*Q1.*
COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

The Maryland Health Services Cost Review Commission (HSCRC or Commission) is required to collect community benefit information from individual hospitals in Maryland and compile into an annual statewide, publicly available report. The Maryland General Assembly updated §19-303 of the Health General Article in the 2020 Legislative Session (HB1169/SB0774), requiring the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments. The reporting is split into two components, a Financial Report and a Narrative Report. This reporting tool serves as the narrative report. In response to the legislation, some of the reporting questions have changed for FY 2021. Detailed reporting instructions are available here:
https://hscrc.maryland.gov/Pages/init_cb.aspx

In this reporting tool, responses are mandatory unless specifically marked as optional. If you submit a report without responding to each question, your report may be rejected. You would then be required to fill in the missing answers before resubmitting. Questions that require a narrative response have a limit of 20,000 characters. This report need not be completed in one session and can be opened by multiple users.

For technical assistance, contact HCBHelp@hilltop.umbc.edu.

## *Q2.* Section I - General Info Part 1 - Hospital Identification

*Q3.* Please confirm the information we have on file about your hospital for the fiscal year.

| | Is this information correct? Yes | No | If no, please provide the correct information here: |
|---|---|---|---|
| The proper name of your hospital is: University of Maryland Baltimore Washington Medical Center | ◉ | ○ | |
| Your hospital's ID is: 210043 | ◉ | ○ | |
| Your hospital is part of the hospital system called University of Maryland Medical System | ◉ | ○ | |
| The primary Narrative contact at your hospital is Kimberly Davidson and Donna Jacobs | ○ | ◉ | Rebecca Dooley |
| The primary Narrative contact email address at your hospital is kimberly.davidson@umm.edu; djacobs@umm.edu | ○ | ◉ | Rebecca.Dooley@umm.edu |
| The primary Financial contact at your hospital is UNKNOWN | ○ | ◉ | Al Pietsch |
| The primary Financial email at your hospital is ACUNNINGHAM@UMM.EDU | ○ | ◉ | Al.Pietsch@umm.edu |

*Q4.* The next group of questions asks about the area where your hospital directs its community benefit efforts, called the Community Benefit Service Area. You may find these community health statistics useful in preparing your responses.

*Q5.* Please select the community health statistics that your hospital uses in its community benefit efforts.

- [x] Median household income
- [x] Percentage below federal poverty line (FPL)
- [x] Percent uninsured
- [ ] Percent with public health insurance
- [x] Percent with Medicaid
- [ ] Mean travel time to work
- [ ] Percent speaking language other than English at home
- [x] Race: percent white
- [x] Race: percent black
- [x] Ethnicity: percent Hispanic or Latino
- [ ] Life expectancy
- [ ] Crude death rate
- [x] Other

*Q6.* Please describe any other community health statistics that your hospital uses in its community benefit efforts.

UM BWMC remains committed to assessing ongoing community trends and uses additional data compiled and available from public sources including but not limited to, United States Census Bureau, Maryland State Health Improvement Plan, Maryland Vital Statistics Data, CDC Wonder Database, Anne Arundel County Department of Health Report Card, Anne Arundel County Public School System. UM BWMC uses our Community Health Needs Assessment (CHNA) and internal data. The quantitative portion of the CHNA consisted of secondary data analysis of local, state and federal data sources. The Anne Arundel County Department of Health assisted with secondary data analysis. The CHNA includes estimates from hard to reach portions of the population, such as drug users, domestic violence victims, and homeless individuals. Data on these subpopulations primarily came from police reports, Emergency Department (ED) data, and the public school system. It only captures individuals who have come in contact with these services. Therefore, the CHNA may underestimate the true burden of some health issues within Anne Arundel County. Another limitation of the data in the report is there is a delay between when secondary data is collected and made available. Focus groups (11) and key informant interviews (26) were used to solicit the thoughts and opinions of diverse Anne Arundel County residents, health care providers, social service providers and community leaders. A shortcoming of the qualitative data is that not all community perspectives will be obtained, although we did our best to engage a diverse representative sample.

*Q7.* Attach any files containing community health statistics that your hospital uses in its community benefit efforts.

CHNA FY1921.pdf
606.4KB
application/pdf

## *Q8.* Section I - General Info Part 2 - Community Benefit Service Area

*Q9.* Please select the county or counties located in your hospital's CBSA.

| | | |
|---|---|---|
| ☐ Allegany County | ☐ Charles County | ☐ Prince George's County |
| ☑ Anne Arundel County | ☐ Dorchester County | ☐ Queen Anne's County |
| ☐ Baltimore City | ☐ Frederick County | ☐ Somerset County |
| ☐ Baltimore County | ☐ Garrett County | ☐ St. Mary's County |
| ☐ Calvert County | ☐ Harford County | ☐ Talbot County |
| ☐ Caroline County | ☐ Howard County | ☐ Washington County |
| ☐ Carroll County | ☐ Kent County | ☐ Wicomico County |
| ☐ Cecil County | ☐ Montgomery County | ☐ Worcester County |

*Q10.* Please check all Allegany County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q11.* Please check all Anne Arundel County ZIP codes located in your hospital's CBSA.

| | | | |
|---|---|---|---|
| ☐ 20701 | ☐ 20776 | ☐ 21062 | ☑ 21146 |
| ☐ 20711 | ☐ 20778 | ☑ 21076 | ☑ 21225 |
| ☐ 20714 | ☐ 20779 | ☐ 21077 | ☐ 21226 |
| ☐ 20724 | ☐ 20794 | ☑ 21090 | ☐ 21240 |
| ☐ 20733 | ☐ 21012 | ☐ 21106 | ☐ 21401 |
| ☐ 20736 | ☐ 21032 | ☑ 21108 | ☐ 21402 |
| ☐ 20751 | ☐ 21035 | ☑ 21113 | ☐ 21403 |
| ☐ 20754 | ☐ 21037 | ☐ 21114 | ☐ 21404 |
| ☐ 20755 | ☑ 21054 | ☑ 21122 | ☐ 21405 |
| ☐ 20758 | ☐ 21056 | ☐ 21123 | ☐ 21409 |
| ☐ 20764 | ☑ 21060 | ☐ 21140 | ☐ 21411 |
| ☐ 20765 | ☑ 21061 | ☑ 21144 | ☐ 21412 |

*Q12.* Please check all Baltimore City ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q13.* Please check all Baltimore County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q14.* Please check all Calvert County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q15.* Please check all Caroline County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q16.* Please check all Carroll County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q17.* Please check all Cecil County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q18.* Please check all Charles County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q19.* Please check all Dorchester County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q20.* Please check all Frederick County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q21.* Please check all Garrett County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q22.* Please check all Harford County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q23.* Please check all Howard County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q24.* Please check all Kent County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q25.* Please check all Montgomery County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q26.* Please check all Prince George's County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q27.* Please check all Queen Anne's County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q28.* Please check all Somerset County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q29.* Please check all St. Mary's County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q30.* Please check all Talbot County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q31.* Please check all Washington County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q32.* Please check all Wicomico County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q33.* Please check all Worcester County ZIP codes located in your hospital's CBSA.

*This question was not displayed to the respondent.*

*Q34.* How did your hospital identify its CBSA?

Based on ZIP codes in your Financial Assistance Policy. Please describe.

- [x] Based on ZIP codes in your global budget revenue agreement. Please describe.

UM BWMC considers our Community Benefit Service Area (CBSA) to be the Anne Arundel County portions of our primary and secondary service areas as defined by our Global Budget Revenue Agreement with the Maryland Health Services Cost Review Commission.

The primary service area surrounding UM BWMC where most of our discharges originate from has some of the most vulnerable, high-risk residents in Anne Arundel County based on socioeconomic and health data. We make concerted efforts to reach vulnerable, at-risk populations, including the uninsured, racial/ethnic minorities, persons with risky health behaviors (e.g. smoking), and people with chronic health conditions (e.g. diabetes, cancer). Zip codes in our secondary service area have more localized pockets of community health needs.

- [ ] Based on patterns of utilization. Please describe.

- [ ] Other. Please describe.

*Q35.* Provide a link to your hospital's mission statement.

https://www.umms.org/bwmc/about/mission

*Q36.* (Optional) Is there any other information about your hospital's Community Benefit Service Area that you would like to provide?

*Q37.* Section II - CHNAs and Stakeholder Involvement Part 1 - Timing & Format

*Q38.*
Within the past three fiscal years, has your hospital conducted a CHNA that conforms to IRS requirements?

- (x) Yes
- ( ) No

*Q39.* Please explain why your hospital has not conducted a CHNA that conforms to IRS requirements, as well as your hospital's plan and timeframe for completing a CHNA.

*This question was not displayed to the respondent.*

*Q40.* When was your hospital's most recent CHNA completed? (MM/DD/YYYY)

06/18/2019

*Q41.* Please provide a link to your hospital's most recently completed CHNA.

https://www.umms.org/bwmc/community/assessment-plan

*Q42.* Please upload your hospital's most recently completed CHNA.

CHNA FY1921.pdf
626.9KB
application/pdf

## *Q43.* Section II - CHNAs and Stakeholder Involvement Part 2 - Internal CHNA Partners

*Q44.* Please use the table below to tell us about the internal partners involved in your most recent CHNA development.

| | CHNA Activities | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | N/A - Person or Organization was not Involved | N/A - Position or Department does not exist | Member of CHNA Committee | Participated in development of CHNA process | Advised on CHNA best practices | Participated in primary data collection | Participated in identifying priority health needs | Participated in identifying community resources to meet health needs | Provided secondary health data | Other (explain) | Other - If you selected "Other (explain)," please type your exp below: |
| CB/ Community Health/Population Health Director (facility level) | | | X | X | X | X | X | X | | X | Manager of Strategic Planning and Service Line Developn |
| CB/ Community Health/ Population Health Director (system level) | X | | | | | | | | | | |
| Senior Executives (CEO, CFO, VP, etc.) (facility level) | | | | X | | X | X | | | | |
| Senior Executives (CEO, CFO, VP, etc.) (system level) | | | | | X | | | | | | |
| Board of Directors or Board Committee (facility level) | | | | | | | X | X | | | |
| Board of Directors or Board Committee (system level) | X | | | | | | | | | | |

| | N/A - Person or Organization was not Involved | N/A - Position or Department does not exist | Member of CHNA Committee | Participated in development of CHNA process | Advised on CHNA best practices | Participated in primary data collection | Participated in identifying priority health needs | Participated in identifying community resources to meet health needs | Provided secondary health data | Other (explain) | Other - If you selected "Other (explain)," please type your exp below: |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Leadership (facility level) | ☐ | ☐ | ☐ | ☑ | ☐ | ☑ | ☑ | ☑ | ☐ | ☐ | |
| Clinical Leadership (system level) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | ☐ | ☐ | ☐ | |
| Population Health Staff (facility level) | ☐ | ☐ | ☐ | ☑ | ☑ | ☐ | ☑ | ☑ | ☑ | ☐ | |
| Population Health Staff (system level) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | ☐ | ☐ | ☐ | |
| Community Benefit staff (facility level) | ☐ | ☐ | ☑ | ☑ | ☑ | ☐ | ☑ | ☑ | ☑ | ☐ | |
| Community Benefit staff (system level) | ☐ | ☐ | ☐ | ☐ | ☑ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Physician(s) | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | ☑ | ☑ | ☐ | ☐ | |
| Nurse(s) | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | ☑ | ☑ | ☐ | ☐ | |
| Social Workers | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | ☑ | ☑ | ☐ | ☐ | |

| | N/A - Person or Organization was not Involved | N/A - Position or Department does not exist | Member of CHNA Committee | Participated in development of CHNA process | Advised on CHNA best practices | Participated in primary data collection | Participated in identifying priority health needs | Participated in identifying community resources to meet health needs | Provided secondary health data | Other (explain) | Other - If you selected "Other (explain)," please type your exp below: |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital Advisory Board | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | Hospital Patient Family Advisory Committee (PFAC) provide i CHNA and community initiatives and activities. |
| Other (specify) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

*Q45.* Section II - CHNAs and Stakeholder Involvement Part 3 - Internal HCB Partners

*Q46.* Please use the table below to tell us about the internal partners involved in your community benefit activities during the fiscal year.

| | Activities | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | N/A - Person or Organization was not Involved | N/A - Position or Department does not exist | Selecting health needs that will be targeted | Selecting the initiatives that will be supported | Determining how to evaluate the impact of initiatives | Providing funding for CB activities | Allocating budgets for individual initiativves | Delivering CB initiatives | Evaluating the outcome of CB initiatives | Other (explain) | Other - If you selected "Other (explain)," please type your explanation below: |
| CB/ Community Health/Population Health Director (facility level) | ☐ | ☐ | ☑ | ☑ | ☑ | ☑ | ☑ | ☑ | ☑ | ☑ | Provided by Community Outreach Manager and Director of Marketing and Communications |
| CB/ Community Health/ Population Health Director (system level) | ☑ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Senior Executives (CEO, CFO, VP, etc.) (facility level) | ☐ | ☐ | ☑ | ☑ | ☑ | ☑ | ☑ | ☐ | ☑ | ☐ | |
| Senior Executives (CEO, CFO, VP, etc.) (system level) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☑ | UMMS SVP provides overall guidance related to community benefit including facilitating the identification of best practices for community outreach and community benefit planning. |
| Board of Directors or Board Committee (facility level) | ☐ | ☐ | ☐ | ☑ | ☑ | ☑ | ☐ | ☐ | ☐ | ☐ | |
| Board of Directors or Board Committee (system level) | ☑ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | |

| | N/A - Person or Organization was not Involved | N/A - Position or Department does not exist | Selecting health needs that will be targeted | Selecting the initiatives that will be supported | Determining how to evaluate the impact of initiatives | Providing funding for CB activities | Allocating budgets for individual initiativves | Delivering CB initiatives | Evaluating the outcome of CB initiatives | Other (explain) | Other - If you selected "Other (explain)," please type your explanation below: |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Leadership (facility level) | [ ] | [ ] | [x] | [x] | [x] | [ ] | [ ] | [ ] | [ ] | [ ] | |
| Clinical Leadership (system level) | [x] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | |
| Population Health Staff (facility level) | [ ] | [ ] | [x] | [x] | [x] | [ ] | [ ] | [ ] | [x] | [ ] | |
| Population Health Staff (system level) | [x] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | |
| Community Benefit staff (facility level) | [ ] | [ ] | [x] | [x] | [x] | [x] | [x] | [x] | [x] | [ ] | |
| Community Benefit staff (system level) | [x] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | |
| Physician(s) | [ ] | [ ] | [x] | [x] | [x] | [ ] | [ ] | [x] | [x] | [ ] | |
| Nurse(s) | [ ] | [ ] | [x] | [x] | [x] | [ ] | [ ] | [x] | [x] | [ ] | |
| Social Workers | [ ] | [ ] | [x] | [x] | [x] | [ ] | [ ] | [x] | [x] | [ ] | |
| Hospital Advisory Board | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [x] | Hospital Patient Family Advisory Committee (PFAC) provide input on CHNA and community initiatives and activities. |
| Other (specify) | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | [ ] | |

*Q47.* ## Section II - CHNAs and Stakeholder Involvement Part 4 - Meaningful Engagement

*Q48.* Community participation and meaningful engagement is an essential component to changing health system behavior, activating partnerships that improve health outcomes and sustaining community ownership and investment in programs. Please use the table below to tell us about the external partners involved in your most recent CHNA. In the first column, select and describe the external participants. In the second column, select the level of community engagement for each participant. In the third column, select the recommended practices that each stakeholder was engaged in. The Maryland Hospital Association worked with the HSCRC to develop this list of eight recommended practices for engaging patients and communities in the CHNA process.

Refer to the FY 2021 Community Benefit Guidelines for more detail on MHA's recommended practices. Completion of this self-assessment is optional for FY 2021, but will be mandatory for FY 2022.

| | Level of Community Engagement | | | | | | Recommended Practices | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
| Other Hospitals -- Please list the hospitals here: ____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
| Local Health Department -- Please list the Local Health Departments here: ____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
| Local Health Improvement Coalition -- Please list the LHICs here: ____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
| Maryland Department of Health | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
| Other State Agencies -- Please list the agencies here: ____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Local Govt. Organizations -- Please list the organizations here: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Faith-Based Organizations | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| School - K-12 -- Please list the schools here: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| School - Colleges, Universities, Professional Schools -- Please list the schools here: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Behavioral Health Organizations -- Please list the organizations here: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Social Service Organizations -- Please list the organizations here: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Post-Acute Care Facilities -- please list the facilities here: [ ] | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
| Community/Neighborhood Organizations -- Please list the organizations here: [ ] | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
| Consumer/Public Advocacy Organizations -- Please list the organizations here: [ ] | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |
| Other -- If any other people or organizations were involved, please list them here: [ ] | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | Informed - To provide the community with balanced & objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions | Consulted - To obtain community feedback on analysis, alternatives and/or solutions | Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered | Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution | Delegated - To place the decision-making in the hands of the community | Community-Driven/Led - To support the actions of community initiated, driven and/or led processes | Identify & Engage Stakeholders | Define the community to be assessed | Collect and analyze the data | Select priority community health issues | Document and communicate results | Plan Implementation Strategies | Implement Improvement Plans | Evaluate Progress |

## *Q49.* Section II - CHNAs and Stakeholder Involvement Part 5 - Follow-up

*Q50.* Has your hospital adopted an implementation strategy following its most recent CHNA, as required by the IRS?

