COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

FY2017 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.

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

(A) A definition of the community served by the hospital facility and a description of how the community was determined;

(B) A description of the process and methods used to conduct the CHNA;

(C) A description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant; and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the CHNA; and

(F) An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).

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

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

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

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

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

HSCRC COMMUNITY BENEFIT REPORTING REQUIREMENTS

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. (For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12-month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

   a. Bed Designation – The total number of licensed beds
   b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
   c. Primary Service Area (PSA) zip codes;
   d. Listing of all other Maryland hospitals sharing your PSA;

e. The percentage of the hospital's uninsured patients by county. (Please provide the source for this data, e.g., "review of hospital discharge data");

f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data (e.g., "review of hospital discharge data.")

g. The percentage of the hospital's patients who are Medicare beneficiaries. (Please provide the source for this data (e.g., "review of hospital discharge data.")

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area zip codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of the Hospital's Patients who are Uninsured:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
206 Source: MGSH Finance Department	9,185 Source: MGSH Finance Department	21239 21234 21206 21212 21214 21218 Source: HSCRC PSA Report, 2017	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 Source: HSCRC Acute	Baltimore City 6.6% Baltimore County 2.8% OTHER 1.4% TOTAL 10.7% Source: MGSH Finance Department	25.9% Source: MGSH Finance Department	30.7% Source: MGSH Finance Department

			Hospital PSA Report, 2017			

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

   a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):

      (i) A list of the zip codes included in the organization's CBSA, and

      (ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.

      (iii) A description of how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, e.g., individuals with > 3 hospitalizations in the past year). This information may be copied directly from the community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Statistics may be accessed from:

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

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

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

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

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

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

Table II

Demographic Characteristic	Description	Source
Zip codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations (including but not necessarily limited to medically underserved, low-income, and minority populations) reside.	CBSA 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.	
Median Household Income within the CBSA	41,819 - Baltimore City 36,531 - Govans	2017 Neighborhood Health Profile https://health.baltimorecity.gov/sites/default/files/NHP%202017%20-%2020%20Greater%20Govans%20(rev%206-9-17).pdf
Percentage of households in the CBSA with household income below the federal poverty guidelines	28.8% -Baltimore City 30.5% - Govans	2017 Neighborhood Health Profile https://health.baltimorecity.gov/sites/default/files/NHP%202017%20-%2020%20Greater%20Govans%20(rev%206-9-17).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	11.7% Baltimore City 11.6% Govans	2017 Neighborhood Health Profile https://health.baltimorecity.gov/sites/default/files/NHP%202017%20-%2020%20Greater%20Govans%20(rev%206-9-17).pdf
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/Pages/Home.aspx	MD 2017 Ship Goal – 79.9 Baltimore City - 73.6 Govans - 73.3	2014 Maryland State's Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/Pages/home.aspx 2017 Neighborhood Health Profile https://health.baltimorecity.gov/sites/default/files/NHP%202017%20-%2020%20Greater%20Govans%20(rev%206-9-17).pdf
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/ship/Pages/home.aspx	Baltimore City (per 100,000 Residents) All Cause Mortality Rate – 99.5 All Cause Mortality Rate Govans – 105.2 Baltimore City Youth Mortality Rate – 31.3 Govans Youth Mortality Rate – 21.7	2017 Neighborhood Health Profile https://health.baltimorecity.gov/sites/default/files/NHP%202017%20-%2020%20Greater%20Govans%20(rev%206-9-17).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://ship.md.networkofcare.org/ph/county-indicators.aspx	The Hardship Index combines information from six socioeconomic indicators - housing, poverty, unemployment, education, income, and dependency. Estimates are presented for Greater Govans compared to Baltimore City overall. (The Index ranges from 100 =most hardship to 1= least hardship) Baltimore City – 51 Govans - 57 The percentage of land area that is covered by a food dessert in Govans is 36.2%, compared to Baltimore City overall which is 11.4% The percentage of kindergartners rated as demonstrating readiness to learn in composite scoring in Greater Govans compared to Baltimore City overall (in school year 2012-2013). The percentage of 3rd and 8th graders who are reading at "Proficient" or "Advanced" level in Greater Govans compared to Baltimore City overall (school year	2017 Neighborhood Health Profile https://health.baltimorecity.gov/sites/default/files/NHP%202017%20-%2020%20Greater%20Govans%20(rev%206-9-17).pdf

