COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2015 Community Benefit Reporting

MedStar Harbor Hospital

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 regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) the general demographics of the hospital community, (2) how hospitals determined the needs of the communities they serve, (3) hospital community benefit administration, and (4) community benefit external collaboration to develop and implement community benefit initiatives.

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

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

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

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

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

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

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

A description of how the hospital organization obtains input from persons who represent the broad interests of the community served by the hospital facility, (including working with private and public health organizations, such as: the local health officers, local health improvement coalitions ("LHIC's)[see: http://dhmh.maryland.gov/healthenterprisezones/Documents/Local_Population_Health Improvement_Contacts_4-26-12.pdf] schools, behavioral health organizations, faith based community, social service organizations, and consumers) including a description of when and how the hospital consulted with these persons. If the hospital organization takes into account input from an organization, the written report should identify the organization and provide the name and title of at least one individual in such organizations with whom the hospital organization consulted. In addition, the report must identify any individual providing input, who has special knowledge of or expertise in public health by name, title, and affiliation and provide a brief description of the individual's special knowledge or expertise. The report must identify any individual providing input who is a "leader" or "representative" of certain populations (i.e., healthcare consumer advocates, nonprofit organizations, academic experts, local government officials, community-based organizations, health care providers, community health centers, low-income persons, minority groups, or those with chronic disease needs, private businesses, and health insurance and managed care organizations);

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

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

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

(1) Maryland Department of Health and Mental Hygiene's State Health Improvement Process (SHIP)(http://dhmh.maryland.gov/ship/);
(2) SHIP's CountyHealth Profiles 2012 (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx);
(3) the Maryland ChartBook of Minority Health and Minority Health Disparities (http://dhmh.maryland.gov/mhhd/Documents/2ndResource_2009.pdf);
(4) Consultation with leaders, community members, nonprofit organizations, local health officers, or local health care providers;
(5) Local Health Departments;

(6) County Health Rankings (http://www.countyhealthrankings.org);
(7) Healthy Communities Network (http://www.healthycommunitiesinstitute.com/index.html);
(8) Health Plan ratings from MHCC (http://mhcc.maryland.gov/hmo);
(9) Healthy People 2020 (http://www.cdc.gov/nchs/healthy_people/hp2010.htm);
(10) Behavioral Risk Factor Surveillance System (http://www.cdc.gov/BRFSS);
(11) Youth Risk Behavior Survey (http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx)
(12) Focused consultations with community groups or leaders such as superintendent of schools, county commissioners, non-profit organizations, local health providers, and members of the business community;
(13) For baseline information, a CHNA developed by the state or local health department, or a collaborative CHNA involving the hospital; Analysis of utilization patterns in the hospital to identify unmet needs;
(14) Survey of community residents; and
(15) Use of data or statistics compiled by county, state, or federal governments.

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

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

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

Reporting Requirements

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).

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
164	8,571	21225 21061 21230 21227 21122 21060 http://www.hscrc.state.md.us/init_cb.cfm	Baltimore Washington Medical Center, St. Agnes Hospital, and Mercy Medical Center http://www.hscrc.state.md.us/init_cb.cfm	Anne Arundel County: 54.8% Baltimore City: 26.1%	Anne Arundel County: 57.9% Baltimore City: 25.4%

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

a. Describe in detail the community or communities the organization serves. Based on findings from the CHNA, provide a list of the Community Benefit Service Area (CBSA) zip codes. These CBSA zip codes should reflect the geographic areas where the most vulnerable populations reside. Describe how the CBSA was determined, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the section of the CHNA that refers to the description of the Hospital's Community Benefit Community.

MedStar Harbor Hospital's Community Benefit Service Area is defined as ZIP code 21225, the same ZIP code in which the hospital is located. The CBSA includes neighborhoods in Anne Arundel County and Baltimore City. Within the CBSA, the focus is on the Cherry Hill community, MedStar Harbor Hospital's closest neighbor. Cherry Hill is a historically African-American neighborhood, with roots going back to the 17th century. After World War II, more than 600 housing units were built there by the United States War Housing Administration specifically for African-American war workers.

Shortly after the war, these units were made into low-income housing. Additional low-income housing units have been added throughout the years, making Cherry Hill one of the largest housing projects east of Chicago. The 2013 American Community Survey estimates the population of our CBSA is 34,315. The population in Cherry Hill, estimated by the 2012 American Community Survey, is 9,285. Of the Cherry Hill population, 94.9% is African American and 2.4% is white. In the CBSA, the population is 43.8% white and 44.7% African-American.

The median household income for Cherry Hill is $18,118, which is less than half of the median household income for the entire CBSA ($37,487). In the CBSA, the poverty rate is 26.5%; in Cherry Hill, the poverty rate is 47.5%. In terms of health care, the CBSA

includes MedStar Harbor Hospital as well as two local branches of the Family Health Centers of Baltimore, which are Federally Qualified Health Centers (FQHC) providing health care services on a sliding fee scale. In addition, Baltimore City Health Department programs operate city-wide, and various mobile services—such as a needle exchange program, violence prevention, maternal and infant nursing, lead poisoning and abatement programs and others.

