COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2016 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

MedStar Good Samaritan Hospital

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.)

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
165 Acute 51 Acute rehab 30 Sub-acute Source: MGSH Finance Department	Acute 8912 Acute rehab 51 Sub-acute 617 Source: MGSH Finance Department	21239 21234 21206 21214 21212 21218 Source: HSCRC Acute Hospital PSA 2016	MedStar Union Memorial Hospital MedStar Franklin Square Medical Center University of Maryland Medical Center Mercy Medical Center Johns Hopkins Hospital Johns Hopkins Bayview University of Maryland – Midtown Greater Baltimore Medical Center University of Maryland Rehabilitation and Orthopaedic Institute	Baltimore City 3.7% Baltimore County 1.7% Other 0.6% Source: MGSH Finance Department	6.2% Source: MGSH Finance Department	33.3% Source: MGSH Finance Department

			Source: HSCRC Acute Hospital PSA 2016			

Table I

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 in the Govans area of Baltimore but also provides services to residents that live in the hospital's service area (21234,21239,21206,21214) Focus area: Govans (zip code 21212) This geographic area was selected because of its close proximity to the hospital, coupled with a high density of low-income residents.	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 City - $41,819 Hospital Service Area Median Household Range: $48,721 – $61,734 Govans (zip code 21212) - $37,047	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 2011 Neighborhood Health Profile: Greater Govans http://health.baltimorecity.gov/sites/default/files/20%20Greater%20Govans.pdf
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Baltimore City – 19.5% Hospital Service Area Range – 6.9% - 12.8%, Govans (zip code 21212) – 11.6%	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 2011 Neighborhood Health Profile: Greater Govans http://health.baltimorecity.gov/sites/default/files/2

		0%20Greater%20Govans.pdf
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	Baltimore City – 11.6%	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 City – 31.3%	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 City – 74.1 African American – 72.3 White – 76.8 Govans(zip code 21212) – 73.9	2014 Maryland State's Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/Pages/home.aspx 2011 Neighborhood Health Profile: Greater Govans http://health.baltimorecity.gov/sites/default/files/20%20Greater%20Govans.pdf
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Baltimore City (per 100,000 residents) All Cause Mortality Rate – 1001.7 Cardiovascular Disease Mortality Rate – 300.3 Diabetes Mortality Rate – 29.0 Stroke Mortality Rate – 45.5	Maryland Vital Statistics Administration 2013 Report Card http://health.baltimorecity.gov/sites/default/files/Health%20Disparities%20Report%20Card%20FINAL%2024-Apr-14.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** Percent of zip codes in County with a healthy food outlet : Baltimore City – 48.89% State of Maryland – 40.4% Percentage of working age people who use public transportation: Baltimore City – 18.22% State of Maryland – 8.8% National – 4.7% Percentage of students who have a high school degree: Baltimore City – 63.7% State of Maryland – 79,2% HP2020 82.4% Number of days with maximum ozone concentration over the National Ambient Air Quality Standard: Baltimore City – 20 State of Maryland – 11.7 Homeownership Rate: Baltimore City – 47.15 State of Maryland – 67.1 **Govans (zip code 21212)** Percent of residents 25 years and older with a bachelors degree or more – 14.2% Number of energy cut-offs per 10,000 households each month compared to Baltimore City Govans – 46.5 Baltimore City – 39.1 Estimated travel time to nearest supermarket by car (in mins) – 4.0; by bus (in mins) – 15.0	Maryland State's Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/Pages/home.aspx 2011 Neighborhood Health Profile Greater Govans http://health.baltimorecity.gov/sites/default/files/20%20Greater%20Govans.pdf
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	Govans (zip code 21212) **Demographics** Total population – 10,680 Black or African American – 91.3% White – 5.7% Hispanic – 1.3% American Indian and Alaska Native – 33	2011 Neighborhood Health Profile Greater Govans http://health.baltimorecity.gov/sites/default/files/20%20Greater%20Go

	Two or more races – 2.5% Some Other Race – 1.0% Some other race includes American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and choosing other races as an option on the census.	vans.pdf

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 6/17/2015
   ___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/President (Executive Sponsor)
2. _X__CFO
3. ___Other (please specify)

Describe the role of Senior Leadership.