	2013-2014). Baltimore City – 77.6% Govans – 74.2% The number of lead paint violations per 10,000 households per year in Govans compared Baltimore City overall. Baltimore City -9.0 Govans - 10.1 The number of vacant lots per 10,000 housing units in Govans compared to Baltimore City overall Baltimore City -677.3 Govans - 700.9 The number of vacant buildings per 10,000 housing units in Greater Govans compared to Baltimore City overall. Baltimore City – 562.4 Govans – 358.9	
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://ship.md.networkofcare.org/ph/county-indicators.aspx	Total population – 10,762 Black or African American – 90.4% White – 6.4% Hispanic – 2.3% Two or more races – 2.6% Some Other Race – 0.3% 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.	2017 Neighborhood Health Profile https://health.baltimorecity.gov/sites/default/files/NHP%202017%20-%2020%20Greater%20Govans%20(rev%206-9-17).pdf

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

__X_Yes Provide date approved by the hospital's governing body or an authorized body thereof here: 3/3/2015

____No

If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).
https://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf?_ga=2.30139900.256144551.1507291018-20306325.1499272941 (Pg, 17-19)

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

_X_Yes Enter date approved by governing body/authorized body thereof here: 3/3/2015

___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?

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

_X_Yes
___No

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

MedStar Health's vision is to be the trusted leader in caring for people and advancing health. As part of MedStar Health's fiscal 2018-2020 system strategic plan (which acts as the umbrella plan for all MedStar hospitals), community health and community benefit initiatives and tactics are organized under the Evolving Care Delivery Model domain, with recognition of health disparities and an aim to integrate community health initiatives into the interdisciplinary model of care.

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

i. Senior Leadership

1. _X__CEO
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. _X__Physician
2. _X__Nurse
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

Medical Director (physician)-
Assures the delivery of quality care to clients seeking services.

Coordinator of Community Education & Health Ministries(nurse) -
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. Coordinates with local community groups, including churches, senior centers, and business associations, to create health programs focused on the elements of wellness.

iii. Population Health Leadership and Staff

1. __X__ Population health VP or equivalent (please list)
    a. Martin Binstock, Vice President Medical Affairs, MGSH
2. ____ Other population health staff (please list staff)

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

The Vice President of Medical Affairs is designated to serve as the Community Health Executive Sponsor to ensure community benefit processes and activities align with hospital's strategic priorities and population health efforts.

iv. Community Benefit Operations

1. _X__the Title of Individual(s) (please specify FTE)
    a. Community Health Hospital Lead (1FTE)

b. Finance Manager (1FTE)

2. ___Committee (please list members)
3. ___Department (please list staff)
4. _X__Task Force (please list members)

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

The Community Health 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 works collaboratively with representatives from the Corporate Community Health Department and Georgetown University. The Lead also works closely with the writer. He/she reviews all narratives prior to publication.

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

Advisory Task Force Members:

Name/Title	**Organization**
Brad Chambers	President, MGSH and MUMH
Martin Binstock	Vice President Medical Affairs, MGSH
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 Professor	Morgan State University, Department of Behavioral Health Sciences

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.

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

___X__Yes _____No

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

1. Chronic Disease Management

The main thrust of these investments has been to greatly expand, develop, and strengthen MedStar Good Samaritan outreach and engagement in community activities by developing partnerships with community stakeholders and organizations, engaging patients in their care, moving care from high-cost venues such as acute care hospitals and full-service Emergency Departments to the patient's community-based environment.

Initial efforts are focused on "high utilizers" of health care resources within our community, while working proactively to identify individuals who are at risk of becoming a high utilizer, and working to prevent that from occurring through our community outreach efforts. Recognizing the many social barriers to maintaining individual health make it imperative to develop collaborative working relationships with public, private, and faith based organizations to remove or mitigate the detrimental effects of those barriers.