The average life expectancy in Anne Arundel County and Baltimore City are 79.8 years and 73.9 years, respectively. The highest mortality rates for both areas are attributable to heart disease, cancer, stroke, chronic lung disease, and diabetes. Within the CBSA, there are high rates of type 2 diabetes and heart disease, including stroke. For a variety of reasons, including the high poverty rate and low rate of health care insurance coverage—14.1 percent of the CBSA is uninsured, as estimated by the 2013 American Community Survey—many residents often use the MedStar Harbor Hospital emergency department for primary care services. We anticipate a steady decrease in this area over the next few fiscal years as patients become insured through the Affordable Care Act and learn how to utilize their coverage. Despite the convenient neighborhood locations of the FQHC, many residents do not utilize primary care physicians. Typically, chronic conditions, such as diabetes or heart disease, present severe enough symptoms to warrant visiting the emergency department. In many cases, several co-morbidities are found to be present at this time. Without primary care follow-up, however, these conditions usually cannot be addressed fully in the time allotted for the emergent issue. In other cases, patients may have symptoms of much less serious illnesses—simple colds, for example—but because they do not have primary health care providers, they also visit the emergency department for these ailments. As a result, many of their most basic health needs often are not met.

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

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/) and its Area Health Profiles 2013, (http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx), the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014) (http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), the Maryland ChartBook of Minority Health and Minority Health Disparities, 2nd Edition (http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Health%20Disparities%20Data%20Chartbook%202012%20corrected%202013%2002%2022%2011%20AM.pdf), The Maryland State Department of Education (The Maryland Report Card) (http://www.mdreportcard.org) Direct link to data– (http://www.mdreportcard.org/downloadindex.aspx?K=99AAAA)

Table II

Median Household Income within the CBSA	CBSA $37,487 Source: 2013 American Community Survey Five-Year Estimates Cherry Hill $18,118 Source: Baltimore Neighborhood Profiles
Percentage of households with incomes below the federal poverty guidelines within the CBSA	CBSA 26.5% Source: 2013 American Community Survey Five-Year Estimates Cherry Hill 47.5% Source: Baltimore Neighborhood Profiles
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	CBSA 14.1 % Anne Arundel County 7.9% Baltimore City 13.1% Source: 2013 American Community Survey Five-Year Estimates
Percentage of Medicaid recipients by County within the CBSA.	Anne Arundel County 12.73% Baltimore City 34.71% Source: Maryland Medicaid eHealth Statistics
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Anne Arundel County 79.8 years - county average 77.8 years - black 79.9 years - white Baltimore City 73.9 years - city average 72.2 years - black 76.5 years - white

	Source: Maryland SHIP 2013
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Anne Arundel County 813 per 100,000—white 932 per 100,000—black Baltimore City Mortality by Race (per 10,000 residents) Total: 100.2 Black: 104.8 White: 107.8 http://health.baltimorecity.gov/sites/default/files/Health%20Disparities%20Report%20Card%20FINAL%2024-Apr-14.pdf
Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	**Access to Healthy Food** Baltimore City 25% live within a food desert Source: Baltimore City Department of Planning Supermarket Proximity Estimated Travel Time to Nearest Supermarket by Car (in min) Cherry Hill – 7 Baltimore City – 3.7 Estimated Travel Time to Nearest Supermarket by Bus (in min) Cherry Hill– 32 Baltimore City – 12.3 Estimated Travel Time to Nearest Supermarket by Walking (in min) Cherry Hill – 43 Baltimore City – 16.6 Source: Baltimore City 2011 Neighborhood Health Profiles **Transportation** CBSA 30.2%have no available vehicle 34% have one vehicle 35.9 % have two or more vehicles

	Anne Arundel County 4.2% have no available vehicle 28.4% have one vehicle 67.4% have two or more vehicles Baltimore City 30.3% have no available vehicle 41.2% have one vehicle 28.5% have two or more vehicles Source: 2013 American Community Survey Five-Year Estimates Cherry Hill 55.6% have no available vehicle 36.7% have one vehicle 7.6% have two or more vehicles Source: Baltimore Neighborhood Profiles **Education** CBSA 64.8% residents 25 or older with a high school degree or less 8.6% residents 25 years and older with a bachelors degree or more Anne Arundel County 34.6% residents 25 or older with a high school degree or less 37% residents 25 years and older with a bachelors degree or more Baltimore City 52.6% residents 25 or older with a high school degree or less 25% residents 25 years and older with a bachelors degree or more Source: 2013 American Community Survey Five-Year Estimates Cherry Hill 65.5% residents 25 years and older with a high school degree or less 5.7% residents 25 years and older with a bachelors degree or more Source: Baltimore Neighborhood Profiles