President/CEO (Executive Sponsor)
MedStar Good Samaritan Hospital's Board of Directors, President 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. __Physician
2. __Nurse
3. __Social Worker
4. __Other (please specify)

Describe the role of Clinical Leadership

iii. Population Health Leadership and Staff

1. ____ 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.

iv. Community Benefit Operations

1. _X__Individual (please specify FTE)
    a. Hospital Lead (1FTE)
    b. Finance Manager (1FTE)

The Community Health Needs Assessment (CHNA) Hospital Lead serves as the coordinator of all aspects of the community health assessment process. He/she helps establish and coordinate the activities of the Advisory Task Force. The Lead also helps produce the hospital's Community Health Needs Assessment and Implementation Strategy. He/she reviews all narratives and reports prior to publication.

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

2. ___Committee (please list members)

3. _X__Department (please list staff)

Coord- Community Education & Health Ministries/ RN

The Coordinator of Community Education & Health Ministries/ RN coordinates community outreach activities with target audiences, including preparing health presentations, providing liaison services to selected groups, and promoting the hospital's mission of creating healthier, communities. The Coordinator also coordinates with local community groups, including churches, senior centers, and business associations, to create health programs focused on the elements of wellness.

4. _X__Task Force (please list members)

Name/Title	**Organization**
Allan Noonan, MD , MGSH Board member	MedStar Good Samaritan Hospital
Sonya Gray, MGSH Board member	MedStar Good Samaritan Hospital
Carol Pacione, Pastoral Life Director	St. Pius Church
David Weisman, MD, MGSH Board member	MedStar Good Samaritan Hospital
Michelle Zikusoka, MD, Physician	MedStar Good Samaritan Hospital
Andrew Dziuban, Director of Philanthropy	MedStar Good Samaritan Hospital
Bernadette Krol, Registered Nurse	MedStar Good Samaritan Hospital
Moira Larsen, MD, Physician and Board Member	MedStar Good Samaritan Hospital
Rachael V. Neill, CARES Program Director, Resident	Govans Ecumenical Development Corporation (GEDCO)
Loretha Myers, Resident	Loch Raven Improvement Association, Northeast Community Organization
Patricia Stabile, Program Director	HARBEL Prevention and Recovery Center
Randolph Rowel, PhD, Chair and Associate	Morgan State University, Department of

Professor	Behavioral Health Sciences

5. ___Other (please describe)

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 Community Health Lead, 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
_____ Local health improvement coalitions (LHICs)
_____ Schools
___X__ Behavioral health organizations
___X__ Faith based community organizations
_____ 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
GEDCO/CARES	Rachael V. Neill	Program Director, Resident	Member of Community Health Needs Assessment Task Force. Provides space for health education programs.
Harbel Community Organization	Patricia Stabile	Program Director	Member of Community Health Needs Assessment Task Force
Morgan University	Randolph Rowel, PhD	Chair and Associate Professor	Member of Community Health Needs Assessment Task Force
Local Community Member	Loretha Myers	Resident	Member of Community Health Needs Assessment Task Force
Healthy Communities Institute	N/A	N/A	Provided quantitative data based on 129

			community health indicators by county. Using a dashboard methodology, the web-based portal

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?

_____yes __X___no

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	<u>Cardiovascular Disease - Heart Disease</u> Heart disease is the leading cause of death in Baltimore City "Promote Heart Health" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015, with a related goal of decreasing the rate of premature deaths from cardiovascular disease (CVD) by 10%. Baltimore City's age-adjusted mortality rate from heart disease as measured by the number of heart disease deaths per 100,000 population is 242.7, compared to the state's 171.7 (Maryland State Health Improvement Process (SHIP), 2011-2013).
Hospital Initiative	Keep the Beat Heart Health Program One hour program given over 4 weeks. Topics include a general overview of the most common types of heart disease and stroke with an emphasis on lifestyle changes to support cardiovascular health (nutrition, exercise, stress reduction).
Primary Objective	Objective 1: To increase awareness related to risks, symptoms and treatment of heart disease. Objective 2: To increase awareness and promote lifestyle choices that reduces the risk of heart disease.
Single or Multi-Year Initiative Time Period	Multi-Year (2013– 2016)
Key Partners in Development and/or Implementation	Govans Ecumenical Development Corporation (GECDO) provides affordable housing, supportive services, and emergency assistance to community residents. • Harford Senior Center

