COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2015 Community Benefit Reporting

Health Services Cost Review Commission  
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**BACKGROUND**

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

The Commission’s response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others’ community benefit reporting experience, and was then tailored to fit Maryland’s unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (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 hitting aggressive quality targets, this model must 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, 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 reporting 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 (“LHIC’s)[see: [http://dhmh.maryland.gov/healthenterprisezones/Documents/Local\_Population\_Health Improvement\_Contacts\_4-26-12.pdf](http://dhmh.maryland.gov/healthenterprisezones/Documents/Local_Population_Health%20Improvement_Contacts_4-26-12.pdf)] 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. SHIP’s CountyHealth Profiles 2012 (<http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx>);
3. the Maryland ChartBook of Minority Health and Minority Health Disparities (<http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf>);
4. Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
5. Local Health Departments;
6. County Health Rankings ( <http://www.countyhealthrankings.org>);
7. Healthy Communities Network (<http://www.healthycommunitiesinstitute.com/index.html>);
8. Health Plan ratings from MHCC (<http://mhcc.maryland.gov/hmo>);
9. Healthy People 2020 (<http://www.cdc.gov/nchs/healthy_people/hp2010.htm>);
10. Behavioral Risk Factor Surveillance System (<http://www.cdc.gov/BRFSS>);
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.

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.

**Reporting Requirements**

1. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:
2. 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).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Bed Designation: | Inpatient Admissions: | Primary Service Area Zip Codes: | All other Maryland Hospitals Sharing Primary Service Area: | Percentage of Uninsured Patients, by County: | Percentage of Patients who are Medicaid Recipients, by County: |
|  |  |  |  |  |  |

Table I

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

a. Describe in detail the community or communities the organization serves. Based on findings from the CHNA, provide a list of the Community Benefit Service Area (CBSA) zip codes. These CBSA zip codes should reflect the geographic areas where the most vulnerable populations reside. Describe how the CBSA was determined, (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 section of the CHNA that refers to the description of the Hospital’s Community Benefit Community.

b. In Table II, describe the population within the CBSA, including significant demographic characteristics and social determinants that are relevant to the needs of the community and ***include the source of the information in each response***. For purposes of this section, social determinants are factors that contribute to a person’s current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, transportation, education and healthy environment, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Some statistics may be accessed from the Maryland State Health Improvement Process, (<http://dhmh.maryland.gov/ship/>) and its Area Health Profiles 2013, (<http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx>), 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>)

Table II

|  |  |
| --- | --- |
| Median Household Income within the CBSA |  |
| Percentage of households with incomes below the federal poverty guidelines within the CBSA |  |
| Please estimate the percentage of uninsured people by County within the CBSA 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> |  |
| Percentage of Medicaid recipients by County within the CBSA. |  |
| 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> |  |
| Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). |  |
| 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> |  |
| 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> |  |
| Other |  |

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

\_\_\_\_Yes

\_\_\_\_No

Provide date here. \_\_/\_\_ /\_\_ (mm/dd/yy)

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).

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

\_\_\_Yes \_\_/ \_\_/\_\_ (mm/dd/yy) Enter date approved by governing body here:

\_\_\_No

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

1. 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,)**

* 1. Is Community Benefits planning part of your hospital’s strategic plan?

\_\_\_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.

* 1. 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)
     1. Senior Leadership  
        1. \_\_\_CEO
        2. \_\_\_CFO

3. \_\_\_Other (please specify)

Describe the role of Senior Leadership.

* + 1. Clinical Leadership  
       1. \_\_\_Physician
       2. \_\_\_Nurse
       3. \_\_\_Social Worker
       4. \_\_\_Other (please specify)

Describe the role of Clinical Leadership

* + 1. Community Benefit Operations  
       1. \_\_\_Individual (please specify FTE)
       2. \_\_\_Committee (please list members)
       3. \_\_\_Department (please list staff)
       4. \_\_\_Task Force (please list members)
       5. \_\_\_Other (please describe)

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

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

Spreadsheet \_\_\_\_\_yes \_\_\_\_\_no

Narrative \_\_\_\_\_yes \_\_\_\_\_no

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

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

Spreadsheet \_\_\_\_\_yes \_\_\_\_\_no

Narrative \_\_\_\_\_yes \_\_\_\_\_no

If no, please explain why.

1. 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.

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

\_\_\_\_\_ Other hospital organizations

\_\_\_\_\_ Local Health Department

\_\_\_\_\_ Local health improvement coalitions (LHICs)

\_\_\_\_\_ Schools

\_\_\_\_\_ Behavioral health organizations

\_\_\_\_\_ Faith based community organizations

\_\_\_\_\_ 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 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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 \_\_\_\_\_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 \_\_\_\_\_no

1. 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:

* 1. 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.
  2. 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 link: <http://www.thecommunityguide.org/> )  
     (Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: [www.guideline.gov/index.aspx](http://www.guideline.gov/index.aspx) )
  3. 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)?
  4. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?
  5. 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.
  6. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?
  7. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.
  8. 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.

* 1. 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.
  2. 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?
  3. 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?

1. 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.
2. 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)  
     
   STATE INNOVATION MODEL (SIM) <http://hsia.dhmh.maryland.gov/SitePages/sim.aspx>  
   MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) <http://dhmh.maryland.gov/ship/SitePages/Home.aspx>  
   HEALTH CARE INNOVATIONS IN MARYLAND  
   <http://www.dhmh.maryland.gov/innovations/SitePages/Home.aspx>  
   MARYLAND ALL-PAYER MODEL <http://innovation.cms.gov/initiatives/Maryland-All-Payer-Model/>  
   COMMUNITY HEALTH RESOURCES COMMISSION <http://dhmh.maryland.gov/mchrc/sitepages/home.aspx>
3. PHYSICIANS

1. As required under HG§19-303, provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.
2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please 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.
3. APPENDICES

***To Be Attached as Appendices***:

1. Describe your Financial Assistance Policy (FAP):
   1. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital’s FAP. (label appendix I)

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

* Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
  + in a culturally sensitive manner,
  + at a reading comprehension level appropriate to the CBSA’s population, and
  + in non-English languages that are prevalent in the CBSA.
* posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
* provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
* provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
* includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
* discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.
  1. 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).
  2. Include a copy of your hospital’s FAP (label appendix III).
  3. 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).

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

Attachment A

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

* Increase life expectancy
* 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
* 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 the % of children who are considered obese
* Increase the % of adults who are at a healthy weight
* Reduce hospital ED visits from asthma
* Reduce hospital ED visits related to behavioral health
* Reduce Fall-related death rate