- (●) Yes
- ( ) No

*Q51.* Please enter the date on which the implementation strategy was approved by your hospital's governing body.

06/17/2019

*Q52.* Please provide a link to your hospital's CHNA implementation strategy.

https://www.umms.org/bwmc/community/assessment-plan

*Q222.* Please upload your hospital's CHNA implementation strategy.

CHNA Implementation Strategy FY1921.pdf
1.2MB
application/pdf

*Q53.* Please explain why your hospital has not adopted an implementation strategy. Please include whether the hospital has a plan and/or a timeframe for an implementation strategy.

*This question was not displayed to the respondent.*

*Q54.* Please select the CHNA Priority Area Categories most relevant to your most recent CHNA. The list of categories is based on the Healthy People 2030 objectives available here. This list is not exhaustive. Please select "other" and describe any CHNA Priority Area Categories that are not captured by this list. Select all that apply even if a need was not addressed by a reported initiative.

- [ ] Health Conditions - Addiction
- [ ] Health Conditions - Arthritis
- [ ] Health Conditions - Blood Disorders
- [x] Health Conditions - Cancer
- [ ] Health Conditions - Chronic Kidney Disease
- [ ] Health Conditions - Chronic Pain
- [ ] Health Conditions - Dementias
- [x] Health Conditions - Diabetes
- [ ] Health Conditions - Foodborne Illness
- [ ] Health Conditions - Health Care-Associated Infections
- [x] Health Conditions - Heart Disease and Stroke
- [ ] Health Conditions - Infectious Disease
- [x] Health Conditions - Mental Health and Mental Disorders
- [x] Health Conditions - Oral Conditions
- [ ] Health Conditions - Osteoporosis
- [x] Health Conditions - Overweight and Obesity
- [x] Health Conditions - Pregnancy and Childbirth
- [x] Health Conditions - Respiratory Disease
- [ ] Health Conditions - Sensory or Communication Disorders
- [ ] Health Conditions - Sexually Transmitted Infections
- [ ] Health Behaviors - Child and Adolescent Development
- [ ] Health Behaviors - Drug and Alcohol Use
- [ ] Health Behaviors - Emergency Preparedness
- [ ] Health Behaviors - Family Planning
- [ ] Health Behaviors - Health Communication
- [ ] Health Behaviors - Injury Prevention
- [x] Health Behaviors - Nutrition and Healthy Eating
- [ ] Health Behaviors - Physical Activity
- [ ] Health Behaviors - Preventive Care
- [ ] Health Behaviors - Safe Food Handling
- [ ] Health Behaviors - Sleep
- [x] Health Behaviors - Tobacco Use
- [ ] Health Behaviors - Vaccination
- [ ] Health Behaviors - Violence Prevention
- [ ] Populations - Adolescents
- [ ] Populations - Children
- [x] Populations - Infants
- [ ] Populations – LGBT
- [ ] Populations - Men
- [ ] Populations - Older Adults
- [ ] Populations - Parents or Caregivers
- [ ] Populations - People with Disabilities
- [x] Populations - Women
- [ ] Populations - Workforce
- [x] Settings and Systems - Community
- [x] Settings and Systems - Environmental Health
- [ ] Settings and Systems - Global Health
- [ ] Settings and Systems - Health Care
- [x] Settings and Systems - Health Insurance
- [ ] Settings and Systems - Health IT
- [ ] Settings and Systems - Health Policy
- [ ] Settings and Systems - Hospital and Emergency Services
- [x] Settings and Systems - Housing and Homes
- [ ] Settings and Systems - Public Health Infrastructure
- [ ] Settings and Systems - Schools
- [x] Settings and Systems - Transportation
- [ ] Settings and Systems - Workplace
- [x] Social Determinants of Health - Economic Stability
- [ ] Social Determinants of Health - Education Access and Quality
- [x] Social Determinants of Health - Health Care Access and Quality
- [ ] Social Determinants of Health - Neighborhood and Built Environment
- [ ] Social Determinants of Health - Social and Community Context
- [ ] Other (specify)

*Q56.* (Optional) Please use the box below to provide any other information about your CHNA that you wish to share.

*Q57.* (Optional) Please attach any files containing information regarding your CHNA that you wish to share.

*Q58.* Section II - CHNAs and Stakeholder Involvement Part 6 - Initiatives

*Q59.* Please use the questions below to provide details regarding the initiatives to address the CHNA Priority Area Categories selected in the previous question.

For those hospitals completing the ***optional*** CHNA financial reporting in FY 2021, please ensure that these tie directly to line item initiatives in the financial reporting template.

For those hospitals **not** completing the ***optional*** CHNA financial template, please provide this information for as many initiatives as you deem feasible.

***Please note that hospitals will be required to report on each CHNA-related initiative in FY 2022.***

*Q163.* Please describe the initiative(s) addressing Health Conditions - Addiction.

*This question was not displayed to the respondent.*

*Q182.* Please describe the initiative(s) addressing Health Conditions - Arthritis.

*This question was not displayed to the respondent.*

*Q183.* Please describe the initiative(s) addressing Health Conditions - Blood Disorders.

*This question was not displayed to the respondent.*

*Q184.* Please describe the initiative(s) addressing Health Conditions - Cancer.

| | Health Conditions - Cancer Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q185.* Please describe the initiative(s) addressing Health Conditions - Chronic Kidney Disease.

*This question was not displayed to the respondent.*

*Q186.* Please describe the initiative(s) addressing Health Conditions - Chronic Pain.

*This question was not displayed to the respondent.*

*Q187.* Please describe the initiative(s) addressing Health Conditions - Dementias.

*This question was not displayed to the respondent.*

*Q188.* Please describe the initiative(s) addressing Health Conditions - Diabetes.

| | Health Conditions - Diabetes Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |

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|---|---|---|---|---|
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q189.* Please describe the initiative(s) addressing Health Conditions - Foodborne Illness.

*This question was not displayed to the respondent.*

*Q190.* Please describe the initiative(s) addressing Health Conditions - Health Care-Associated Infections.

*This question was not displayed to the respondent.*

*Q191.* Please describe the initiative(s) addressing Health Conditions - Heart Disease and Stroke.

| | Health Conditions - Heart Disease and Stroke Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q192.* Please describe the initiative(s) addressing Health Conditions - Infectious Disease.

*This question was not displayed to the respondent.*

*Q193.* Please describe the initiative(s) addressing Health Conditions - Mental Health and Mental Disorders.

| | Health Conditions - Mental Health and Mental Disorders Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q194.* Please describe the initiative(s) addressing Health Conditions - Oral Conditions.

| | Health Conditions - Oral Conditions Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |

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| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q195.* Please describe the initiative(s) addressing Health Conditions - Osteoporosis.

*This question was not displayed to the respondent.*

*Q196.* Please describe the initiative(s) addressing Health Conditions - Overweight and Obesity.

| | Health Conditions - Overweight and Obesity Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q197.* Please describe the initiative(s) addressing Health Conditions - Pregnancy and Childbirth.

| | Health Conditions - Pregnancy and Childbirth Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q198.* Please describe the initiative(s) addressing Health Conditions - Respiratory Disease.

| | Health Conditions - Respiratory Disease Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |

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|---|---|---|---|---|
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q199.* Please describe the initiative(s) addressing Health Conditions - Sensory or Communication Disorders.

*This question was not displayed to the respondent.*

*Q200.* Please describe the initiative(s) addressing Health Conditions - Sexually Transmitted Infections.

*This question was not displayed to the respondent.*

*Q201.* Please describe the initiative(s) addressing Health Behaviors - Child and Adolescent Development.

*This question was not displayed to the respondent.*

*Q202.* Please describe the initiative(s) addressing Health Behaviors - Drug and Alcohol Use.

*This question was not displayed to the respondent.*

*Q203.* Please describe the initiative(s) addressing Health Behaviors - Emergency Preparedness.

*This question was not displayed to the respondent.*

*Q204.* Please describe the initiative(s) addressing Health Behaviors - Family Planning.

*This question was not displayed to the respondent.*

*Q205.* Please describe the initiative(s) addressing Health Behaviors - Health Communication.

*This question was not displayed to the respondent.*

*Q206.* Please describe the initiative(s) addressing Health Behaviors - Injury Prevention.

*This question was not displayed to the respondent.*

*Q207.* Please describe the initiative(s) addressing Health Behaviors - Nutrition and Healthy Eating.

| | Health Behaviors - Nutrition and Healthy Eating Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q208.* Please describe the initiative(s) addressing Health Behaviors - Physical Activity.

*This question was not displayed to the respondent.*

*Q209.* Please describe the initiative(s) addressing Health Behaviors - Preventive Care.

*This question was not displayed to the respondent.*

*Q210.* Please describe the initiative(s) addressing Health Behaviors - Safe Food Handling.

*This question was not displayed to the respondent.*

*Q211.* Please describe the initiative(s) addressing Health Behaviors - Sleep.

*This question was not displayed to the respondent.*

*Q212.* Please describe the initiative(s) addressing Health Behaviors - Tobacco Use.

| | Health Behaviors - Tobacco Use Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q213.* Please describe the initiative(s) addressing Health Behaviors - Vaccination.

*This question was not displayed to the respondent.*

*Q214.* Please describe the initiative(s) addressing Health Behaviors - Violence Prevention.

*This question was not displayed to the respondent.*

*Q215.* Please describe the initiative(s) addressing Populations - Adolescents.

*This question was not displayed to the respondent.*

*Q216.* Please describe the initiative(s) addressing Populations - Children.

*This question was not displayed to the respondent.*

*Q217.* Please describe the initiative(s) addressing Populations - Infants.

| | Populations - Infants Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q218.* Please describe the initiative(s) addressing Populations - LGBT.

*This question was not displayed to the respondent.*

*Q219.* Please describe the initiative(s) addressing Populations - Men.

*This question was not displayed to the respondent.*

*Q220.* Please describe the initiative(s) addressing Populations - Older Adults.

*This question was not displayed to the respondent.*

*Q221.* Please describe the initiative(s) addressing Populations - Parents or Caregivers.

*This question was not displayed to the respondent.*

*Q222.* Please describe the initiative(s) addressing Populations - People with Disabilities.

*This question was not displayed to the respondent.*

*Q223.* Please describe the initiative(s) addressing Populations - Women.

| | Populations - Women Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q224.* Please describe the initiative(s) addressing Populations - Workforce.

*This question was not displayed to the respondent.*

*Q225.* Please describe the initiative(s) addressing Settings and Systems - Community.

| | Settings and Systems - Community Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q226.* Please describe the initiative(s) addressing Settings and Systems - Environmental Health.

| | Settings and Systems - Environmental Health Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |

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|---|---|---|---|---|
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q227.* Please describe the initiative(s) addressing Settings and Systems - Global Health.

*This question was not displayed to the respondent.*

*Q228.* Please describe the initiative(s) addressing Settings and Systems - Health Care.

*This question was not displayed to the respondent.*

*Q229.* Please describe the initiative(s) addressing Settings and Systems - Health Insurance.

| | Settings and Systems - Health Insurance Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q230.* Please describe the initiative(s) addressing Settings and Systems - Health IT.

*This question was not displayed to the respondent.*

*Q231.* Please describe the initiative(s) addressing Settings and Systems - Health Policy.

*This question was not displayed to the respondent.*

*Q232.* Please describe the initiative(s) addressing Settings and Systems - Hospital and Emergency Services.

*This question was not displayed to the respondent.*

*Q233.* Please describe the initiative(s) addressing Settings and Systems - Housing and Homes.

| | Settings and Systems - Housing and Homes Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |

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|---|---|---|---|---|
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q234.* Please describe the initiative(s) addressing Settings and Systems - Public Health Infrastructure.

*This question was not displayed to the respondent.*

*Q235.* Please describe the initiative(s) addressing Settings and Systems - Schools.

*This question was not displayed to the respondent.*

*Q236.* Please describe the initiative(s) addressing Settings and Systems - Transportation.

| | Settings and Systems - Transportation Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | | | | |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q237.* Please describe the initiative(s) addressing Settings and Systems - Workplace.

*This question was not displayed to the respondent.*

*Q238.* Please describe the initiative(s) addressing Social Determinants of Health - Economic Stability.

| | Social Determinants of Health - Economic Stability Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |
| Initiative A | Hungry Harvest Produce Boxes | Provide free boxes of fresh produce to residents to encourage a healthy diet and make healthy foods accessible. | 2,300 provided | Number of boxes distributed. |
| Initiative B | | | | |
| Initiative C | | | | |
| Initiative D | | | | |
| Initiative E | | | | |
| Initiative F | | | | |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q239.* Please describe the initiative(s) addressing Social Determinants of Health - Education Access and Quality.

*This question was not displayed to the respondent.*

*Q240.* Please describe the initiative(s) addressing Social Determinants of Health - Health Care Access and Quality.

| | Social Determinants of Health - Health Care Access and Quality Initiative Details | | | |
|---|---|---|---|---|
| | Initiative Name | Initiative Goal/Objective | Initiative Outcomes to Date | Data Used to Measure Outcomes |

| | | | | |
|---|---|---|---|---|
| Initiative A | Free Flu Vaccinations | Provide free flu vaccinations to anyone age 3 and up, focusing on vulnerable zip code areas | 500 vaccinated | Number vaccinated |
| Initiative B | Free COVID-19 Mobile Vaccination | Provide free COVID-19 vaccinations to anyone age 12 and up, focusing on vulnerable zip code areas | 1,280 doses | Number of first and second doses of COVID-19 vaccine administered at pop-up community sites. |
| Initiative C | Free COVID-19 Testing | Provide free COVID-19 testing to increase access to testing within the county | 2,147 tested | Number of people tested |
| Initiative D | COVID-19 Education Kits | Provide free education kits that include a face mask, hand sanitizer, and information on staying healthy during the COVID pandemic. | 1,850 kits distributed | Number of kits distributed. |
| Initiative E | COVID-19 Vaccine Education Sessions | Provide an outlet for community members to learn about the COVID-19 vaccines and ask questions to a medical expert directly. | 7 sessions; 232 attended | Number of attendees at listening sessions. |
| Initiative F | Community COVID-19 Vaccine Clinic at UM BWMC | Provide free COVID-19 vaccinations to our community, increasing access to broader community. | 19,041 doses | Number of first and second doses of COVID-19 vaccine administered in community-facing vaccine clinic on UM BWMC hospital campus. |
| Initiative G | | | | |
| Initiative H | | | | |
| Initiative I | | | | |
| Initiative J | | | | |
| All Other Initiatives | | | | |

*Q241.* Please describe the initiative(s) addressing Social Determinants of Health - Neighborhood and Built Environment.

*This question was not displayed to the respondent.*

*Q242.* Please describe the initiative(s) addressing Social Determinants of Health - Social and Community Context.

*This question was not displayed to the respondent.*

*Q243.* Please describe the initiative(s) addressing other priorities.

*This question was not displayed to the respondent.*

*Q130.* Were all the needs identified in your most recently completed CHNA addressed by an initiative of your hospital?

- ( ) Yes
- (•) No

*Q131.*
In your most recently completed CHNA, the following community health needs were identified:
**Health Conditions - Cancer, Health Conditions - Diabetes, Health Conditions - Heart Disease and Stroke, Health Conditions - Mental Health and Mental Disorders, Health Conditions - Oral Conditions, Health Conditions - Overweight and Obesity, Health Conditions - Pregnancy and Childbirth, Health Conditions - Respiratory Disease, Health Behaviors - Nutrition and Healthy Eating, Health Behaviors - Tobacco Use, Populations - Infants, Populations - Women, Settings and Systems - Community, Settings and Systems - Environmental Health, Settings and Systems - Health Insurance, Settings and Systems - Housing and Homes, Settings and Systems - Transportation, Social Determinants of Health - Economic Stability, Social Determinants of Health - Health Care Access and Quality**
**Other:**

Using the checkboxes below, select the needs that appear in the list above that were NOT addressed by your community benefit initiatives.