How were the outcomes evaluated?	• Number of participants enrolled • Number of classes held • Number of sites • Number of encounters • Demographic information of participants • Information on healthy lifestyle is provided • Pre and Post Tests	
Outcomes	• 18 enrolled participants • 4 weekly classes held at 1 site (Offered at 2 other locations, but canceled due to lack of registrants) • 72 encounters for FY14 • Age of participants: 50 and over • Majority of participants -Black/African American • Healthy lifestyle information provided at all classes • Pre and posttest were given at each of the 4 weekly classes Pretest - 8 of 18 participants scored 90% or above (45% of participants) Posttest – 15 of 18 participants scored 90% or above (83% of participants)	
Continuation of Initiative	This program will not be offered in FY17 This program is ending due to lack of community interest. Two programs were canceled this year due to no registration.	
A. Total Cost of Initiative for Current Fiscal Year B. B. What amount is Restricted Grants/Direct offsetting revenue	A. 768	B. Direct Offsetting Revenue from Restricted Grants

Table III - Initiative II

Identified Need	Cardiovascular Disease - Heart Disease/ Obesity Heart disease is the leading cause of death in Baltimore City "Promote Heart Health" is one of the ten priority areas from Baltimore City Health Department's Health Baltimore 2015, with a related goal of decreasing the rate of premature deaths from cardiovascular disease (CVD) by 10%. Baltimore City's age-adjusted mortality rate from heart disease as measured by the number of heart disease deaths per 100,000 population is 242.7, compared to the state's 171.7 (Maryland State Health Improvement Process (SHIP), 2011-2013). Approximately one in three Baltimore City residents is obese. In 2013, only 16.7% of Baltimore City residents were getting the recommended amount of weekly physical activityhttp://health.baltimorecity.gov/sites/default/files/HealthyBaltimore2015_May2016Update_web.pdf
Hospital Initiative	1) Senior Fitness Program 2)Advanced Senior Fitness Program Fitness programs include low impact aerobics, strength training, and stretching. Participants are encouraged to participant at their individual fitness level.
Primary Objective	Increase awareness of healthy behaviors and provide exercise classes that prevent/decrease obesity and reduce the risk of heart disease.
Single or Multi-Year Initiative Time Period	Multi-Year, in operation since 2013
Key Partners in Development and/or Implementation	GEDCO • Harford Senior Center • Senior Network of North Baltimore
How were the outcomes evaluated?	• Number of participants enrolled • Number of classes held • Number of sites • Number of encounters • Demographic information of participants • Weight Loss (one program)

Outcomes	<u>GEDCO/Harford Senior Center</u> Senior Fitness Program (Class 1) • Number of participants enrolled - 18 • Number of classes held - 30 • Number of sites - Site 1 (Harford Senior Center) • Number of encounters -354 • Demographic information of participants - Majority of participants are Black/African American • Participant weight loss <u>GEDCO/Senior Network of North Baltimore</u> Senior Fitness Program (Class 2) • Number of participants enrolled - 45 • Number of classes held - 42 • Number of sites -Site2 (Senior Network of North Baltimore) • Number of encounters -1,845 • Demographic information of participants - Majority of participants are Black/African American • Number of participants achieving at least a 5 pound weight loss – 14 (32%) <u>GEDCO/Senior Network of North Baltimore</u> Advanced Senior Fitness Class • Number of participants enrolled - 15 • Number of classes held - 41 • Number of sites- Site 2 (Senior Network of North Baltimore) • Number of encounters -460 • Demographic information of participants - Majority of participants are Black/African American
Continuation of Initiative	Yes

C. Total Cost of Initiative for Current Fiscal Year D. B. What amount is Restricted Grants/Direct offsetting revenue	A. 13,536	B. Direct offsetting revenue from Restricted Grants $0

