



UNIVERSITY *of* MARYLAND  
MEDICAL CENTER

**Community Benefit Report**

**Fiscal Year 2016**

Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore MD 21215

## **BACKGROUND**

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

The Commission's response to its mandate to oversee the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet were guided, in part, by the VHA, CHA, and others' community benefit reporting experience, and was then tailored to fit Maryland's unique regulatory environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

On January 10, 2014, the Center for Medicare and Medicaid Innovation (CMMI) announced its approval of Maryland's historic and groundbreaking proposal to modernize Maryland's all-payer hospital payment system. The model shifts from traditional fee-for-service (FFS) payment towards global budgets and ties growth in per capita hospital spending to growth in the state's overall economy. In addition to meeting aggressive quality targets, the Model requires the State to save at least \$330 million in Medicare spending over the next five years. The HSCRC will monitor progress overtime by measuring quality, patient experience, and cost. In addition, measures of overall population health from the State Health Improvement Process (SHIP) measures will also be monitored (see Attachment A).

To succeed in this new environment, hospital organizations will need to work in collaboration with other hospital and community based organizations to increase the impact of their efforts in the communities they serve. It is essential that hospital organizations work with community partners to identify and agree upon the top priority areas, and establish common outcome measures to evaluate the impact of these collaborative initiatives. Alignment of the community benefit operations, activities, and investments with these larger delivery reform efforts such as the Maryland all-payer model will support the overall efforts to improve population health and lower cost throughout the system.

For the purposes of this report, and as provided in the Patient Protection and Affordable Care Act ("ACA"), the IRS defines a CHNA as a:

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

The written document (CHNA), as provided in the ACA, must include the following:

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

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

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions (LHICs) schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input, who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

A prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs; and

A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

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

- (1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(<http://dhmh.maryland.gov/ship/>);
- (2) the Maryland ChartBook of Minority Health and Minority Health Disparities ([http://dhmh.maryland.gov/mhhd/Documents/2ndResource\\_2009.pdf](http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf));
- (3) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
- (4) Local Health Departments;
- (5) County Health Rankings ( <http://www.countyhealthrankings.org>);
- (6) Healthy Communities Network (<http://www.healthycommunitiesinstitute.com/index.html>);
- (7) Health Plan ratings from MHCC (<http://mhcc.maryland.gov/hmo>);
- (8) Healthy People 2020 ([http://www.cdc.gov/nchs/healthy\\_people/hp2010.htm](http://www.cdc.gov/nchs/healthy_people/hp2010.htm));
- (9) CDC Behavioral Risk Factor Surveillance System (<http://www.cdc.gov/BRFSS>);

- (10) CDC Community Health Status Indicators (<http://wwwn.cdc.gov/communityhealth>)
- (11) Youth Risk Behavior Survey (<http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx>)
- (12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
- (13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
- (14) Survey of community residents; and
- (15) Use of data or statistics compiled by county, state, or federal governments such as Community Health Improvement Navigator (<http://www.cdc.gov/chinav/>)
- (16) CRISP Reporting Services

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

The IMPLEMENTATION STRATEGY, as provided in the ACA, must:

- a. Be approved by an authorized governing body of the hospital organization;
- b. Describe how the hospital facility plans to meet the health need, such as how they will collaborate with other hospitals with common or shared CBSAs and other community organizations and groups (including how roles and responsibilities are defined within the collaborations); and
- c. Identify the health need as one the hospital facility does not intend to meet and explain why it does not intend to meet the health need.

### **HSCRC Community Benefit Reporting Requirements**

#### **I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:**

- 1. Please list the following information in Table I below. (For the purposes of this section, “primary services area” means the Maryland postal ZIP code areas from which the first 60 percent of a hospital’s patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).
  - a. Bed Designation – The number of licensed Beds;
  - b. Inpatient Admissions: The number of inpatient admissions for the FY being reported;
  - c. Primary Service Area Zip Codes;
  - d. List all other Maryland hospitals sharing your primary service area;

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

Table I

a. Bed Designation:	b. Inpatient Admissions:  (FY2016)	c. Primary Service Area Zip Codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of Hospital's Uninsured Patients:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
UMMC University Campus  750 Beds	28,864	21217, 21223, 21229, 21216, 21201, 21215, 21230, 21225, 21218, 21061, 21207, 21122, 21213, 21206, 21228, 21227, 21234, 21202, 21222, 21060, 21224, 21244, 21212, 21117, 21014, 21040, 21144, 21740, 21784, 21001, 21133, 21221, 21208, 21601, 21157, 21236,	Meritus Medical Center  UM Harford Memorial  UM SJMC  Mercy  Johns Hopkins  St. Agnes  Sinai  Bon Secours  Franklin Square  Anne Arundel  Union Memorial  Hopkins Bayview  Union of Cecil  Carroll County  Harbor Hospital  UM SMC at Easton  UMMC Midtown	1%	37%	32%

	21009, 21220, 21239, 21043, 21205, 21078, 21136, 21015, 21044, 21214, 21231	Northwest UM BWMC GBMC Howard County General UM Upper Chesapeake UM Rehab & Ortho Good Samaritan Levindale Hebrew Geriatric			
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2. For purposes of reporting on your community benefit activities, please provide the following information:

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

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

(ii) An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations reside.

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

Some statistics may be accessed from the Maryland State Health Improvement Process, (<http://dhmh.maryland.gov/ship/>). the Maryland Vital Statistics Administration (<http://dhmh.maryland.gov/vsa/SitePages/reports.aspx>), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014)([http://dhmh.maryland.gov/mhhd/Documents/Maryland\\_Health\\_Disparities\\_Plan\\_of\\_Action\\_6.10.10.pdf](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, 2<sup>nd</sup> Edition (<http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf>), The Maryland State Department of Education (The Maryland Report Card)

(<http://www.mdreportcard.org>) Direct link to data–  
(<http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA>)  
Community Health Status Indicators (<http://wwwn.cdc.gov/communityhealth>)

Table II

Demographic Characteristic	Description	Source
Zip Codes included in the organization’s CBSA, indicating which include geographic areas where the most vulnerable populations reside.	21201, 21215, 21216, 21217, 21218, 21223, 21229, 21230  (Vulnerable population defined as ZIP Codes containing census tract with 20% population below poverty level and 25% population less than high school education)	American Community Survey, 2010-2014, 5-Year Estimates data from <a href="http://assessment.communitycommons.org/Footprint/">http://assessment.communitycommons.org/Footprint/</a>
Median Household Income within the CBSA	<b>CBSA</b> \$ 49,766 Within some neighborhoods, the median income is as low as \$13,700	American Community Survey, 2010-2014, 5-Year Estimates, U.S. Census Bureau
Percentage of households with incomes below the federal poverty guidelines within the CBSA	<b>CBSA</b> 23%	American Community Survey, 2010-2014, 5-Year Estimates, U.S. Census Bureau
For the counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: <a href="http://www.census.gov/hhes/www/hlthins/data/acs/aff.html">http://www.census.gov/hhes/www/hlthins/data/acs/aff.html</a> ; <a href="http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml">http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml</a>	<b>Baltimore City</b> 8.5%	American Community Survey, 2010-2014, 1-Year Estimates, U.S. Census Bureau
Percentage of Medicaid recipients by County within the CBSA.	<b>Baltimore City</b> 32.4 %	American Community Survey, 2014, 1-Year Estimates, U.S. Census Bureau
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: <a href="http://dhmh.maryland.gov/ship/SitePages/Home.aspx">http://dhmh.maryland.gov/ship/SitePages/Home.aspx</a> and county profiles: <a href="http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx">http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx</a>	<b>Baltimore City</b> All races/ethnicity:74.1 years White: 76.8 years Black: 72.3 years	Maryland Vital Statistics Annual Report, 2014

<p>Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).</p>	<p><b>Baltimore City</b> 978.5 per 100,000 population (age-adjusted)</p> <p>Crude Death Rates by Race and Ethnicity: White: 930 per 100,000 population Black: 1042.3 per 100,000 population Asian: 208.8 per 100,000 population Hispanic: 142.6 per 100,000 population</p>	<p>Maryland Vital Statistics Annual Report, 2014</p>
<p>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)</p> <p>See SHIP website for social and physical environmental data and county profiles for primary service area information: <a href="http://dhmh.maryland.gov/ship/SitePages/measures.aspx">http://dhmh.maryland.gov/ship/SitePages/measures.aspx</a></p>	<p><b>Baltimore City</b></p> <p>% Households with Severe Problems<sup>1</sup>: 24% % Food Insecure: 23% % Adult Smokers: 21% Violent crime per 100,000 population: 1,449 % Unemployed: 13.9% % Less than High School Education (age 25 and over) : 19.1% % Without vehicle (age 16 and over): 16.1%</p>	<p><sup>1</sup>Comprehensive Housing Affordability Strategy (CHAS), 2013 data from <a href="http://www.countyhealthrankings.org/">http://www.countyhealthrankings.org/</a></p> <p>USDA Food Environment Atlas, Map the Meal Gap from Feeding America data from <a href="http://www.countyhealthrankings.org/">http://www.countyhealthrankings.org/</a></p> <p>Behavioral Risk Factor Surveillance System data from <a href="http://www.countyhealthrankings.org/">http://www.countyhealthrankings.org/</a></p> <p>American Community Survey, 2010-2014, 5-Year Estimates, U.S. Census Bureau</p>
<p>Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. <a href="http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx">http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx</a></p>	<p><b>CBSA</b></p> <p>Total population: 351,643 <i>White: 22%</i> <i>Black or African American: 70%</i> <i>Asian: 2%</i> <i>Hispanic, Any Race: 3%</i> <i>Others: 3%</i></p> <p>Total housing units: 171,074</p> <p>Language Spoken: <i>English: 93%</i> <i>Spanish or Spanish Creole: 3%</i> <i>Indo-European languages: 2%</i> <i>Asian and Pacific Island languages: 2%</i> <i>Other languages: 1%</i></p>	<p>American Community Survey, 2010-2014, 5-Year Estimates, U.S. Census Bureau</p>