Collaboration with other healthcare systems to meet the complex needs of our patients include Govans Ecumenical Development Corporation, Friendship Baptist Church

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)

__X___ Schools

_____ Behavioral health organizations

__X___Faith based community organizations

__X___Social service organizations

_____Post-acute care facilities

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

Organization	Name of Key Collaborator	Title	Collaboration Description
GEDCO/CARES Food Pantry/Emergency/Financial Assistance	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
GEDCO/Senior Network of North Baltimore	Gwen Lloyd	Director	Provides space and assists with promotion of health programs
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
Friendship Baptist Church	Denise Moore	Church Member/ Lay Leader for Stanford's Living Well Programs	Provided space and facilitate Living Well Program for church member and general community

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

_____yes __X__no

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

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

_____yes __X__no

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

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

a. 1. Identified need: This may have been identified through a CHNA, a documented request from a public health agency or community group, or other generally accepted practice for developing community benefit programs. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include a description of the collaborative process used to identify common priority areas and alignment with other public and private organizations.

2. Please indicate how the community's need for the initiative was identified.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based community health improvement initiatives may be found on the CDC's website using the following links: http://www.thecommunityguide.org/ or http://www.cdc.gov/chinav/), or from the County Health Rankings and Roadmaps website, here: http://tinyurl.com/mmea7nw.
(Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

c. Total number of people within the target population (how many people in the target area are affected by the particular disease or other negative health factor being addressed by the initiative)?

d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?

e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need,

f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)

g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposes of the collaboration.

h. Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.

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

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

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

(iii) The number of people served by the initiative.

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

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)

j. Continuation of Initiative:
What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? If not, why? What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:
A. what were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, and grants associated with the fiscal year being reported.
B. Of the total costs associated with the initiative, what amount, if any, was provided through a restricted grant or donation?

Initiative I – Heart Disease/Chronic Disease Prevention and Management – Stanford's Living Well with Chronic Disease Self-Management Program

A. 1. Identified Need A. 2. How was the need identified:	Heart Disease/Chronic Disease Prevention and Management. The need for chronic disease management programs was identified during the FY15 CHNA process. The Advisory Task Force members compiled BCHD data and survey responses from the local community and identified this need. MGSH and Friendship Baptist Church have had a longstanding partnership and share the goal of a healthy community. In FY17 two church members took Stanford's Living Well lay leader training under MedStar Health and the church is now a site to host the programs. Baltimore City Heart Disease: Age-adjusted Mortality Rate (Deaths per 10,000) 24.4%. Number one cause of death in Baltimore City in 2017. https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports BCHD released a report -- *Healthy Baltimore 2015* -- that summarized 55 neighborhood health profiles and identified CVD as a leading cause of death, with a 20-year life-expectancy gap between high-income and low-income neighborhoods. https://health.baltimorecity.gov/node/155 There is a Healthy Baltimore 2015 goal of increasing the percent of adults with high blood pressure on medication by 10%. Baltimore City's emergency department visit rate due to hypertension is 615/100,000 persons, compared to 265/100,000 for the state (MD SHIP, 2013). In 2014, the cardiovascular premature death rate (deaths before 75 years of age) among black residents was about 1.6 times that of white residents. https://health.baltimorecity.gov/sites/default/files/health/attachments/Baltimore%20City%20CHA%20-%20Final%209.20.17.pdf 35% (n=175) of responses from the 2015 MGSH Community Health Needs Assessment listed "Heart Disease" as a health condition they see most in their community.
B: Name of hospital initiative:	Stanford University's Living Well: Chronic Disease Self Management Program
C: Total number of people within target population:	Percentage of deaths in Baltimore City due to heart disease 24.4% Govans area 23.7% Source: 2017 Neighborhood Health Profiles (Baltimore City) http://health.baltimorecity.gov/neighborhood-health-profile-reports