	Housing Quality CBSA 48.6% of homes are owner occupied 51.4% of homes are renter occupied Anne Arundel County 74.2% of homes are owner occupied 25.8% of homes are renter occupied Baltimore City 48.3% owner occupied 51.7% of homes are renter occupied Source: 2013 American Community Survey Five-Year Estimates Cherry Hill 16.6% of homes are owner occupied 83.4% of homes are renter occupied Source: Baltimore Neighborhood Profiles
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	**CBSA (ZIP code 21225, which includes the Brooklyn, Brooklyn Park, Cherry Hill, and Pumphrey neighborhoods)** 34,315 people 16,235 (47.3%) male 18,080 (52.7%) female 15,043 (43.8%) white 15,346 (44.7%) African American 111 (0.3%) American Indian or Alaska native 1,056 (3.1%) Asian 33 (0.1%) native Hawaiian or other Pacific islander 1,736 (5.1%) two or more races 2,128 (6.2%) Hispanic or Latino Median age is 33.2

	Source: 2013 American Community Survey Five-Year Estimates **Cherry Hill (focus area within the CBSA)** 9,285 people 3,835 (41.3%) male 5,450 (58.7%) female 225 (2.4%) white 8,810 (94.9%) African American 20 (0.2%) American Indian or Alaska native 25 (0.3%) Asian 15 (0.2%) native Hawaiian or other Pacific islander 185 (2 percent) two or more races 40 (0.4 percent) Hispanic or Latino Median age is 25.2 Source: Baltimore Neighborhood Profiles **Language** CBSA 91.2% speak only English 5.2% speak Spanish 1.2% speak an Indo European language 2.1%speak an Asian or Pacific Islander language 0.3% speak another language Anne Arundel County 89.4% speak only English 5.1% speak Spanish 2.6% speak an Indo European language 2.4% speak an Asian or Pacific Islander language 0.6% speak another language Baltimore City 91.2% speak only English 3.7% speak Spanish 2.6% speak an Indo European

	language 1.4% speak an Asian or Pacific Islander language 1.2% speak another language Source: 2013 American Community Survey Five-Year Estimates Cherry Hill 96.8% speak only English 1.8% speak Spanish 0.5% speak an Indo European language 0.4% speak an Asian or Pacific Islander language Source: Baltimore Neighborhood Profiles
Other	

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

__X__Yes
____No

Provide date here. 6/30 /12

If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).
http://ct1.medstarhealth.org/content/uploads/sites/16/2015/11/MedStar-Systemwide-CHA-2012.pdf (Page 42-50)

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

_X_Yes 6/30 /12
___No

If you answered yes to this question, provide the link to the document here.
http://ct1.medstarhealth.org/content/uploads/sites/16/2015/11/MedStar-Systemwide-CHA-2012.pdf (Page 51-54)

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. Is Community Benefits planning part of your hospital's strategic plan?

_X_Yes
___No

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

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

The executive team at MedStar Harbor Hospital is committed to serving our community, both as an organization and individuals. Each member of the executive team is charged with being regularly involved in the community, which may include providing a service, attending community events, and/or being a member of a community group. Through this level of community engagement, our community stays at the forefront of all we do.

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

i. Senior Leadership

1. _X_CEO
2. _X_CFO
3. _X_Other (please specify)

Vice President of Operations

Describe the role of Senior Leadership.

MedStar Harbor Hospital's Board of Directors, CEO and the organization's operations leadership team work thoroughly to ensure that the hospital's strategic and clinical goals are aligned with unmet community needs though the planning, monitoring and evaluation of its community benefit activities.

ii. Clinical Leadership

1. _X_Physician
2. _X_Nurse
3. _X_Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

The hospital's chief or orthopedics, chief of nursing and director of case and quality management are members of the advisory task force.

iii. Community Benefit Operations

1. ___Individual (please specify FTE)
2. ___Committee (please list members)
3. _X_Department (please list staff)
   Leslie Hughan, Community Relations Manager, MedStar Harbor Hospital
   Calvert Moore, DNP, MS, RN, APHN-BC, School Health Resource Coordinator, MedStar Harbor Hospital

Community Relations Manager
The manager of community relations writes all reports, chairs the advisory task force committee, and coordinates activities outlined by the implementation plan.

School Health Resource Coordinator
The school health resource coordinator runs our Healthy Schools Healthy Families program, which benefit the families with children enrolled in the three elementary/middle schools in the neighborhood with the highest poverty rate within the CBSA.

_X_ Task Force (see members listed below)

Advisory Task Force
The purpose of the Advisory Task Force is to obtain community and institutional buy-in for the CHNA process, including priority setting and implementation strategy development. Advisory Task Force scope included review of secondary data and state and national community health goals, contribute to the prioritization of community health needs, and provide a recommendation on the direction of the hospital's implementation strategy.