- [x] Access to Health Services: Health Insurance
- [ ] Access to Health Services: Practicing PCPs
- [ ] Access to Health Services: Regular PCP Visits
- [x] Access to Health Services: ED Wait Times
- [ ] Access to Health Services: Outpatient Services
- [ ] Adolescent Health
- [ ] Arthritis, Osteoporosis, and Chronic Back Conditions
- [ ] Behavioral Health, including Mental Health and/or Substance Abuse
- [ ] Cancer
- [ ] Children's Health
- [ ] Chronic Kidney Disease
- [ ] Community Unity
- [ ] Dementias, including Alzheimer's Disease
- [ ] Heart Disease and Stroke
- [ ] HIV
- [ ] Immunization and Infectious Diseases
- [ ] Injury Prevention
- [ ] Lesbian, Gay, Bisexual, and Transgender Health
- [ ] Maternal and Infant Health
- [ ] Nutrition and Weight Status
- [ ] Older Adults
- [x] Oral Health
- [ ] Physical Activity
- [ ] Respiratory Diseases
- [ ] Sexually Transmitted Diseases
- [ ] Sleep Health

- [ ] Diabetes
- [ ] Disability and Health
- [ ] Educational and Community-Based Programs
- [x] Environmental Health
- [ ] Family Planning
- [ ] Food Safety
- [ ] Global Health
- [ ] Health Communication and Health Information Technology
- [ ] Health Literacy
- [ ] Health-Related Quality of Life & Well-Being
- [ ] Telehealth
- [ ] Tobacco Use
- [ ] Violence Prevention
- [ ] Vision
- [ ] Wound Care
- [x] Housing & Homelessness
- [ ] Transportation
- [x] Unemployment & Poverty
- [x] Other Social Determinants of Health
- [x] Other (specify) Affordable Child Care

*Q132.* Why were these needs unaddressed?

Lack of affordable dental services, environmental health concerns, and transportation barriers are community health needs identified through the CHNA not directly being addressed by UM BWMC. UM BWMC will support the advancement of community health improvement initiatives in these areas as feasible.UM BWMC not not provide routine dental care at this time, but we do refer patients to low-cost dental clinics for care. We subsidized oral surgery on-call services and have oral surgeons on our medical staff. UM BWMC partners with the Anne Arundel County Department of Health to divert dental patients presenting to the ED to providers in the community. Patients will be treated within 24-48 hours of their ED visit. Care Coordination will be provided to prevent repeat ED visits. Environmental health concerns are being addressed by the Anne Arundel County Department of Health' Bureau of Environmental Health Services and other local environmental advocacy organizations. Public transportation is not in the scope of services that UM BWMC can provide as a hospital; however, we do provide some transportation assistance through our care management program and our Transitional Care Center. We also provide transportation assistance for participants in our Stork's Nest pre-natal education program. Anne Arundel and surrounding county governments are collaborating to expand access to public transportation in the Central Maryland region. Other needs identified in the CHNA include affordable housing, homelessness, and affordable and quality child care. UM BWMC will support these priorities through participation in economic development initiatives and community building activities, and health profession training designed to help improve socioeconomic wellbeing of individuals and the local community.

*Q244.* Please describe the hospital's efforts to track and reduce health disparities in the community it serves.

UM BWMC uses its Community Health Needs Assessment and other available public data to target outreach programming to areas with vulnerable populations. Programming such as food insecurity and healthy food distributions can be tracked and compared to ongoing data collection to see the reduction in diabetes and heart disease cases. Patient data is also tracked through care managers, nurse navigators, and through the Transitional Care Center for high-risk utilizers in need of additional support services.

*Q245.* If your hospital reported rate support for categories other than Charity Care, Graduate Medical Education, and the Nurse Support Programs in the financial report template, please select the rate supported programs here:

- [ ] Regional Partnership Catalyst Grant Program
- [ ] The Medicare Advantage Partnership Grant Program
- [ ] The COVID-19 Long-Term Care Partnership Grant
- [x] The COVID-19 Community Vaccination Program
- [ ] The Population Health Workforce Support for Disadvantaged Areas Program
- [ ] Other (Describe)

*Q129.* If you wish, you may upload a document describing your community benefit initiatives in more detail.

## *Q60.* Section III - CB Administration

*Q61.* Does your hospital conduct an internal audit of the annual community benefit financial spreadsheet? Select all that apply.

- [x] Yes, by the hospital's staff
- [x] Yes, by the hospital system's staff
- [x] Yes, by a third-party auditor
- [ ] No

*Q246.* Please describe the third party audit process used.

A third-party audit is completed by Ernst & Young.

*Q62.* Does your hospital conduct an internal audit of the community benefit narrative?

- (x) Yes
- ( ) No

*Q63.* Please describe the community benefit narrative audit process.

Community Benefit reporting is coordinated by the Community Outreach Manager and Strategic Planning and Service Line Development Manager. Data is collected throughout the year, with annual reporting occurring at the close of the fiscal year for some activities. The data is collected, validated, and entered into Lyon Software's Community Benefit Inventory for Social Accountability (CBISA) program. Maryland HSCRC Community Benefit guidance is consulted to determine what category to report community benefit activities under, along with other resources such as the Catholic Health Association and the VHA. Additional, the University of Maryland Medical System convenes a bi-monthly Community Health Improvement Committee meeting that includes leaders form community benefit reporting across the system. There is a roundtable at each meeting to discuss any questions or concerns related to community benefit reporting. The UMMS Finance Department provides additional guidance on financial reporting. The Hospital's Finance Department calculates staff salary rates, the indirect cost rations and the physician subsidy amounts. The Finance Department reviews and approves the HSCRC spreadsheet inventory report documents. The HSCRC Community Benefit narrative report and data collection tool is reviews and approved by the Chief Financial Officer and Chief Executive Officer. The report is then reviewed and approved by the UM BWMC Board Finance and/or Community Engagement Committee and the University of Maryland Medical System Senior Leadership.

*Q64.* Does the hospital's board review and approve the annual community benefit financial spreadsheet?

- (x) Yes
- ( ) No

*Q65.* Please explain:

*This question was not displayed to the respondent.*

*Q66.* Does the hospital's board review and approve the annual community benefit narrative report?

- (x) Yes
- ( ) No

*Q67.* Please explain:

*This question was not displayed to the respondent.*

*Q68.* Does your hospital include community benefit planning and investments in its internal strategic plan?

- (x) Yes
- ( ) No

*Q69.* Please describe how community benefit planning and investments are included in your hospital's internal strategic plan.

UM BWMC's Strategic Plan for Fiscal Years 2020-2024, a summary of which is available on our web site, includes several community benefit investments. Specifically, our strategic plan has the strategic goal of ease of access to care for our community. This includes comprehensive and affordable health care services that results in "right care in the right place at the right time" and investments in physician specialties to meet community needs. Physician investments counted in community benefit include primary care, transitional care, women's health, behavioral health, cardiology and Emergency Department on-call. This goal also calls for robust population health initiatives to reduce preventable utilization. Population health initiatives include community benefit classes and activities designed to help people prevent and manage chronic conditions and screen for illnesses when they are most treatable. Our Annual Operation Plan, which is derived from our strategic plan, includes community benefit and population health priorities. UM BWMC's FY19-21 Community Benefit Implementation Plan is a strategic framework that is reviewed each fiscal year and adjustments are made to implementation strategies as appropriate based on community needs, available resources, best practices and lessons learned.

*Q70.* If available, please provide a link to your hospital's strategic plan.

https://www.umms.org/bwmc/about/mission

*Q133.* Do any of the hospital's community benefit operations/activities align with the Statewide Integrated Health Improvement Strategy (SIHIS)? Please select all that apply and describe how your initiatives are targeting each SIHIS goal. More information about SIHIS may be found here.

- [x] Diabetes - Reduce the mean BMI for Maryland residents
- [ ] Opioid Use Disorder - Improve overdose mortality
- [x] Maternal and Child Health - Reduce severe maternal morbidity rate

- [ ] Maternal and Child Health - Decrease asthma-related emergency department visit rates for children aged 2-17

*Q134.* (Optional) Did your hospital's initiatives during the fiscal year address other state health goals? If so, tell us about them below.

*Q135.* Section IV - Physician Gaps & Subsidies

*Q223.* Did your hospital report physician gap subsidies on Worksheet 3 of its community benefit financial report for the fiscal year?

- ( ) No
- (x) Yes

*Q218.* As required under HG§19-303, please select all of the gaps in physician availability resulting in a subsidy reported in the Worksheet 3 of financial section of Community Benefit report. Please select "No" for any physician specialty types for which you did not report a subsidy.

| | Is there a gap resulting in a subsidy? | | What type of subsidy? |
|---|---|---|---|
| | Yes | No | |
| Allergy & Immunology | ( ) | (x) | |
| Anesthesiology | ( ) | (x) | |
| Cardiology | ( ) | (x) | |
| Dermatology | ( ) | (x) | |
| Emergency Medicine | (x) | ( ) | Coverage of emergency department call |
| Endocrinology, Diabetes & Metabolism | (x) | ( ) | Physician provision of financial assistance |
| Family Practice/General Practice | (x) | ( ) | Physician provision of financial assistance |
| Geriatrics | ( ) | (x) | |
| Internal Medicine | ( ) | (x) | |
| Medical Genetics | ( ) | (x) | |
| Neurological Surgery | ( ) | (x) | |
| Neurology | ( ) | (x) | |
| Obstetrics & Gynecology | (x) | ( ) | Physician provision of financial assistance |
| Oncology-Cancer | ( ) | (x) | |
| Ophthamology | ( ) | (x) | |
| Orthopedics | ( ) | (x) | |
| Otololaryngology | ( ) | (x) | |
| Pathology | ( ) | (x) | |
| Pediatrics | ( ) | (x) | |
| Physical Medicine & Rehabilitation | ( ) | (x) | |
| Plastic Surgery | ( ) | (x) | |
| Preventive Medicine | ( ) | (x) | |
| Psychiatry | (x) | ( ) | Physician provision of financial assistance |
| Radiology | ( ) | (x) | |
| Surgery | ( ) | (x) | |
| Urology | ( ) | (x) | |
| Other. (Describe) Transitional Care Center | (x) | ( ) | Physician provision of financial assistance |

*Q219.* Please explain how you determined that the services would not otherwise be available to meet patient demand and why each subsidy was needed, including relevant data. Please provide a description for each line-item subsidy listed in Worksheet 3 of the financial report.

Hospital-based physicians: physician rates are subsidized for our Pediatric Dept, Labor and Delivery, Women's Health Services, Inpatient Psychiatric Care, Transitional Care Center, and Diabetes Center to ensure access and continuity of care, particularly among vulnerable populations. Coverage of Emergency Department Call: Physician services are subsidized to ensure specialized care in urology, general surgery, orthopedic surgery, neuro surgery, as well as services for victims of crimes care in our ED.

*Q139.* Please attach any files containing further information and data justifying physician subsidies your hospital.

*Q140.* ## Section VI - Financial Assistance Policy (FAP)

*Q141.* Upload a copy of your hospital's financial assistance policy.

Financial Assistance Policy.pdf
475.5KB
application/pdf

*Q220.* Provide the link to your hospital's financial assistance policy.

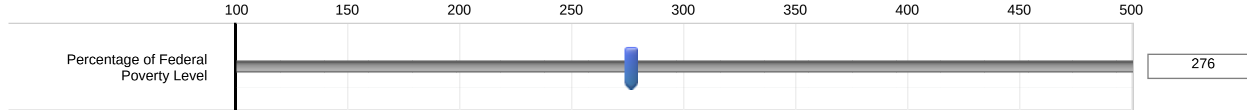
https://www.umms.org/bwmc/patients-visitors/for-patients/financial-assistance

*Q147.* Has your FAP changed within the last year? If so, please describe the change.

- (selected) No, the FAP has not changed.
- Yes, the FAP has changed. Please describe:

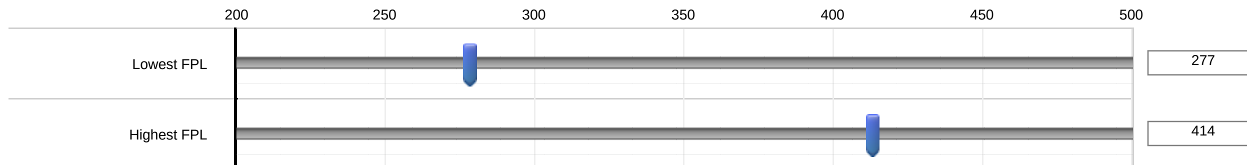
*Q143.* Maryland hospitals are required under Health General §19-214.1(b)(2)(i) COMAR 10.37.10.26(A-2)(2)(a)(i) to provide free medically necessary care to patients with family income at or below 200 percent of the federal poverty level (FPL).

Please select the percentage of FPL below which your hospital's FAP offers free care.



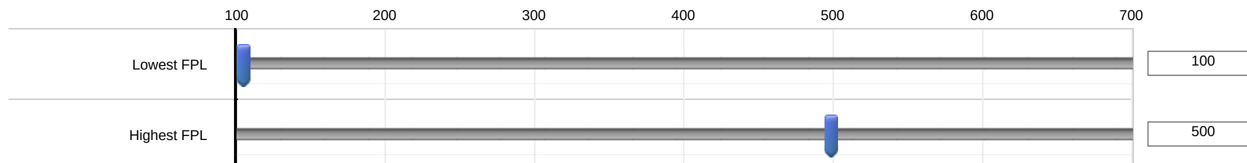

*Q144.* Maryland hospitals are required under COMAR 10.37.10.26(A-2)(2)(a)(ii) to provide reduced-cost, medically necessary care to low-income patients with family income between 200 and 300 percent of the federal poverty level.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care.

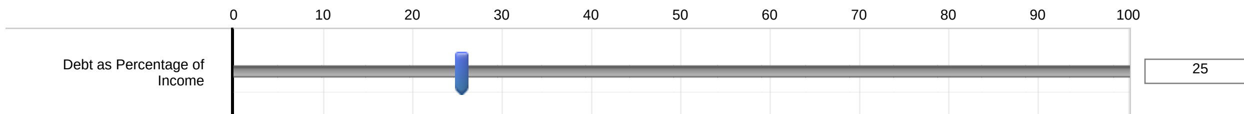



*Q145.* Maryland hospitals are required under Health General §19-214.1(b)(2)(iii) COMAR 10.37.10.26(A-2)(3) to provide reduced-cost, medically necessary care to patients with family income below 500 percent of the federal poverty level who have a financial hardship. Financial hardship is defined in Health General §19-214.1(a)(2) and COMAR 10.37.10.26(A-2)(1)(b)(i) as a medical debt, incurred by a family over a 12-month period that exceeds 25 percent of family income.

Please select the range of the percentage of FPL for which your hospital's FAP offers reduced-cost care for financial hardship.




*Q146.* Please select the threshold for the percentage of medical debt that exceeds a household's income and qualifies as financial hardship.




*Q221.* Per Health General Article §19-303 (c)(4)(ix), list each tax exemption your hospital claimed in the preceding tax able year (select all that apply)

- [x] Federal corporate income tax
- [x] State corporate income tax
- [x] State sales tax
- [x] Local property tax (real and personal)
- [ ] Other (Describe)

*Q150.* Summary & Report Submission

*Q151.*

Attention Hospital Staff! IMPORTANT!

You have reached the end of the questions, but you are not quite finished. Your narrative has not yet been fully submitted. Once you proceed to the next screen using the right arrow button below, you cannot go backward. You cannot change any of your answers if you proceed beyond this screen.

We strongly urge you to contact us at hcbhelp@hilltop.umbc.edu to request a copy of your answers. We will happily send you a pdf copy of your narrative that you can share with your leadership, Board, or other interested parties. If you need to make any corrections or change any of your answers, you can use the Table of Contents feature to navigate to the appropriate section of the narrative.

Once you are fully confident that your answers are final, return to this screen then click the right arrow button below to officially submit your narrative.

