COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2015 Community Benefit Reporting
MedStar St. Mary's 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:
82	8242 Newborns: 1288 Without newborns: 6954	20653 20659 20650 20619 20636 20627 20686 20635 20660 20620 20656 20626 20628 20634 20603 20667 20670 20621 20624 20684 20630	Calvert Memorial Hospital University of MD Charles Regional Medical Center (Formally Civista)	Percentage of Hospital inpatients and observations that are self pay patients is 3.5%	Percentage of hospital inpatient and observation who are Medicaid is 17.2%

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.

St. Mary's County is located on a peninsula in Southern Maryland with over 400 miles of shoreline on the Patuxent River, Potomac River and the Chesapeake Bay. MedStar St. Mary's Hospital, located in Leonardtown, Maryland, is the only acute care hospital in the county. The county is designated by the Bureau of Primary Care as a health professions shortage area for dental and mental health. The southern half of the county is designated as a primary care shortage area.

With a population of over 110,382 residents (2014 US Census estimate), St. Mary's County is a federally designated rural area with a diverse population. Farmers, waterman, high tech scientists, defense contractors/engineers and military members live alongside Amish and Mennonite communities, making the St. Mary's County population unique. The residents of St. Mary's County are majority Caucasian (79.3%), followed by African American (14.3%), Hispanic or Latino origin (4.5%), Asian (2.8%), American Indian and Native Alaskan (0.4%) and Native Hawaiian and other Pacific Islander (0.1%).

St. Mary's County has been the fastest growing county in Maryland within the past 10 years with a population increase of 22% since 2000, and 4.3% growth in the last three years. The county also has the highest percentage of veterans in Maryland, one of the lowest median ages, and an emerging population that is increasingly Hispanic, all of which impact health and delivery of health services. Heart disease, cancer, lower respiratory illnesses, stroke and diabetes are the leading causes of death. Most residents (76.5%) work in the county. The high paying jobs associated with the Patuxent River Naval Air Station mask a growing underserved area located outside the base gates in the Lexington Park community (ZIP code 20653).

With approximately 18.6% of the population living below the federal poverty level, Lexington Park has the greatest number of medically underserved citizens in the area. Approximately 11% (11,626 residents) of the St. Mary's population lives in the Lexington Park Census Designated Place (CDP), which is the single largest center of population in the county, with a disproportionate number living in poverty or near poverty levels. The largest number of minorities (32% African American and 7.4% Hispanic) live within this census tract. The median annual family income for Lexington Park is $64,948, as compared to the median annual family income in St. Mary's County of $85,672. Certain census tracts within the Lexington Park area have a high concentration of poverty, with one having a median annual family income as low as $42,766. Lexington Park has a lower per capita income and a higher unemployment rate than the rest of St. Mary's County, a combination contributing to the county's health disparities. Lexington Park and California, Maryland have been combined by the United States Census into a micropolitan CDP with a total population of 23,483 for infrastructure considerations related to population density within this small, rural community.

MSMH applied to Maryland Department of Health and Mental Hygiene (DHMH) for Health

Enterprise Zone (HEZ) designation on behalf of the Greater Lexington Park area in 2012. Lexington Park is a census designed micropolitan area in St. Mary's County, Maryland. The three combined zip codes comprising the HEZ (Lexington Park, Great Mills and Park Hall) contain over a third of St. Mary's County's population. Home to SMC's highest concentration of socio-economic disparities, access to medical care, healthy food and exercise in the HEZ is severely limited. From the MSMH 2012 DHMH HEZ application:

> "These contiguous zip codes are home to 30,902 residents and 28% of the county's overall population with 18.6% falling below the federal poverty level (2012 US Census data). Thus, the target area is also home to the greatest health disparities, economic inequalities and social deterrents to health that exist in St. Mary's County."

There were over 57,000 MSMH Emergency Department visits in 2011. In 2012, a Med Chi study reported an 86.2% physician shortage in Southern Maryland, which was predicted to increase to 93.1% by 2015 because SMC is one of the fastest growing districts in Maryland. Today, SMC has one primary care physician for every 2,725 citizens, compared to 1045 in top performing counties and 1131:1 in Maryland. Dentists are equally scarce. SMC has 2,069 citizens per dentist, compared to 1,377:1 in top performing areas and 1,392:1 in Maryland. In FY 2013, MSMH ED experienced 994 emergency dental patients. MSMH leadership stays closely in tune with SMC community healthcare needs. Regularly conducted Community Health Needs Assessments (CHNA), Robert Wood Johnson Foundation's County Health Rankings and Roadmaps, MedChi reports, US government census data and MSMH data drive community health decision making. The HEZ *Access Health* program is the culmination of years of a rapidly improving focused response to SMC population health needs.