Other Infant Mortality Rate	<b>Baltimore City</b> All races/ethnicity: 10.4 per 1,000 live births White: 7.0 per 1,000 live births Black: 12.8 per 1,000 live births Hispanic: 7.6 per 1,000 live births	Maryland Vital Statistics Annual Report, 2014
Diabetes Prevalence	Baltimore City: 13%	CDC Diabetes Interactive Atlas data from <a href="http://www.countyhealthrankings.org/">http://www.countyhealthrankings.org/</a>

**Additional Disparity Information for Baltimore and Targeted CBSA**

County Ranking (Out of 24 Counties in Maryland, including Baltimore City)*								
	Health Outcomes	Length of Life	Quality of Life	Health Factors	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Baltimore City	24	24	24	24	24	21	24	10

\*Ranking key - Lower is worse

Source – Robert Wood Johnson Foundation, County Health Rankings, 2016

<http://www.countyhealthrankings.org/app/maryland/2016/rankings/baltimore-city/county/outcomes/overall/snapshot>

As evident in the Table above using the County Health Rankings, Baltimore is the lowest ranked area in Maryland in 6 out of 8 categories. Within the City of Baltimore, there are further health disparities. In the following Life Expectancy Map, there is a 20 year difference in the life expectancy between many of the CBSA targeted zips (Southwest Baltimore, Upton, Pimlico, Poppleton, etc.) and other zips which include Roland Park. In some areas of targeted CBSA, the life expectancy is equivalent to the life expectancy in Nepal and India. Many social determinants (i.e. literacy, poverty, food deserts, unsafe environments, and violence to name a few) have a large impact on the overall health outcomes in these communities. The Medical Center has initiatives (as seen later in Table 3) addressing all of these above social determinants in an effort to positively impact the health outcomes in the targeted CBSA.

## Baltimore City Life Expectancy Map

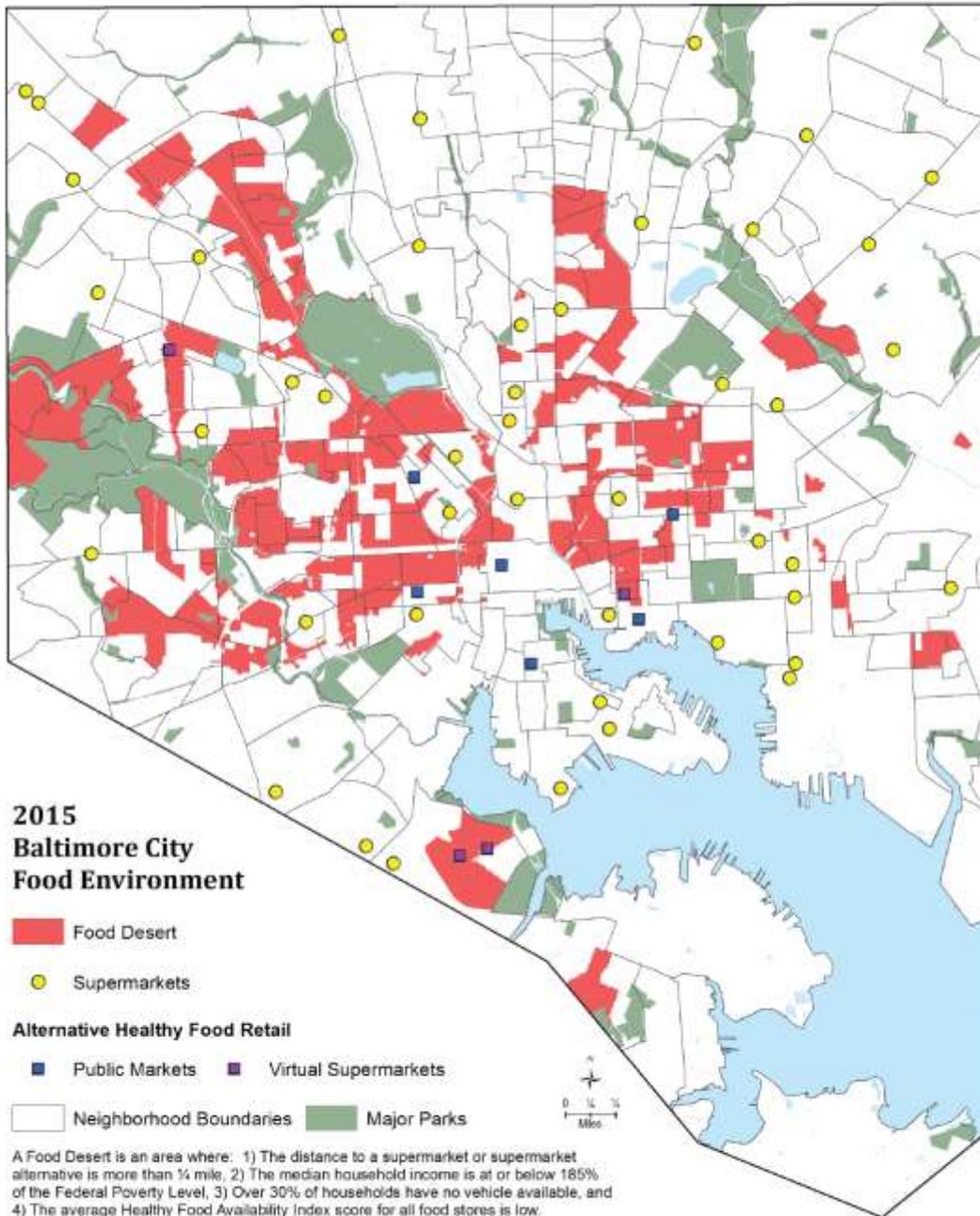


Prepared by the Baltimore City Health Department.  
2013 Life Expectancy data provided by DHMH's Vital Statistics Administration.

<http://khn.org/news/map-in-poor-baltimore-neighborhoods-life-expectancy-similar-to-developing-countries/>

# Food Environment Map of Baltimore

## #BmoreFoodMap



As seen above targeted CBSAs are in identified food deserts

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

Yes  
 No

Provide date here. **6/18/15** (mm/dd/yy) – **Date approved by Governing Body**

If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).

<http://umm.edu/~media/umm/pdfs/about-us/community-outreach/ummc-chna-executive-report-fy2015.pdf?la=en>

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

Yes **6/18/15** (mm/dd/yy) Enter date approved by governing body here: **Date approved by Governing Body**  
 No

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

<http://umm.edu/~media/umm/pdfs/about-us/community-outreach/ummc-chna-executive-report-fy2015.pdf?la=en>

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital? **(Please note: these are no longer check the blank questions only. A narrative portion is now required for each section of question b.)**

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

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.

Elements of the CHNA are integrated into the Strategic Plan within the following sections - Environmental Assumptions, Strategic Plan Guiding Principles, which lead to the Strategic Goals and Strategies. Specifically, the community benefit planning and findings of the CHNA are embedded within the Population Health Strategy to.....”implement evidence-based community interventions targeting the West Baltimore community, to improve the

health status of primary service residents”. This Strategic Plan covers both campuses – University of Maryland Medical Center and UMMC Midtown Campus.

The Strategic Plan supports our Mission, and the Community Health Improvement initiatives outlined in this document support the one of the key strategies of Stewardship & Community Engagement.

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

i. Senior Leadership

1.  CEO
2.  CFO
3.  Other (please specify) Senior Vice President, Strategy, Community & Business Development

Describe the role of Senior Leadership.

- Provides strategic oversight and leadership for community health improvement
- Translates connections to population health initiatives
- Provides contacts to external partners and academic organizations
- Advises Director and CHI Team on strategic direction and planning
- Executive sponsor/link to the Board of Directors

ii. Clinical Leadership

1.  Physician
2.  Nurse
3.  Social Worker
4.  Other (please specify)

Describe the role of Clinical Leadership

- Provides clinical knowledge/context for needs assessment and programming
- Develops/approves protocols for health screenings
- Provides oversight to health screenings program
- Insures regulatory compliance
- Collaborates with UMB Professional Schools (Medicine, Nursing, Social Work)

iii. Population Health Leadership and Staff

1.  Population health VP or equivalent (please list) Dr. Charles Callahan, Vice President, Population Health
2.  Other population health staff (please list staff)

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

- Leads organization with value-based care and population health initiatives
  - Works with medical staff to reduce PAUs and readmissions, works with new Coordinated Care Center for high utilizer patients to prevent readmissions
- Partners with the University of Maryland School of Medicine
- Partners with the University of Maryland Baltimore Campus

iv. Community Benefit Operations

1.  Individual (please specify 3.5 FTEs)
2.  Committee (please list members)
3.  Department (please list staff)
4.  Task Force (please list members)
5.  Other (please describe)

Anne D. Williams, DNP, RN – Director, Community Health Improvement  
Mariellen Synan – Community Outreach Manager  
Asunta Henry, BS – Community Health Advocate  
Lauren Davis, BA – Administrative Coordinator (.5 FTE)

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

Anne Williams, Director – Leads CHNA process and CB reporting process; Collaborates with numerous internal departments and Finance to produce annual reports/filings; Prepares Board summary

Mariellen Synan, Manager – Manages day-day operations and programming of community health improvement initiatives; Data entry into CBSA

Asunta Henry, CH Advocate – Manages Hypertension program and assists Manager with community events, Data entry into CBSA

Lauren Davis, Administrative Coordinator – Data entry into CBSA, Assists with event scheduling

c. 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?)