D: Total number of people reached by the initiative:	11 persons served
E: Primary objective of initiative:	Seven week evidenced-based workshops with the goal of helping participants become better managers of their chronic disease (Improving heart health and managing hypertension). Topics include nutrition, exercise, medications, managing emotions, better communication, pain management, decision making and goal setting for better health
F: Single or multi-year plan:	Multi-year / 2007 - ongoing
G: Key collaborators in delivery:	MAC - Wendy Farthing Director of Evidence Based Integration CDSME/FALLS Friendship Baptist Church, local church –Denise Moore, lay leader/church member
H: Impact of hospital initiative:	2017 Neighborhood Health Profiles (Baltimore City) indicates a decrease in the % of deaths from heart disease. 2011 Report - Baltimore City % of deaths: 25.8%; Govans % of deaths: 25.7% 2017 Report - Baltimore City % of deaths: 24.4%; Govans % of deaths: 23.7%
I: Evaluation of outcome:	11 participants were screened for blood pressure, weight, BMI and body fat at the start of the program. Screenings were repeated for 7 participants on the last week of the workshop. 100% of participants had lower blood pressure readings 86% of participants had weight loss 7 participants filled out a survey on the last week Survey results 1. I have a better understanding of how to manage the symptoms of my health condition Strongly Agree – 6 Agree - 1 2. I learned how to set a goal and action plan and follow it. Strongly Agree - 7 3. I have more self-confidence in my ability to manage my health than I did before taking the workshop. Strongly Agree - 5 Agree - 2

	4. I feel more motivated to take care of my health since I took this workshop. Strongly Agree - 7	
J: Continuation of initiative	Yes – MedStar is working to training more community partners to expand this program	
K: Expense:	a. $994.00	b. N/A

Initiative II: Heart Disease - Community Blood Pressure Screening Program

A. 1. Identified Need:	Heart Disease There is a Healthy Baltimore 2015 goal of increasing the percent of adults with high blood pressure on medication by 10%. Baltimore City's emergency department visit rate due to hypertension is 615/100,000 persons, compared to 265/100,000 for the state (MD SHIP, 2013). MedStar Good Samaritan hospital partners with local senior centers and senior resident housing to provide monthly blood pressure screenings. Baltimore City Stroke: Age-adjusted Mortality Rate (Deaths per 10,000) 4.9%. https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports Baltimore City Heart Disease: Age-adjusted Mortality Rate (Deaths per 10,000) 24.4%. Number one cause of death in Baltimore City in 2017. https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports Heart disease is the No. 1 cause of death and stroke is the No. 3 cause of death in Baltimore City. https://health.baltimorecity.gov/node/155 In 2014, the cardiovascular premature death rate (deaths before 75 years of age) among black residents was about 1.6 times that of white residents. https://health.baltimorecity.gov/sites/default/files/health/attachments/Baltimore%20City%20CHA%20-%20Final%209.20.17.pdf In Maryland, 30% of all deaths were attributed to heart disease and stroke. Heart disease and stroke can be prevented by control of high blood pressure. Hypertension admission rate (per 100,000 beneficiaries) Maryland - Baltimore City http://ship.md.networkofcare.org/ph/indicator.aspx?id=2040 35% (n=175) of responses from the 2015 MGSH Community Health Needs Assessment listed "Heart Disease" as a health condition they see most in their community. **Need identified by: MedStar Good Samaritan Hospital Community Health Needs Assessment**
A. 2. How was the need identified:	
B: Name of hospital initiative:	Community Blood Pressure Screening Program
C: Total number of people within target population:	Baltimore City Stroke: Age-adjusted Mortality Rate (Deaths per 10,000) 4.9%. https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports

