 in MD. The 2014 MD target is 202.4. Heart disease prevention is identified as a top priority in the State Health Improvement Plan. Decreased rate of ED visits for hypertension is a Baltimore County Health Coalition goal. Smoking contributes to over 90% of all lung cancers. It is also the leading cause of heart disease and stroke in the United States and results in over 480,000 deaths each year. Percentage of adults who smoke Baltimore County 17.7 MD 14.6 MD SHIP 2017 Goal 15.5 MDSHIP, http://baltimorecounty.md.networkofcare.org/ph/ship-detail.aspx?id=md_ship32, 10-5-16
Hospital Initiative	Living Well Stanford Chronic Disease Self-Management Program – six-week (2.5 hour/week), self-management program provides information and teaches practical skills on managing chronic health problems CDC National Diabetes Prevention Program – year-long lifestyle change program to reduce the risk of type 2 diabetes and improve overall health Stop Smoking Today! - six week program to provide highly motivated adults with the practical counseling, support and encouragement needed to become smoke free.
Primary Objectives	Primary Goal: To promote heart health in Southeast Baltimore County Objective 1: To deliver evidence-based chronic disease self management programs. Objective 2: To provide blood pressure education and self-screening at community sites. Objective 3: To serve as an official partner of the

	Baltimore Heart-walk. Objective 4: To facilitate monthly diabetes support group. Objective 5: To present Stop Smoking Today smoking cessation program. Objective 6: To support Baltimore County Health Coalition smoking cessation initiatives.
Single or Multi-Year Initiative Time Period	Multi-year (2003 – ongoing)
Key Partners in Development and/or Implementation	American Heart Association Million Hearts Campaign American Medical Association (AMA) Baltimore County Department of Aging Baltimore County Department of Health Baltimore County Health Coalition Johns Hopkins Medicine (JHU) MedStar Health Southeast Network
How were the outcomes evaluated?	Participation and quit rates are documented and reported to Baltimore County Tobacco Coalition Center for Disease Control – Age Adjusted Death Rate MD SHIP Emergency Department Visits due to Hypertension MedStar Franklin Square Medical Center Emergency Department – Visits due to Hypertension Improving Health Outcomes: Blood Pressure (IHI:BP) Community Engagement Pilot, AMA-JHU-MSFSMC
Outcomes (Include process and impact measures)	Outcome 1: The Stanford Chronic Disease Self-Management Program (Living Well) was offered twice in FY16 (January, March) to 15 attendees. Five classes are scheduled for FY17. The National Diabetes Prevention Program was facilitated as a pilot starting Jan. 2016 for 13 participants, mostly MFSMC Associates. The first program for community members is scheduled to begin in February 2017. Baltimore County Department of Health invited MFSMC to be part of a grant application for further dissemination of NDPP in the County. Outcome 2: Family Health Center Blood Pressure project is part of the Improving Health Outcomes Blood Pressure Learning Collaborative, sponsored by the American Medical Association (AMA), in collaboration with Johns Hopkins Medicine. MedStar physicians and care teams at the Family Health Center and Department of Family Medicine are using a specific framework to help manage blood pressure among their patient population.

	https://www.youtube.com/watch?v=0y5PVwJ1_40 The Family Health Center at MedStar Franklin was a selected practice that was part of the AMA's Improving Health Outcomes initiative, in which the AMA and participating physicians and care teams worked with the Johns Hopkins Armstrong Institute for Patient Safety and Quality and the Johns Hopkins Center to eliminate cardiovascular health disparities to develop and test evidence-based recommendations to improve hypertension control. Along with clinical changes, teams focused on establishing clinical-community linkages and "partnering with patients to promote self-management", where physicians refer patients to community resources that can help them improve their blood pressure and promote lifestyle changes. Blood pressure control rate data was added to the FHC quality dashboard. Dr. Rixey continues to participate in the Southeast Network, community service provider coalition. FHC continues to re-evaluate and improve the "M.A.P. framework" (measure accurately, act rapidly and partner with patients, families and communities. Action items include: • re-train and review, secret shopper (see below) • provide patients with our act rapidly brochure (see attached) that contain general information and community resources. • partnering with Giant Food for educational grocery shopping tours. Six sessions were held in FY16. Participation: 41 total unique attendees, 7 FHC patients, 3 staff Outcome 3: As a Baltimore Heart-walk partner, MFSMC had 26 people participate on 5 teams which raised a total of $556. Outcome 4: Diabetes Support Group was facilitated ten times in FY16; total registration was 313. Outcome 5: Stop Smoking Today (SST) was offered