After completion, the Narrative is reviewed by the UMMS Director, Community Health Improvement, and UMMC Senior VP of Strategy, Community & Business Development. After their approval, it is then reviewed by the UMMS SVP for Government & Regulatory Affairs. After completion, the Spreadsheet is reviewed by the UMMS Director, Community Health Improvement, UMMC Senior VP of

Strategy, Community & Business Development, and UMMS SVP for Government & Regulatory Affairs, and the UMMS Vice President of Reimbursement & Revenue. A high level overview of both reports are reviewed and approved at the UMMC Community Benefits Committee of the Board at a meeting in early December.

- d. 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.

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:

- 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
<b>University of Maryland Medical</b>	<b>Don Ray</b>	<b>Vice President, Operations</b>	<b>Strategic Leadership</b>

<b>Center – Midtown Campus</b>	<b>Multiple other staff</b>	<b>Mgr, Supervisor, Clinical Nutritionist</b>	<b>Members of joint CHI Team</b>
<b>University of Maryland Medical System</b>	<b>Donna Jacobs</b>	<b>Senior Vice President</b>	<b>Hosted community partner focus group</b>
<b>University of Maryland – Professional Schools</b>	<b>Dr. Russell Lewis, Dr. Pat Maclaine Bronwyn Mayden</b>	<b>School of Medicine School of Nursing School of Social Work</b>	<b>Attended strategic retreat; Provided insight into UMB comm. initiatives</b>
<b>Mt Washington Pediatric Hospital</b>	<b>Melissa Beasley</b>	<b>Community Outreach Coordinator</b>	<b>Co-hosted community partner focus group; Attended strategic retreat</b>
<b>Mt Washington Pediatric Hospital</b>	<b>Melissa Beasley</b>	<b>Community Outreach Coordinator</b>	<b>Co-hosted community partner focus group; Attended strategic retreat</b>
<b>Baltimore City Health Dept</b>	<b>Laura Fox</b>	<b>Director, Chronic Disease Prevention</b>	<b>Provided City’s &amp; Mayor’s health priorities</b>
<b>University of Maryland Baltimore</b>	<b>Ashley Valis</b>	<b>Director, Community Initiatives</b>	<b>Attended strategic retreat; Provided insight into UMB community initiatives</b>
<b>Union Baptist Church</b>	<b>Rev. Dr. Al Hathaway</b>	<b>Senior Pastor</b>	<b>Provided input re: community faith leaders’ perspectives on community health priorities</b>

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

Donna Jacobs, Senior Vice President, UMMS attends the new meetings on behalf of all of the Baltimore-based hospitals

## V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

- a. 1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.  
2. Please indicate whether the need was identified through the most recent CHNA process.
- b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following links: <http://www.thecommunityguide.org/> or <http://www.cdc.gov/chinav/>)  
(Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: [www.guideline.gov/index.aspx](http://www.guideline.gov/index.aspx) )
- c. Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?
- d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?

- e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results.
  - f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)
  - g. Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.
  - h. Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.
    - What were the measurable results of the initiative?
    - For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.
  - i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas. These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.
  - j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?
  - k. Expense:
    - A. what were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
    - B. of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?
2. Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples include other social issues related to health status, such as unemployment, illiteracy, the fact that another nearby hospital is focusing on an identified community need, or lack of resources related to prioritization and planning.) This information may be copied directly from the CHNA that refers to community health needs identified but unmet.

Analysis of all quantitative and qualitative data during the CHNA FY15 process identified the following top five areas of need within Baltimore City. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths

and mission. These priorities (listed in priority order) were identified and approved by the UMMC/Midtown CHI Team and validated with the health experts from the UMB Campus Panel:

- 1. Cardiovascular Disease**
- 2. Workforce Development (as a shared component of literacy and SDoH)**
- 3. Maternal & Child Health**
- 4. Violence Prevention (related to behavioral/mental health)**
  - **Health Literacy (shared UMMS priority)**

Several additional topic areas were identified by the Community Health Improvement Team during the CHNA process including: Behavioral/mental health, safe housing, transportation, and substance abuse. While UMMC & Midtown Campuses will focus the majority of our efforts on the identified strategic priorities outlined earlier, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through either existing clinical programs (i.e. Methadone clinics, Residential Psychiatric program) or through collaboration with other health care organizations as needed (Baltimore City Health Department, Johns Hopkins, Medstar, St Agnes, Mercy, and others for health literacy and other issues). Additionally, substance abuse programming is already integrated into either existing clinical programs or community health programs, like – Stork’s Nest and Violence Prevention programs. The additional unmet needs not addressed by UMMC/Midtown will also continue to be addressed by key Baltimore City governmental agencies and existing community-based organizations.

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)

The Population Health Strategy and Implementation Plan was finalized and submitted to the State on 12/7/15. This plan covers both the University of Maryland Medical Center and Midtown Campuses. The Community Health Needs Assessments and Community Benefits Reports are integrated into the Plan to provide a context of the community for planning purposes. Two of the five goals within the plan directly reflect the work already conducted by the Community Benefits Team. The two goals which are most closely linked to current community health improvement work are:

Goal 2: Improve patient outcomes and quality of care for patients suffering from chronic disease

Goal 3: Promote health and well-being through enhanced screening, prevention and health promotion

Initiatives specifically for high utilizers were started in FY16. Additionally, the Living Well/Chronic Disease Self Management Program and the CDC’s Diabetes Prevention Program was fully integrated into the community health improvement programming. These current programs led by the Community Health Improvement Department augment both above population health goals.

In addition, there are six workgroups which are tasked with specific elements of the overall strategy. The Social Determinants of Health (SDoH)/Community Partnership Workgroup is led by the Senior Vice President, Strategy, Business, and Community Engagement along with the VP of Population Health. The Director of Community Health Improvement staffs this group. Several initiatives are currently in pilot phase or were implemented which address the SDoH which are barriers (transportation and literacy) in the targeted West Baltimore population.

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>

VI. PHYSICIANS

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

There are no gaps in the availability of specialist providers, including inpatient, outpatient, and specialty care to serve the uninsured at UMMC.

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 – **Not Applicable**

Category of Subsidy	Explanation of Need for Service
Hospital-Based physicians	
Non-Resident House Staff and Hospitalists	
Coverage of Emergency Department Call	
Physician Provision of Financial Assistance	
Physician Recruitment to Meet Community Need	
Other – (provide detail of any subsidy not listed above – add more rows if needed)	

## VII. APPENDICES

### To Be Attached as Appendices:

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

For *example*, state whether the hospital:

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
    - in a culturally sensitive manner,
    - at a reading comprehension level appropriate to the CBSA's population, and
    - in non-English languages that are prevalent in the CBSA.
  - posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
  - provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
  - provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
  - includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
  - besides English, in what language(s) is the Patient Information sheet available;
  - discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.
- b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).
  - c. Include a copy of your hospital's FAP (label appendix III).
  - d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: [http://www.hsrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD\\_HospPatientInfo/PatientInfoSheetGuidelines.doc](http://www.hsrc.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).

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

**Table III – Health Literacy**

<p>Identified Need</p>	<p><u>Health Literacy</u>            During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Health Literacy. This need was identified both years and was based on the low rates of high school completion rates as well as public in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data:            Overall high school completion rate in Baltimore City is 80.3%. However, within the targeted CBSA zip codes, the high school completion rate ranges from 73.1% to 86.8%. These rates are far lower than the State of Maryland average of 87%.. As a result of a lack of health literacy is the overall misuse of emergency services when urgent care or preventive/primary care is, at times, more appropriate. In a survey of Baltimore City residents during the FY15 CHNA, 69% of residents reported they did not have health insurance. When further questioned, many participants actually had the new ACA health care coverage but didn't know that it covered preventive care and didn't understand the process of selecting a physician for primary care. Therefore, many individuals do not pursue primary/preventive care and eventually seek emergency care after a problem becomes significantly worse.</p> <p>Health literacy is a significant social determinant of health in Baltimore City which affects patients' health outcomes and speaks to the identified need, and subsequently, the UMMC and UMMS priority of Health Literacy.</p>
<p>Hospital Initiatives</p>	<p>To work on the issue of health literacy, UMMC had one major initiative to address the above identified need with healthcare professionals in FY16.  <b>Health Literacy</b> (for professionals)</p>
<p>Primary Objectives</p>	<p><b>Health Literacy</b></p> <ol style="list-style-type: none"> <li>1) Develop video for healthcare professionals on importance of health literacy</li> <li>2) Post video on staff intranet</li> <li>3) Engage staff in at least 5 key organizational staff meetings</li> <li>4)             <ul style="list-style-type: none"> <li>• <u>Description:</u> Provide health literacy information to health care professionals to inform their practice</li> <li>• <u>Metrics:</u> <ul style="list-style-type: none"> <li>• Video developed</li> <li>• Video posted on the intranet</li> <li>• # of key organizational staff meetings</li> <li>• # of meetings where video shown</li> <li>• # of healthcare professionals watching video</li> <li>• # of page views</li> </ul> </li> </ul> </li> </ol>
<p>Single or Multi-Year Initiative Time Period</p>	<p>Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>