**Location Data**

**Location:** (39.264495849609, -76.622398376465)

**Source:** GeoIP Estimation

UNIVERSITY of MARYLAND
BALTIMORE WASHINGTON
MEDICAL CENTER

# Community Health Needs Assessment Fiscal Years 2019-2021

Approved by the UM BWMC Board
Community Benefit Committee: June 10, 2019

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## Table of Contents

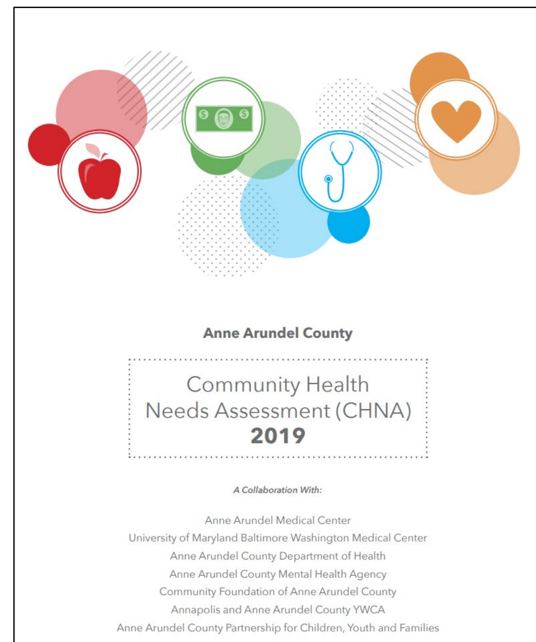

Section 1: Community Health Needs Assessment (CHNA) ........................................ 3

Process ..... 3
Summary of CHNA Findings ..... 5
Section 2: Prioritization of Community Health Needs ..... 18
Process ..... 18
UM BWMC's Selected Community Benefit Priorities ..... 19
Community Health Needs Not Selected as Community Benefit Priorities ..... 20

## Section 1: Community Health Needs Assessment (CHNA)

The Anne Arundel County Health Needs Assessment (CHNA) was conducted under the auspices of the Healthy Anne Arundel Coalition with leadership from UM BWMC, Anne Arundel Medical Center, Anne Arundel County Department of Health, Anne Arundel County Mental Health Agency, Inc., Community Foundation of Anne Arundel County, Annapolis and Anne Arundel County YWCA, and the Anne Arundel County Partnership for Children, Youth and Families. The goal of the CHNA was to help frame informed decisions about community health needs and trends in Anne Arundel County in order plan, implement and evaluate actions to address those needs. The CHNA was unveiled at a community meeting and has been made widely available to the public. The CHNA is intended to be used by hospitals, health care providers, social service organizations, government agencies, community organizations, businesses, county residents and other key stakeholders.

### Process




The author of the CHNA was Dr. Pamela Brown. Dr. Brown is the Executive Director of the Anne Arundel County Partnership for Children, Youth and Families. She completed her Ph.D. in Educational Leadership at Florida Atlantic University. She is a University Research Reviewer and Dissertation Chair for the University of Phoenix specializing in qualitative case study methods. She is certified to conduct ethical research through the Collaborative Institutional Training Initiative at the University of Miami. She has been conducting community needs assessments for over 20 years.

The CHNA used quantitative and qualitative methods and was designed to be as comprehensive as feasible. No written comments on the previous CHNA were received to be incorporated into this CHNA. A community meeting sponsored by the Healthy Anne Arundel Coalition to discuss and prioritize the CHNA findings was attended by approximately 40 community members, including county residents, health care and social service provider and representatives from schools, businesses and community organizations.

The quantitative portion of the CHNA consisted of a secondary data analysis of local, state and federal data sources. The Anne Arundel County Department of Health assisted with secondary data analysis. The CHNA includes estimates from hard to reach portions of the population, such as drug users, domestic violence victims, and homeless individuals. Data on these subpopulations primarily came from police reports, Emergency Department (ED) data, and the public school system. It only captures individuals who have come in contact with these services. Therefore, the CHNA may underestimate the true burden of some health issues within Anne Arundel County. Another limitation of the data in the report is that there is a delay between when secondary data is collected and made available.

Focus groups and key informant interviews were used to solicit the thoughts and opinions of diverse Anne Arundel County residents, health care providers, social service providers and community leaders. A shortcoming of the qualitative data is that not all community perspectives will be obtained, although we did our best to engage a diverse and representative sample.

A total of eleven focus groups were conducted. The groups included representation from:

- AAAMC and UM BWMC Emergency Department and Emergency Response personnel
- Low-income youth from public housing
- Behavioral health providers
- Domestic violence and sexual assault victims
- Seniors
- Hispanic community
- Human services providers and advocates
- Early childhood advocates
- Community health providers
- Aging and disabilities providers
- Pupil Personnel Workers
- Anne Arundel County Health Department senior staff
- Criminal justice system representatives

The twenty-six key informants that provided qualitative data for the report included:

- CEO, Anne Arundel Medical Center
- CEO, University of Maryland Baltimore Washington Medical Center
- Anne Arundel County Health Officer
- Executive Director, Anne Arundel County Mental Health Agency
- Director, Anne Arundel County Crisis Response
- Clinical Director, Anne Arundel County Mental Health Agency
- Domestic Violence Coordinator, Anne Arundel Medical Center
- County legislative leader
- Director, Department of Social Services
- Schools Superintendent
- Middle School Ambassador
- Three Domestic Violence victims
- Director, Anne Arundel County Department of Aging and Disabilities
- Hispanic Community leader
- Anne Arundel County Chief of Police
- Anne Arundel County Transportation Director
- County Executive
- County Administrative Officer
- Faith leader
- Public housing resident
- Formally homeless youth
- Executive Director, Community Health Agency
- Executive Director, YWCA
- Executive Director of Alternate Education for the public school system

The CHNA provided a detailed profile of Anne Arundel County and illustrated the social determinants of health that impact residents. The assessment identified a variety of community health needs including:

- Chronic Health Conditions
- Behavioral Health
- Maternal and Child Health
- Access to Health Care and Utilization
- Healthy and Safe Social Environments

The county-wide CHNA is available from UM BWMC's web site at www.umbwmc.org/community-benefit and from the Healthy Anne Arundel Coalition's web site at www.aahealth.org/healthyannearundel/chna. This report contains detailed narratives, tables, graphs and maps. Where possible, comparisons were made to state and national data and data was distilled by age, gender, race, ethnicity and zip code; however, not all data was published in the county-wide CHNA.

A summary of the county-wide CHNA findings is included in the next section, with additional commentary and analysis specific to UM BWMC.

## Summary of CHNA Findings

### Demographics

According to 2016 census estimates, the Anne Arundel County population is 537,565. The Hispanic population in Anne Arundel County is growing more significantly than all races/ethnicities, increasing 205% from 2000 to 2016.

**Anne Arundel County Ethnic and Racial Composition (2000-2016)**

| Ethnic/Racial Composition in Anne Arundel County, 2000-2016 | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 2000 | | 2010 | | 2016 | | Percent Change 2010 - 2016 |
| | Amount | % | Amount | % | Amount | % | % |
| **Total** | **489,656** | **100** | **537,656** | **100** | **559,737** | **100%** | **14.3** |
| Non-Hispanic Whites | 390,519 | 79.8 | 405,456 | 75.4 | 393,514 | 70.3% | 0.8 |
| **Other Races:** | **99,137** | **20.2** | **132,200** | **24.6** | **166,223** | **29.7%** | **27.9** |
| Hispanic or Latino | 12,902 | 2.6 | 32,902 | 6.1 | 39,402 | 7.9% | 205.4 |
| Black/African- American | 65,755 | 13.4 | 83,484 | 15.5 | 87,090 | 15.6% | 32.4 |
| Other* | 20,480 | 4.2 | 15,814 | 3 | 39,731 | 7.1% | 94 |
| * Includes: "American Indian and Alaskan Native", "Asian", "Native Hawaiian or other Pacific Islander", "Some other race", or "Two or more races". Therefore, the "White" and "Black" figures are those who were counted as "White alone" or "Black alone." | | | | | | | |

*U.S. Census Bureau, American Community Survey, 2016*

Currently, 13.4% of Anne Arundel's population is 65 or older. This portion of the population is expected to increase until 2030. As such, seniors will have an increasing impact on county services, supports, resource allocation, and health care use. The number of Medicare beneficiaries is rising in the county as a result of the growing senior population. The county has served almost 3,000 new beneficiaries in the last three years. The number who are also eligible for Medicaid, due to low income, rose from 10.9 percent to 11.3 percent in three years.

The income gap between rich and poor in the county has widened since 2010. Anne Arundel County's median household income is $99,652, which is 19% higher than Maryland and 65% more than the nation. Poverty is concentrated in the northern (near UM BWMC) and southern portions of the county. The highest percentage of poverty is in the ZIP Code that contains Brooklyn Park at a staggering 27.3 percent followed by Curtis Bay; both areas that border Baltimore City.

**Anne Arundel County Selected Poverty Percentages by ZIP Code**

| Selected Poverty Percentages by ZIP Code, 2016 | | |
|---|---|---|
| **ZIP Code** | **Area** | **Poverty Percentage** |
| 21225 | Brooklyn Park | 27.3% |
| 21226 | Curtis Bay | 16.6% |
| 21060 | Glen Burnie (East) | 7.9% |
| 21061 | Glen Burnie (West) | 9.2% |
| | Anne Arundel County | 5.8% (2017 estimates) |

*US Census Bureau, American Community Survey, 2016 and 2017 Estimates*

## Social Determinants of Health

Social determinants of health can impact individual and community health. Social determinants of health include race and ethnicity, employment status and income level, education, housing quality, neighborhood safety, family and social supports, and sense of community belonging. Many demographic and health indicators associated with poorer health status and outcomes are found in the northern (near UM BWMC) and southern portions of the county, and parts of Annapolis.

**Rising Demographic, Socioeconomic and Health Indicators by Selected ZIP Codes, 2013**

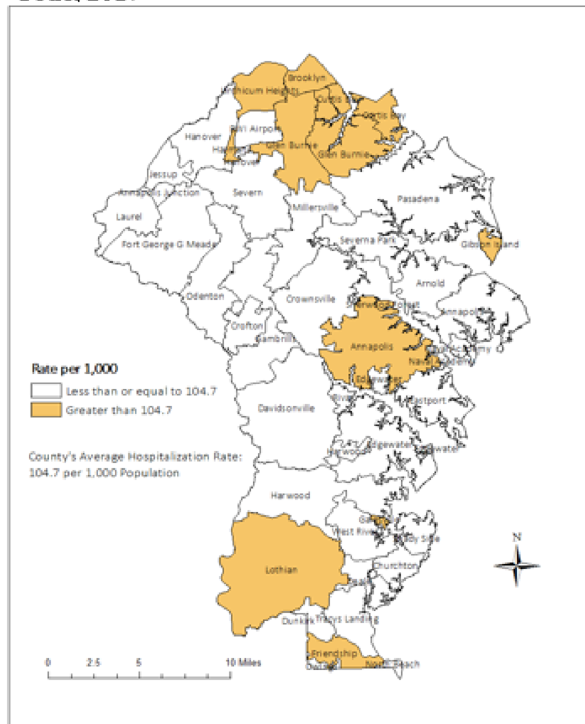
| Rising Demographic, Socioeconomic, and Health Indicators by ZIP Code Anne Arundel County, 2017 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **ZIP Code** | **Area** | Poverty Percentage | Percent without High School | Percent of Households on Snap | ED Visit Rate per 1,000 | Percent Low Birth Weight Infants | Preventable Hospitalization Rate per 1,000 | Minority Population |
| 20711 | Lothian | 11.7% | 13.2% | 23.4% | 389.7 | 8.4% | 6.8 | 25.6% |
| 20714 | North Beach | 10.6% | 7.5% | 8.6% | 285.0 | 8.9% | <11 | 12.4% |
| 20724 | Laurel | 3.8% | 9.1% | 4.2% | 234.6 | 9.3% | 2.4 | 64.6% |
| 20751 | Deale | 10.8% | 8.7% | 5.4% | 233.1 | 9.2% | 4.6 | 7.1% |
| 20758 | Friendship | 7.1% | 3.9% | 0.0% | 562.4 | 8.8% | <11 | 7.1% |
| 20765 | Galesville | 14.7% | 20.2% | 9.6% | 352.8 | 6.3% | <11 | 22.5% |
| 20776 | Harwood | 10.8% | 7.6% | 8.8% | 293.1 | 4.4% | 6.0 | 15.5% |
| 20794 | Jessup | 7.9% | 20.6% | 11.8% | 220.4 | 11.3% | 2.9 | 52.5% |
| 21060 | Glen Burnie (East) | **7.9%** | **13.7%** | **12.6%** | **406.5** | **8.0%** | **6.9** | **29.8%** |
| 21061 | Glen Burnie (West) | **9.2%** | **13.6%** | **12.8%** | **441.9** | **8.0%** | **5.5** | **45.0%** |
| 21090 | Linthicum Heights | 7.5% | 10.1% | 5.1% | 270.5 | 6.9% | 5.6 | 10.8% |
| 21144 | Severn | 7.9% | 8.2% | 10.4% | 289.2 | 9.2% | 3.5 | 51.7% |
| 21225 | Brooklyn | **27.3%** | **20.1%** | **32.6%** | **858.2** | **9.9%** | **8.9** | **59.4%** |
| 21226 | Curtis Bay | 16.6% | 15.8% | 16.8% | 509.6 | 8.7% | 6.6 | 26.9% |
| 21401 | Annapolis | 7.9% | 7.2% | 8.9% | 364.5 | 7.7% | 5.4 | 31.5% |
| 21403 | Eastport | 6.9% | 9.8% | 6.9% | 331.8 | 7.5% | 4.4 | 37.5% |
| | **Anne Arundel** | **6.1%** | **8.1%** | **7.0%** | **340.0** | **7.7%** | **4.6** | **29.7%** |

*** Red Shading= Higher than County Average**
**** Green Shading = UM BWMC Service Area**

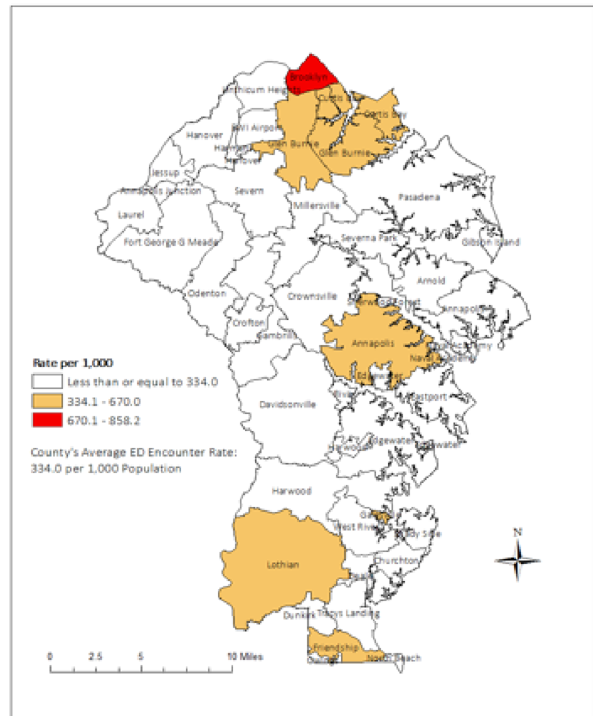
*US Census American Community Survey 5 year estimates, 2012-2016; Maryland Health Services Cost Review Outpatient Files, 2017*

When patterns of hospitalization and Emergency Department visits are examined by ZIP code they generally reflect the social determinants illustrated above. ZIP code 21225, which contains Brooklyn Park, has the highest hospitalization and emergency department visit in the county.

**Hospitalization Rate per 1,000 Population by ZIP Code, 2017**




**Emergency Department Encounters per 1,000 Population by ZIP Code, 2017**




There are a variety of needs concerning social determinants of health. There is a lack of public transportation throughout Anne Arundel County, and the operating bus routes have limited hours. This is especially an issue for the county's low-income and elderly residents. Limited transportation affects residents' ability to access health care services and their educational and employment options. Thirteen percent of county residents live in areas considered food deserts and don't have ready access to healthy eating options which contributes to higher levels of obesity and associated chronic health conditions such as diabetes. Affordable, quality child care is in scarce supply. There is limited affordable housing in the county, and homelessness has been increasing. The amount of money spent on housing limits the funds available for meeting other personal needs, including health care, healthy food, and opportunities for physical activity and recreational activities that can reduce stress.

## Health Care Access and Utilization

Anne Arundel County is served by two major hospitals: University of Maryland Baltimore Washington Medical Center (UM BWMC) in Glen Burnie and Anne Arundel Medical Center (AAMC) in Annapolis. Both hospitals are affiliated with academic medical centers, which offer advantages to patients requiring highly-specialized tertiary care. MedStar Harbor Hospital, which is located just north of the county line in Baltimore City, also serves county residents. However, the medical-surgical services

available at Harbor Hospital have been declining over recent years, although an inpatient Behavioral Health service was added.

Additionally, there are four Federally Qualified Health Centers (FQHCs) that serve county residents: Chase Brexton Health Care (Glen Burnie), Total Health Care (Odenton), Family Health Centers of Baltimore (Brooklyn neighborhood of Baltimore City), and Owensville Primary Care (West River area in South County). Chase Brexton Health Care is located across the street from UM BWMC and we have a formal partnership agreement with them. We also collaborate with Total Health Care.