Table III - Initiative III

Identified Need	Diabetes Management 29.1 million people or 9.3% of the U.S. population have diabetes 21.0 million people diagnosed 8.1 million people undiagnosed Diabetes was the seventh leading cause of death in the United States in 2010 based on the 69,071 death certificates in which diabetes was listed as the underlying cause of death. In 2010, diabetes was mentioned as a cause of death in a total of 234,051 certificates. Diabetes may be underreported as a cause of death. Studies have found that only about 35% to 40% of people with diabetes who died had diabetes listed anywhere on the death certificate and about 10% to 15% had it listed as the underlying cause of death. In 2003–2006, after adjusting for population age differences, rates of death from all causes were about 1.5 times higher among adults aged 18 years or older with diagnosed diabetes than among adults without diagnosed diabetes. http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf
Hospital Initiative	"Living Well: Take Charge of Your Diabetes" Six-week evidenced based workshop designed by Stanford University for diabetes management. Topics include counting carbohydrates, health nutrition, exercise, stress management, glucose monitoring, medications, and communication skills.
Primary Objective	To provide participants with a set of "tools" to enable them to become better self-managers of their diabetes.
Single or Multi-Year Initiative Time Period	Multi-Year FY 15- FY 18

Key Partners in Development and/or Implementation	GEDCO • Govans Manor
How were the outcomes evaluated?	• Number of participants enrolled • Number of Workshops • Number of classes held • Number of sites • Number of encounters • Demographic information of participants • Participant Survey Questions
Outcomes	<u>Workshop 1 held at Govans Manor</u> • Number of participants enrolled - 10 • Number of Workshop -1 • Number of classes held - 6 • Number of sites –(Site one Govans Manor) • Number of encounters - 40 • Demographic information of participants - Majority of participants -Black/African American • Participant Survey Questions Results 1. I have a better understanding of how to manage the symptoms of my health condition(s). Strongly Agree - 7 Agree – 2 2. I learned how to set goal and action plan and follow it. Strongly Agree - 8 Agree - 1 3. I have more self-confidence in my ability to manage my health than I did before taking the

	workshop. Strongly Agree - 7 Agree - 2 4. I feel more motivated to take care of my health since I took this workshop. Strongly Agree - 9 Agree - 0 <u>Workshop 2 held at MGSH</u> • Number of participants enrolled – 6 • Number of Workshops -1 • Number of classes held - 6 • Number of sites – Site 1 (MGSH) • Number of encounters - 36 • Demographic information of participants - Majority of participants -Black/African American • Participant Survey Questions Results 1. I have a better understanding of how to manage the symptoms of my health condition(s). Strongly Agree - 5 Agree - 1 2. I learned how to set goal and action plan and follow it. Strongly Agree - 6 Agree - 0 3. I have more self-confidence in my ability to

	manage my health than I did before taking the workshop. Strongly Agree - 5 Agree - 1 4. I feel more motivated to take care of my health since I took this workshop. Strongly Agree - 4 Agree - 2	
Continuation of Initiative	Yes	
E. Total Cost of Initiative for Current Fiscal Year F. B. What amount is Restricted Grants/Direct offsetting revenue	A. 2,820	B. Direct offsetting revenue from Restricted Grants $0

Table III - Initiative IV

Identified Need	Diabetes Prevention Prediabetes among people aged 20 years or older, United States, 2012 In 2009−2012, based on fasting glucose or A1C levels, 37% of U.S. adults aged 20 years or older had prediabetes (51% of those aged 65 years or older). Applying this percentage to the entire U.S. population in 2012 yields an estimated 86 million Americans aged 20 years or older with prediabetes
Hospital Initiative	"Life Balance/Weight Management Program" (National Diabetes Prevention Program) A yearlong evidenced-based program designed to help participants adopt healthy lifestyle behaviors.
Primary Objective	To reduce the risk of developing Type 2 diabetes by losing 5-7 % of total body weight and exercising for at least 150 minutes per week
Single or Multi-Year Initiative Time Period	Multi-Year FY 15 – FY 18
Key Partners in Development and/or Implementation	GEDCO • Senior Network of North Baltimore
How were the outcomes evaluated?	• Number of participants enrolled • Number of participants completing program • Number of participants with weight loss of 5 –7% • Number participants exercising 150 minutes per week