Task Force Members:

Name / Title	Organization
Jill Johnson, VP, Operations	MedStar Harbor Hospital
Leslie Hughan, Manager, Community Relations	MedStar Harbor Hospital
Calvert Moore, DNP, MS, RN, APHN-BC, School Health Resource Coordinator	MedStar Harbor Hospital
Nilda Ledesma, Director, Case/Quality Management	MedStar Harbor Hospital
Cathy McClain, Executive Director	Cherry Hill Trust
James E. Wood Jr., M.D., Chief of the Department of Orthopaedic Surgery	MedStar Harbor Hospital
Robert Dart, M.D., Primary Care Physician	MedStar Harbor Primary Care
Joanne Robinson, community advocate (Brooklyn/Curtis Bay/South Baltimore) Health Planner	Anne Arundel County Health Department

4. ___Other (please describe)

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

Spreadsheet __X__yes _____no
Narrative __X__yes _____no

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

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

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

Spreadsheet	__X___yes	_____no
Narrative	__X__yes	_____no

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

_____ Other hospital organizations
__X__ Local Health Department
__X__ Local health improvement coalitions (LHICs)
__X__ Schools
_____ Behavioral health organizations
__X__ Faith based community organizations
_____ Social service organizations

b. Use the table below to list the meaningful, core partners with whom the hospital organization collaborated to conduct the CHNA. Provide a brief description of collaborative activities with each partner (please add as many rows to the table as necessary to be complete)

Organization	Collaboration Description
Holleran	A public health research and consulting firm with 20 years of experience in conducting community health assessments. The firm provided the following support: 1) assisted in the development of a community health assessment survey tool; 2) facilitated the community health assessment face-to-face group session; and 3) facilitated an implementation planning session.
Healthy Communities Institute	Provided quantitative data based on 129 community health indicators by county. Using a dashboard methodology, the web-based portal supported the hospital's prioritization process

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

_____yes __X___no

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

__X__yes _____no

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 link: http://www.thecommunityguide.org/)
(Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

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?

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

k. based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?

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.

Table III A. Initiative I

a. 1. Identified Need 2. Was this identified through the CHNA process?	Diabetes Prevention and Management In 2007, diabetes was the seventh leading cause of death in the United States. In 2010, an estimated 25.8 million people or 8.3% of the population had diabetes. Diabetes disproportionately affects minority populations and the elderly and its incidence is likely to increase as minority populations grow and the U.S. population becomes older (MD BRFSS). From 2008, the average prevalence of diagnosed diabetes among white Marylanders was 7.5% and 12.3% among black Marylanders. Black females (12.5%) had almost double the diabetic rates of white females (6.8%). Diabetes is widely associated with older age, and the older working age population (50-64) represents the fastest growing diabetic group in Maryland. Additionally, 15.4% of diabetic Marylanders have less than a high school education and 17.1% of diabetic Marylanders earn less than $15,000 annually, (Healthy Maryland – Project 2020). At MedStar Harbor Hospital, diabetes and related conditions are top causes of inpatient admissions and readmissions, due to failure/inability to comply with disease management protocols. Yes, this was identified through the CHNA process.

b. Hospital Initiative	Diabetes education seminars and screenings Hold events both on campus and in the community to discuss reducing the risk of developing type 2 diabetes and hold events to promote how to live well with diabetes targeting community members
c. Total Number of People Within the Target Population	CBSA = 34,315 people targeted
d. Total Number of People Reached by the Initiative Within the Target Population	161 participants in FY15 1,270 participants from 2012-2015
e. Primary Objective of the Initiative	To increase knowledge and awareness of diabetes prevention and management through diabetes education, seminars and screenings
f. Single or Multi-Year Initiative –Time Period	Multi-Year initiative period (July 1, 2012 to June 30, 2015)
g. Key Collaborators in Delivery of the Initiative	Diabetes educator Dietitian Endocrinologist Cherry Hill Senior Center Brooklyn Park Senior Center
h. Impact/Outcome of Hospital Initiative?	In FY15, MedStar Harbor Hospital offered 3 talks and 3 cooking demonstrations to reach 161community members, which is 423 percent more community members reached in FY12. (One of our FY14 goals was to increase participation by 50% using FY12 as a baseline.) Of those 161 community members, 53 (32.9%) reported gaining new knowledge from our diabetes events. From 2012 to 2015, we've offered 12 classes, reaching 1,270 community members. Of the 1,270 community members 116 reported gaining new knowledge in FY15 (the only year with complete knowledge assessments. The three talks were held in the community and the three cooking demonstrations were held on the hospital's campus.

i. Evaluation of Outcomes:	Through this program, we were able to introduce community members to new knowledge about diabetes and how to take preventative steps against developing diabetes.	
j. Continuation of Initiative?	Yes	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 868	B. Direct Offsetting Revenue from Restricted Grants $0