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	$85,672
Percentage of households with incomes below the federal poverty guidelines within the CBSA	7.2%
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	9.9%
Percentage of Medicaid recipients by County within the CBSA.	16.13%
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	79.5 Black, 2012: 76.4 White, 2012: 78.3
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Infant mortality rate All races:6.8 African American:23.4 Age adjusted Mortality rate from cancer:187.5 Non Hispanic White:193.4 Non Hispanic Black:195.3 Drug induced death rate: 9.5 Age adjusted mortality rate from heart disease: 187.6 Non Hispanic White: 189.6 Non Hispanic Black: 202.9 http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx
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	Food Desert - The 24037996001 census tract in Lexington Park is the only designated food desert in the county USDA food desert tracker Teen Birth Rate, 2012: 28.4 Black Teen Birth Rate, 2012: 60.8 White Teen Birth Rate, 2012: 20.6 Non-fatal Child Maltreatment

	Reported to Social Services, per 1000 children under age 18, 2012: 5.8 Rates of Suicide per 100,000 population: 12.3 Students who enter kindergarten ready to learn, 2012: 93% AIAN—83% Asian—96% AA—88% Hispanic—95% NHOPI—100% White—90% Proportion of students who graduate high school four years after entering in 9th grade, 2012: 83.7% Asian— 89.4% Black—75.5% Hispanic—83.3% White—85.4% Emergency Room visits related to domestic violence/ abuse per 100,000, 2012: 52.1 NH White, 2012: 45.3 http://dhmh.maryland.gov/ship/SitePages/measures.aspx
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	109,633 NH White, 2013: 86,939 Black or African American, 2013: 15,678 American Indian and Alaskan Native, 2013: 438 Asian, 2013: 3,070 Native Hawaiian or Pacific Islander, 2013: 110 Two or more races, 2013: 3,289 Hispanic or Latino, 2013: 4,933 White alone, not Hispanic or Latino, 2013: 83,321 Language other than English spoken at home, pct age 5+, 2009-2013 6.6% http://quickfacts.census.gov/qfd/states/

	24/24037.html
Other	Selected health disparities for southern Maryland: % of Adults with Healthy Weight White: 31% Black: 27% ER visits due to Hypertension White: 241 Black: 845 ER visits due to Asthma White: 54 Black: 148 Deaths from heart disease White: 213 Black: 243 Diabetes related ER visits White: 231 Black: 1,184 http://dhmh.maryland.gov/ship/PDFs/Southern%20Maryland%20County%20Level%20SHIP%20Disparities%20Data%20Charts%20Final%202012%2004%2009.pdf_
	Adults that report binge or excessive drinking in comparison to state and national average. 18% - St. Mary's County 15% - Maryland 8% - National http://www.countyhealthrankings.org/#app/maryland/2012/st-marys/county/2/overall

	Adults that currently smoke in comparison to state and national average 21% - St. Mary's County 17% - Maryland 14% - National http://www.countyhealthrankings.org/#app/maryland/2012/st-marys/county/2/overall

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. 06/30 /2012

   If you answered yes to this question, provide a link to the document here.
   http://ct1.medstarhealth.org/content/uploads/sites/16/2015/11/MedStar-Systemwide-CHA-2012.pdf (Pages 100-110)

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

   _X_ Yes: 06/13/2012
   ___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 (Pages 111-118)

II. 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 2013-2017 MedStar Health Strategic Plan, community health and community benefit initiatives and tactics are organized under the implementation strategy of "Develop coordinated care/population health management capabilities." At the hospital-level, community health and community benefit initiatives and tactics are organized under the "Market Leadership" focus area.

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

i. Senior Leadership

1. _X_ CEO
2. _X_ CFO
3. _X_ Other (please specify)

Describe the role of Senior Leadership.

MedStar St. Mary's Board of Directors, President and the organization's operations leadership team work thoroughly to ensure that the hospitals strategic and clinical goals are aligned with unmet community needs through the planning, monitoring and evaluation of its community benefit activities. All members of Senior Leadership sit on the Advisory Task Force of the Board of Directors for Community Health along with other board members, hospital leadership and community member and community partners. The Chief Medical /Operating Officer is the Executive Sponsor for Community Benefits and Community Health initiatives.

ii. Clinical Leadership

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

Describe the role of Clinical Leadership

The Chief Medical/Operating Officer and Chief of Staff are on the ATF as is the hospital Chief Nursing Officer. Our county health officer is an MD and is also on the committee as are leaders in the community from behavioral health.

iii. Community Benefit Operations

1. ___ Individual (please specify FTE)
2. ___ Committee (please list members)
3. _X_ Department Health Connections (see below)

4. _X_ Task Force (See table below)

The Health Connections department is composed of 33 associates including the Director, Medical Director, 3 operational leads, 5 RN care coordinators, 5 administrative support persons and 15 associates that function in the community as community health workers, community health educators, program coordinators or clinical health educators. Three CDL level drivers complete this team. The director and department secretary are responsible for CB reporting and database management with support from an administrative aid.