Outcomes	Life Balance/Weight Management held at MGSH • Start Date –September 9, 2015 • End Date – August 2016 • Number of participants enrolled – 32 • Number of participants in program at end of FY 16 – 16 (50 %) • Participant's weight loss at end of FY16 (June) 7% of body weight loss -8 5% of body weight loss - 2 • Participant's minutes of exercise at end of FY16 (June) 150 minutes of exercise per week – 14 Life Balance/Weight Management held at Senior Network of North Baltimore • Start Date – May 4, 2015 • Number of participants enrolled – 20 • No further data to report at this time
Continuation of Initiative	Yes – Currently Pending CDC Recognition Planning to expand this program,

G. Total Cost of Initiative for Current Fiscal Year H. B. What amount is Restricted Grants/Direct offsetting revenue	A. 10,675	B. Direct offsetting revenue from Restricted Grants $0

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	Lead
Housing	In the 2015 MGSH Community Health Input Survey, when asked which services are needed most in the community, 26% (n=175) of respondents stated "Affordable Housing".	The hospital does not have the expertise to have 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.	Housing Authority of Baltimore City; Department of Housing and Community Development; community organizations
Density of Liquor Stores, Tobacco Retail, Fast Food, Carryout and Corner Stores.	The density of Liquor Stores, Tobacco Retail, Fast Food, Carryout and Corner Stores is very high in the identified target area, as ranked in the 2011 Baltimore City Neighborhood Health Profiles.		Baltimore City Planning Department, Baltimore City Liquor License Board, Maryland Department of Health and Mental Hygiene

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)

In alignment with the State's population health strategy, the goals of the community benefit initiatives are to promote health and wellness and improve health knowledge and behaviors among communities and populations disproportionately affected by highly prevalent diseases and conditions. According to Maryland's State Health Improvement Process, 30% of all deaths were attributed to heart disease and stroke. MGSH's primary focus from fiscal year 2016 – 2018 is to implement evidence-based interventions that address chronic disease, specifically targeting heart disease, diabetes and obesity.

VI. 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.

    - 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
    - Medication assistance
    - Dentistry

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**
1. Hospital-Based physicians	MedStar Good Samaritan Hospital is a safety net hospital with a considerable uninsured and underinsured population with no primary care physicians. Subsidy is required to maintain sufficient coverage.
2. Renal Dialysis Services	The demand for dialysis services in the immediate area surrounding MedStar Good Samaritan is high and is expected to increase. The outpatient dialysis center at the hospital is consistently full and maintains a waitlist for services. Renal specialists are in high demand in this market. Subsidy is required to maintain sufficient coverage.
3. Subsidized Continuing Care	Continuing Care services provides a highly focused environment of care to meet the needs of vulnerable patients and has multiple resources available to assist in the management of complex

	medical needs.
4. Behavior Health Services	The overall cost of 24/7 Psychiatry physician coverage is disproportionate to the total collections from the patients seen by these physicians during off hours. Many of these patients are uninsured. Our hospital absorbs the cost of providing psychiatric supervision for the Emergency Department on a 24/7 basis. If these services were not provided, the patient would be transported to another facility to receive these services. The community needs are being met and commitment to patients is exhibited by providing these services.

VII. 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).

Appendices

Appendix I
Description of Financial Assistance Policy

MedStar Good Samaritan'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
Financial Assistance Policy Changes

Since the Affordable Health Care Act took effect, MedStar Health has made the following changes to its Financial Assistance Policy:

- Includes state and federal insurance exchange navigators as resources for patients
- Defines underinsured patients who may receive assistance
- Began placing annual financial assistance notices in newspapers serving the hospitals' target populations
- Added section 2 under responsibilities (see Appendix III)

Appendix III
Financial Assistance Policy

Title:	**Hospital Financial Assistance Policy**
Purpose:	To ensure uniform management of the MedStar Health Corporate Financial Assistance Program within all MedStar Health hospitals
Effective Date:	07/01/2011

Policy

1. As one of the region's leading not-for-profit healthcare systems, MedStar Health is committed to ensuring that uninsured patients within the communities we serve who lack financial resources have access to necessary hospital services. MedStar Health and its healthcare facilities will:

1.1 Treat all patients equitably, with dignity, with respect and with compassion.
1.2 Serve the emergency health care needs of everyone who presents at our facilities regardless of a patient's ability to pay for care.
1.3 Assist those patients who are admitted through our admissions process for non-urgent, medically necessary care who cannot pay for the care they receive.
1.4 Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep its hospitals' doors open for all who may need care in the community.