	Baltimore City Heart Disease: Age-adjusted Mortality Rate (Deaths per 10,000) 24.4%. Number one cause of death in Baltimore City in 2017. https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports	
D: Total number of people reached by the initiative:	247 blood pressure screenings	
E: Primary objective of initiative:	To identify undetected hypertension within the community and give appropriate educational information and referrals to health care providers. To refer people with diagnosed hypertension to their physician for follow-up if readings are elevated.	
F: Single or multi-year plan:	Multi-year / 2001-ongoing	
G: Key collaborators in delivery:	GEDCO/CARES – Rachael Neill, Director Hampden Family Center, Lisa Ginger, Director Seven Oaks Senior Center Walk Co-Op Senior Resident Building GBS Services – Local Business	
H: Impact of hospital initiative:	2017 Neighborhood Health Profiles (Baltimore City) indicates a decrease in the % of deaths from heart disease. 2011 Report - Baltimore City % of deaths: 25.8%; Govans % of deaths: 25.7% 2017 Report - Baltimore City % of deaths: 24.4%; Govans % of death: 23.7 % 2017 Neighborhood Health Profiles (Baltimore City) indicates an increase in the % of deaths from stroke. 2011 Report - Baltimore City % of deaths: 4%; Govans % of deaths: 5% 2017 Report - Baltimore City % of deaths: 4.9 %; Govans % of deaths: 6.8%	
I: Evaluation of outcome:	Total # of screenings - 247 Total # of participants referred to PCP who were not previously diagnosed with hypertension – Less than 5% -10 participants Participants who were previously diagnosed with hypertension and had an elevated reading were given health information and/or referred to their PCP – 23% - 57 participants	
J: Continuation of initiative	Yes –more emphasis to be placed on screenings for people who are participating in evidenced-based programs such as “Living Well :Chronic Disease Management Program”	
K: Expense:	a.$1,975	b. N/A

Initiative III: Heart Disease/Chronic Disease Prevention and Management - Senior Fitness Program

A. 1. Identified Need: A. 2. How was the need identified:	Heart Disease/Chronic Disease Prevention and Management. The need for chronic disease management programs was identified during the FY15 CHNA process. The Advisory Task Force members compiled BCHD data and survey responses from the local community and identified this need. MGSH and GEDCO's Senior Network of North Baltimore (SNNB) have had a longstanding partnership and share the goal of a healthy community. SNNB has been instrumental in promotion and providing space and participants for fitness programs. Baltimore City Heart Disease: Age-adjusted Mortality Rate (Deaths per 10,000) 24.4%. Number one cause of death in Baltimore City in 2017. https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports BCHD released a report -- *Healthy Baltimore 2015* -- that summarized 55 neighborhood health profiles and identified CVD as a leading cause of death, with a 20-year life-expectancy gap between high-income and low-income neighborhoods. https://health.baltimorecity.gov/node/155 In 2014, the cardiovascular premature death rate (deaths before 75 years of age) among black residents was about 1.6 times that of white residents. https://health.baltimorecity.gov/sites/default/files/health/attachments/Baltimore%20City%20CHA%20-%20Final%209.20.17.pdf 35% (n=175) of responses from the 2015 MGSH Community Health Needs Assessment listed "Heart Disease" as a health condition they see most in their community.
B: Name of hospital initiative	Senior Fitness Programs at SNNB
C: Total number of people within target population	Baltimore City Heart Disease: Age-adjusted Mortality Rate (Deaths per 10,000) 24.4%. Number one cause of death in Baltimore City in 2017. https://health.baltimorecity.gov/neighborhoods/neighborhood-health-profile-reports
D: Total number of people reached by the initiative	95 persons
E: Primary objective of initiative:	Improve health and fitness Weight management

F: Single or multi-year plan:	Multi- year /2003 - ongoing	
G: Key collaborators in delivery:	GEDCO - Nichole Battle- Executive Director Senior Network of North Baltimore - Gwen Lloyd, Director	
H: Impact of hospital initiative:	95 participants attending bi-weekly exercise programs that included aerobics, strengthening and stretching 23% of participants lost at least 3% of body weight	
I: Evaluation of outcome	2017 Neighborhood Health Profiles (Baltimore City) indicates a decrease in the % of deaths from heart disease. 2011 Report - Baltimore City % of deaths: 25.8%; Govans % of deaths: 25.7% 2017 Report - Baltimore City % of deaths: 24.4%; Govans % of deaths: 23.7%	
J: Continuation of initiative:	Yes	
K: Expense:	a. $11,335	b. N/A

Initiative IV: Diabetes Prevention - Life Balance/Weight Management (National Diabetes Prevention Program)