Task Force members include:

Name/Title	Organization
Mary Leigh Harless – Board Member (ATF chairperson)	MedStar St. Mary's Hospital
Christine Wray – President	MedStar St. Mary's Hospital
Stephen Michaels, MD – Chief Operating/ Medical Officer	MedStar St. Mary's Hospital
Ric Braam - Chief Financial Officer	MedStar St. Mary's Hospital
Mary Lou Watson – Chief of Nursing Officer	MedStar St. Mary's Hospital
Joan Gelrud - VP (hospital executive lead)	MedStar St. Mary's Hospital
Lori Werrell - Director of Health Connections (hospital lead)	MedStar St. Mary's Hospital
Holly Meyer - Director of Marketing	MedStar St. Mary's Hospital
Dr Avani Shah	Community Physician/Chief of Staff
Dr Roxanne Richards	Community Physician
Kathleen O'Brien	Walden Sierra
Ella Mae Russell	Department of Social Services
Lori Jennings Harris	Department of Aging and Human Services
Meena Brewster, MD – Health Officer	St. Mary's County Health Department
Barbara Thompson – Board member	
Nathaniel Scroggins	Minority Outreach Coalition
Jane Sypher – Board Member	
Colinthia Malloy	Greater Baden Medical Center

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

Spreadsheet _x_ yes ____no
Narrative _x_ yes ____no

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

The internal review of the Community Benefit Report is performed by the Community Health Lead, the Financial Services Manager, and the CFO. The CFO provides oversight of the CBISA reporting function, auditing process and approval of Community Benefit funding. The CEO's signature is obtained through an

attestation letter supporting their approval of the Community Benefit Report. The MedStar Health Corporate Office also conducts a review/audit of the hospital's Community Benefit Report annually.

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

Spreadsheet _x_ yes ____ no
Narrative _x_ yes ____ no

If no, please explain why.

III. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

_X_ Other hospital organizations
_X_ Local Health Department
_X_ Local health improvement coalitions (LHICs)
_X_ Schools
_X_ Behavioral health organizations
_X_ Faith based community organizations
_X_ 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
St. Mary's County Health Department (SMCHD)	Dr. Meena Brewster, MD, MPH	Public Health Officer	MSMH and SMCHD collaborate on the Local Health Improvement Coalition (LHIC) called the Healthy St. Mary's Partnership (HSMP).

Local Health Improvement Coalition (LHIC), Healthy St. Mary's Partnership (HSMP)	Jenna Mulliken	Health Improvements Coordinator/Health Planner	MSMH associates are active members of the Healthy Eating Active Living (HEAL) Team, the Behavioral Health Team and the Access to Care Team.
Maryland Breast & Cervical Health Program (BCCP)	Tami Gaido, BSN Lori Norton, RN	Certified Breast Health Navigator, Komen Grant Manager	MSMH Health Connections Get Connected to Health mobile primary care clinic refers women to SMCHD Breast and Cervical Care Program (BCCP) and coordinates with SMCHD Million Hearts initiatives such as Medication Therapy Management
Million Hearts	Angela Cochran	Million Hearts Program Coordinator	
St. Mary's County Public Schools (SMCPS)	Andrew C. Roper, CAA, Ph.D.	Supervisor of Instruction for Physical Education, Health Education, and Athletics	MSMH Health Connections Health Educator Andrea Hamilton assisted four Title I schools in achieving Healthiest United States Schools Challenge (HUSSC) goals.
Walden Behavioral Health	Kathleen O'Brien	Executive Director	MSMH and Walden collaborate on the LHIC HSMP Behavioral Health and Access to Care Action Teams. Partnerships with Walden provide collocated somatic and behavioral health on MSMH *GCTH* mobile primary care clinic and the HEZ *Access Health* Programs. As St. Mary's County's

			designated crisis hotline manager, Walden provides patient advocates to Domestic Violence (DV) Victims in partnership with MSMH DV program
Department of Social Services	Ella Mae Russell	Director	Health Enterprise Zone; Health Share
Department of Aging and Human Services	Lori Jennings-Harris Matthew Reisdorph Cynthia Brown Alice Allen	Director Prevention Coordinator Core Service Agency Senior Centers	St. Mary's County Community Alcohol Coalition formalized; began *Can You Afford it?* and *Parents Who Host Lose the Most* media campaigns; outreach to 50 local businesses that employ or target 18-25 year olds; 10 fake IDs were turned in St. Mary's Police; hosted 2 workshops to address parental responsibilities; attended 18 community events to spread awareness. 55 employees Responsible Alcohol Services Training (RAST). *Gold Card* program provides a monthly educational seminar and luncheon for an average of 45 residents ages 55 and older; *Walking with Ease* an organized wellness activity for the Senior community.

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?

_x_ 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?