Scope

1. In meeting its commitments, MedStar Health's facilities will work with their uninsured patients to gain an understanding of each patient's financial resources prior to admission (for scheduled services) or prior to billing (for emergency services). Based on this information and patient eligibility, MedStar Health's facilities will assist uninsured patients who reside within the communities we serve in one or more of the following ways:

1.1 Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
1.2 Assist with consideration of funding that may be available from other charitable organizations.
1.3 Provide charity care and financial assistance according to applicable guidelines.
1.4 Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
1.5 Offer periodic payment plans to assist patients with financing their healthcare services.

Definitions

1. **Free Care**
Financial assistance for medically necessary care provided to uninsured patients in households between 0% and 200% of the FPL.

2. **Reduced Cost-Care**
Financial assistance for medically necessary care provided to uninsured patients in households between 200% and 400% of the FPL.

3. **Medical Hardship**
Medical debt, incurred by a household over a 12-month period, at the same hospital that exceeds 25% of the family household income.

4. **Maryland State Uniform Financial Assistance Application**
A uniform data collection document developed through the joint efforts of Maryland hospitals and the Maryland Hospital Association.

5. **Maryland Patient Information Sheet / MedStar Patient Information Sheet (Non-Maryland Hospitals)**
A patient education document that provides information about MedStar's Financial Assistance policy, and patient's rights and obligations related to seeking and qualifying for free or reduced cost medically necessary care.

Responsibilities

1. Each facility will post the policy, including a description of the applicable communities it serves, in each major patient registration area and in any other areas required by applicable regulations, will communicate the information to patients as required by this policy and applicable regulations and will make a copy of the policy available to all patients. Additionally, the Maryland Patient Information Sheet / MedStar's Patient Information Sheet will be provided to inpatients on admission and at time of final account billing.

2. MedStar Health believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. The charity care, financial assistance, and periodic payment plans available under this policy will not be available to those patients who fail to fulfill their responsibilities. For purposes of this policy, patient responsibilities include:

2.1 Completing financial disclosure forms necessary to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.

2.2 Working with the facility's financial counselors and other financial services staff to ensure there is a complete understanding of the patient's financial situation and constraints.

2. 3Completing appropriate applications for publicly-funded healthcare programs. This responsibility includes responding in a timely fashion to requests for documentation to support eligibility.

2. 4 Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.

2 .5 Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

2.6 It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

3. Uninsured patients of MedStar Health's facilities may be eligible for charity care or sliding-scale financial assistance under this policy. The financial counselors and financial services staff will determine eligibility for charity care and sliding-scale financial assistance based on review of income for the patient and their family (household), other financial resources available to the patient's family, family size, and the extent of the medical costs to be incurred by the patient.

4. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

4.1 Federal Poverty Guidelines. Based on family income and family size, the percentage of the then-current Federal Poverty Level (FPL) for the patient will be calculated.

4.1.1 Free Care: Free Care will be available to uninsured patients in households between 0% and 200% of the FPL.

4.1.2 Reduced Cost-Care: Reduced Cost-Care will be available to uninsured patients in households between 200% and 400% of the FPL. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

4.1.3 Ineligibility. If this percentage exceeds 400% of the FPL, the patient will not be eligible for Free Care or Reduced-Cost Care assistance (unless determined eligible based on Medical Hardship criteria, as defined below).

4.2 Basis for Calculating Amounts Charged to Patients: Free Care or Reduced-Cost Care Sliding Scale Levels:

	Financial Assistance Level Free / Reduced-Cost Care	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services1**	**Washington Facilities and non-HSCRC Regulated Services**
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

4.3 **MedStar Health Washington DC Hospitals** will comply with IRS 501(r) requirements on limiting the amounts charged to uninsured patients seeking emergency and medically necessary care.

4.3.1 Amounts billed patients who qualify for financial assistance will be an average of the three best negotiated commercial rates.