Initiative II

a. 1. Identified Need 2. Was this identified through the CHNA process?	Heart Disease Prevention and Management Heart disease is the leading cause of death in Baltimore City (Healthy Baltimore 2015). Heart disease accounts for 24.6% of all deaths in Cherry Hill (Cherry Hill Health Profile, 20011) The age-adjusted death rate due to heart disease is 262.9 deaths per 100,000, placing it in the red zone for severity and prevalence (MD DHMH, 2011). The majority (59.5%; n=37) of community input survey respondents, who live and/or work in the CBSA, classified the incidence of heart disease as very severe. Yes, this was identified through the CHNA process.
b. Hospital Initiative	Heart Smart Church Program
c. Total Number of People Within the Target Population	CBSA = 34,315 people targeted
d. Total Number of People Reached by the Initiative Within the Target Population	375 participants in FY15; 38 live within the CBSA. 600 participants from 2012 to 2015; 61 lived within the CBSA.
e. Primary Objective of the Initiative	Train lay-people in the congregations of participating churches to take blood pressures. Have participating churches screen members monthly, reporting all results to MedStar Harbor Hospital. Reduce blood pressures among those tracked.
f. Single or Multi-Year Initiative –Time Period	Multi-Year initiative period (July 1, 2012 to June 30, 2015)
g. Key Collaborators in Delivery of the Initiative	Parish Nurse

	Church volunteer blood pressure screeners Participating churches: Asbury Town Neck United Methodist Church, Brooklyn Seventh Day Adventist Church, Davidsonville United Methodist Church, Empowering Believers Church, Jenkins Memorial Church, Metropolitan United Methodist Church, Mt. Zion United Methodist Church – Laurel, Mt. Zion United Methodist Church - Magothy, New Life International Ministry, Pasadena United Methodist Church, St. John's Lutheran Church, and St. John's United Methodist Church	
h. Impact/Outcome of Hospital Initiative?	In FY15, 12 sites participated with 375 participants, 69 screening events, and 858 individual blood pressure screenings. Of the 12 sites, three are located within the CBSA ZIP code 21225. In FY15, 38 participants (10%) were residents of the CBSA. Of the individuals who participated in the screening since FY13 (102 total participants), 24.7 percent saw their blood pressure decrease. During the past three-year period, FY12 to FY15, the program had a total of 600 participants, 203 screening events, and 2,532 individual blood pressure screenings.	
i. Evaluation of Outcomes:	Through this program, we helped members lower their blood pressure. This program served as an excellent reminder about the importance of taking prescribed blood pressure medications. Screeners regularly reported that many participants had blood pressure medications, but didn't take them prior to the screening. This screening program provided participants with information to start or continue conversations about their blood pressure with their primary care providers.	
j. Continuation of Initiative?	Yes	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $2,186	B. Direct Offsetting Revenue from Restricted Grants $0

Initiative III

a. 1. Identified Need 2. Was this identified through the CHNA process?	Heart Disease Prevention and Management Heart disease is the leading cause of death in Baltimore City (Healthy Baltimore 2015). Heart disease accounts for 24.6% of all deaths in Cherry Hill (Cherry Hill Health Profile, 2011). The age-adjusted death rate due to heart disease is 262.9 deaths per 100,000, placing it in the red zone for severity and prevalence (MD DHMH, 2011). The majority (59.5%; n=37) of community input survey respondents, who live and/or work in the CBSA, classified the incidence of heart disease as very severe. Yes, this was identified through the CHNA process.
b. Hospital Initiative	Community Blood Pressure Screenings
c. Total Number of People Within the Target Population	CBSA = 34,315 people targeted
d. Total Number of People Reached by the Initiative Within the Target Population	147 participants in FY15; 39 live within the CBSA. 311 participants FY13 to FY15; 68 lived within the CBSA.
e. Primary Objective of the Initiative	Offer free monthly blood pressure screenings in area senior centers and other community locations. Increase the number of individual screenings by 25% using FY12 as a baseline.
f. Single or Multi-Year Initiative –Time Period	Multi-Year initiative period (July 1, 2012 to June 30, 2015)
g. Key Collaborators in Delivery of the Initiative	Parish Nurse MedStar Visiting Nurse Association

	MedStar Harbor Hospital CNO Community sites: Allen Center for Seniors, Body and Soul, Curtis Bay Senior Center, Curtis Bay Recreation Center, Glen Squares Apartments, Locust Point Recreation Center, and Shop Rite	
h. Impact/Outcome of Hospital Initiative?	In FY15, with the help of MedStar VNA, we conducted blood pressure screenings in six community locations with 147 participants, 43 screening events, and 411 blood pressures taken. The number of blood pressures taken through this program in FY15 compared to FY12 increased by 151 percent, which is better than our goal of 25 percent. Participants with high blood pressures were advised to follow up with their primary care providers. Those with dangerously high blood pressures were recommended to go the nearest hospital, with our screener always offering to call 911 on their behalf – almost all participants in these situations declined the call to 911. During the past three-year period, FY12 to FY15, the program had a total of 311 participants, 127 screening events, and 1,237 individual blood pressure screenings.	
i. Evaluation of Outcomes:	This program, similar to the program in initiative II, served as an excellent reminder about the importance of taking prescribed blood pressure medications. Screeners regularly reported that many participants had prescribed blood pressure medications, but either hadn't taken them prior to the screenings or forgot to take them. This screening program provided participants with information to start or continue conversations about their blood pressure with their primary care providers.	
j. Continuation of Initiative?	Yes	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $7,769	B. Direct Offsetting Revenue from Restricted Grants $0