_x_ yes ____no

IV. 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?

Key Collaborators in Delivery: Name the partners (community members and/or hospitals) involved in the delivery of the initiative.

g. 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.

h. 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.

i. 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?

j. 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? Impact/Outcome of Hospital Initiative: Initiatives should have measurable health outcomes. The hospital initiative should be in collaboration with community partners, have a shared target population and common priority areas.

- What were the measurable results of the initiative?
- For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

1. Identified Need 2. Was this identified through the CHNA process?	Adult overweight/obesity 33.2% of St. Mary's County adults are at a healthy weight. The State of Maryland 2014 Goal is 35.7. http://dhmh.maryland.gov/SHIP/SitePages/Home.aspx Yes this was identified through the CHNA process.
a. Hospital Initiative	More to Explore Program as part of the Healthy St Mary's Partnership/ Fit and Healthy St. Mary's Coalition now the Healthy Eating Active Living (HEAL) team
b. Total Number of People Within the Target Population	65% of adults in St. Mary's County who are overweight or obese 30% of preschool children who are obese
c. Total Number of People Reached by the Initiative Within the Target Population	2400 participants received educational booklets between May 2014 and June 2015
d. Primary Objective of the Initiative	Increase the education and awareness of what is a healthy BMI to those residents who are managing conditions associated with obesity. Increase number of residents who are managing chronic conditions associated with overweight/obese lifestyle.
e. Single or Multi-Year Initiative –Time Period	Multi-Year May 2014 -June 2015
f. Key Collaborators in Delivery of the Initiative	Fit and Healthy St Mary's Coalition, which is led by MedStar St. Mary's Hospital and includes the following organizations: St. Mary's County Health Department , University of Maryland Extension Office, St. Mary's Nursing Center, St. Mary's County Office of Aging and Human Services, College of Southern Maryland, St. Mary's County Tennis Association, World Gym, St. Mary's County Public Schools, St. Mary's County Parks and Recreation, Chesapeake-Potomac Home Health Care, Southern Maryland Agricultural Development Commission
g. Impact/Outcome of Hospital Initiative?	2400 individuals received booklets, however only 200 returned and completed booklets.

h. Evaluation of Outcomes:	Chronic disease and obesity management education disseminated to at-risk underserved pediatric population	
i. Continuation of Initiative?	Program continuation decision under review	
j. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $2,632	B. Direct Offsetting Revenue from Restricted Grants $0

Identified Need 2. Was this identified through the CHNA process?	Substance Abuse - Tobacco 19 % of St. Mary's adult residents currently smoke; top performing US jurisdictions have a 14% smoking population http://admin.medstarhealth.thehcn.net/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=4022606 In 2010, 23.7% of adolescents in St. Mary's County reported smoking in the last thirty days. http://dhmh.maryland.gov/SHIP/SitePages/Home.aspx Yes, this was identified through the CHNA
a. Hospital Initiative	Membership on Tobacco free living team of the Healthy St Mary's Partnership Support tobacco cessation program with health department Fax to Assist
b. Total Number of People Within the Target Population	19% of St. Mary's County adults who smoke 23.7% of St. Mary's County adolescents who smoke
c. Total Number of People Reached by the Initiative Within the Target Population	Smoking Cessation classes completed by 482 residents and Fax to Assist certification by 6 associates – 3 inpatient and 3 outpatient
d. Primary Objective of the Initiative	Reduce # of adults who smoke tobacco products
e. Single or Multi-Year Initiative –Time Period	Multi-Year June 2014 - June 2015
f. Key Collaborators in Delivery of the Initiative	Health Department, Minority Outreach Coalition

g. Impact/Outcome of Hospital Initiative?	Increase the number of staff trained to make Fax to Assist referral. Six currently trained with Physical and Respiratory Therapists pending training.	
h. Evaluation of Outcomes:	Implemented program to decrease the number of residents who use tobacco products and decrease the number of resident exposed to second-hand smoke Use of the MD Quit Line will provide supportive data for tracking purposes Analysis pending for second-hand smoke	
i. Continuation of Initiative?	Yes, county smoking rates still above state averages Tobacco free living team will take the lead on this moving forward	
j. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $800	B. Direct Offsetting Revenue from Restricted Grants $0

1. Identified Need 2. Was this identified through the CHNA process?	Substance Abuse -- Alcohol 63.5% of Youth who report ever having had a drink http://www.msde.maryland.gov/NR/rdonlyres/707B5FB5-9A0C-4A06-A741-92D16DC7B2E7/32700/MYRBS_Brochure_2011_w.pdf Adults who binge drink 24.1% http://admin.medstarhealth.thehcn.net/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=4022508 Yes, this was identified through the CHNA process.
a. Hospital Initiative	Community Alcohol Coalition(CAC)
b. Total Number of People Within the Target Population	Total number of: Youth ages 12-21 years: Information not available Young adults ages 21-25 years: Information not available
c. Total Number of People Reached by the Initiative Within the Target Population	Responsible beverage service training sponsored for 55 owners and employees of licensed beverage establishments. Engagement of CAC members and others in the Communities Mobilizing for Change on Alcohol (CMCA) training which will strengthen underage drinking prevention efforts in St. Mary's County. *Can You Afford it?* And *Parents Who Host Lose the Most* media campaigns; Outreach to 50 local businesses that employ or target 18-25 year olds; 10 fake IDs were turned in to St. Mary's County Police; Hosted two workshops to address parental responsibilities; attended 18 community events to spread