4.3.2 MedStar Health will calculate the average of the three best negotiated commercial rates annually.

5. FINANCIAL ASSISTANCE: ADDITIONAL FACTORS USED TO DETERMINE ELIGIBILITY FOR MEDICAL ASSISTANCE: MEDICAL HARDSHIP.

5.1 MedStar Health will evaluate patients for Medical Hardship Financial Assistance if they exceed the 400% of the FPL and are deemed ineligible for Free Care or Reduced-Cost Care.
5.2 Medical Hardship is defined as medical debt, incurred by a household over a 12-month period, at the same hospital that exceeds 25% of the family household income.
5.3 MedStar Health will provide Reduced-Cost Care to patients with income below 500% of the FPL that, over a 12 month period, has incurred medical debt at the same hospital in excess of 25% of the patient's household income. Reduced Cost-Care will be available based on a sliding-scale as outlined below.
5.4 A patient receiving reduced-cost care for medical hardship and the patient's immediate family members shall receive/remain eligible for Reduced-Cost medically necessary care when seeking subsequent care for 12 months beginning on the date which the reduced-care was received. It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.
5.5 If a patient is eligible for both Free Care / Reduced-Cost Care, and Medical Hardship, the hospital will employ the more generous policy to the patient.
5.6 Medical Hardship Reduced-Care Sliding Scale Levels:

	Financial Assistance Level – Medical Hardship	
Adjusted Percentage of Poverty Level	**HSCRC-Regulated Services**	**Washington Facilities and non-HSCRC Regulated Services**
Less than 500%	**Not to Exceed 25% of Household Income**	**Not to Exceed 25% of Household Income**

6. METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE: INCOME AND ASSET DETERMINATION.

6.1 Patients may obtain an application for Financial Assistance Application:

6.1.1 On Hospital websites

6.1.2 From Hospital Patient Financial Counselor Advocates

6.1.3 By calling Patient Financial Services Customer Service

6.2 MedStar Health will evaluate the patient's financial resources (assets convertible to cash) by calculating a pro forma net worth **EXCLUDING**:

6.2.1 The first $150,000 in equity in the patient's principle residence

6.2.2 Funds invested in qualified pension and retirement plans where the IRS has granted preferential treatment

6.2.3 The first $10,000 in monetary assets e.g., bank account, stocks, CD, etc

6.3 MedStar Health will use the Maryland State Uniform Financial Assistance Application as the standard application for all MedStar Health Hospitals. MedStar Health will require the patient to supply all documents necessary to validate information to make eligibility determinations.
6.4 Financial assistance applications and support documentation will be applicable for determining program eligibility one (1) year from the application date. Additionally, MedStar will consider for eligibility all accounts (including bad debts) 6 months prior to the application date.

7. PRESUMPTIVE ELIGIBILTY

7.1 Patients already enrolled in certain means-tested programs are deemed eligible for free care on a presumptive basis. Programs eligible under the MedStar Health financial assistance program include, but may not be limited to:

7.1.1 Maryland Primary Adult Care Program (PAC)

7.1.2 Maryland Supplemental Nutritional Assistance Program (SNAP)
7.1.3 Maryland Temporary Cash Assistance (TCA)
7.1.4 Maryland State and Pharmacy Only Eligibility Recipients
7.1.5 DC Healthcare Alliance or other Non-Par Programs
7.2 Additional presumptively eligible categories will include with minimal documentation:
7.2.1 Homeless patients
7.2.2 Deceased patients with no known estate
7.2.3 Members of a recognized religious organization who have taken a vow of poverty
7.2.4 All patients based on other means test scoring campaigns
7.2.5 All secondary balances after primary Medicare insurance where patients meet income and asset eligibility tests
7.2.6 All spend-down amounts for eligible Medicaid patients.