A. 1. Identified Need A. 2. How was the need identified:	Diabetes Prevention 86 million Americans have prediabetes –only 9 million of the 86 million people with prediabetes know they have it. 15% to 30% of those people with prediabetes will develop type 2 diabetes within 5 years. Type 2 diabetes can be prevented if caught in the stage of prediabetes. By developing and maintaining healthy lifestyle changes prediabetes can be reversed. Type 2 diabetes is the most common form of diabetes. Currently, diabetes affects more than 29 million people. Prediabetes may be reversible, but diabetes has no cure, so it is that much more important to address this potentially life altering disease as early as possible. Obesity is a risk factor for diabetes. Diabetes and hypertension are two of the leading indicators within this priority area that contributes to heart disease, the leading cause of death in Baltimore City. http://health.baltimorecity.gov/sites/default/files/HealthyBaltimore2015_Final_Web.pdf **Need identified by: MedStar Good Samaritan Hospital Community Health Needs Assessment**
B: Name of hospital initiative	Life Balance/Weight Management (National Diabetes Prevention Program)
C: Total number of people within target population	2017 Neighborhood Health Profiles –deaths from diabetes(Baltimore City) 2017 Report - Baltimore City % of deaths 3.0% Govans % of death 2.8% Obesity Rate for adults over 18 in Maryland 27.7% http://ship.md.networkofcare.org/ph/county-health-ranking-detail.aspx?id=15&c=8 Adult Obesity Rate for adults over 18 in Baltimore 33.6% https://www.opendatanetwork.com/entity/0500000US24510/Baltimore_city_MD/health.health_behaviors.adult_smoking_value?year=2015

D: Total number of people reached by the initiative	28 participants
E: Primary objective of initiative:	A CDC-recognized lifestyle change program developed specifically to prevent type 2 diabetes. It is designed for people who have prediabetes or are at risk for type 2 diabetes. A trained lifestyle coach leads the program to help individuals change certain aspects of their lifestyle, like eating healthier, reducing stress, and getting more physical activity. The program also includes group support from others who share the same goals and struggles. This is a year-long program focused on long-term changes and lasting results. Goals: 1. Lose 5%-& 7% of body weight 2. Exercise for at least 150 minutes per week
F: Single or multi-year plan:	Multi-year (2015- ongoing)
G: Key collaborators in delivery:	Center for Chronic Disease Prevention and Control DHMH Prevention and Health Promotion Administration Sue Vaeth, Diabetes Program Coordinator GEDCO/Senior Network of North Baltimore - Gwen Lloyd, Director
H: Impact of hospital initiative:	MedStar Good Samaritan Hospital location, dates January 2017 – December 2017 Total # participants that started - 12 Total # completing the program - 10 Total with at least 5% body weight loss - 4 Total with at least 150 minutes of exercise - 9 Senior Network of North Baltimore location, dates May 2017 – May 2017 Total # participants that started - 26 Total # completing the program - 18 Total with at least 5%-7% body weight loss- 6 Total with at least 150 minutes of exercise - 15
I: Evaluation of outcome	2017 Neighborhood Health Profiles (Baltimore City) indicates a slight decrease in the % of deaths from diabetes.

	2011 Report - Baltimore City % of deaths 3.2.% Govans % of death 2.9% 2017 Report - Baltimore City % of deaths 3.0% Govans % of death 2.8%	
J: Continuation of initiative:	Yes	
K: Expense:	a. $13,003	b. 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: the fact that another nearby hospital is focusing on that identified community need, or that the hospital does not have adequate resources to address it.) This information may be copied directly from the section of the CHNA that refers to community health needs identified but unmet.

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 2017 Baltimore City Neighborhood Health Profiles.		Baltimore City Planning Department, Baltimore City Liquor License Board, Maryland Department of Health and Mental Hygiene

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

   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.

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.

   - 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**
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.
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.
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.

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Financial Assistance Policy (FAP):

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

      For ***example***, state whether the hospital:

      - Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
        - in a culturally sensitive manner,
        - at a reading comprehension level appropriate to the CBSA's population, and
        - in non-English languages that are prevalent in the CBSA.
      - Posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
      - Provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
      - Provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
      - Includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills;
      - Besides English, in what language(s) is the Patient Information sheet available;
      - Discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

   b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).

   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
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

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.

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