	eight times in FY16. Number of programs was increased from four to increase access. According to the Clinical Practice Guidelines for Treating Tobacco Use and Dependence, interventions that include >300 minutes of contact time/counseling had an estimated abstinence rate of 25.5%. Stop Smoking Today FY16 #Registrants – 82 #Participants who quit – 25 #Participants who completed program – 44 Quit rate for completers – 57% Overall class average quit rate – 49% Stop Smoking for Good, a monthly support group was also offered but there were no registrants. Eight classes are scheduled in FY17, both day and evening sessions. Discharge instructions in electronic medical records (EMR) were improved to offer complete and accurate SST information and handouts. Future goals include automatic EMR referrals for all smokers with follow-up phone call invitations to SST Outcome 6: Participation In the Tobacco Coalition continues.	
Continuation of Initiative	Stop Smoking Today will be continued indefinitely and updated based on current research.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $89,780	B. Direct offsetting revenue from Restricted Grants N/A

2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

Issue	**Evidence**	**Explanation**	**Name of community based lead organizations and/or key stakeholders (These are organization that would be interested in these findings)**
Housing	35% of CHNA respondents identified homelessness affecting the quality of life. 21% of CHNA respondents indicated affordable housing as a needed service in the community (MedStar Franklin Square Medical Center Community Health Needs Assessment, 2015).	The hospital does not have the expertise to have a leadership role in these areas. When possible, the hospital will support stakeholders by contributing to initiatives and participating in conversations on the topics – particularly as they relate to health status and health outcomes.	Baltimore County Housing Department
Transportation	8% of CHNA respondents identified better public transportation as a needed service (MedStar Franklin Square Medical Center Community Health Needs Assessment, 2015). MSFSMC charity care for transportation assistance increased 66% in FY2014 from that of FY2013 (MedStar Franklin Square Medical Center Community Benefits Report to HSCRC, 2014).		MD Department of Transportation Maryland Transit Authority

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)

By using benchmarks established by Healthy People 2020, the State Health Improvement Plan and Baltimore County Health Coalition, MFSMC's CHNA evaluated the current community health status and established aligned community benefit priorities. MFSMC's primary focus from fiscal year 2016 – 2018 is to leverage partnerships across service sectors to implement innovative evidence-based programs that address chronic diseases, specifically targeting heart disease, support of healthy birth outcomes, and access to mainstream resources for Medicaid and self pay patients. Efforts include the implementation of Heart Smart Seniors program, the Family Health Center's patient-centered medical home model, Smoking Cessation Resource Awareness campaign and Baltimore County School Nurse communication project. Hot spotting analysis has resulted in focused use of resources for maximum impact for community collaborations and for readmission reduction efforts, especially for Medicare, Medicaid and CHIP beneficiaries.

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

PHYSICIANS

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

    a. MedStar Franklin Square Medical Center (MFSMC) is in a HRSA-designated medically underserved area. Many of the services provided by MFSMC would otherwise not be available in our service area due to lack underinsurance or uninsured patients and availability to healthcare resources. Many of the needs of the larger uninsured or underinsured population are addressed by our financial assistance policy. We posed this issue to our physician leadership and case management staff who identified several areas of concern: Timely placement of patients in need of inpatient psychiatry services, limited availability of outpatient psychiatry services, limited availability of inpatient and outpatient substance abuse treatment.