Initiative IV

a. 1. Identified Need 2. Was this identified through the CHNA process?	Heart Disease Prevention and Management Heart disease is the leading cause of death in Baltimore City (Healthy Baltimore 2015). Heart disease accounts for 24.6% of all deaths in Cherry Hill (Cherry Hill Health Profile, 2011). The age-adjusted death rate due to heart disease is 262.9 deaths per 100,000, placing it in the red zone for severity and prevalence (MD DHMH, 2011). The majority (59.5%; n=37) of community input survey respondents, who live and/or work in the CBSA, classified the incidence of heart disease as very severe. Yes, this was identified through the CHNA process.
b. Hospital Initiative	Healthy Heart and Risky Business Seminars
c. Total Number of People Within the Target Population	CBSA = 34,315 people targeted
d. Total Number of People Reached by the Initiative Within the Target Population	136 seminar participants in FY15; 18 live within the CBSA. 211 seminar participants FY13 to FY15; 39 lived within the CBSA.
e. Primary Objective of the Initiative	Hold events both on the hospital campus and in the community to discuss ways to reduce risk factors for heart disease. Offer free cholesterol screenings to the community. Increase the number of seminars held in the community by 25% using FY12 as a baseline. Improved awareness and knowledge of behaviors that support heart health using FY13 as the baseline. Increase to 50% and maintain number of seminars in the community using FY12 as

	a baseline.	
f. Single or Multi-Year Initiative –Time Period	Multi-Year initiative period (July 1, 2012 to June 30, 2015)	
g. Key Collaborators in Delivery of the Initiative	Cardio educator Cherry Hill Senior Center Brooklyn Park Senior Center	
h. Impact/Outcome of Hospital Initiative?	In FY15, we held six healthy heart educational sessions and encountered 136 community members. During the three-year period, a total of four sessions were held within the community. Program survey results showed that of the 136 participant, 92 (67.6 percent) reported gaining new knowledge. Participation in FY15 compared to FY13 increased by 69 percent.	
i. Evaluation of Outcomes:	Through this program, we were able to introduce community members to new knowledge about heart health and how to take steps to keep their hearts healthy.	
j. Continuation of Initiative?	Yes	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $846	B. Direct Offsetting Revenue from Restricted Grants $0

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

   There are five health needs identified through our CHNA that were not addressed in through the hospital's implementation plan.

Condition / Issue	**Classification**	**Provide statistic and source**	**Explanation**
Mental and Behavioral Illness	Wellness & Prevention	80.5% (n=36) of Community Input Survey respondents identified this as a "severe" or "very severe" health condition	While MedStar Harbor, like many community hospitals, has very basic in-house support systems, most of the expertise in treating this condition is provided by other community providers. The MedStar Baltimore hospitals are exploring new partnerships to allow them to better meet the health needs of patients with mental/behavioral illness. At this time, the hospital does not have the infrastructure or the core competencies to effectively program around this disease condition. However, MedStar Harbor has a robust case management program, through which the hospital creates access to the appropriate level of outside inpatient and outpatient treatment and management programs.
Cancer	Wellness & Prevention	55.6% (n=37) of Community Input Survey respondents identified this as a "severe" or "very severe" health condition	Oncology is a clinical service that MedStar Harbor provides. In addition, the hospital has a solid infrastructure of support, through seminars, screenings, and, the Breast & Cervical Cancer Program. With those in place, and with finite resources available, the hospital determined it was best to focus its efforts on other health priorities.
Arthritis and Joint Health	Wellness & Prevention	44.4% (n=36) of Community Input Survey respondents	Orthopaedics is a major area of clinical expertise at MedStar Harbor. The hospital offers a solid infrastructure of support, through seminars and screenings. With those in place, and with finite resources

		identified this as a "severe" or "very severe" health condition	available, the hospital determined it was best to focus efforts on other health priorities.
Stroke	Wellness & Prevention	61.1% (n=36) of Community Input Survey respondents identified this as a "severe" or "very severe" health condition	MedStar Harbor is certified as a primary stroke center. Through the hospital's Emergency Department and inpatient efforts, as well as other community involvement such as stroke Awareness Month activities, other groups within the hospital are forming the lead on education about stroke. In addition, many outreach efforts around heart disease, and even diabetes, will support education related to Stroke. The hospital believes this is being thoroughly covered both directly and indirectly.
Overweight / Obesity	Wellness & Prevention	91.7% (n=36) of Community Input Survey respondents identified this as a "severe" or "very severe" health condition	MedStar Harbor already has existing programming in place that specifically targets obesity/overweight. Additionally, by targeting factors that contribute to heart disease and diabetes, the hospital will indirectly address overweight/obesity.

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health

   In alignment with the State's population health strategy, the goals of the community benefit initiatives were to promote health and wellness and improve health knowledge and behaviors among communities and populations disproportionately affected by highly prevalent diseases and conditions.

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.