The Anne Arundel County Department of Health offers a range of physical and behavioral health services at five clinic sites. The Anne Arundel County Mental Health Agency, Inc. provides a wide range of mental health services to Medicaid recipients and other low-income and uninsured county residents who meet certain criteria. Other health care services available in the county include primary care practices, outpatient specialty care, community clinics, urgent care facilities and retail store-based health clinics.

***Financial Assistance and Medicaid Enrollment***

Many providers of health care offer financial assistance. All hospitals in Maryland have financial assistance policies that provide medically necessary services to all people regardless of their ability to pay. Depending on their circumstances, patients can receive coverage for up to 100% of their medically necessary care. Payment plans are also available. FQHCs, community clinics and governmental providers offer services on a sliding scale or free basis. Assistance with enrolling in publicly funded entitlement programs and health insurance plans through the state health benefit exchange are available from the hospitals, county health departments, social service agencies and the Maryland Health Connection. However, it is important to note that not all health care providers, particularly behavioral health providers, accept all insurance plans or self-pay patients.

In Maryland, under the Affordable Care Act (ACA), persons whose income is up to 138% of the poverty level are eligible for Medicaid. The number of Medicaid enrollments increased from 84,616 in 2014 to 93,425 in May 2018, a ten percent increase. However, there are still many primary care providers who do not accept Medicare/Medicaid. In addition, a small percentage of county residents such as undocumented people, those not enrolled in Medicaid despite being eligible, and people opting to pay the annual penalty instead of purchasing insurance will remain uninsured.

***Health Care Provider Access***

Access to primary care physicians, dentists, and mental health services are demonstrated needs within the county. Having a primary care provider reduces nonfinancial barriers to obtaining care, facilitates access to services, and increases the frequency of contacts with health care providers. Without a primary care provider, people have more difficulty obtaining prescriptions and attending necessary appointments.

**Primary Care Physicians, Dentists and Mental Health Providers in Anne Arundel County (2018)**

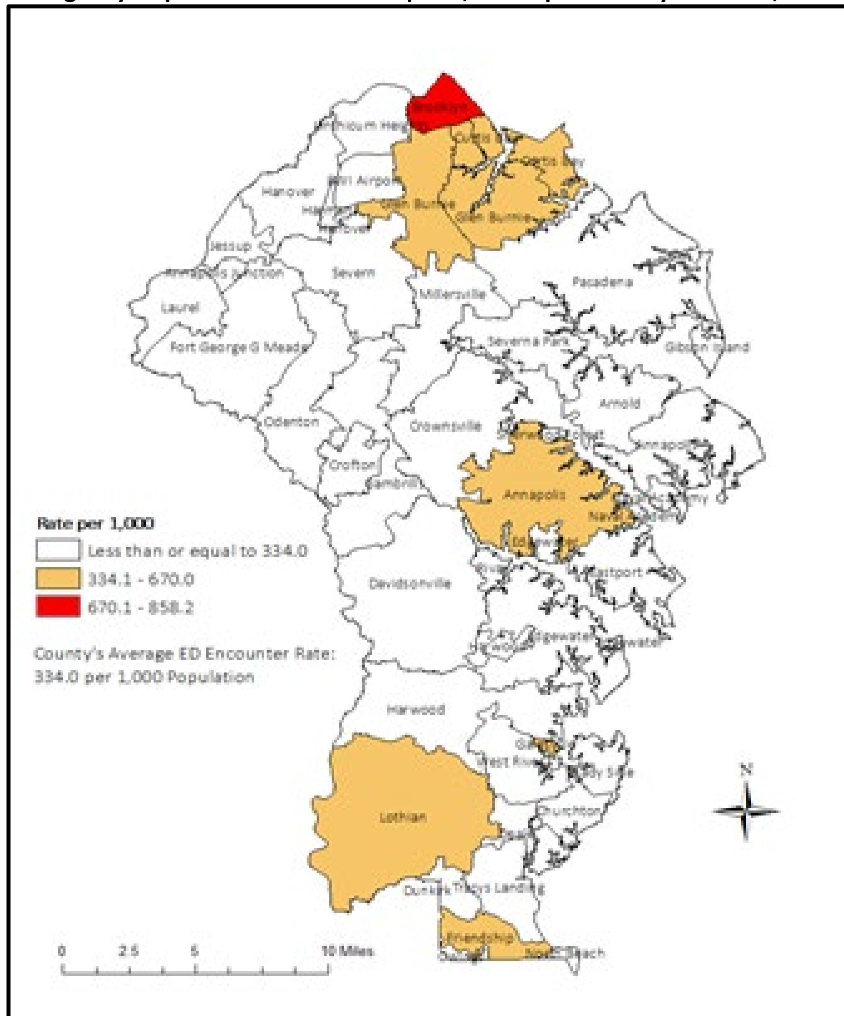
| Primary Care Physicians, Dentists and Mental Health Providers<br>Anne Arundel County, Maryland | | | | |
|---|---|---|---|---|
| | Anne Arundel County Total | Anne Arundel County Ratio | Maryland Ratio | Top U.S. Counties (90th percentile) |
| Primary Care Physicians (2018) | 386 | 1,450:1 | 1,140:1 | 1,030:1 |
| Dentists (2018) | 378 | 1,480:1 | 1,320:1 | 1,280:1 |
| Mental health providers (2018) | 861 | 650:1 | 460:1 | 330:1 |

*County Health Rankings, Anne Arundel County Department of Health, 2018,*

### *Emergency Department and Hospital Utilization*

In 2016, 9.6 percent of Emergency Department visits were by uninsured residents. Although not all visits to the Emergency Department are avoidable, care in lower level settings for some conditions, such as diabetes and hypertension, can potentially reduce the number of visits, thereby reducing costs and increasing the quality of care.

**Emergency Department Encounters per 1,000 Population by ZIP Code, Anne Arundel County, 2017**



*Anne Arundel County Department of Health, 2018*

In 2017 there were 59, 277 hospital stays in Anne Arundel County; a rate of 104.3 stays per thousand population. The hospitalization rate increased with age from 68.7 hospitalizations per 1,000 population among 0–18 year olds, to 262.5 hospitalizations per 1,000 population among those aged 65 years and over. (Note: This data only includes Anne Arundel County residents admitted to hospitals in Maryland.)

**Inpatient Hospitalizations in Anne Arundel County, 2017**

| Inpatient Hospitalizations Anne Arundel County 2017 | | |
|---|---|---|
| | **Number** | **Rate per 1,000** |
| **Total Hospitalizations** | 59,277 | 104.3 |
| **Age** | | |
| 0 to 18 Years | 9,763 | 68.7 |
| 19 to 39 Years | 12,917 | 83.3 |
| 40 to 64 Years | 16,607 | 84.9 |
| 65 Years and Over | 19,990 | 262.5 |
| **Sex** | | |
| Male | 25,656 | 92.7 |
| Female | 33,621 | 118.8 |
| **Race/Ethnicity** | | |
| White, NH | 38,719 | 96.9 |
| Black, NH | 11,747 | 132.5 |
| Asian, NH | 1,271 | 62.1 |
| Hispanic (Any Race) | 3,368 | 84.7 |

*Anne Arundel County Department of Health, 2017*

The rate changes depending on ZIP code. The ZIP Code containing Brooklyn Park has the highest rate of hospitalization at 163.9 per 1,000 residents. The Glen Burnie rates are also notable when population density is considered. These three zip codes are in UM BWMC's service area. Lack of access to primary care, multiple health issues presenting at the same time, poverty, unhealthy food and lack of medication management were reasons given for the high rates.

**Inpatient Hospitalizations by ZIP Code, Anne Arundel County, 2017**

| Inpatient Hospitalizations by ZIP Code Anne Arundel County 2017 | | | |
|---|---|---|---|
| **Town** | **Zip Code** | **Number** | **Rate per 1,000** |
| Brooklyn | 21225 | 2396 | 169.3 |
| Curtis Bay | 21226 | 555 | 126.4 |
| Friendship | 20758 | 66 | 155.3 |
| Galesville | 20765 | 53 | 147.2 |
| Glen Burnie (East) | 21060 | 4307 | 133.9 |
| Glen Burnie (West) | 21061 | 6717 | 123.8 |

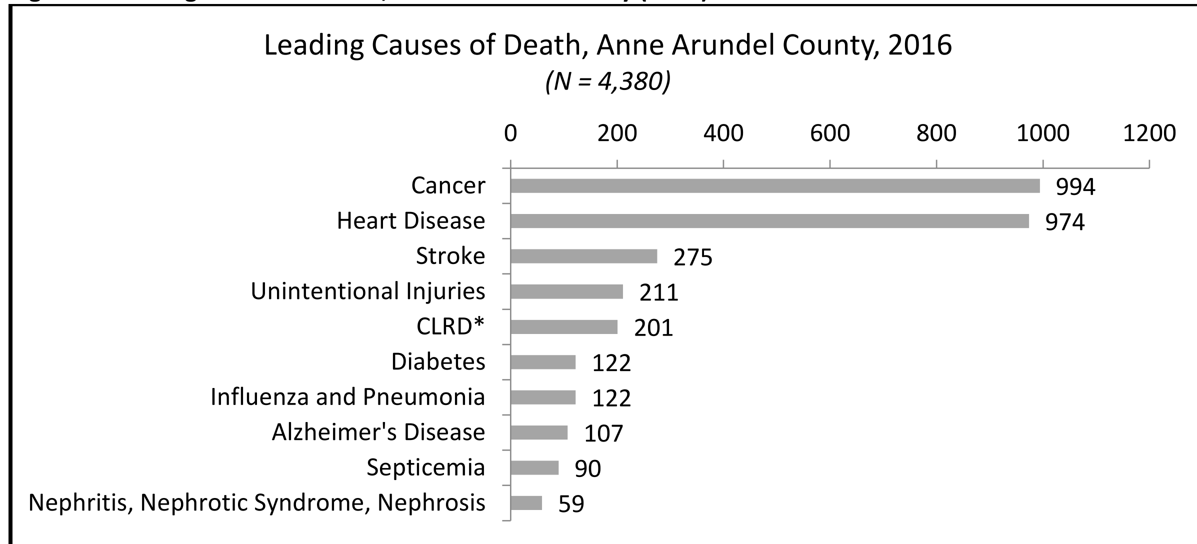
*Anne Arundel County Department of Health, 2018*

## Health Indicators

***Leading Causes of Death***

In 2016, there were 4,380 deaths in Anne Arundel County, and life expectancy was 79.6 years. Accidental (unintentional injury) deaths rose to the fourth leading cause of death driven by increases in opioid overdose deaths. Cancer was the leading cause of death, although these number have seen a 1 percent decrease since 2013. Overweight and obesity continue to drive poor health outcomes for the county, including secondary issues such as diabetes. Diabetes was the sixth leading cause of death.

**Figure 7: Leading Causes of Death, Anne Arundel County (2016)**




*Maryland Department of Health, Vital Statistics Administration, 2016*

Heart disease accounts for 22 percent or 974 of all county deaths as of 2016. That number has risen almost 10 percent since 2013. Age-adjusted death rates for coronary heart disease decreased for Blacks and Whites between 2013 and 2016. While Blacks still have the highest death rates in the county per 100,000 residents, that number decreased by 18 percent in just three years . The decrease for Whites was only 8 percent.

***Chronic Health Conditions***

Several chronic somatic health conditions were identified in the CHNA as community health needs including cardiovascular disease, cancer, diabetes and respiratory disease. Overweight and obesity are risk factors for many chronic health conditions was also identified as a community health problem.

Overweight and obesity are determined using weight and height to determine a BMI or “body mass index” measure. Between 2012 and 2016, the percent of overweight adults (Body Mass Index of 25 to 29.9) 18 years and older in Anne Arundel County rose slightly from 36.7 percent to 37.2 percent while the state average fell. The percent of county residents who are classified as obese (Body Mass Index 30 and over) also rose from 27 to 31 percent, as did the state average. Many factors play a role in weight including low income, lifestyle, surrounding environment, access to healthy food, genetics and certain diseases. Obesity is prevalent in low income families in the county for a variety of reason: their neighborhoods often lack full-service grocery stores and farmers’ markets, healthy food can be more

expensive, there is no transportation to get to a supermarket, there is a greater availability of fast food restaurants selling cheap, filling food, and there are fewer recreational facilities for exercise. The streets may be unsafe and there is little for children to do.

Smoking is associated with an increased risk of heart disease, stroke, lung and other types of cancers, and chronic lung diseases (Centers for Disease Control, 2018.) The rate of adult tobacco use has continued to drop in the county and is now equal to the state and less than the nation. According to the 2016 Middle School Risk Behavior Survey, cigarette smoking by Anne Arundel Middle School students is trending significantly downwards. However, many participants commented on the increased use of e-cigarettes and vaping, in and outside of the school gates.

UM BWMC clinical staff have identified cardiovascular disease, cancer, diabetes, and respiratory disease as a particular concern to the UM BWMC service area. These diagnoses have a significant contribution to Emergency Department utilization, hospital admissions, and hospital readmissions. Co-morbid chronic conditions are common in the hospital's patient population.

***Senior Health***

Most seniors have at least one chronic health condition, and many have multiple conditions. The top five conditions seniors suffer from are hypertension, hyperlipidemia, arthritis, ischemic heart disease and diabetes (Administration on Aging Administration for Community Living, 2018).

When parents and/or caregivers of the elderly lack the ability or the dollars to care for an aging family member, the Emergency Department may be the only option to achieve some respite. When family members are unable to care for their relative, or are absent or non-existent, some entity or professional has to become the guardian for that person. Hospital and Emergency Department employees may apply for guardianship of the patient so that decisions can be made about their living arrangements and future care, although the process to obtain guardianship through the court system can take months.
As one CHNA participant commented, "We're seeing a lot more respite care. We're seeing a lot more care management cases where a person may be in the Emergency Department for weeks on end. We've seen guardianship cases when patients are in the hospital for months, taking up a bed for no reason when there is no medical indication that they need to be here, but they need to be somewhere safe."

***Behavioral Health***

The rise in behavioral health issues for every age group, and the lack of appropriate services and service providers (e.g. psychiatrists, crisis beds, residential services), were the major concerns for all participants in the needs assessment. These issues are exacerbated by providers who don't accept Medicaid and Medicare, and patients with inadequate health insurance, or no insurance at all. Participants in this needs assessment shared many opinions as to why mental health issues are increasing including, poverty, isolation, social media, increasing societal violence, the fast pace of a technological world and the reduction of stigma around mental health services.

Emergency Department Utilization

The County's hospital Emergency Departments are often the receiving facilities for behavioral health issues. In 2017, there were 12,446 behavioral health encounters; mood disorders accounted for 26.3 percent of those and over 38 percent were alcohol or substance abuse related.

**ED Encounters for Behavioral Health Conditions in Anne Arundel County (2017)**

| ED Encounters for Behavioral Health Conditions<br>Anne Arundel County 2017 | | | |
|---|---|---|---|
| | **Condition** | **Frequency** | **Percent** |
| 1 | Mood Disorders | 3,277 | 26.3 |
| 2 | Alcohol-Related Disorders | 2,546 | 20.8 |
| 3 | Substance-Related Disorders | 2,212 | 17.8 |
| 4 | Anxiety Disorders | 1,654 | 13.3 |
| 5 | Suicide and Intentional Self-Inflicted Injuries | 724 | 5.8 |
| 6 | Schizophrenia and Other Psychotic Disorders | 655 | 5.3 |
| 7 | Attention-Deficit Conduct and Disruptive Behavior Disorders | 379 | 3.1 |
| 8 | Delirium Dementia and Amnestic and Other Cognitive Disorders | 348 | 2.8 |
| 9 | Adjustment Disorders | 295 | 2.4 |
| 10 | Miscellaneous Mental Health Disorders | 112 | 0.9 |
| | Total | 12,446 | |

*Anne Arundel County Department of Health, 2018*

Early Childhood and School-Aged Youth

The availability of affordable, quality child care was identified as a significant issue.

Increased behavioral issues in the birth to five early childhood population are causing widespread concern in every system. Behavioral problems in children as young as two years old are disrupting child care facilities including Early Head Start and Head Start. Professionals are divided as to the cause of this increase but they all agree that this is a new phenomenon unrelated to income. Many suggested the use of social media by parents and young children is leading to huge deficits in social and emotional skills. Some serious mental health issues are surfacing earlier; often co-occurring with developmental issues such as autism. The number of crisis interventions in the public school system for social and emotional issues has doubled since 2013, reaching close to 5,000 during the 2016-2017 school year.