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**
Hospitalist - Physician Provision of Financial Assistance	MedStar Franklin Square Medical Center (MFSMC) is in a HRSA-designated medically underserved area. Many of the services provided by MFSMC would otherwise not be available in our service area due to underinsured or uninsured patients and limited availability to healthcare resources. Many of the needs of the larger uninsured or underinsured population are addressed by our financial assistance policy.
Hospital Outpatient Services	Accessibility to Primary Care services is crucial to the health and wellness of the population. In order to promote healthy lifestyles and a focus on awareness of one's health. The PCC provides these services to many patients who utilize public transportation to obtain health services by being located on MFSMC's campus. The lack of Primary Care and Family Health Services in our

	service area would lead to a decrease in health and life quality in the community which would eventually translate to increased hospital utilization.
Women's and Children Services	OB/GYN services in the MFSMC community are key to maintaining healthy relationships with patients and their families. The quality of services provided along with the easily accessible facilities in the MFSMC area allow for effective and efficient care to take place for women who need both general women's health services along with treatment and advice during and after pregnancy. Many areas in the MFSMC service area include underinsured or uninsured patients. This being said, many other health networks do not provide services in these areas to patients who are unable to pay making it crucial for MFSMC to maintain the services provided for women in the community.
Palliative Care	MFSMC provides Inpatient Acute Care services to many patients in Baltimore County who would otherwise not have access to health care facilities. Palliative Care is essential to ensuring patients are receiving pain and symptom management as well as psychosocial and spiritual support to seriously ill patients in the acute care setting. The overall goal of both Hospitalists and Palliative Care is to improve care, decrease suffering, and ensure quality and safe care is being provided to all patients at MFSMC. Being the easiest accessible acute care setting to the many underinsured or uninsured patients in our service area, it is crucial that MFSMC continue to provide these services.

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
    - besides English, in what language(s) is the Patient Information sheet available;
    - discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

    b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).
    c. Include a copy of your hospital's FAP (label appendix III).
    d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

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

Appendix I

Financial Assistance Policy

MedStar Franklin Square's FAP and financial assistance contact information is:

- available in both English and Spanish
- posted in all admissions areas, the emergency room, and other areas of facilities in which eligible patients are likely to present
- provided with financial assistance contact information to patients or their families as part of the intake process
- provided to patients with discharge materials
- included in patient bills

Patient Financial Advocates visit all private pay patients and are available to all patients and families to discuss the availability of various government benefits, such as Medicaid or state programs, and assist patients with qualification for such programs, where applicable.

Appendix II

There have been no changes in the Financial Aid Policy at MedStar Franklin Square since the ACA Health Care Coverage Expansion Option became effective (January 1, 2014). The current policy meets all ACA requirements.

Appendix III

Financial Assistance Policy

MedStar Franklin Square Medical Center is committed to ensuring that uninsured patients within its service area who lack financial resources have access to medically necessary hospital services. If you are unable to pay for medical care, have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability, you may qualify for **Free or Reduced Cost Medically Necessary Care**.

MedStar Franklin Square Medical Center meets or exceeds the legal requirements by providing financial assistance to those individuals in households below 200% of the federal poverty level and reduced cost-care up to 400% of the federal poverty level.

Patients' Rights

MedStar Franklin Square Medical Center will work with their uninsured patients to gain an understanding of each patient's financial resources.

- They will provide assistance with enrollment in publicly-funded entitlement programs (e.g. Medicaid) or other considerations of funding that may be available from other charitable organizations.
- If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.
- If you believe you have been wrongfully referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

Patients' Obligations

MedStar Franklin Square Medical Center believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

- Cooperate at all times by providing complete and accurate insurance and financial information.
- Provide requested data to complete Medicaid applications in a timely manner.
- Maintain compliance with established payment plan terms.
- Notify us timely at the number listed below of any changes in circumstances.