	awareness of underage drinking and alcohol abuse.
d. Primary Objective of the Initiative	Decreases # of youth who report alcohol use Decrease # of youth and young adults who report binge drinking
e. Single or Multi-Year Initiative –Time Period	Multi-Year October of 2010 - June 2015
f. Key Collaborators in Delivery of the Initiative	St. Mary's County Department of Aging and Human Services St. Mary's County Treatment and Prevention Office St. Mary's County Health Department St. Mary's County Department of Social Services St. Mary's County Sheriff's Office St. Mary's County Public Schools St. Mary's Ryken High School College of Southern Maryland St. Mary's County Licensed Beverage Association St. Mary's County Alcohol Beverage Board Walden Behavioral Health, Inc. Maryland Choices (CME) Minority Outreach Coalition Southern Maryland News Net NAS PAX River Community Members (Parents and youth) Marketing Support (Full Stride Communications, Black Cat Design, Sail On Social Media) Third Party Evaluation (RMA, Inc.)
g. Impact/Outcome of Hospital Initiative?	Funding renewed for an additional 5 years through competitive MSPF process. One of 10 jurisdictions to receive award
h. Evaluation of Outcomes:	Reduction in reported rate of Binge Drinking by age
i. Continuation of Initiative?	Yes, one of 10 counties in the state recently funded for another 5 years

j. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	C. Total Cost of Initiative $117,000	D. Direct Offsetting Revenue from Restricted Grants: $71,291

1. Identified Need 2. Was this identified through the CHNA process?	Access to Care – Physician Shortage Identified Primary Care Physician Shortage-1:2,725 Maryland average of 1:1,131 providers to patient ratio County health rankings data Yes, this was identified through the CHNA process.
a. Hospital Initiative	Recruit Providers Get Connected to Health (GCTH) MSMH Primary Care
b. Total Number of People Within the Target Population	3,850 or 3.5%: residents who are uninsured Approximately 13,200 or 12%: Medical Assistance recipients who have barriers to access
c. Total Number of People Reached by the Initiative Within the Target Population	1,314: Patient visits through the Get Connected to Health Program in FY15. Patients are screened for health risk factors and offered lifestyle change education options such as the Diabetes Prevention Program (DPP) and Smoking Cessation.
d. Primary Objective of the Initiative	To provide a safety-net clinic in county for those with barriers to care
e. Single or Multi-Year Initiative –Time Period	July 2012-June 2015
f. Key Collaborators in Delivery of the Initiative	Walden Sierra: Behavioral Health Department of Social Services
g. Impact/Outcome of Hospital Initiative?	Reduction in readmissions rate in the Lexington Park area, which is greater than the county as a whole.
h. Evaluation of Outcomes:	Hospital readmission rate reduced over 15% with rate trending down since the inception of the GCTH Program
i. Continuation of Initiative?	Yes , community safety net clinic will continue offering services to this critical shortage area.

j. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	E. Total Cost of Initiative $307,009.84 (GCTH) $403,920 (Primary Care) $52,094 (Recruitment)	F. Direct Offsetting Revenue from Restricted Grants $0

1. Identified Need 2. Was this identified through the CHNA process?	Access to Care – Health Disparities Identified Primary Care Physician Shortage-1:2,725 Maryland average of 1:1,131 providers to patient ratio Dental care provider shortage: (SMC-1:2,069, MD-1,131:1) and Mental Health Care provider shortage (SMC-906:1, MD-502:1). http://www.countyhealthrankings.org/app/#!/maryland/2014/rankings/st-marys/county/outcomes/overall/snapshot Health disparities in ER usage for Asthma, diabetes and High blood pressure for AA citizens in St Mary's County http://dhmh.maryland.gov/mhhd/Documents/Maryland%20Chartbook%20of%20Minority%20Health%20and%20Minority%20Health%20Disparities%20Data,%20Third%20Edition%20(December%202012).pdf Yes, this was identified through the CHNA process.
a. Hospital Initiative	Health Enterprise Zone (HEZ)
b. Total Number of People Within the Target Population	35,000 people in the three identified zones of Lexington Park, Great Mills and Park Hall.
c. Total Number of People Reached by the Initiative Within the Target Population	MSMH employs Community Health Workers in two capacities: Clinical Care Coordinators (CCC) and Neighborhood Wellness Advocates (NWA). Clinical educators (2.0 FTE), health educators (3FTE, 1-.5FTE) and NWAs (1 FTE, 5-.5 FTEs) are trained to deliver the Center for Disease Control and Prevention (CDC) sixteen-week National Diabetes Prevention Program (NDPP) and the six-week Stanford Living Well With Chronic Disease Course. "Bridges Out of Poverty" training and DHMH Cultural Diversity Training ensure case workers approach community members and case management patients with the appropriate cultural respect. **Health Screenings: 470 provided in HEZ** Transportation is a major inhibitor for St. Mary's County's most disparate populations. The *GCTH* driver, and two HEZ shuttle and medical transportation drivers ensure access to healthy food, exercise and follow up doctor's appointments in the HEZ area. **Shuttle Ridership: 7,161 Rides** CCCs manage carefully screened caseloads to promote best possible outcomes for chronic disease patients. Hospital discharges are examined by the Operations Specialist daily. Patients with a combination of eight chronic diseases are scored on their likelihood to readmit and are assigned CCC assistance based on this