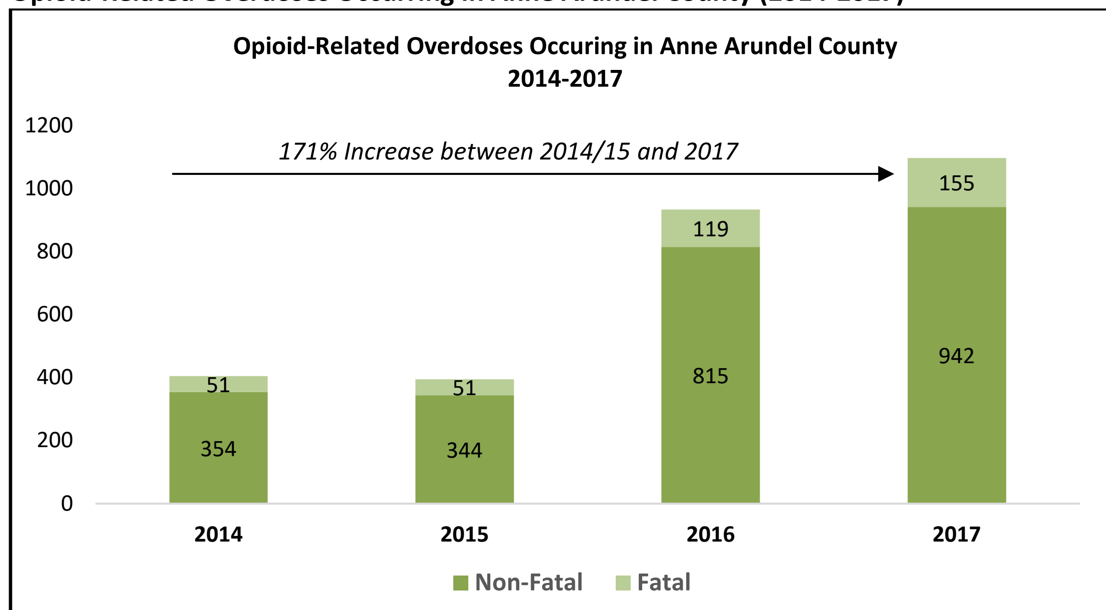
As of 2016, the Anne Arundel County youth suicide rate was 7.8 per 100,000, an increase compared to the rate of 5.3 per 100,000 in 2012. The Centers for Disease Control and Prevention (CDC) estimates that for each youth suicide, there are 25 suicide attempts. Between 2012 and 2016, there were 1,306 Emergency Department encounters in Maryland hospitals for suicide attempts by Anne Arundel County youth aged 10 to 24 years, an average of 261 per year.

Opioid Overdoses

Prescription opioid addiction is now a major public health crisis. Although Anne Arundel County is the fifth largest county in the state in terms of population, it has the third highest rate of prescription opioid related deaths as of 2017. In 2017, Anne Arundel County police reported almost 1,100 opioid-related overdoses occurring, a 171 percent increase since 2014. The rate of fatal overdoses continues to

increase, driven by the introduction of fentanyl into the community. Fentanyl-related deaths in the county have increased significantly since 2013 and surpassed heroin related deaths through 2017. As with many other county issues, geography plays a part with the majority of overdoses occur in North County and Annapolis.

**Opioid-Related Overdoses Occurring in Anne Arundel County (2014-2017)**




Note: In 2017, there were 117 Persons with 2 or more overdoses.
*Anne Arundel County Police Department, 2018*

The current opioid crisis has many victims. The number of newborns assessed positive for substances in their systems, including methadone, According to all participants, the children of opioid victims are traumatized and ashamed. Several suggested we need narcotics support groups for teen family members. Young children born into homes where heroin is used may be neglected, has risen 144 percent since 2014 from 74 to 181 (Department of Social Services, 2018).

## Maternal and Child Health

The infant mortality rate in Anne Arundel County between 2010 and 2014 was 5.5 deaths per 1,000 live births which is lower than both the United States (6.0 deaths per 1,000 live births) and Maryland (6.6 deaths per 1,000 live births) during the same period. Although the overall infant mortality rate is lower for the county than the state average, disparities exist when stratifying the data by race and ethnicity. Blacks have the highest infant mortality rate in the county (11.2 deaths per 1,000 live births) compared to 5.3 deaths and 4.0 deaths per 1,000 births for Hispanics and Whites respectively.

**Infant Deaths and Infant Mortality Rates by Race and Ethnicity, Anne Arundel County, 2010-2014**

| Race/Ethnicity | Number of Infant Deaths | Infant Mortality Rate |
|---|---|---|
| White, Non-Hispanic | 89 | 4.0 |
| Black, Non-Hispanic | 68 | 11.2 |
| Hispanic, Any Race | 22 | 5.3 |

Source: Maryland Department of Health and Mental Hygiene Vital Statistics Administration, 2013

Low birth weight (less than 2,500 grams) is the single most important factor affecting neonatal mortality (newborn infants up to 28 days old) and a significant determinant of post neonatal mortality (newborn infant between 28 and 364 days old). Low birth weight infants run the risk of developing health issues ranging from respiratory disorders to neurodevelopmental disabilities. In Anne Arundel County, the percentage of low birth weight babies is dropping slowly and is less than the state average at 8.7%. However, there are several ZIP codes concentrated in the northern part of the county where the percentage of low birth weight infants is much higher than the overall county average of 7.9%, especially in Brooklyn, Severn, Laurel, Glen Burnie (West), Hanover, Millersville, and Jessup. Five of these zip codes within UM BWMC's service area.

## Social Environment and Violence in the Community

Many participants in this needs assessment lamented the lack of sports and recreation opportunities for children, youth and adults across the county. Parents from every race, ethnicity and income level decried the lack of "active things to do" for children and youth. While some communities have a recreation center for youth, many do not.

Social media, including the active use of smart phones and tablets, is a major concern for residents and professionals in every area of the county. Several suggested that the ease of electronic access to pornography for very young children is linked to rising child on child sexual abuse within the school system. The constant access to electronic information is impacting every age group and demographic: Increases in bullying, suicide and suicidal ideation for youth, have been linked to the constant use of social media apps such as Instagram and Snapchat. Youth in low income communities are emulating international gang members, their colors and lifestyles by following their on-line presence. Body language, eye contact and social behavior of every kind is now lessened by the isolation of cell phone use. Video-gaming is replacing outdoor sports and recreation, and it is addictive.

All participants commented on the increase in the use of social media for adults. Some commented on the isolation it causes and the need to look at every experience through the lens of a photo for Facebook. As one professional said. Others linked the use of social media and rapid electronic communication with rising rates of drug use, depression and anxiety.

Anne Arundel County Police Department tracks domestic violence statistics. The data shows an upward trend although there was a dip in numbers for the 2015-2016 year. The statistics for the 2018 year are alarming. The numbers for the six month period are almost as high as for the previous 12 months, with slightly over 1000 assaults. These statistics confirm anecdotal data from police, schools and hospital personnel who all reported a notable increase in domestic violence over the same period.

The CHNA also identified rising youth gang activity, particularly in the Annapolis area and the western part of the County.

In 2018, the county's Child Advocacy Center investigated 326 sexual abuse cases, of which seven were for sexual assault (Anne Arundel County Department of Social Services, 2018). Respondents noted a large increase in the number of child on child sexual assaults that are being reported by the school system and other agencies.

The 50-mile radius surrounding BWI airport is becoming known as the third-most-lucrative area in the nation for trafficking in people (Maryland Human Trafficking Taskforce, 2018.) Anne Arundel County

Police Department tracks the number of sex trafficking incidents for the county. While the numbers were stable between 2015 and 2017, data for the first 6 months of 2018 are showing an almost 100 percent increase in cases, with 18 cases during those six months. UM BWMC has identifies and treated sex trafficking victims in its Emergency Department.

## The Environment

The 2016 State of the Bay Report from the Chesapeake Bay Foundation showed that each of the three indicator categories—pollution, habitat, and fisheries have improved since 2014. However, despite many efforts by federal, state, and local governments and other interested parties, pollution in the Bay does not meet existing water quality standards. All of the county's waterways are considered "impaired" because of excessive levels of major contaminants, which are largely a result of untreated storm water runoff.

Air quality is another issue for the county. Anne Arundel was given an F by the American Lung Association in 2018 for an average of 13 high ozone days, a reduction from the 2013 rate of 23 days. High ozone causes respiratory harm (e.g. worsened asthma, worsened COPD, inflammation,) can cause cardiovascular harm (e.g. heart attacks, strokes, heart disease, congestive heart failure) and may cause harm to the central nervous system.

## Impact of Community Health Initiatives Since the Previous CHNA

UM BWMC's last CHNA, conducted in FY16, identified the following community health improvement priorities:

- Chronic Health Conditions
- Behavioral Health
- Maternal and Child Health
- Access to Health Care and Utilization
- Community Support

A CHNA conducted in FY13, identified the following community health improvement priorities:

- Chronic Disease (Obesity, Heart Disease, Diabetes & Cancer)
- Violence Prevention
- Healthy Babies
- Influenza Education and Prevention
- Access to Healthy Food and Healthy Food Education

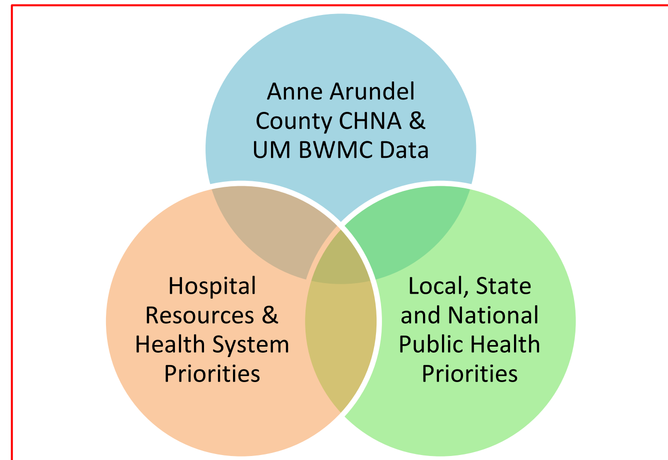
The priorities from the FY16 CHNA overlap with the community health needs and improvement priorities identified by the most current CHNA. During the past three years considerable work was undertaken by UM BWMC to address these significant priorities. Each year, state and federal reports described the actions UM BWMC undertook and the resources that we committed to community health improvement initiatives that met applicable guidelines related to community benefit. Process measures related to the number of participants reached and partnerships developed and program-specific short term outcomes were tracked, measured and reported. In FY16-18, UM BWMC dedicated over $74 million to community benefit initiatives that reached more than 26,000 people.

The similarity between the health improvement priorities identified through the FY13, FY16 and FY19 CHNAs demonstrate the difficulty in measuring the long-term impact of the community health improvement initiatives at the population level. Many indicators, such as cancer incidence and mortality rates, are the result of long term health status, behaviors, policies and environmental factors. It can take years and even decades to see significant and sustained progress. As focus groups participants acknowledged, there is no quick fix for eliminating chronic disease risk factors, and significant behavior changes might take a generation. Also, there is often a delay between when population-level quantitative data is available.

Qualitative feedback obtained from the focus groups and stakeholder interviews provided “real time” feedback on our efforts. Although these respondents have seen progress in partnership development, and collaborative initiatives, improved access to health care, and new initiatives to improve care coordination and transitions of care, there was also consensus that much work remains to be done.

## Section 2: Prioritization of Community Health Needs

UM BWMC took a multi-pronged approach to prioritizing our local community health needs. This approach helped to assure that our community benefit implementation plan addressed the most significant needs identified in the CHNA while also being aligned with UMMS community health improvement initiatives and national, state and local public health priorities. The plan was also developed to be responsive to Maryland's health system transformation, including the increased focus on population health and community partnerships. This approach also helped to assure that we had the necessary infrastructure and resources to successfully implement our Community Benefit Implementation Plan.




## Process

Our process included:

- Convening a Community Benefit Implementation Planning Committee to develop the Community Benefit Implementation Plan. This committee included UM BWMC clinical and administrative leadership.
- Reviewing CHNA data and UM BWMC Emergency Department, inpatient and ambulatory utilization data to inform the plan development.
- Reviewing community health improvement priorities identified during UMMS Community Health Improvement Retreats.
- Reviewing the Maryland State Health Improvement Process (SHIP) priorities established as being important to improving the health status of all Marylanders (these are aligned with Healthy People 2020 national goals) and considering additional public health priorities identified by county, state and national governments and health organizations.
- Identifying the infrastructure, staffing, clinical expertise and other resources at UM BWMC and in the community to support the successful implementation of community benefit strategies.
- Refining the plan with input from executive UM BWMC and UMMS leadership.
- Formally adopting the CHNA and Community Benefit Implementation Plan for FY19-21 by both the UM BWMC Community Benefit Board and the UM BWMC Board of Directors.

## UM BWMC's Selected Community Benefit Priorities

This process resulted in the following community benefit strategic priorities being identified for UM BWMC's Community Benefit Implementation Plan.

- Chronic Health Conditions (Cancer, Cardiovascular Disease, Diabetes, Obesity/Overweight, Chronic Lower Respiratory Diseases[i])
- Behavioral Health
- Maternal and Child Health
- Health Care Access and Utilization
- Healthy and Safe Social Environments

An overarching theme is the reduction of health disparities among vulnerable populations.

The table below illustrates the synergies between UM BWMC, local, state and national priorities:

**Alignment of UM BWMC Community Benefit Priorities with Public Health Priorities**

| **UM BWMC Community Benefit Priority** | **Healthy Anne Arundel Priority** (Local Health Improvement Coalition priority) | **Maryland SHIP Priority** (aligned with Healthy People 2020 National Goals) |
|---|---|---|
| **Chronic Health Conditions** (Cancer, Cardiovascular Disease, Diabetes, Obesity/Overweight, Chronic Lower Respiratory Diseases) | **Obesity Prevention** – selected because it a major contributing factor to several chronic health conditions (diabetes, heart disease, cancer) | **Healthy Living** (healthy weight, physical activity, tobacco cessation, life expectancy) **Quality Preventive Care** (mortality rates for cancer and heart disease) |
| **Behavioral Health** | **Prevention and Management of Behavioral Health Conditions** | **Healthy Communities** (child maltreatment, domestic violence, suicide) |
| **Maternal and Child Health** | This is not an identified HAAC priority since it is being addressed by the county's Fetal and Infant Mortality Review Community Action Team. | **Healthy Beginnings** (early prenatal care, low birth weight, sudden unexpected infant death rate, infant death rate) |
| **Health Care Access and Utilization** | **Access to Care** | **Access to Health Care** (persons with a primary care provider, uninsured ED visits) **Quality Preventive Care** (ED visit rates for ambulatory sensitive conditions, annual seasonal influenza vaccinations) **Quality Preventive Care** (cancer mortality rate drug-induced death rate, mortality rates for cancer and heart disease) |
| **Healthy and Safe Social Environments** | **Vision of "Healthy County, Healthy People"** | **Vision of "Healthier Maryland"** |

Within these priority areas, a number of potential health improvement strategies have been identified (as described in Section 4) to address community needs. Some of the strategies are the continuation or expansion of existing community benefit activities. Existing programs will be enhanced and expanded through new partnerships to expand their reach in the community, with an emphasis on reaching vulnerable populations. Other strategies are new initiatives that will be planned and implemented to address community needs.

The role UM BWMC will take in each implementation strategy will depend on a number of factors. Depending on the specific activity, UM BWMC will either take a leadership role, collaborating role or supportive role. When taking on a leadership role, UM BWMC will provide the leadership and devote the necessary resources to assure the success of the activity or initiative. Resources can include staff time and expertise, financial allocations, in-kind contributions. When serving in a partner role, UM BWMC will collaborate with other organizations to provide the leadership and/or resources for the activity or initiative. In a supportive role, UM BWMC recognizes the contribution to health and importance to the community, but does not have the organizational strengths or available resources to take on a key leadership or partnership role. In these instances, UM BWMC will provide assistance as resources are available.

## Community Health Needs Not Selected as Community Benefit Priorities

Lack of affordable dental services, environmental health concerns, transportation barriers are community health needs identified through the CHNA not directly being addressed by UM BWMC. UM BWMC will support the advancement of community health improvement initiatives in these areas as feasible.

UM BWMC does not provide routine dental care at this time, but we do refer patients to low-cost dental clinics for care. We subsidize oral surgery on-call services and have oral surgeons on our medical staff. UM BWMC partners with the Anne Arundel County Department of Health to divert dental patients presenting to the ED to providers in the community. Patients will be treated within 24-48 hours of their ED visit. Care coordination will be provided to prevent repeat ED visits. UM BWMC is supportive of this grant application and will assist with grant implementation, if awarded.