Key Partners in Development and/or Implementation	UMMS System hospitals, UMMC Dept of Communications, Healthcare professionals across the UMMS system	
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.	
Outcomes (Include process and impact measures)	<p><b><u>Health Literacy Objectives:</u></b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• Video developed</li> <li>• # of meetings where video shown</li> <li>• # of healthcare professionals watching video</li> <li>• # of page views</li> </ul> <p><u>Outcomes:</u></p> <ul style="list-style-type: none"> <li>• Video developed and finalized 4/2016</li> <li>• 6 major organizational meetings with video shown</li> <li>• Over 250 professionals watched video in meetings</li> <li>• 1,714 page views on the intranet where video is posted – <a href="http://www.umm.edu/community">www.umm.edu/community</a> (only for April - June 2016)</li> </ul>	
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.	
<p>A. Total Cost of Initiative for Current Fiscal Year</p> <p>B. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>A. Total Cost of Initiative</p> <p>Approx. \$10,000 to develop video (utilized across UMMS)</p>	<p>B. Direct offsetting revenue from Restricted Grants</p> <p>\$0</p>

**Table III – Cardiovascular Disease Prevention**

Identified Need	<p><u>Cardiovascular Disease/Obesity Prevention</u></p> <p>During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Cardiovascular Disease Prevention. This need was identified both years and was based on the high prevalence of cardiovascular disease, hypertension, obesity, and stroke in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data: County Health Rankings reports that Baltimore City is ranked the lowest of all counties within Maryland on 6 of 8 major categories. 68% of Baltimore City adults are either overweight or obese. 34% of Baltimore adults report a BMI of &gt; 30. Heart Disease is the number one leading cause of death, and stroke is the third leading cause of death in Baltimore City. Baltimore City’s Hypertension ED visit rate is 658/100,000 as compared to 252/100,000 for Maryland. Significant health disparities exist among African Americans in Baltimore City. Food deserts exist in half of the targeted CBSA zips. Thirty five percent of Baltimore high school students are obese or overweight compared with 26% statewide. All of these significant health disparities in Baltimore City speaks to the identified need, and subsequently, the UMMC priority of Cardiovascular Disease Prevention.</p>
Hospital Initiatives	<p>To combat the high prevalence of cardiovascular disease, hypertension, obesity, and stroke in the targeted CBSA area, UMMC has several initiatives to address the above identified need:</p> <p><b>Know Your Numbers Initiative</b></p>
Primary Objectives	<p><b>Know Your Numbers Initiative</b></p> <ol style="list-style-type: none"> <li>1) Increase the % of adults who are at a healthy weight (Maryland SHIP)</li> <li>2) Reduce the % of youth who are obese (Maryland SHIP) <ul style="list-style-type: none"> <li>• <u>Description:</u> Provide education and information on heart healthy lifestyle through engaging, evidence-based programs in the community</li> <li>• <u>Metrics:</u> <ul style="list-style-type: none"> <li>• # of people attending health events receiving info on heart healthy lifestyle through health fairs and events</li> <li>• # of Living Well with High Blood Pressure Classes</li> <li>• # of Living Well classes</li> </ul> </li> </ul> </li> </ol>
Single or Multi-Year Initiative Time Period	<p>Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
Key Partners in Development and/or Implementation	<p>UMMC Dept of Family Medicine, Dept of Cardiology, Dept of Clinical Nutrition, UMMC Midtown Campus, University of Maryland Baltimore Campus, Baltimore City Health Department, Maryland DHMH, Maintaining Active Citizens, (MAC, Inc.)</p>

How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.	
Outcomes (Include process and impact measures)	<p><b><u>Know Your Numbers Outcomes</u></b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• # of people attending health events receiving info on heart healthy lifestyle through health fairs and events</li> <li>• # of Living Well with High Blood Pressure Classes</li> <li>• # of Living Well participants</li> </ul> <p><u>Outcomes:</u></p> <ul style="list-style-type: none"> <li>• 1,926 people attending various heart healthy events</li> <li>• 1<sup>st</sup> Pilot class of Living Well with High Blood Pressure</li> <li>• 14 people participated in the 1<sup>st</sup> Living Well with High Blood Pressure class in May</li> <li>• 24 seniors participated in the second class offered in June <ul style="list-style-type: none"> <li>○ While this first pilot was small, results on post class evaluations were positive</li> <li>○ 100% of participants reported that they were more motivated to take care of their health after the workshop</li> <li>○ 100% of participants reported that they knew more about lifestyle changes that are recommended for their health after the workshop</li> <li>○ Future classes in FY17 will be evaluated with same survey as provided by MAC, Inc.</li> </ul> </li> </ul>	
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.	
C. Total Cost of Initiative for Current Fiscal Year D. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative  \$33,829	B. Direct offsetting revenue from Restricted Grants  N/A

**Table III – Cardiovascular Disease Prevention**

<p>Identified Need</p>	<p><u>Cardiovascular Disease/Obesity Prevention</u>                  During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Cardiovascular Disease Prevention. This need was identified both years and was based on the high prevalence of cardiovascular disease, hypertension, obesity, and stroke in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data:                  68% of Baltimore City adults are either overweight or obese. Heart Disease is the number one leading cause of death, and stroke is the third leading cause of death in Baltimore City. Baltimore City’s Hypertension ED visit rate is 658/100,000 as compared to 252/100,000 for Maryland. Significant health disparities exist among African Americans in Baltimore City. Food deserts exist in half of the targeted CBSA zips. All of these significant health disparities in Baltimore City speaks to the identified need, and subsequently, the UMMC priority of Cardiovascular Disease Prevention.</p>
<p>Hospital Initiatives</p>	<p>To combat the high prevalence of cardiovascular disease, hypertension, obesity, and stroke in the targeted CBSA area, UMMC has several initiatives to address the above identified need:</p> <p><b>Maryland Healthy Men Initiative</b></p>
<p>Primary Objectives</p>	<p><b>Maryland Healthy Men</b></p> <ol style="list-style-type: none"> <li>1) Decrease the ED visit rate due to hypertension (Maryland SHIP)</li> <li>2) Engage at least 440 African American men with hypertension education after identifying them with BP reading &gt; 139/89 (Baltimore City Health Dept Goal)                         <ul style="list-style-type: none"> <li>• <u>Description</u>: Provide hypertension screening, education and referral to African American men in Baltimore</li> <li>• <u>Metrics</u>:                                 <ul style="list-style-type: none"> <li>• # of BP screenings (all races, both genders)</li> <li>• # of AA men with hypertension</li> <li>• # of AA men in program</li> <li>• BP after program</li> <li>• Self-reported behaviors after the program</li> </ul> </li> </ul> </li> </ol>
<p>Single or Multi-Year Initiative Time Period</p>	<p>Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
<p>Key Partners in Development and/or Implementation</p>	<p>UMMC Dept of Family Medicine, Dept of Cardiology, Dept of Clinical Nutrition, University of Maryland Baltimore Campus, Local Farmers, American Heart Association, Shopper’s Food Warehouse, Buy-Rite, Druid Hill YMCA, MAC, Inc., and Baltimore City Health Department</p>

How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.	
Outcomes (Include process and impact measures)	<p><b><u>Maryland Healthy Men Outcomes:</u></b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• # of BP screenings (all races, both genders)</li> <li>• # of AA men with hypertension</li> <li>• # of AA men educated</li> <li>• # of AA men in program</li> <li>• BP after program</li> <li>• Self-reported behaviors after the program</li> </ul> <p><u>Outcomes:</u></p> <ul style="list-style-type: none"> <li>• 1500 BP screenings (all races, both genders)</li> <li>• 499 African American men identified with hypertension &gt;139/89</li> <li>• 499 men received education (risk factors, nutrition, exercise, tobacco use, fast food, and salt intake)</li> <li>• 125 men fully participated in program</li> <li>• 51% of men participating in the program decreased their BP, 33% had same BP, and 16% increased their BP</li> <li>• 93% reported now taking their BP regularly at home as a result of the program</li> <li>• 87% reported they knew their BP reading as a result of the program</li> </ul>	
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.	
<p>E. Total Cost of Initiative for Current Fiscal Year</p> <p>F. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>A. Total Cost of Initiative</p> <p style="text-align: center;">\$155,512</p>	<p>B. Direct offsetting revenue from Restricted Grants</p> <p style="text-align: center;">\$139,644</p>

**Table III – Cardiovascular Disease Prevention**

<p>Identified Need</p>	<p><u>Cardiovascular Disease/Obesity Prevention</u>                  During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Cardiovascular Disease Prevention. This need was identified both years and was based on the high prevalence of cardiovascular disease, hypertension, obesity, and stroke in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data:                  68% of Baltimore City adults are either overweight or obese. Heart Disease is the number one leading cause of death, and stroke is the third leading cause of death in Baltimore City. Baltimore City’s Hypertension ED visit rate is 658/100,000 as compared to 252/100,000 for Maryland. Significant health disparities exist among African Americans in Baltimore City. Food deserts exist in half of the targeted CBSA zips. Additionally, the Healthy Food Availability Index (HFAI) ranges from 7.8 to 14. This Index ranges from 0-25 with the higher numbers indicating better availability of healthy food. Thirty five percent of Baltimore high school students are obese or overweight compared with 26% statewide. All of these significant health disparities in Baltimore City speaks to the identified need, and subsequently, the UMMC priority of Cardiovascular Disease Prevention.</p>
<p>Hospital Initiatives</p>	<p>To combat the high prevalence of cardiovascular disease, hypertension, obesity, and stroke in the targeted CBSA area, UMMC has several initiatives to address the above identified need:</p> <p><b>Farmer’s Market</b></p>
<p>Primary Objectives</p>	<p><b>Farmer’s Market</b></p> <ol style="list-style-type: none"> <li>1) Reduce the % of children who are considered obese (Maryland SHIP)</li> <li>2) Increase the % of adults who are at a healthy weight (Maryland SHIP)</li> <li>3) Increase healthy food access</li> <li>4) Increase the variety of fruits and vegetables to the diets of the population aged 2 years and older</li> </ol> <ul style="list-style-type: none"> <li>• <u>Description:</u> Provide Farmers’ Market in identified food desert to improve access to variety of healthy fruits and vegetables</li> <li>• <u>Metrics:</u> <ul style="list-style-type: none"> <li>• # of Farmers’ Markets held</li> <li>• # attending (approximate)</li> </ul> </li> </ul>
<p>Single or Multi-Year Initiative Time Period</p>	<p>Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>