Physician leadership and case management staff continued to identify several areas of concern. Areas include:

-Timely placement of patients in need of inpatient psychiatry services
-Limited availability of outpatient psychiatry services
-Limited availability of inpatient and outpatient substance abuse treatment
-Limited healthcare services for the homeless
-Limited healthcare services for undocumented residents

1. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please indicate the category of subsidy, and explain why the services would not otherwise be available to meet patient demand. The categories include: Hospital-based physicians with whom the hospital has an exclusive contract; Non-Resident house staff and hospitalists; Coverage of Emergency Department Call; Physician provision of financial assistance to encourage alignment with the hospital financial assistance policies; and Physician recruitment to meet community need.

   Category 1 - Hospital-Based Physician Subsidies:
   Primary Care: Primary Care includes physician practices that provide primary healthcare services. Most of the patients are from the local community and are low-income families. This service generates a negative margin. However, the practice addresses a community need and supports the hospital's mission of commitment to patients, communities, physicians and employees. Providing this service allows the local community access to healthcare services, and therefore more preventive measures and an improvement of the patients' health status are achieved.
   Women's and Children's Services: Physician practices provide healthcare services for obstetrics and gynecology. A negative margin is generated. A large number of our patients receiving these services are from minority and low income families. Prenatal care is provided. Ob-Gyn coverage is provided 24 hours a day. Preventive measures and improvement of the patient's health status are achieved. The services address a community need for women's health and children's services for lower income and minority families.
   Pediatric Services: Physician practices provide 24-hour health care services for pediatrics. A negative margin is generated. A large number of the patients receiving these services are from minority and low-income families. Preventive measures and improvement of the patient's health status are achieved. The services address a community need for children's services for lower income and minority families.
   Psychiatric Services: MedStar Harbor Hospital absorbs the cost of providing psychiatric supervision for the Emergency Department on a 24-7 basis. If these services were not provided, patients would be transported to another facility to receive them. The community needs are being met and commitment to patients is exhibited by providing these services.

   Category 2 – Non-Resident House Staff and Hospitalist Physician Subsidies:
   Hospitalists: MedStar Harbor Hospital provides physicians (hospitalists) for patients who do not have primary care providers handling their stay. Our community includes many low-income and minority families who have this requirement. The community needs for these services are being met, and a negative margin is generated.

   Category 3- Coverage of ED Call Physician Subsidies:
   Emergency Room On-Call Services: MedStar Harbor Hospital absorbs the cost of providing on-

call specialists for the Emergency Department for certain surgical specialties. These specialists otherwise would not provide the services because of the low volumes of specialists and a large number of indigent patients served. If these services were not provided, the patient would be transported to another facility to receive the specialty services. The community needs are being met and commitment to patients is exhibited by providing these services.

VII. APPENDICES

To Be Attached as Appendices:

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

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

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

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

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

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

- Increase life expectancy
- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization
- Reduce the % of adults who are current smokers
- Reduce the % of youth using any kind of tobacco product
- Increase the % vaccinated annually for seasonal influenza
- Increase the % of children with recommended vaccinations
- Reduce new HIV infections among adults and adolescents
- Reduce diabetes-related emergency department visits
- Reduce hypertension related emergency department visits
- Reduce the % of children who are considered obese
- Increase the % of adults who are at a healthy weight
- Reduce hospital ED visits from asthma
- Reduce hospital ED visits related to behavioral health
- Reduce Fall-related death rate

VII. APPENDICES

Appendix I
Financial Assistance Policy

MedStar Harbor Hospital provides a brochure for patients who need help paying for their hospital services. This brochure (pictured below) is available upon request and is readily available to patients during the hospital registration process. Copies of this brochure are provided to all patients who identify as "self-pay" at the time of registration. The brochure is:

- available in all admission areas, the emergency room, and other areas in which eligible patients are likely to present
- provided with financial assistance contact information to patients or their families as part of the intake process

Appendix II
Financial Assistance Policy Changes

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

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

Appendix III
Financial Assistance Policy

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

Policy

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

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

Scope

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

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

Definitions

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

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

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

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

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

Responsibilities

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

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

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

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

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

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

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

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

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

4. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

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

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

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

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

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

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

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

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

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

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

5.1 MedStar Health will evaluate patients for Medical Hardship Financial Assistance if they exceed the 400% of the FPL and are deemed ineligible for Free Care or Reduced-Cost Care.

5.2 Medical Hardship is defined as medical debt, incurred by a household over a 12-month period, at the same hospital that exceeds 25% of the family household income.

5.3 MedStar Health will provide Reduced-Cost Care to patients with income below 500% of the FPL that, over a 12 month period, has incurred medical debt at the same hospital in excess of 25% of the patient's household income. Reduced Cost-Care will be available based on a sliding-scale as outlined below.