Environmental health concerns are being addressed by the Anne Arundel County Department of Health's Bureau of Environmental Health Services and other local environmental advocacy organizations.

Public transportation is not in the scope of services that UM BWMC can provide as a hospital; however, we do provide some transportation assistance through our care management program and our Transitional Care Center. We also provide transportation assistance for participants in our Stork's Nest prenatal education program. Anne Arundel and surrounding county governments are collaborating to expand access to public transportation in the Central Maryland region.

Other needs identified in the CHNA included affordable housing and affordable, quality child care. UM BWMC will support these priorities through participation in economic development initiatives and health professions training designed to help improve socioeconomic wellbeing of individuals and the local community.

[i] Chronic lower respiratory diseases include chronic obstructive pulmonary disease and asthma.

# Community Benefit Implementation Plan Fiscal Years 2019-2021

Approved by the UM BWMC Board
Community Benefit Committee: June 10, 2019

Approved by the Executive Committee of the
UM BWMC Board of Directors: June 17, 2019

Published: June 18, 2019

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## Table of Contents

Section 1: Introduction ..... 3
UM BWMC Mission, Vision and Values ..... 4
Community Benefit Overview ..... 5
Community Benefit Operations & Oversight ..... 7
Section 2: Prioritization of Community Health Needs ..... 11
Process ..... 11
UM BWMC's Selected Community Benefit Priorities ..... 12
Community Health Needs Not Selected as Community Benefit Priorities ..... 13
Section 3: Community Benefit Implementation Plan ..... 14
Priority: Chronic Health Conditions ..... 15
Priority: Behavioral Health ..... 17
Priority: Maternal and Child Health ..... 18
Priority: Health Care Access and Utilization ..... 20
Priority: Healthy and Safe Social Environments ..... 22
Section 4: Community Benefit Annual Reporting ..... 24
Section 5: Conclusion ..... 25
Appendix A: Financial Assistance Policy Summary ..... 26
Appendix B: Sample Community Benefit Partner List ..... 28

## Section 1: Introduction

University of Maryland Baltimore Washington Medical Center's (UM BWMC) mission is to provide the highest quality health care services to the communities we serve. We provide emergency, inpatient and outpatient services in more than sixty specialties. In addition to clinical care, we offer a variety of community benefit activities. Community benefits are programs or activities that promote health, increase access to health care services or improve the well-being of the community. Our clinical and community benefit programs and services are developed in response to an assessment of community health needs, analysis of hospital-specific data and feedback from our patients and their families, medical staff and community partners.

This plan summarizes the findings of our recently completed community health needs assessment (CHNA), and describes the process we took to prioritize our community's health needs. UM BWMC's goals, strategies, and partnerships for improving the health of the communities we serve are detailed in this document. In addition, this plan describes our alignment with local, state and national health improvement priorities and health system transformation initiatives. This plan also explains our structure for assuring that our community benefit program has the appropriate guidance, oversight and resources to support the successful implementation of this plan and the reporting of progress.

Our Community Benefit Implementation Plan for FY19-21 addresses these community health improvement priorities:

- Chronic Health Conditions (Cancer, Cardiovascular Disease, Diabetes, Obesity/Overweight)
- Behavioral Health
- Maternal and Child Health
- Health Care Access and Utilization
- Healthy and Safe Communities

Our community benefit programming includes:

- community outreach and health education services to provide people with the education and tools to lead healthier lives
- screenings so that people can be diagnosed with health problems when they are most treatable
- support groups for patients and their families
- financial assistance to those who could not otherwise afford health care services
- provider subsidies to increase access to care
- health care workforce development
- partnership development and other community building activities

UM BWMC is pleased to present our Community Benefit Implementation Plan. At UM BWMC we truly believe that community benefit is an investment in the communities and people we serve. For more information about our community benefit activities, please visit www.umbwmc.org/community-benefit, send an email to bwmcpr@umm.edu or call 410-553-8103.

## UM BWMC Mission, Vision and Values

**Vision Statement:**

To be the preferred regional medical center through nationally recognized quality, personalized service and outstanding people.

**Mission Statement:**

The mission of University of Maryland Baltimore Washington Medical Center is to provide the highest quality healthcare services to the communities we serve.

**Values:**

**C**ommunication - That which is proactive, timely, thorough and understood as an essential thread to teamwork and excellence in patient care and service.

**A**ccountability - Is demonstrated through our integrity, ownership and action to the care and service of our patients, families and creating a healthy work environment.

**R**espect - Our actions (of omission and commission) reflect the respect and dignity our patients, their families and all UM BWMC associates deserve.

**E**xcellence - In the compassionate and empathetic care, service and support of our patients and their families, our colleagues and our service.

## Community Benefit Overview

### Definition of Community Benefit[i]

A community benefit is a planned, organized, and measured approach, by a non-profit health care organization, to meet identified community health needs within its service area. It most often requires collaboration with other non-profit and public organizations within the community in determining the health needs of its residents. Such planning relies on the use of objective data and information to determine community needs, and the impact of the organization's participation on those needs.

Community benefits respond to an identified community need, and meet the following criteria:

- Ultimately improve the health status and well-being of specific populations in the organization's service area who are known to have difficulty accessing care and/or who have chronic needs;
- Generate a low or negative margin;
- Are not provided for marketing purposes; and/or
- The service or programs would likely be discontinued if the decision were made on a purely financial basis.

### Community Benefit Service Area

UM BWMC considers our Community Benefit Service Area (CBSA) to be the Anne Arundel County portions of our primary and secondary service areas as defined by our Global Budget Revenue Agreement with the Maryland Health Services Cost Review Commission. These zip codes include:

| | |
|---|---|
| 21060- Glen Burnie | Primary Service Area |
| 21061- Glen Burnie | Primary Service Area |
| 21122- Pasadena | Primary Service Area |
| 21144- Severn | Primary Service Area |
| 21225- Brooklyn | Primary Service Area |
| 21054- Gambrills | Secondary Service Area |
| 21076- Hanover | Secondary Service Area |
| 21090- Linthicum Heights | Secondary Service Area |
| 21108- Millersville | Secondary Service Area |
| 21113- Odenton | Secondary Service Area |
| 21146- Severna Park | Secondary Service Area |

The primary service area surrounding UM BWMC where most of our discharges originate from has some of the most vulnerable, high-risk residents in Anne Arundel County based on socioeconomic and health data. We make concerted efforts to reach vulnerable, at-risk populations, including the uninsured, racial/ethnic minorities, persons with risky health behaviors (e.g. smoking), and people with chronic health conditions (e.g. diabetes, cancer). Zip codes in our secondary service area have more localized pockets of community health needs.

We have leadership roles in county-wide collaborative population health initiatives such as the Healthy Anne Arundel Coalition (local health improvement coalition), Bay Area Transformation Partnership between UM BWMC and Anne Arundel Medical Center, and the Opioid Action Task Force.

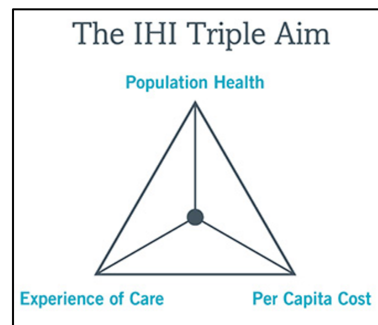
## Community Benefit as a UM BWMC Strategy Priority

UM BWMC's Strategic Goals for FY20-24 are listed below along with some of the strategies related to our community benefit program.

- Exceptional Quality, Safety & Patient Experience
  - Community Benefit offerings that are aligned with UM BWMC patient conditions (e.g. diabetes education)
  - Support Groups for patients and families
- Ease of Access to Care for Our Community
  - Physician Subsidies for Primary Care, Women's Health, Transitional Care and Behavioral Health
  - Health screenings and flu shots
- Innovative and Effective Organization
  - Alignment between strategic planning, community outreach and marketing
  - Activities with no net community benefit expense – Bay Area Transformation Partnership, Grants
- Highly Engaged Associates
  - Volunteers for community-based activities
- Consistently Strong Financial Results
  - Charity Care enrollment assistance

Note: Similar goals and related community benefit initiatives were included in the hospital FY15-19 Strategic Plan.

## Alignment of Community Benefit with Local and State Initiatives for Population Health Improvement




UM BWMC's Community Benefit Implementation Plan is aligned with Maryland's Medicare Waiver/All-Payer and Total Cost of Care model and the Institute for Healthcare Improvement's "Triple Aim" of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.

The second phase of Maryland's Medicare Wavier, effective January 1, 2019, focuses on the Total Cost of Care, not just hospital costs. UM BWMC's Community Benefit initiatives focus on health outreach and education to help prevent and manage chronic health conditions in the least restrictive setting order to help people live healthier lives and keep them in their community settings.

Our plan is aligned with the Maryland Department of Health's State Health Improvement Process (SHIP) and the Maryland Health Services Cost Review Commission's Regional Health System Transformation grant program to. Our plan includes public health priorities that are also identified by the SHIP as important to improving the health of all Marylanders.

UM BWMC's Community Benefit Implementation Plan incorporates the Maryland Department of Health State Health Improvement Process (SHIP) framework. UM BWMC serves as Co-Vice Chair of the Healthy Anne Arundel

Coalition, the local health improvement coalition (LHIC) established as part of the SHIP.

The Anne Arundel County Community Health Needs Assessment used to develop this plan was conducted under the auspices of the Healthy Anne Arundel Coalition with leadership from UM BWMC, Anne Arundel Medical Center and several Anne Arundel County government agencies.

The alignment of these priorities is discussed in greater detail in Section 3: Prioritization of Community Health Needs.

### External Partnerships for Community Benefit

UM BWMC collaborates with numerous external partners for Community Benefit planning and implementation. These external partnerships were also cited in our Strategic Transformation plan as essential to improving population health. UM BWMC works with many county government agencies including the Anne Arundel County Departments of Health, Aging and Disabilities, Recreation and Parks, and Social Services, the Office of Community and Constituent Services, and Anne Arundel County Public Schools. We collaborate with Anne Arundel Medical Center, MedStar Harbor Hospital, Federally Qualified Health Centers (Chase Brexton Health Care, Total Health Care) and primary care, behavioral health, specialty and post-acute care providers. Most importantly, we partner with local community and faith based organizations such as Maryland Health Care for All, March of Dimes Maryland Chapter, Zeta Phi Beta Sorority – Rho Eta Zeta Chapter, Safe Sitter, Inc., American Red Cross, American Cancer Society, Judy Center at Hilltop Elementary, Glen Burnie Improvement Association, Severna Park Community Center, Arundel Mills Mall, several local businesses and Chambers of Commerce and numerous churches.

## Community Benefit Operations & Oversight

### UM BWMC Board of Directors

The UM BWMC Board of Directors formally adopts the CHNA, the Community Benefit Implementation Plan and annual reports. This committee also ensures that population health improvement and community benefit initiatives are included in the medical center's strategic and annual operating plans.

### UM BWMC Board Community Benefit Committee

The UM BWMC Community Benefit Board of Directors provides oversight and guidance to UM BWMC's Community Benefit programming. This Committee is comprised of members of the UM BWMC Board of Directors (including UM BWMC's President and Chief Executive Officer), members of the UM BWMC Foundation Board of Directors and a member of University of Maryland Medical System (UMMS) Executive Leadership. The Committee is staffed by UM BWMC Executive Team members including the Senior Vice President and Chief Operating Officer and Senior Vice President and Chief Financial Officer. This Committee recommends the adoption of the CHNA, the Community Benefit Implementation Plan and annual reports to the UM BWMC Board of Directors. This committee also provides feedback related to community benefit strategies and monitors the implementation of community benefit activities.

**UM BWMC Community Benefit Planning Committee**

UM BWMC convened a Community Benefit Planning Committee consisting of clinical and administrative leadership to develop this plan. This committee was charged with reviewing needs assessment data, assessing existing organizational resources and capacities, prioritizing community needs, and developing the Community Benefit Implementation Plan for review by the UM BWMC Community Benefit Board and the UM BWMC Board of Directors. Committee members included the Chairman of Medicine/Medical Director for Population Health, Manager of Strategic Planning and Service Line Development, Manager of Community Outreach, Executive Director of the Tate Cancer Center, Director of Care Management, Director of Psychiatric Services, Director of Emergency Nursing, Manager of Women's Health, Operations Manager of the University of Maryland Center for Diabetes and Endocrinology, and Clinical Director of Addiction Medicine. This committee will continue to provide their guidance throughout the plan's implementation. Other administrators and clinicians will also provide guidance and support to community benefit as needed.

**UM BWMC Community Benefit Staffing**

UM BWMC's Community Benefit primary staffing consists of representatives from the Departments of Community Outreach and Strategic Planning. The Departments collaborate on conducting the CHNA, developing and refining the community benefit implementation strategies, and completing community benefit reports to meet state and federal requirements. These staff members are also involved in the planning, development, implementation and evaluation of broader population health initiatives. The Community Benefit program also receives initiative-specific assistance from various hospital departments and staff members depending on the purpose and scope of the initiative or activity.

The Community Outreach Department plans and executes community benefit programs, activities and events in partnership with UM BWMC staff and community partners. The Community Outreach Department builds relationships with community-based partners to extend the reach of community benefit programs and solicits community input into community benefit activities.

The Strategic Planning Department provides support to the needs assessment process, ongoing data analysis, and the development, implementation, evaluation and reporting of community benefit. This Department helps to assure alignment between community benefit, the annual operating plan, and population health initiatives throughout UM BWMC and UMMS.

**University of Maryland Medical System Community Health Improvement Committee**

The University of Maryland Medical System convenes a System Community Health Improvement Committee that includes leaders for community benefit and community health improvement from across the medical system. This committee identifies community health needs that impact all system hospitals and develops system-driven initiatives to address those needs. A current focus of the SCHIC is increasing health literacy. Additionally, this committee discusses any questions or concerns related to conducting CHNAs and community benefit reporting. The committee's monthly meetings also provide an opportunity to shares best practices and lessons learned for community benefit and related population health improvement activities.

## Community Benefit Policy

UM BWMC maintains a Community Benefit Policy that describes important definitions and processes related to community benefit. It defines community benefit per state and federal regulations and what is permissible as a community benefit activity. The policy describes the strategic approach of the Community Benefit Implementation Plan and its relationship to the CHNA. The policy identifies the need to meet all federal and state regulations and outlines the structure for the oversight of community benefit.

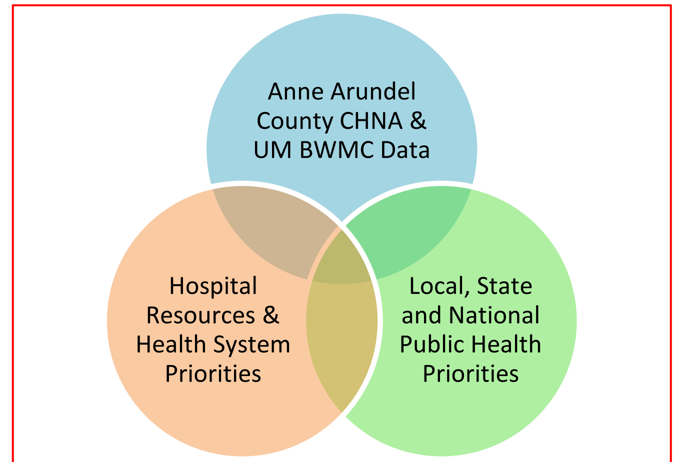
## Financial Assistance Policy

UM BWMC's Financial Assistance Policy (FAP) was established to assist patients in obtaining financial aid when the services rendered are beyond a patient's ability to pay. UM BWMC provides emergency, inpatient, and other care regardless of ability to pay. UM BWMC's FAP complies with Maryland regulations and provides assistance ranging up to 100% of the total cost of hospital services. A patient who qualifies for financial assistance at any UMMS affiliated hospital will be offered the same terms at all UMMS facilities.

UM BWMC assists patients with applying for its financial assistance program and other financial assistance programs for health care services. UM BWMC discusses with patients or their families the availability of various government benefits, such as Medicaid and other federal, state and local programs.

## Section 2: Prioritization of Community Health Needs

UM BWMC took a multi-pronged approach to prioritizing our local community health needs. This approach helped to assure that our community benefit implementation plan addresses the most significant needs identified in the CHNA while also being aligned with UMMS community health improvement initiatives and national, state and local public health priorities. The plan was also developed to be responsive to Maryland's health system transformation, including the increased focus on population health and community partnerships. This approach also helped to assure that we had the necessary infrastructure and resources to successfully implement our Community Benefit Implementation Plan.