KeyPartners in Development and/or Implementation	UMMC Dept of Family Medicine, Dept of Community Health Improvement, Dept of Clinical Nutrition, University of Maryland Baltimore Campus, Local Farmers, UMMC “Green Team”	
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.	
Outcomes (Include process and impact measures)	<p><b><u>Farmer’s Market Outcomes:</u></b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• # of Farmers’ Markets held</li> <li>• # attending (approximate)</li> </ul> <p><u>Outcomes:</u></p> <ul style="list-style-type: none"> <li>• 28 Farmers’ Markets held</li> <li>• 2,800 attending (based on approx. 100 at each market day)</li> </ul>	
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.	
<p>G. Total Cost of Initiative for Current Fiscal Year</p> <p>H. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>A. Total Cost of Initiative</p> <p style="text-align: center;">\$13,730</p>	<p>B. Direct offsetting revenue from Restricted Grants</p> <p style="text-align: center;">N/A</p>

**Table III – Cardiovascular Disease Prevention**

<p>Identified Need</p>	<p><u>Cardiovascular Disease/Obesity Prevention</u>                  During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Cardiovascular Disease Prevention. This need was identified both years and was based on the high prevalence of cardiovascular disease, hypertension, obesity, and stroke in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data:                  68% of Baltimore City adults are either overweight or obese. Heart Disease is the number one leading cause of death, and stroke is the third leading cause of death in Baltimore City. Baltimore City’s Hypertension ED visit rate is 658/100,000 as compared to 252/100,000 for Maryland. Significant health disparities exist among African Americans in Baltimore City. Food deserts exist in half of the targeted CBSA zips. Additionally, the Healthy Food Availability Index (HFAI) ranges from 7.8 to 14. This Index ranges from 0-25 with the higher numbers indicating better availability of healthy food. Thirty five percent of Baltimore high school students are obese or overweight compared with 26% statewide. All of these significant health disparities in Baltimore City speaks to the identified need, and subsequently, the UMMC priority of Cardiovascular Disease Prevention.</p>
<p>Hospital Initiatives</p>	<p>To combat the high prevalence of cardiovascular disease, hypertension, obesity, and stroke in the targeted CBSA area, UMMC has several initiatives to address the above identified need:</p> <p><b>Kids to Farmer’s Market</b></p>
<p>Primary Objectives</p>	<p><b>Kids to Farmer’s Market</b></p> <ol style="list-style-type: none"> <li>1) Reduce the % of children who are considered obese (Maryland SHIP)</li> <li>2) Increase healthy food access</li> <li>3) Increase the variety of fruits and vegetables to the diets of the population aged 2 years and older</li> <li>4) Expose elementary school children to healthy produce they may not have experienced                         <ol style="list-style-type: none"> <li>a. <u>Description</u>: Provide education and information on healthy produce to elementary school children living identified food deserts</li> <li>b. <u>Metric</u>:</li> <li>c. # of children attending</li> <li>d. % of children trying new fruit or vegetable item</li> <li>e. # of children reporting that they liked the new item</li> </ol> </li> </ol>

Single or Multi-Year Initiative Time Period	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.	
Key Partners in Development and/or Implementation	UMMC Dept of Community Health Improvement, Dept of Clinical Nutrition, University of Maryland Baltimore Campus, Local Farmers, UMMC “Green Team”, Baltimore City Public Schools	
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.	
Outcomes (Include process and impact measures)	<p><b><u>Kids to Farmer’s Market Outcomes:</u></b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• # of children attending</li> <li>• % of children trying new fruit or vegetable item</li> <li>• # of children reporting that they liked the new item</li> </ul> <p><u>Outcomes:</u></p> <ul style="list-style-type: none"> <li>• 91 children participated from 3 Baltimore City Public Schools</li> <li>• 90% tried new fruit/vegetable item (spaghetti squash, pumpkin dip, fresh applesauce)</li> <li>• 97% liked the new item tried</li> </ul>	
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.	
<p>I. Total Cost of Initiative for Current Fiscal Year</p> <p>J. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>A. Total Cost of Initiative</p> <p style="text-align: center;">\$8732</p>	<p>B. Direct offsetting revenue from Restricted Grants</p> <p style="text-align: center;">N/A</p>

**Table III – Maternal and Child Health**

Identified Need	<p><u>Maternal and Child Health</u></p> <p>During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Maternal and Child Health. This need was identified both years and was based on the high rates of prematurity, low birth weights, low breastfeeding rates, high pediatric asthma rates and unintentional injury rates in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data:</p> <p>Pediatric asthma prevalence (20%) within Baltimore City is much higher than the State with a rate of 9.2%. According to the Maryland State Health Improvement Plan (SHIP), the ED visit rate for Baltimore City is 224.8 per 10,000 as compared to 63.8 per 10,000 for Maryland. The ED visit rate for African Americans is 100.8 per 10,000. All of these significant disparities in prevalence in Baltimore City speaks to the identified need, and subsequently, the UMMC priority of Maternal and Child Health with an emphasis on pediatric asthma.</p>
Hospital Initiatives	<p>To combat the high prevalence of pediatric asthma, UMMC has one major initiative to address the above identified need:</p> <p><b>Breathmobile</b></p>
Primary Objectives	<p><b>Breathmobile</b></p> <p>1)Decrease the ED visit rate due to (pediatric) asthma (Maryland SHIP)</p> <p>2)Decrease hospitalizations due to pediatric asthma</p> <p>3)Decrease missed school days due pediatric asthma</p> <ul style="list-style-type: none"> <li>• <u>Description:</u> Provide mobile primary treatment and health education to school-age children with asthma in Baltimore City using the Breathmobile</li> <li>• <u>Metrics:</u> <ul style="list-style-type: none"> <li>• # of site visits</li> <li>• # of individual students seen</li> <li>• # of total visits</li> <li>• % of ED visits</li> <li>• % of hospitalizations</li> <li>• %of missed school days</li> </ul> </li> </ul>
Single or Multi-Year Initiative Time Period	<p>Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>

Key Partners in Development and/or Implementation	UMMC Dept of Pediatrics, UMMC Dept of Family Medicine, Baltimore City Public Schools, Baltimore City Health Department, Kohls Cares Foundation	
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.	
Outcomes (Include process and impact measures)	<p><b><u>Breathmobile Objectives:</u></b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• # of site visits</li> <li>• # of individual students seen</li> <li>• # of total visits</li> <li>• % of ED visits</li> <li>• % of hospitalizations</li> <li>• % of missed school days</li> </ul> <p><u>Outcomes:</u></p> <ul style="list-style-type: none"> <li>• 21 different sites visited</li> <li>• 529 children treated</li> <li>• 921 total visits</li> <li>• 50.6% had any ED Visits</li> <li>• 11.5% hospitalization rate</li> <li>• 51.6% had any missed school days</li> </ul>	
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.	
K. Total Cost of Initiative for Current Fiscal Year L. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative  Breathmobile - \$178,139	B. Direct offsetting revenue from Restricted Grants  \$139,808

**Table III – Maternal and Child Health**

<p>Identified Need</p>	<p><u>Maternal and Child Health</u>            During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Maternal and Child Health. This need was identified both years and was based on the high rates of prematurity, low birth weights, low breastfeeding rates, high pediatric asthma rates and unintentional injury rates in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data:            The pedestrian injury rate in Baltimore City is 113.8 (per 100,000 population) as compared to 42.5 in the State. Motor vehicle crashes are the number 1 reason for unintentional death in children 0-19 years. Contributing to this statistic, there is a high misuse rate of car seats. One CDC study found that, in one year, more than 618,000 children ages 0-12 rode in vehicles without the use of a child safety seat or booster seat or a seat belt at least some of the time. Of the children ages 12 years and younger who died in a crash in 2014, 34% were not buckled up. All of these significant health disparities in Baltimore City children speaks to the identified need, and subsequently, the UMMC priority of Maternal and Child Health.</p>
<p>Hospital Initiatives</p>	<p>To combat the high prevalence of unintentional injuries in children, UMMC has one major initiative to address the above identified need:  <b>Safe Kids</b></p>
<p>Primary Objectives</p>	<p><b>Safe Kids</b></p> <ol style="list-style-type: none"> <li>1) Decrease number of fire-related deaths to children under 14 years of age (Safe Kids goal)</li> <li>2) Decrease the pedestrian injury rate on public roads (Maryland SHIP)</li> <li>3) Increase the percentage of correctly installed child safety seats (Safe Kids goal)</li> <li>4) Increase in participants’ knowledge and awareness of fire safety, pedestrian safety, and child passenger seat safety (Safe Kids goal)           <ul style="list-style-type: none"> <li>• <u>Description:</u> Provide education and information on child passenger safety, fire safety, pedestrian safety, and distracted pedestrian awareness to children and families</li> <li>• <u>Metric:</u> <ul style="list-style-type: none"> <li>• # of encounters with children and/or families</li> <li>• # of fire-related deaths under 14 yrs in Balto City</li> <li>• # of pedestrian injuries</li> </ul> </li> </ul> </li> </ol>