	score. CCCs work with patients to increase the patients' chronic disease self-management confidence. By guiding patients to chronic disease education, addiction cessation and other services, outpatient case managers measurably improve population health. **Care Coordination Services: 643 unduplicated patients served**	
d. Primary Objective of the Initiative	Increase access to care, reduce health disparities, reduce unnecessary readmissions and ER utilization	
e. Single or Multi-Year Initiative –Time Period	Multi-Year: April 2013-June 2015	
f. Key Collaborators in Delivery of the Initiative	Health Department, Walden Sierra, Department of Social Services, Department of Aging and Human Services, Housing Authority, Minority Outreach Coalition	
g. Impact/Outcome of Hospital Initiative?	Readmission percentages by Fiscal Year: FY 12 (Baseline): 17.45% FY 13: 15.03% FY 14: 12.34% FY 15: *data pending* http://dhmh.maryland.gov/healthenterprisezones/SitePages/Home.aspx	
h. Evaluation of Outcomes:	http://dhmh.maryland.gov/healthenterprisezones/SitePages/Home.aspx	
i. Continuation of Initiative	Yes –grant will continue through FY17	
j. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	G. Total Cost of Initiative $775,000	H. Direct Offsetting Revenue from Restricted Grants $700,000 per year

1. Identified Need	Childhood Obesity Direct measurements from the 2009 Maryland Pediatric Nutrition Surveillance Survey (PedNSS) suggest that 35.1% of low-income preschoolers (2-4 years old) in St. Mary's were overweight or obese. CDC's PedNSS 2013 shows Maryland at 15.7%, and the Healthy People 2020 goal is to reduce the national average to 9.6. http://www.cdc.gov/pednss/pdfs/PedNSS_2010_Summary.pdf
2. Was this identified through the CHNA process?	Yes this was identified through the CHNA process.
a. Hospital Initiative	Breast feeding Resource Center
b. Total Number of People Within the Target Population	FY15 approximately 1200 deliveries at MSMH
c. Total Number of People Reached by the Initiative Within the Target Population	Health Connections hosts a weekly ongoing breastfeeding support group 4,026 persons assisted by lactation consultants through various services and programs in FY15
d. Primary Objective of the Initiative	Increase breastfeeding initiation rate Achieve Baby Friendly Hospital status
e. Single or Multi-Year Initiative –Time Period	Multi Year: Breastfeeding Resource Center has hosted this group since 2000

f. Key Collaborators in Delivery of the Initiative	Local OB/GYN and Pediatric providers, WIC, La Leche League, Southern Maryland Breastfeeding Alliance, Fleet and Family Support at Patuxent River Naval Air Station	
g. Impact/Outcome of Hospital Initiative?	Increased rate in breastfeeding initiation and exclusive breast milk feeding Breastfeeding rate continues to increase and is currently 78% This year the hospital exclusive breastfeeding rate was 65%	
h. Evaluation of Outcomes:	Breastfeeding Initiation Rate FY 13: 65% FY14: 74% FY15: 78%* **Rate is based on Calendar year data (January 2015-August 2015)* Exclusive breastfeeding rate FY15: 65% *(Prior year rates are not currently available)*	
i. Continuation of Initiative?	Yes, this is ongoing area of focus	
j. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $100,000	B. Direct Offsetting Revenue from Restricted Grants $0