5.4 A patient receiving reduced-cost care for medical hardship and the patient's immediate family members shall receive/remain eligible for Reduced-Cost medically necessary care when seeking subsequent care for 12 months beginning on the date which the reduced-care was received. It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

5.5 If a patient is eligible for both Free Care / Reduced-Cost Care, and Medical Hardship, the hospital will employ the more generous policy to the patient.
5.6 Medical Hardship Reduced-Care Sliding Scale Levels:

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

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

6.1 Patients may obtain an application for Financial Assistance Application:
6.1.1 On Hospital websites
6.1.2 From Hospital Patient Financial Counselor Advocates
6.1.3 By calling Patient Financial Services Customer Service
6.2 MedStar Health will evaluate the patient's financial resources (assets convertible to cash) by calculating a pro forma net worth **EXCLUDING**:
6.2.1 The first $150,000 in equity in the patient's principle residence
6.2.2 Funds invested in qualified pension and retirement plans where the IRS has granted preferential treatment
6.2.3 The first $10,000 in monetary assets e.g., bank account, stocks, CD, etc
6.3 MedStar Health will use the Maryland State Uniform Financial Assistance Application as the standard application for all MedStar Health Hospitals. MedStar Health will require the patient to supply all documents necessary to validate information to make eligibility determinations.
6.4 Financial assistance applications and support documentation will be applicable for determining program eligibility one (1) year from the application date. Additionally, MedStar will consider for eligibility all accounts (including bad debts) 6 months prior to the application date.

7. **PRESUMPTIVE ELIGIBILTY**

7.1 Patients already enrolled in certain means-tested programs are deemed eligible for free care on a presumptive basis. Programs eligible under the MedStar Health financial assistance program include, but may not be limited to:
7.1.1 Maryland Primary Adult Care Program (PAC)
7.1.2 Maryland Supplemental Nutritional Assistance Program (SNAP)
7.1.3 Maryland Temporary Cash Assistance (TCA)
7.1.4 Maryland State and Pharmacy Only Eligibility Recipients
7.1.5 DC Healthcare Alliance or other Non-Par Programs
7.2 Additional presumptively eligible categories will include with minimal documentation:
7.2.1 Homeless patients
7.2.2 Deceased patients with no known estate
7.2.3 Members of a recognized religious organization who have taken a vow of poverty
7.2.4 All patients based on other means test scoring campaigns
7.2.5 All secondary balances after primary Medicare insurance where patients meet income and asset eligibility tests
7.2.6 All spend-down amounts for eligible Medicaid patients.

8 **MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS**

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

9. **PAYMENT PLANS**

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

10 **BAD DEBT RECONSIDERATIONS AND REFUNDS**

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

Exceptions

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

1.1 Insured patients who may be "underinsured" (e.g. patient with high deductibles/coinsurance)
1.2 Patient seeking non-medically necessary services, including cosmetic procedures
1.3 Non-US Citizens,
  1.3.1 Excluding individuals with permanent resident /resident alien status as defined by the Bureau of Citizenship and Immigration Services has issued a green card
1.4 Patients residing outside a hospital's defined zip code service area
  1.4.1 Excluding patient referral between MedStar Health Network System
  1.4.2 Excluding patients arriving for emergency treatment via land or air ambulance transport

1.4.3 Specialty services specific to each MedStar Health hospital and approved as a program exclusion

1.5 Patients that are non-compliant with enrollment processes for publicly –funded healthcare programs, charity care programs, and other forms of financial assistance

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

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

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

Explanation And Details/Examples
N/A

Requirements And Guidelines For Implementing The Policy
N/A
Related Policies
N/A

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

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

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

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

Appendix IV
Patient Information Sheet

Harbor Hospital
MedStar Health

MARYLAND HOSPITAL PATIENT INFORMATION SHEET

HOSPITAL FINANCIAL ASSISTANCE POLICY

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

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

PATIENTS' RIGHTS

Harbor Hospital will work with their uninsured patients to gain an understanding of each patient's financial resources.

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

PATIENTS' OBLIGATIONS

Harbor Hospital believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

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

CONTACTS:

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

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

For Information about Maryland Medical Assistance

Contact your local Department of Social Services

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

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

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

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Appendix V
Mission, Vision, Value Statement

Mission
MedStar Harbor Hospital is committed to always providing a quality, caring experience for our patients, our communities, and those who serve them.

Quality, Caring and Service
These are the sentinel guideposts for MedStar Harbor, forming the foundation for the hospital's journey from good to great.

Our Patients and Communities
Our patients are our primary reason for existence. They are at the heart of our mission. Our communities are comprised of our employees, our physicians, other caregivers, and the residents of the areas we serve.

Vision
The Trusted Leader in Caring for People and Advancing Health.

Values

- Service: We strive to anticipate and meet the needs of our patients, physicians and coworkers.
- Patient First: We strive to deliver the best to every patient every day. The patient is the first priority in everything we do.
- Integrity: We communicate openly and honestly, build trust and conduct ourselves according to the highest ethical standards.
- Respect: We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.
- Innovation: We embrace change and work to improve all we do in a fiscally responsible manner.
- Teamwork: System effectiveness is built on collective strength and cultural diversity of everyone, working with open communication and mutual respect.