	<ul style="list-style-type: none"> <li>• # of child passenger safety seat errors identified and corrected</li> <li>• Increase in knowledge using pre/post-tests for: fire safety, pedestrian safety, child passenger seat safety (new for this year)</li> </ul>
Single or Multi-Year Initiative Time Period	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	Safe Kids Worldwide, UMMC Dept of Pediatrics, Baltimore City Public Schools, Baltimore City Health Department, Baltimore City Fire and Police Departments, DHMH, MIEMSS Child Passenger Programs
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.
Outcomes (Include process and impact measures)	<p><b><u>Safe Kids Outcomes:</u></b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• # of encounters with children and/or families</li> <li>• # of fire-related deaths under 14 yrs in Balto City</li> <li>• # of pedestrian injuries</li> <li>• # of child passenger safety seat errors identified and corrected</li> </ul> <p><u>Outcomes:</u></p> <ul style="list-style-type: none"> <li>• 5,304 children served through program</li> <li>• 4 child (&lt;18 yrs) fire-related deaths for calendar year 2015</li> <li>• 242 child (&lt;18 yrs) pedestrian injuries for calendar year 2015</li> <li>• 124 child passenger safety seats checked with a 86% <b><u>misuse</u></b> rate (only 14% correctly installed prior to event) corrected to 0% errors (100% correct after event)</li> </ul>
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.

<p>M. Total Cost of Initiative for Current Fiscal Year</p> <p>N. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>A. Total Cost of Initiative</p> <p>Safe Kids – \$78,274</p>	<p>B. Direct offsetting revenue from Restricted Grants</p> <p>Safe Kids – \$1,120</p>
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**Table III – Maternal and Child Health**

<p>Identified Need</p>	<p><u>Maternal and Child Health</u></p> <p>During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Maternal and Child Health. This need was identified both years and was based on the high rates of prematurity, low birth weights, low breastfeeding rates, high pediatric asthma rates and unintentional injury rates in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data:  Baltimore City’s infant mortality rate is 10.4 (deaths/1,000 live births) for the entire city. However, within the targeted CBSA zip codes, the infant mortality rate ranges from 10.3 to 21. These rates are far higher than the State of Maryland average of 6.5. Contributing to this high infant mortality rate is low birth weight infants (LBW &lt; 5 lbs, 8 oz). Baltimore City’s rate is 12.8 overall with rates in the targeted CBSA from 13.8 – 18. All of these significant health disparities in Baltimore City children speaks to the identified need, and subsequently, the UMMC priority of Maternal and Child Health.</p>
<p>Hospital Initiatives</p>	<p>To combat the high prevalence of infant mortality, UMMC has one major initiative to address the above identified need:  <b>Stork’s Nest</b></p>

Primary Objectives	<p>Stork’s Nest</p> <ol style="list-style-type: none"> <li>1) Increase the percentage of babies born &gt;37 weeks gestation</li> <li>2) Decrease infant mortality (Maryland SHIP &amp; Baltimore City Health Dept)</li> <li>3) Reduce the percentage of births that are low birth weight (Maryland SHIP)</li> <li>4) Increase the percentage of women breastfeeding at discharge/after delivery (Baby-Friendly Hospital Goal) <ul style="list-style-type: none"> <li>• <u>Description:</u> Provide education and information on healthy pregnancies, breastfeeding, and early infant care to pregnant moms and their partners</li> <li>• <u>Metric:</u> <ul style="list-style-type: none"> <li>• # of women enrolled</li> <li>• % of babies born&gt; 37 weeks gestation</li> <li>• % of babies born&gt;2500 grams</li> <li>• % of women breastfeeding</li> </ul> </li> </ul> </li> </ol>
Single or Multi-Year Initiative Time Period	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	UMMC Dept of Pediatrics, UMMC Dept of OB/GYN, UMMC Dept of Family Medicine, March of Dimes, Zeta Phi Beta Sorority, Faith-based partners, B’more Healthy Babies
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.
Outcomes (Include process and impact measures)	<p><b><u>Stork’s Nest Outcomes:</u></b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• # of women enrolled</li> <li>• % of babies born&gt; 37 weeks gestation</li> <li>• % of babies born&gt;2500 grams</li> <li>• % of women breastfeeding</li> </ul> <p><u>Outcomes:</u></p> <ul style="list-style-type: none"> <li>• 87 women enrolled</li> <li>• 81.61% of babies born &gt;37 weeks gestation (decreased slightly from 84.2% in FY15)</li> <li>• 83.33% babies born &gt;2500 grams (improved from 80.8% in FY15)</li> <li>• 80.46% of women breastfeeding prior to discharge (Higher than the 78% for Maryland women initiating breastfeeding overall)</li> </ul>
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.

<p>O. Total Cost of Initiative for Current Fiscal Year</p> <p>P. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>A. Total Cost of Initiative</p> <p>Stork's Nest - \$22,569</p>	<p>B. Direct offsetting revenue from Restricted Grants</p> <p>Stork's Nest - 0</p>
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**Table III – Violence Prevention**

<p>Identified Need</p>	<p><u>Violence Prevention</u></p> <p>During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Violence Prevention. This need was identified both years and was based on the high prevalence of homicide and youth violence in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data:  The overall Baltimore City homicide rate is 20.9 (# of homicides/10,000). However, within the targeted CBSA homicide rates range from 22.2 to a high of 44.2 in Southwest Baltimore. Baltimore City is the third most violent city in the US as ranked by the FBI. More than 90% of homicide victims are African American, and more than half are 18-30 years old. The number one cause of death for African American men in Baltimore aged 18-25 years is homicide. All of these significant health disparities in Baltimore City speaks to the identified need, and subsequently, the UMMC priority of Violence Prevention.</p>
<p>Hospital Initiatives</p>	<p>To combat the high prevalence of violence in the targeted CBSA area, UMMC has several initiatives to address the above identified need:</p> <p><b>Violence Intervention Program</b></p>

Primary Objectives	<p><b>Violence Intervention Program</b></p> <p>1)Reduce the rate recidivism due to violent injury and domestic violence</p> <p>2)Increase life expectancy (Maryland SHIP)</p> <ul style="list-style-type: none"> <li>● <u>Description:</u> Provide education, support, and information through evidence-based program – Violence Intervention Program (VIP)</li> <li>● <u>Metrics:</u> <ul style="list-style-type: none"> <li>○ 100% of violence victims enrolled in program</li> <li>○ 100% participant completion</li> <li>○ Re-injury rate (recidivism)</li> <li>○ VPP Survey and program evaluation</li> </ul> </li> </ul>
Single or Multi-Year Initiative Time Period	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	UMMC Shock Trauma Center, Baltimore City Police Department, Baltimore City Public Schools, and Baltimore City Health Department
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.
Outcomes (Include process and impact measures)	<p><b>Violence Intervention Program</b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• 100% of violence victims enrolled in program</li> <li>• 100% participant completion</li> <li>• Re-injury rate (recidivism)</li> <li>• VPP Survey and program evaluation</li> </ul> <p>Outcomes:</p> <ul style="list-style-type: none"> <li>• 640 people participated (out of 1,373 patients admitted for violence)</li> <li>• Average of 15% enrollment rate per month continued in the program</li> <li>• 63% completion rate</li> <li>• 0.8% (4) reinjury rate of the participants completing the program (stable from FY15 – 2 clients were re-injured last year but more participated this year, so the rate is stable)</li> <li>• VPP Survey Results <ul style="list-style-type: none"> <li>100% of clients screened positive for Adverse Childhood Experience and symptoms of PTSD at intake</li> <li>Ongoing evaluation: showing reduction of symptoms over course of case management services</li> </ul> </li> </ul>

Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.	
<p>Q. Total Cost of Initiative for Current Fiscal Year</p> <p>R. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>A. Total Cost of Initiative</p> <p>\$180,651 – staff salaries split between Youth Violence programs</p>	<p>B. Direct offsetting revenue from Restricted Grants</p> <p>N/A</p>

**Table III – Violence Prevention**

Identified Need	<p><u>Violence Prevention</u></p> <p>During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Violence Prevention. This need was identified both years and was based on the high prevalence of homicide and domestic violence in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data: The overall Baltimore City homicide rate is 20.9 (# of homicides/10,000). However, within the targeted CBSA homicide rates range from 22.2 to a high of 44.2 in Southwest Baltimore. Baltimore City is the third most violent city in the US as ranked by the FBI. More than 90% of homicide victims are African American, and more than half are 18-30 years old. All of these significant health disparities in Baltimore City speaks to the identified need, and subsequently, the UMMC priority of Violence Prevention.</p>
Hospital Initiatives	<p>To combat the high prevalence of violence in the targeted CBSA area, , UMMC has several initiatives to address the above identified need:</p> <p><b>Youth Violence Prevention</b></p>

Primary Objectives	<p><b>Youth Violence Prevention</b></p> <p>1) Promote violence prevention and education in youth populations</p> <p>2) Increase life expectancy (Maryland SHIP)</p> <ul style="list-style-type: none"> <li>• <u>Description:</u> Provide education and information on the importance of violence prevention through 2 evidence-based programs – Promoting Healthy Alternatives for Teens (PHAT) and My Future, My Career (MFMC)</li> <li>• <u>Metrics:</u> <ul style="list-style-type: none"> <li>• # of youth completing programs</li> <li>• PHAT Survey results</li> <li>• MFMC Survey results</li> </ul> </li> </ul>
Single or Multi-Year Initiative Time Period	Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.
Key Partners in Development and/or Implementation	UMMC Shock Trauma Center, Baltimore City Police Department, Baltimore City Public Schools
How were the outcomes evaluated?	The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.
Outcomes (Include process and impact measures)	<p><b>Youth Violence Prevention</b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• # of youth completing programs</li> <li>• PHAT Survey results</li> <li>• MFMC Survey results</li> </ul> <p><u>Outcomes:</u></p> <ul style="list-style-type: none"> <li>• 18 children participated specifically in MFMC (6-8<sup>th</sup> grades)</li> <li>• No PHAT survey results at this time</li> <li>• MFMC surveys showed only 60% of children believed they would graduate from high school and over 80% reported an exposure to violence in the past 6 months; Children will be followed at a later date for further evaluation. (First time survey has been used)</li> </ul>
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.