Contacts

Call 410-933-2424 or 1-800-280-9006 (toll free) with questions concerning:

- Your hospital bill

- Your rights and obligations with regards to your hospital bill
- How to apply for Maryland Medicaid
- How to apply for free or reduced care

For information about Maryland Medical Assistance

Contact your local Department of Social Services at 1-800-332-6347. For TTY, call 1-800-925- 4434.

Learn more about Medical Assistance on the Maryland Department of Human Resources website: www.dhr.maryland.gov/fiaprograms/medical.php

Physician charges are not included in hospitals bills and are billed separately.

Additional Billing Information

You will receive a statement for hospital services approximately one week after your discharge. As a courtesy, your insurance company will be billed for the services you received. You may request a preliminary statement of hospital services when you are discharged. Please note, the statement may not reflect all charges for services you received. If you wish, you may pay the known self-pay portion of your bill at this time and take advantage of a 2% discount. After your insurance pays, you may be responsible for additional amounts due.

Uninsured patients are required to pay their bills when they are discharged or to make arrangements for payment through the Patient Advocacy Department. If you are uninsured and need to apply for assistance to cover your hospital bill or to speak with a Patient Advocate, call 443-777-7323 or 443-777-7732.

Appendix IV

MedStar Health

MARYLAND HOSPITAL PATIENT INFORMATION SHEET

Hospital Financial Assistance Policy

MedStar Franklin Square Medical Center is committed to ensuring that uninsured patients within its service area who lack financial resources have access to medically necessary hospital services. If you are unable to pay for medical care, have no other insurance options or sources of payment including Medical Assistance, litigation or third-party liability, you may qualify for **Free or Reduced Cost Medically Necessary Care**.

MedStar Franklin Square Medical Center meets or exceeds the legal requirements by providing financial assistance to those individuals in households below 200% of the federal poverty level and reduced cost-care up to 400% of the federal poverty level.

Patients' Rights

Medstar Franklin Square Medical Center will work with their uninsured patients to gain an understanding of each patient's financial resources.

- They will provide assistance with enrollment in publicly-funded entitlement programs (e.g. Medicaid) or other considerations of funding that may be available from other charitable organizations.
- If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.
- If you believe you have been wrongfully referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

Patients' Obligations

MedStar Franklin Square Medical Center believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

- Cooperate at all times by providing complete and accurate insurance and financial information.
- Provide requested data to complete Medicaid applications in a timely manner.
- Maintain compliance with established payment plan terms.
- Notify us timely at the number listed below of any changes in circumstances.

Contacts:

Call (410-933-2424) or toll free (1-800-280-9006) with questions concerning:

- Your hospital bill
- Your rights and obligations with regards to your hospital bill
- How to apply for Maryland Medicaid
- How to apply for free or reduced care

For information about Maryland Medical Assistance

Contact your local Department of Social Services

1-800-332-6347 TTY 1-800-925-4434

Or visit: www.dhr.state.md.us

Physician charges are not included in hospitals bills and are billed separately.

(This sheet is also available in Spanish.)

Appendix V

MedStar Franklin Square Medical Center

Mission

MedStar Franklin Square Medical Center, a member of MedStar Health, provides safe, high quality care, excellent service and education to improve the health of our community.

Vision
The trusted leader in caring for people and advancing health.

Values

- **S**ervice: We strive to anticipate and meet the needs of our patients, physicians and co- workers.
- **P**atient First: We strive to deliver the best to every patient every day. The patient is the first priority in everything we do.
- **I**ntegrity: We communicate openly and honestly, build trust and conduct ourselves according to the highest ethical standards.
- **R**espect: We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.
- **I**nnovation: We embrace change and work to improve all we do in a fiscally responsible manner.
- **T**eamwork: System effectiveness is built on collective strength and cultural diversity of everyone, working with open communication and mutual respect.

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