1. Identified Need 2. Was this identified through the CHNA process?	Adult overweight/obesity - 33.2% of St. Mary's County Adults are at a Healthy Weight. The State of Maryland 2014 Goal is 35.7. http://dhmh.maryland.gov/ship/PDFs/Objective%2030.pdf Yes this was identified through the CHNA process.
a. Hospital Initiative	Simple Changes – National Diabetes Prevention Program
b. Total Number of People Within the Target Population	65% of adults in St. Mary's County who are overweight or obese
c. Total Number of People Reached by the Initiative Within the Target Population	Simple Changes FY2015 participants: 107
d. Primary Objective of the Initiative	Increase the number of citizens who are at a healthy BMI Increase number of residents who are managing chronic conditions associated with overweight/obese lifestyle.
e. Single or Multi-Year Initiative –Time Period	Multi Year: Sept 2013 to June 2015
f. Key Collaborators in Delivery of the Initiative	Health Department, Primary Care Physicians, Endocrinologist, St Mary's College of Maryland Fit and Healthy St. Mary's Coalition, which is led by MedStar St. Mary's Hospital and includes the following organizations: St. Mary's County Health Department University of Maryland Extension Office

	St. Mary's Nursing Center St. Mary's County Office of Aging and Human Services College of Southern Maryland St. Mary's County Tennis Association World Gym St. Mary's County Public Schools St. Mary's County Parks and Recreation Chesapeake-Potomac Home Health Care Southern Maryland Agricultural Development Commission	
g. Impact/Outcome of Hospital Initiative?	Total Classes: 8 Total Pounds Lost: 762 Average Attendance: 73% Tracking for recognition in next fiscal year; implemented Workplace Wellness at St. Mary's College of MD through Simple Changes Class; 86 participants including 30 employees have completed program; 74% reported increased activity; 82% achieved weight loss during the program; continued implementation of bariatric program with monthly support group to 25 participants per month.	
h. Evaluation of Outcomes:	Program is progressing well and is providing data to the CDC to achieve recognition. Program being administered in three distinct populations with varying results. The three categories are general public paying a fee, workplace wellness where employer pays and in the underserved community at no cost. N is small but underserved class has the least impactful results at this time as this is an ongoing effort.	
i. Continuation of Initiative?	Yes, obesity rates appear to be trending down, national evidence based program to reduce or delay onset of type 2 diabetes	
j. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	C. Total Cost of Initiative $51,046	D. Direct Offsetting Revenue from Restricted Grants $2,673

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.

Condition / Issue	**Classification**	**Provide statistic and source**	**Explanation**
Transportation	Access to Care	41.8% (n=153) of Community Input Survey respondents either "disagreed" or "strongly disagreed" they have access to transportation for medical appointments	Human Services Council of St. Mary's County mobilizing resources to address this identified need.
Mental / Behavioral Illness	Access to Care	61.1% (n=154) of Community Input Survey respondents rated mental/behavioral illness as either "Severe" or "Very Severe" in the CBSA	Walden Sierra and NAMI are partners who lead
Colon Cancer Screening	Wellness & Prevention	The current prevalence of colon cancer in St. Mary's County is 64.1% (MD BRFSS)	Health Department is lead
Pap Test History	Wellness & Prevention	84.2% of women in St. Mary's County have ever had a Pap Smear Maryland Behavioral Risk Factor Surveillance System	Health Department is lead
Infant Mortality Rate	Wellness & Prevention	Current infant mortality rate in St. Mary's County is 7.6 deaths/1,000 live births- (MD DHMH)	Health Department is lead
Mean Travel Time to Work	Quality of Life	The average commute time in St. Mary's County is 29.7 minutes (American Community Survey)	MSMH does not have the expertise or infrastructure to serve as a lead around this area of need.
Workers who drive alone to work	Quality of Life	82.1% of workers in St. Mary's County drive to work alone (American Community Survey)	MSMH does not have the expertise or infrastructure to serve as a lead around this area of need.
SNAP certified stores	Quality of Life	0.4 stores/1,000 population (USDA Food Environment Atlas)	MSMH does not have the expertise or infrastructure to serve as a lead around this area of need.
Student to Teacher ratio	Quality of Life	16.4 students/teacher (NCES)	School system is lead

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)

MSMH is closely aligned with State initiatives for improvement of population health. The hospital Community Benefits lead served on the State Innovations Model taskforce and the model closely resembles key elements of MSMH led Health Enterprise Zone project funded through the Community Health Resources Commission. We are active participants in all teams of the Healthy St. Mary's Partnership (local LHIC) and regularly use SHIP metrics in program planning and evaluation. The Innovations website is used to examine projects already underway in the state to better harness best practices and model programs during project planning. This cycle of the needs assessment contains priority areas that are priorities for the State as well like Obesity, Substance Abuse, and Access to Care. We are active participants in State initiatives such as Healthiest Maryland Businesses, Million Hearts Grant work, MSPF and CMCA grants, Living Well with Chronic Conditions and NDPP programming to name a few.

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

V. 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.

MSMH has made great strides to bring in needed surgical and specialty services in this three year cycle. We have added Primary Care, Gynecology, General Surgery, Colorectal Surgery, Vascular Surgery and Orthopedics. A variety of pediatric specialties have also been added to complement the existing Pediatric Endocrinology specialists, including neurology, cardiology and pulmonology via rotating specialists in our Charlotte Hall outpatient facility.