<p>S. Total Cost of Initiative for Current Fiscal Year</p> <p>T. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>A. Total Cost of Initiative</p> <p>\$180,651 – staff salaries split between Violence Intervention Programs</p>	<p>B. Direct offsetting revenue from Restricted Grants</p> <p>N/A</p>
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**Table III – Workforce & Community Development**

Identified Need	<p><b>Workforce and Community Development</b></p> <p>During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Workforce Development. This need was identified both years and was based on the extreme poverty and unemployment in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data:  Baltimore City’s unemployment rate is reported as 13.9% for the entire city. However, within the targeted CBSA zip codes, the unemployment rate ranges from 19.2% to 29.9%. These rates are far higher than the State of Maryland average of 5.3% - ranging from 3-4 times higher in the targeted CBSA. The extreme unemployment leads to the high level of poverty. Households below poverty range from 12.2% - 48.8% with the lowest median income of \$13,811 in the 21201 zip code. The high unemployment rates are a result of limited literacy, low levels of high school graduates and limited job opportunities in the community.</p>
Hospital Initiatives	<p>To combat the high prevalence of unemployment and accompanying poverty, UMMC has several initiatives to address the above identified need:</p> <p><b>Workforce Development Programs</b></p>
Primary Objectives	<p><b>Workforce Development Programs</b></p> <p>Increase the number of people gainfully employed</p> <ul style="list-style-type: none"> <li>• <u>Description:</u> Provide training, coaching, and employment for program participants through 6 key programs. <ul style="list-style-type: none"> <li>○ Healthcare Career Alliance</li> <li>○ Project Search</li> <li>○ Youthworks</li> <li>○ NAHSE</li> <li>○ BACH Fellows</li> <li>○ Urban Alliance</li> </ul> </li> <li>• <u>Metrics:</u> <ul style="list-style-type: none"> <li>○ # of students enrolled in programs</li> <li>○ 100 gainfully employable individuals</li> </ul> </li> </ul>
Single or Multi-Year Initiative Time Period	<p>Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
Key Partners in Development and/or Implementation	<p>Mayor’s Office of Employment Development, University of Maryland Baltimore Campus, Department of Social Services, Center for Urban Families, Helping Up Mission, Catholic Charities, Sinai Hospital VSP</p>
How were the outcomes evaluated?	<p>The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.</p>

<p>Outcomes (Include process and impact measures)</p>	<p><b>Workforce Development Outcomes:</b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• # of students enrolled in programs</li> <li>•100 gainfully employable individuals</li> </ul> <p><u>Outcomes:</u></p> <ul style="list-style-type: none"> <li>• 217 participants- Summer Youth Internships 75 Hospital Tours/Visits</li> <li>18 participants - Patient Care Technician (PCT) Training</li> <li>• 14 PCTs hired as result of above PCT Training</li> </ul>	
<p>Continuation of Initiative</p>	<p>UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.</p>	
<p>U. Total Cost of Initiative for Current Fiscal Year V. What amount is Restricted Grants/Direct offsetting revenue</p>	<p>A. Total Cost of Initiative</p> <p>\$266,646</p>	<p>B. Direct offsetting revenue from Restricted Grants</p> <p>\$80,000</p>

**Table III – Workforce & Community Development**

Identified Need	<p><u>Workforce and Community Development</u></p> <p>During the CHNA conducted in FY12 and FY15, UMMC identified key community priorities, one of which was Workforce Development. This need was identified both years and was based on the extreme poverty and unemployment in the CBSA targeted zip codes as outlined below.</p> <p>Baltimore City Data:          Baltimore City’s unemployment rate is reported as 13.9% for the entire city. However, within the targeted CBSA zip codes, the unemployment rate ranges from 19.2% to 29.9%. These rates are far higher than the State of Maryland average of 5.3% - ranging from 3-4 times higher in the targeted CBSA. The extreme unemployment leads to the high level of poverty. Households below poverty range from 12.2% - 48.8% with the lowest median income of \$13,811 in the 21201 zip code. The high unemployment rates are a result of limited literacy, low levels of high school graduates and limited job opportunities in the community.</p>
Hospital Initiatives	<p>To combat the high prevalence of unemployment and accompanying poverty, UMMC has several initiatives to address the above identified need:</p> <p><b>Live Near Your Work</b></p>
Primary Objectives	<p>Increase number of employees able to purchase a home in Baltimore City</p> <ul style="list-style-type: none"> <li>• <u>Description:</u> Provide incentive for employees purchasing homes within Baltimore City through Live Near Your Work (LNYW) program</li> <li>• <u>Metric:</u></li> <li>• # of employees purchasing home through LNYW program</li> </ul>
Single or Multi-Year Initiative Time Period	<p>Multi-Year – UMMC is working on this identified need over the three year cycle that is consistent with the CHNA cycle. Updates per Implementation Plan metric for each Fiscal Year are provided in the HSCRC Report and to the IRS.</p>
Key Partners in Development and/or Implementation	<p>Mayor’s Office of Employment Development, University of Maryland Baltimore Campus,</p>
How were the outcomes evaluated?	<p>The outcomes were evaluated based on the metrics discussed in the “Primary Objectives” section above.</p>
Outcomes (Include process and impact measures)	<p><b>Live Near Your Work Outcomes:</b></p> <p><u>Metrics:</u></p> <ul style="list-style-type: none"> <li>• # of employees who purchase a home through Live Near Your Work in Balto City</li> </ul> <p><u>Outcome:</u></p>

	<ul style="list-style-type: none"> <li>8 UMMC employees purchased homes in Baltimore City through Live Near Your Work in FY16</li> </ul>	
Continuation of Initiative	UMMC will continue to monitor performance and outcome measures annually. This priority and the accompanying initiatives will continue until the FY18 CHNA.	
W. Total Cost of Initiative for Current Fiscal Year X. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative \$20,000 with matching \$20,000 from Baltimore City (not offsetting)  Each employee receives \$2,500 from UMMC and another \$2,500 from the City, so the employee receives a total of \$5,000 if they meet the criteria	B. Direct offsetting revenue from Restricted Grants  N/A

### Financial Assistance Policy Description

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

It is the policy of the UMMS Entities to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The Financial Clearance Program Policy is a clear, comprehensive policy established to assess the needs of particular patients that have indicated a possible financial hardship in obtaining aid when it is beyond their financial ability to pay for services rendered.

UMMC makes every effort to make financial assistance information available to our patients including, but not limited to:

- Signage in main admitting areas and emergency rooms of the hospital
- UMMC website
- Patient Handbook distributed to all patients
- Brochures explaining financial assistance are made available in all patient care areas
- Patient Plain Language Sheets – Newly revised in June 2016, This handout was revised and is at the 5<sup>th</sup> grade reading level (available in English, Spanish, French, & Chinese based on top languages spoken by UMMC patients) – See English version attached in Appendix 4
- Appearing in print media through local newspapers

## ACA Health Care Coverage Expansion Description

Since implementation of the Affordable Care Act's (ACA) Health Care Coverage Expansion Option became effective on January 1, 2014, there has been a decrease in the number of patients presenting to the hospital in either uninsured and/or self-pay status. Additionally, the ACA's Expansion Option included a discontinuation of the primary adult care (PAC) which has also reduced uncompensated care. While there has been a decrease in the uncompensated care for straight self-pay patients since January 1, 2014, the ACA's Expansion Option has not completely eradicated charity care as eligible patients may still qualify for such case after insurance.

The following additional changes were also made to the hospital's financial assistance policy pursuant to the most recent 501(r) regulatory requirements:

### 1. LANGUAGE TRANSLATIONS

- a. Requirement: The new 501(r) regulations lowered the language translation threshold for limited English proficient (LEP) populations to the lower of 5% of LEP individuals in the community served/1000-LEP individuals. University of Maryland Medical Center translated its financial assistance policy into the following languages: English, Spanish, French, and Chinese.

### 2. PLAIN LANGUAGE SUMMARY

- a. Requirement: The new 501(r) regulations require a plain language summary of the FAP that is clear, concise, and easy for a patient to understand. University of Maryland Medical Center created a new plain language summary of its financial assistance policy in addition to its already-existing patient information sheet.

### 3. PROVIDER LISTS

- a. Requirement: The new 501(r) regulations require each hospital to create and maintain a list of all health care providers (either attached to the FAP or maintained as a separate appendix) and identify which providers on that list are covered under the hospital's FAP and which providers are not. University of Maryland Medical Center maintains that list which is available for review.