8 MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS

8.1 In the event a patient is denied financial assistance, the patient will be provided the opportunity to appeal the MedStar Health denial determination.
8.2 Patients are required to submit a written appeal letter to the Director of Patient Financial Services with additional supportive documentation.
8.3 Appeal letters must be received within 30 days of the financial assistance denial determination.
8.4 Financial assistance appeals will be reviewed by a MedStar Health Appeals Team. Team members will include the Director of Patient Financial Services, Assistance Vice President of Patient Financial Services, and the hospital's Chief Financial Officer.
8.5 Denial reconsideration decisions will be communicated, in writing, within 30 business days from receipt of the appeal letter.
8.6 If the MedStar Health Appeals Panel upholds

9. PAYMENT PLANS

9.1 MedStar Health will make available interest-free payment plans to uninsured patients with income between 200% and 500% of the FPL.
9.2 Patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to meet these continuing responsibilities, the patient will become financially responsible for the original amount owed, less any payments made to date.

10 BAD DEBT RECONSIDERATIONS AND REFUNDS

10.1 In the event a patient who, within a two (2) year period after the date of service was found to be eligible for free care on that date of service, MedStar will initiate a review of the account(s) to determine the appropriateness for a patient refund for amounts collected exceeding $25.
10.2 It is the patient's responsibility to request an account review and provide the necessary supportive documentation to determine free care financial assistance eligibility.
10.3 If the patient failed to comply with requests for documentation, MedStar Health will document the patient's non-compliance. The patient will forfeit any claims to a patient refund or free care assistance.
10.4 If MedStar Health obtains a judgement or reported adverse information to a credit reporting agency for a patient that was later to be found eligible for free care, MedStar Health will seek to vacate the judgement or strike the adverse information.

Exceptions

1 PROGRAM EXCLUSION
MedStar Health's financial assistance program excludes the following:

1.1 Insured patients who may be "underinsured" (e.g. patient with high deductibles/coinsurance)
1.2 Patient seeking non-medically necessary services, including cosmetic procedures

1.3 Non-US Citizens,
1.3.1 Excluding individuals with permanent resident /resident alien status as defined by the Bureau of Citizenship and Immigration Services has issued a green card
1.4 Patients residing outside a hospital's defined zip code service area
1.4.1 Excluding patient referral between MedStar Health Network System
1.4.2 Excluding patients arriving for emergency treatment via land or air ambulance transport
1.4.3 Specialty services specific to each MedStar Health hospital and approved as a program exclusion
1.5 Patients that are non-compliant with enrollment processes for publicly –funded healthcare programs, charity care programs, and other forms of financial assistance

As stated above, patients to whom discounts, payment plans, or financial assistance are extended have continuing responsibilities to provide accurate and complete financial information. In the event a patient fails to meet these continuing responsibilities, the patient will become financially responsible for the original amount owed, less any payments made to date.

What Constitutes Non-Compliance
Actions or conduct by MedStar Health employee or contract employee in violate of this Policy.

Consequences of Non-Compliance
Violations of this Policy by any MedStar Health employee or contract employee may require the employee to undergo additional training and may subject the employee to disciplinary action, including, but not limited to, suspension, probation or termination of employment, as applicable.

Explanation And Details/Examples
N/A

Requirements And Guidelines For Implementing The Policy
N/A

Related Policies
N/A

Procedures Related To Policy
Admission and Registration
Financial Self Pay Screening
Billing and Collections
Bad Debt

Legal Reporting Requirements
HSCRC Reporting as required – Maryland Hospitals Only
Year End Financial Audit Reporting
IRS Reporting

Reference To Laws Or Regulations Of Outside Bodies
Maryland Senate Bill 328 Chapter 60 – Maryland Hospitals Only
COMAR 10.37.10 Rate Application and Approval Procedures – Maryland Hospitals Only
IRS Regulations Section 501(r)

Right To Change Or Terminate Policy
Any change to this Policy requires review and approval by the Legal Services Department.
Proposed changes to this Policy will be discussed with all affected parties at both the Business Unit and Corporate levels of the Organization.
The Corporation's policies are the purview of the Chief Executive Officer (CEO) and the CEO's management team
The CEO has final sign-off authority on all corporate policies.

Appendix IV

Hospital Patient Information Sheet

MedStar Good Samaritan Hospital 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 Good Samaritan Hospital 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 Good Samaritan Hospital 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 Good Samaritan Hospital 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.

Appendix V
Hospital's Mission Vision Values

MedStar Good Samaritan Hospital

Mission

MedStar Good Samaritan Hospital, 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.