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

MSMH provides subsidies in a variety of areas including those listed above. As the sole community hospital serving St Mary's County the closest hospitals are approximately 45 minutes away by car in neighboring Charles and Calvert Counties. The closest tertiary hospitals are over an hour away and often require air transportation as such it is imperative that MSMH have access to at least minimum acceptable levels of coverage in the hospital, emergency department and

community to meet need and as such often subsidizes these practices and practitioners to assure needed coverage.

VI. APPENDICES

To Be Attached as Appendices:

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

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

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

MedStar St. Mary's FAP and financial assistance contact information is:

- available in both English and Spanish
- posted in all admissions areas, the emergency room, and other areas of facilities in which eligible patients are likely to present
- provided with financial assistance contact information to patients or their families as part of the intake process
- provided to patients with discharge materials
- included in patient bills

Patient Financial Advocates visit all private pay patients and are available to all patients and families to discuss the availability of various government benefits, such as Medicaid or state programs, and assist patients with qualification for such programs, where applicable.

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. http://ct1.medstarhealth.org/content/uploads/sites/14/2014/09/Uniform-Financial-Assistance-Application-SMH.pdf

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

MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP) SELECTED 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 St. Mary's FAP and financial assistance contact information is:

- available in both English and Spanish
- posted in all admissions areas, the emergency room, and other areas of facilities in which eligible patients are likely to present
- provided with financial assistance contact information to patients or their families as part of the intake process
- provided to patients with discharge materials
- included in patient bills

Patient Financial Advocates visit all private pay patients and are available to all patients and families to discuss the availability of various government benefits, such as Medicaid or state programs, and assist patients with qualification for such programs, where applicable.

Appendix II
Financial Assistance Policy Changes

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

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

Appendix III
Financial Assistance Policy

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

Policy

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

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

Scope

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

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

Definitions

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

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

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

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

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

Responsibilities

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

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

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

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

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

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

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

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

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

4. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.6 Medical Hardship Reduced-Care Sliding Scale Levels:

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

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

6.1 Patients may obtain an application for Financial Assistance Application:

6.1.1 On Hospital websites

6.1.2 From Hospital Patient Financial Counselor Advocates

6.1.3 By calling Patient Financial Services Customer Service

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

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

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

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

6.3 MedStar Health will use the Maryland State Uniform Financial Assistance Application as the standard application for all MedStar Health Hospitals. MedStar Health will require the patient to supply all documents necessary to validate information to make eligibility determinations.

6.4 Financial assistance applications and support documentation will be applicable for determining program eligibility one (1) year from the application date. Additionally, MedStar will consider for eligibility all accounts (including bad debts) 6 months prior to the application date.

7. **PRESUMPTIVE ELIGIBILTY**

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

7.1.1 Maryland Primary Adult Care Program (PAC)

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

8 **MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS**

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

9. **PAYMENT PLANS**

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

10 **BAD DEBT RECONSIDERATIONS AND REFUNDS**

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

Exceptions

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

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

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

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

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

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

Explanation And Details/Examples
N/A

Requirements And Guidelines For Implementing The Policy
N/A

Related Policies
N/A

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

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

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

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

Appendix IV
Patient Information Sheet

Appendix III – Patient Information Sheet

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

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

PATIENTS' RIGHTS

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

They will provide assistance with enrollment in publicly-funded entitlement programs (e.g. Medicaid) or other considerations of funding that may be available from other charitable organizations.

If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.
If you believe you have been wrongfully referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

PATIENTS' OBLIGATIONS

MedStar St. Mary's 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 301-475-6039 with questions concerning:

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

FOR INFORMATION ABOUT MARYLAND MEDICAL ASSISTANCE

Contact your local Department of Social Services at 1 -800-332-6347. For TTY, call 1-800-925- 4434.

Learn more about Medical Assistance on the Maryland Department of Human Resources website: www.dhr.maryland.gov/fiaprograms/medical.php

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

The patient information sheet is also available in Spanish.

Appendix V Mission
Mission, Vision, Value Statement
MedStar St. Mary's Hospital

Mission

MedStar St. Mary's Hospital, Leonardtown, Maryland, is a community hospital that upholds its tradition of caring by continuously promoting, maintaining and improving health through education and services while assuring quality care, patient safety and fiscal integrity.

Vision

To be the trusted leader in caring for people and advancing health.

Values

When you visit MedStar St. Mary's Hospital, we want you to feel like a treasured guest. This is a time of physical and emotional need, and we are here for you. Not only will we meet your medical needs, but we'll offer you the dignity, comfort and support you deserve during trying times. To make your guest experience the best it can be, we value Service, Patient First, Integrity, Respect, Innovation and Teamwork.

- **Service**
  We strive to anticipate and meet the needs of our patients, physicians and co-workers.
- **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 the collective strength and cultural diversity of everyone, working with open communication and mutual respect.