 University of Maryland Medical Center University of Maryland Medical Center Midtown Campus University of Maryland Rehabilitation & Orthopaedic Institute University of Maryland St. Joseph Medical Center University of Maryland Baltimore Washington Medical Center	<b>The University of Maryland Medical System  Central Business Office  Policy &amp; Procedure</b>	<i>Policy #:</i>	TBD
		<i>Effective Date:</i>	07/01/2016
	<u><b>Subject:</b></u>  <b>FINANCIAL ASSISTANCE</b>	<i>Page #:</i>	1 of 9
		<i>Supersedes:</i>	07-01-2015

### **POLICY**

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

- University of Maryland Medical Center (UMMC)
- University of Maryland Medical Center Midtown Campus (MTC)
- University of Maryland Rehabilitation & Orthopaedic Institute (UMROI)
- University of Maryland St. Joseph Medical Center (UMSJMC)
- University of Maryland Baltimore Washington Medical Center (UMBWMC)

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

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

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

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

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

University of Maryland St. Joseph Medical Center (UMSJMC) adopted this policy effective June 1, 2013.

University of Maryland Medical Center Midtown Campus (MTC) adopted this policy effective September 22, 2014.

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University of Maryland Baltimore Washington Medical Center (UMBWMC) adopted this policy effective July 1, 2016.

### **PROGRAM ELIGIBILITY**

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

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

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

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

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

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

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

Coverage amounts will be calculated based upon 200-300% of income as defined by Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care.

### **Presumptive Financial Assistance**

Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

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

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- n. St. Clare Outreach Program eligible patients
- o. UMSJMC Maternity Program eligible patients
- p. UMSJMC Hernia Program eligible patients

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

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

**PROCEDURES**

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.
2. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
  - a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
  - b. Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
  - c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.
  - d. Upon receipt of the patient's application, they will have thirty (30) days to submit the required documentation to be considered for eligibility. If no data is received within the 30 days, a denial letter will be sent notifying that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The Financial

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Assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.

3. There will be one application process for UMMC, MTC, UMROI, UMSJMC and UMBWMC. The patient is required to provide a completed Financial Assistance Application orally or in writing. In addition, the following may be required:
  - a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...
  - b. A copy of their most recent pay stubs (if employed) or other evidence of income.
  - c. A Medical Assistance Notice of Determination (if applicable).
  - d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.

A written request for missing information will be sent to the patient. Oral submission of needed information will be accepted, where appropriate.

4. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.
  - a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.
    - i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
    - ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
      - (1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.
5. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
6. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination, up to 3 years prior, and up to six (6) calendar months in to the future. However, there are no limitations on the Financial Assistance eligibility period. Each eligibility period will be determined on a case-by-case basis. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

*Extraordinary Collection Actions (ECAs) may be taken on accounts that have not been disputed or are not on a payment arrangement. Except in exceptional circumstances, these actions will occur no earlier than 120 days from submission of first bill to the patient and will be preceded by notice 30 days prior to*

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*commencement of the action. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.*

- i) Garnishments may be applied to these patients if awarded judgment.*
  - ii) A lien will be placed by the Court on primary residences within Baltimore City. The facility will not pursue foreclosure of a primary residence but may maintain our position as a secured creditor if a property is otherwise foreclosed upon.*
  - iii) Closed account balances that appear on a credit report or referred for judgment/garnishment may be reopened should the patient contact the facility regarding the balance report. Payment will be expected from the patient to resolve any credit issues, until the facility deems the balance should remain written off.*
7. If a patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
  8. A letter of final determination will be submitted to each patient who has formally submitted an application.
  9. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds may be issued back to the patient for credit balances, due to patient payments, resulted from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by \$5.00 or more.
  10. Patients who have access to other medical care (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.
  11. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.
  12. The Financial Assistance Program will accept all other University of Maryland Medical System hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.
  13. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.
  14. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.
    - a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
    - b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

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### **Financial Hardship**

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

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

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

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

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

Medical Debt is defined as out of pocket expenses for the facility charges incurred here at UMMC, MTC, UMROI, UMSJMC and UMBWMC for medically necessary treatment.

Once a patient is approved for Financial Hardship Assistance, coverage will be effective starting the month of the first qualifying date of service and up to the following twelve (12) calendar months from the application evaluation completion date. Each patient will be evaluated on a case-by-case basis for the eligibility time frame according to their spell of illness/episode of care. It will cover the patient and the immediate family members living in the household for the approved reduced cost and eligibility period for medically necessary treatment. Coverage shall not apply to elective or cosmetic procedures. However, the patient or guarantor must notify the hospital of their eligibility at the time of registration or admission. In order to continue in the program after the expiration of each eligibility approval period, each patient must reapply to be reconsidered. In addition, patients who have been approved for the program must inform the hospitals of any changes in income, assets, expenses, or family (household) status within 30 days of such change(s).

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

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**Appeals**

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

**Judgments**

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

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**ATTACHMENT A**

**Sliding Scale – Reduced Cost of Care**

MD DHMH 2016 Income Elig Limit Guidelines		Income Level	S	Income Level								
		Up to 200%	L	Level								
		Pt Resp 0%	I	Pt Resp 10%	Pt Resp 20%	Pt Resp 30%	Pt Resp 40%	Pt Resp 50%	Pt Resp 60%	Pt Resp 70%	Pt Resp 80%	Pt Resp 90%
HH	100% MD DHMH	100% Charity	D	90% Charity	80% Charity	70% Charity	60% Charity	50% Charity	40% Charity	30% Charity	20% Charity	10% Charity
Size	Max	Max	I	Max								
1	\$16,395	\$32,790	N	\$34,430	\$36,069	\$37,709	\$39,348	\$40,988	\$42,627	\$44,267	\$45,906	\$49,184
2	\$22,108	\$44,216	G	\$46,427	\$48,638	\$50,848	\$53,059	\$55,270	\$57,481	\$59,692	\$61,902	\$66,323
3	\$27,821	\$55,642		\$58,424	\$61,206	\$63,988	\$66,770	\$69,553	\$72,335	\$75,117	\$77,899	\$83,462
4	\$33,534	\$67,068	S	\$70,421	\$73,775	\$77,128	\$80,482	\$83,835	\$87,188	\$90,542	\$93,895	\$100,601
5	\$39,248	\$78,496	C	\$82,421	\$86,346	\$90,270	\$94,195	\$98,120	\$102,045	\$105,970	\$109,894	\$117,743
6	\$44,961	\$89,922	A	\$94,418	\$98,914	\$103,410	\$107,906	\$112,403	\$116,899	\$121,395	\$125,891	\$134,882
7	\$50,702	\$101,404	L	\$106,474	\$111,544	\$116,615	\$121,685	\$126,755	\$131,825	\$136,895	\$141,966	\$152,105
8	\$56,443	\$112,886	E	\$118,530	\$124,175	\$129,819	\$135,463	\$141,108	\$146,752	\$152,396	\$158,040	\$169,328

Effective 7/1/16

## Financial Help for Patients to Pay Hospital Care Costs

If you cannot pay for all or part of the care you receive from our hospital, you may be able to get **free** or **lower cost** services.

### PLEASE NOTE:

1. We treat all patients needing emergency care, no matter what they are able to pay.
2. Services provided by physicians or other providers may not be covered by the hospital Financial Assistance Policy. You can call (410) 821-4140 if you have questions.

### HOW THE PROCESS WORKS:

When you become a patient, we ask if you have any health insurance. We will not charge you more for hospital services than we charge people with health insurance. The hospital will:

1. Give you information about our financial assistance policy, or
2. Offer you help with a counselor who will help you with the application.

### HOW WE REVIEW YOUR APPLICATION:

The hospital will look at your ability to pay for care. We look at your income and family size. You may receive free or lower costs of care if:

1. Your income or your family's total income is low for the area where you live, or
2. Your income falls below the federal poverty level if you had to pay for the full cost of your hospital care, minus any health insurance payments.

**PLEASE NOTE:** If you are able to get financial help, we will tell you how much you can get. If you are not able to get financial help, we will tell you why not.

### HOW TO APPLY FOR FINANCIAL HELP:

1. Fill out a **Financial Assistance Application Form**.
2. Give us all of your information to help us understand your financial situation.
3. Turn the Application Form into us.

**PLEASE NOTE:** The hospital must screen patients for Medicaid before giving financial help.

### OTHER HELPFUL INFORMATION:

1. You can get a **free copy** of our Financial Assistance Policy and Application Form:

☒ **Online** at <http://umm.edu/patients/financial-assistance>

☒ **In person** at the Financial Assistance Department – University of Maryland Medical System, 11311 McCormick Road, Ste 230, Hunt Valley, MD 21031

☒ **By mail:** call (410) 821-4140 to request a copy

2. You can call the Financial Assistance Department if you have questions or need help applying. You can also call if you need help in another language. Call: (410) 821-4140

Revised 6/2016



## **Our Mission**

University of Maryland Medical Center is the academic flagship of the University of Maryland Medical System. Its mission is to provide health care services on its two campuses for the Baltimore community, the State of Maryland and the nation. In partnership with the University of Maryland School of Medicine and the University of Maryland health professional schools, we are committed to:

- Delivering superior health care
- Training the next generation of health professionals
- Discovering ways to improve health outcomes worldwide

Source: [Vision, Mission and Values - University of Maryland Medical Center](http://umm.edu/about/mission-and-vision#ixzz3cUw0vRnF)  
<http://umm.edu/about/mission-and-vision#ixzz3cUw0vRnF>

## **Our Vision:**

UMMC will be known for providing high value and compassionate care, improving health in Maryland and beyond, educating future health care leaders and discovering innovative ways to advance medicine worldwide.

Source: [Vision, Mission and Values - University of Maryland Medical Center](http://umm.edu/about/mission-and-vision#ixzz3cUwFj4UW)  
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**Our Commitment to Excellence:**

Five Pillars We Focus on Every Day



**Our Community Health Improvement Mission:** To empower and build healthy communities