## Process

Our process included:

- Convening a Community Benefit Planning Committee to develop the Community Benefit Implementation Plan. This committee included UM BWMC clinical and administrative leadership.
- Reviewing CHNA data and UM BWMC Emergency Department, inpatient and ambulatory utilization data to inform the plan development.
- Reviewing community health improvement priorities identified during UMMS Community Health Improvement Retreats.
- Reviewing the Maryland State Health Improvement Process (SHIP) priorities established as being important to improving the health status of all Marylanders (these are aligned with Healthy People 2020 national goals) and considering additional public health priorities identified by county, state and national governments and health organizations.
- Identifying the infrastructure, staffing, clinical expertise and other resources at UM BWMC and in the community to support the successful implementation of community benefit strategies.
- Refining the plan with input from executive UM BWMC and UMMS leadership.
- Formally adopting the CHNA and Community Benefit Implementation Plan for FY19-21 by both the UM BWMC Community Benefit Board and the UM BWMC Board of Directors.

## UM BWMC's Selected Community Benefit Priorities

This process resulted in the following community benefit strategic priorities being identified for UM BWMC's Community Benefit Implementation Plan.

- Chronic Health Conditions (Cancer, Cardiovascular Disease, Diabetes, Obesity/Overweight, Chronic Lower Respiratory Diseases[ii])
- Behavioral Health
- Maternal and Child Health
- Health Care Access and Utilization
- Healthy and Safe Social Environments

An overarching theme is the reduction of health disparities among vulnerable populations.

The table below illustrates the synergies between UM BWMC, local, state and national priorities:

**Alignment of UM BWMC Community Benefit Priorities with Public Health Priorities**

| **UM BWMC Community Benefit Priority** | **Healthy Anne Arundel Priority** (Local Health Improvement Coalition priority) | **Maryland SHIP Priority** (aligned with Healthy People 2020 National Goals) |
|---|---|---|
| **Chronic Health Conditions** (Cancer, Cardiovascular Disease, Diabetes, Obesity/Overweight, Chronic Lower Respiratory Diseases) | **Obesity Prevention** – selected because it a major contributing factor to several chronic health conditions (diabetes, heart disease, cancer) | **Healthy Living** (healthy weight, physical activity, tobacco cessation, life expectancy) **Quality Preventive Care** (mortality rates for cancer and heart disease) |
| **Behavioral Health** | **Prevention and Management of Behavioral Health Conditions** | **Healthy Communities** (child maltreatment, domestic violence, suicide) |
| **Maternal and Child Health** | This is not an identified HAAC priority since it is being addressed by the county's Fetal and Infant Mortality Review Community Action Team. | **Healthy Beginnings** (early prenatal care, low birth weight, sudden unexpected infant death rate, infant death rate) |
| **Health Care Access and Utilization** | **Access to Care** | **Access to Health Care** (persons with a primary care provider, uninsured ED visits) **Quality Preventive Care** (ED visit rates for ambulatory sensitive conditions, annual seasonal influenza vaccinations) **Quality Preventive Care** (cancer mortality rate drug-induced death rate, mortality rates for cancer and heart disease) |
| **Healthy and Safe Social Environments** | **Vision of "Healthy County, Healthy People"** | **Vision of "Healthier Maryland"** |

Within these priority areas, a number of potential health improvement strategies have been identified (as described in Section 4) to address community needs. Some of the strategies are the continuation or expansion of existing community benefit activities. Existing programs will be enhanced and expanded through new partnerships to expand their reach in the community, with an emphasis on reaching vulnerable populations. Other strategies are new initiatives that will be planned and implemented to address community needs.

The role UM BWMC will take in each implementation strategy will depend on a number of factors. Depending on the specific activity, UM BWMC will either take a leadership role, collaborating role or supportive role. When taking on a leadership role, UM BWMC will provide the leadership and devote the necessary resources to assure the success of the activity or initiative. Resources can include staff time and expertise, financial allocations, in-kind contributions. When serving in a partner role, UM BWMC will collaborate with other organizations to provide the leadership and/or resources for the activity or initiative. In a supportive role, UM BWMC recognizes the contribution to health and importance to the community, but does not have the organizational strengths or available resources to take on a key leadership or partnership role. In these instances, UM BWMC will provide assistance as resources are available.

## Community Health Needs Not Selected as Community Benefit Priorities

Lack of affordable dental services, environmental health concerns, transportation barriers are community health needs identified through the CHNA not directly being addressed by UM BWMC. UM BWMC will support the advancement of community health improvement initiatives in these areas as feasible.

UM BWMC does not provide routine dental care at this time, but we do refer patients to low-cost dental clinics for care. We subsidize oral surgery on-call services and have oral surgeons on our medical staff. UM BWMC partners with the Anne Arundel County Department of Health to divert dental patients presenting to the ED to providers in the community. Patients will be treated within 24-48 hours of their ED visit. Care coordination will be provided to prevent repeat ED visits. UM BWMC is supportive of this grant application and will assist with grant implementation, if awarded.

Environmental health concerns are being addressed by the Anne Arundel County Department of Health's Bureau of Environmental Health Services and other local environmental advocacy organizations.

Public transportation is not in the scope of services that UM BWMC can provide as a hospital; however, we do provide some transportation assistance through our care management program and our Transitional Care Center. We also provide transportation assistance for participants in our Stork's Nest prenatal education program. Anne Arundel and surrounding county governments are collaborating to expand access to public transportation in the Central Maryland region.

Other needs identified in the CHNA included affordable housing and affordable, quality child care. UM BWMC will support these priorities through participation in economic development initiatives and health professions training designed to help improve socioeconomic wellbeing of individuals and the local community.

## Section 3: Community Benefit Implementation Plan

UM BWMC's Community Benefit Implementation Plan is designed to be responsive to identified community health needs and be informed by evidence-based and promising practices for community health improvement. Our plan includes sustaining and expanding existing initiatives, as well as the development and implementation of new initiatives. We will build new relationships and strengthen existing partnerships to provide increased outreach to higher-risk individuals and communities.

Over the next three years, UM BWMC is planning to collaborate with community organizations to expand our reach to minority communities that are often impacted by health disparities. We will work with the United Black Clergy and other community partners to provide additional health education, health fairs, screenings and other activities at local churches and community centers. A sample listing of our community benefit partners is included as Appendix B.

UM BWMC staff consulted the following resources to ensure that our community benefit implementation strategies are consistent with best practices:

- Maryland Department of Health and Mental Hygiene's Model Practices Database: http://dhmh.maryland.gov/ship/Pages/home.aspx
- CDC Community Health Improvement Navigator: http://www.cdc.gov/chinav/index.html
- Healthy People 2020 Evidence-Based Resource Tool: http://healthypeople.gov/2020/implement/EBR.aspx
- Community Preventive Services Task Force's Guide to Community Preventive Services: http://www.thecommunityguide.org
- Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase Physical Activity in the Community: http://www.cdc.gov/obesity/downloads/PA_2011_WEB.pdf
- Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables: http://www.cdc.gov/obesity/downloads/fandv_2011_web_tag508.pdf
- Association for Community Health Improvement: http://www.healthycommunities.org
- The CDC Guide to Breastfeeding Interventions: http://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf
- Cancer Control PLANET: http://cancercontrolplanet.cancer.gov
- Substance Abuse and Mental Health Services Administration National Registry of *Evidence-based* Programs and Practices: http://www.samhsa.gov/nrepp

UM BWMC's Community Benefit Implementation Plan is a strategic framework that will be reviewed each year and adjustments will be made to the implementation strategies as appropriate based on community needs, available resources, best practices and lessons learned. Each year, state and federal regulations will be used to determine "what counts" as community benefit. Activities included in this plan will be included in community benefit reports based upon the applicable guidelines for the given reporting period. Activities that do not fall within the definition of community benefit may still be undertaken as part of UM BWMC's broader population and community health initiatives. This plan is not intended to be exhaustive description of UM BWMC's community health improvement initiatives.

## Priority: Chronic Health Conditions

| **Priority Area: Chronic Health Conditions**<br>**(Cancer, Cardiovascular Disease, Diabetes, Obesity/Overweight, Chronic Lower Respiratory Diseases)**<br><br>**Goal:** ***Help community members prevent and manage chronic health conditions.*** | | | | |
|---|---|---|---|---|
| **Strategy** | **Target Population** | **Tactics** | **Outcome Measures** | **Resources/Partners** |
| Provide education to community members on updated/current screening guidelines.<br><br>Provide information on Anne Arundel County Cancer Screening Programs.<br><br>Provide smoking cessation classes and related medical support. | Anne Arundel County | ▪ Community events/health fair outreach<br>▪ Lectures<br>▪ Newspaper articles<br>▪ Provide information on UM BWMC resources<br>▪ Provide information on the Anne Arundel County free/reduced fee Dental, Cervical and Breast Cancer Screening Program | ▪ Number of persons screened and results<br>▪ Number of attendees at events<br>▪ Number of education resources provided<br>▪ Number of referrals provided<br>▪ Decrease in cancer mortality rates *(AACO measures)*<br>▪ Decrease in percentage of adults who smoke *(AACO measures)*<br>▪ Number enrolled in smoking cessation classes | ▪ American Cancer Society<br>▪ American Diabetes Association<br>▪ American Heart Association<br>▪ American Lung Association<br>▪ Anne Arundel County Conquer Cancer Coalition<br>▪ Anne Arundel County Public Library, Public Schools, and Government Agencies<br>▪ Arundel Mills Mall<br>▪ Businesses and Chambers of Commerce<br>▪ Health Care, Behavioral Health and Social Services Providers<br>▪ Healthy Anne Arundel Coalition (HAAC)<br>▪ Maryland University of Integrative Health<br>▪ Non-profit, Community and Faith-based Organizations<br>▪ Y of Central Maryland |
| Provide education, information and screenings to community members to become and remain heart healthy<br><br>Provide education and information on managing blood pressure and medications | Anne Arundel County | ▪ Community events/health fair outreach<br>▪ Lectures<br>▪ Newspaper articles<br>▪ Provide free blood pressure screenings<br>▪ Provide free community vascular screenings<br>▪ Offer Heartbeat for Health event | ▪ Number of persons screened and results<br>▪ Number of attendees at events<br>▪ Number of education resources provided<br>▪ Decline in number of hypertension related ED visits<br>▪ Decrease in heart disease mortality rates *(AACO measures)* | |

| | | | | |
|---|---|---|---|---|
| Provide physical activity programs.<br><br>Provide education on current physical activity guidelines for youth and adults.<br><br>Engage and educate community on the importance of healthy weight goals using evidenced-based health programs. | Primary: Anne Arundel County, emphasis on those categorized as obese with a BMI over 30.<br><br>Secondary: Anne Arundel County youth, emphasis on youth in North and West County. | ▪ Provide *Mills Milers* walking program at Arundel Mills Mall<br>▪ Provide therapeutic yoga classes<br>▪ Increase relationship with local YMCA's for physical activity resources<br>▪ Community events/health fair outreach<br>▪ Lectures<br>▪ Provide elementary schools | ▪ Number of participants in *Mills Milers* walking program<br>▪ Number of participants in therapeutic yoga classes<br>▪ Number of attendees at events<br>▪ Number of education resources provided<br>▪ Number self-reporting an Increase in physical activity<br>▪ Decrease in BMI Parameters *(AACO* | |
| | | in North and West County with nutrition and physical activity resources for students | *measures)* | |
| Provide education, information and resources to help community members to better manage their health conditions. | Anne Arundel County residents who currently have one or more chronic health condition, or at risk for developing a chronic health condition | ▪ Provide stroke, diabetes and cancer support groups<br>▪ Provide *Preventing Diabetes* classes<br>▪ Provide education on the importance of having a regular primary care provider<br>▪ Community events/health fair outreach<br>▪ Lectures<br>▪ Refer current cancer Patients into the *Live Strong* wellness program<br>▪ Social media postings | ▪ Number of attendees at events<br>▪ Number of attendees at support groups<br>▪ Number of education resources provided<br>▪ Decrease in ED visits related to chronic health conditions, (e.g. hypertension and diabetes)<br>▪ Number of referrals into the *Live Strong* program | |

## Priority: Behavioral Health

**Priority Area: Behavioral Health**

**Goal:** ***Help community members prevent and manage behavioral health conditions.***

| Strategy | Target Population | Tactics | Outcome Measures | Resources/Partners |
|---|---|---|---|---|
| Provide education and information to community members on identifying signs, symptoms and resources in the community for mental and behavioral health conditions. | Anne Arundel County | ▪ Community events/health fair outreach<br>▪ Lectures<br>▪ Provide UM BWMC mental health resources to community agencies who service communities in need<br>▪ Provide mental health support group<br>▪ Provide leadership and Resources to Anne Arundel County behavioral health initiatives | ▪ Number of attendees at events<br>▪ Number of education resources provided<br>▪ Number of attendees at support group<br>▪ Decrease in number of ED visits related to mental and behavioral health conditions | ▪ Anne Arundel County Drug and Alcohol Council Workgroup<br>▪ Anne Arundel County Fatal Overdose Review Team<br>▪ Anne Arundel County Public Library, Public Schools, and Government Agencies<br>▪ Businesses and Chambers of Commerce<br>▪ Healthy Anne Arundel Coalition (HAAC)<br>▪ Health Care, Behavioral Health and Social Service Providers<br>▪ Local Development Council (LDC) Anne Arundel County<br>▪ National Alliance for the Mentally Ill – Anne Arundel County Chapter<br>▪ Non-profit, Community and Faith-based Organizations |
| Provide education and information to community members on pain management alternatives.<br><br>Expand outreach and educational services for the prevention and management of opioid misuse.<br><br>Train community members on signs and symptoms of an overdose through the Overdose Response Program. | Anne Arundel County | ▪ Community events/health fair outreach<br>▪ Lectures<br>▪ Provide Therapeutic Yoga for Pain Relief classes<br>▪ Provide a resource list on local locations where unused medications can be discarded<br>▪ Provide Overdose Response Trainings to include education on administering naloxone and CPR<br>▪ Provide overdose resource materials to first responders throughout AACO (e.g. fire departments, police stations) | ▪ Number of attendees at events<br>▪ Number of attendees at Overdose Response Trainings<br>▪ Number of education resources provided<br>▪ Decrease in number of overdoses presenting to the ED<br>▪ Decrease in drug deaths *(AACO measure)* | |

## Priority: Maternal and Child Health

| Priority Area: Maternal and Child Health<br><br>Goal: *Improve pregnancy, birth and early childhood outcomes.* | | | | |
|---|---|---|---|---|
| **Strategy** | **Target Population** | **Tactics** | **Outcome Measures** | **Resources/Partners** |
| Provide education and information on the importance of early prenatal care to women of childbearing age. | Women in Anne Arundel County, emphasis on women in North and West County, and individuals of health disparities. | ▪ Provide childbirth education classes<br>▪ Incentivize women who attend the Stork's Nest education program<br>▪ Provide community agencies (e.g. Healthy Start, Health Department, Public Schools) with women's health and Stork's Nest resources<br>▪ Provide OB/GYN practices with Stork's Nest resources<br>▪ Community events/health fair outreach<br>▪ Social media postings | ▪ Number of women enrolled in Stork's Nest who have a prenatal care provider<br>▪ Number of OB patients within UM BWMC OB/GYN practices<br>▪ Number of attendees at events<br>▪ Number of referrals to/from community agencies<br>▪ Decrease in number of low birth weight births *(Stork's Nest data and AACO measures)*<br>▪ Decrease in number of pre-term births *(Stork's Nest data AACO measures)*<br>▪ Number of social media postings made and engagement recorded | ▪ Anne Arundel County Fetal and Infant Mortality Review Team and Community Action Team<br>▪ Anne Arundel County Public Library, Government Agencies, and Public Schools<br>▪ Assistance League of the Chesapeake<br>▪ Businesses and Chambers of Commerce<br>▪ Health Care, Behavioral Health and Social Services Providers<br>▪ Judy Center at Hilltop Elementary<br>▪ March of Dimes, Maryland Chapter<br>▪ Non-profit, Community and Faith based Organizations<br>▪ Anne Arundel County Partnership for Children, Youth and Families Anne Arundel County<br>▪ Zeta Phi Beta Sorority |
| Provide education and information on breastfeeding to pregnant women. | Women in Anne Arundel County. | ▪ Offer breastfeeding support group<br>▪ Education by lactation consultant during hospital stay<br>▪ Provide Stork's Nest program<br>▪ Community events /health fair outreach | ▪ Number of women educated<br>▪ Number of women who attend support group<br>▪ Number of women who are breastfeeding at discharge | |

| Provide education and information on the importance of infant safe sleep to families. | Anne Arundel County families who have children under the age of two years. | ▪ Stork's Nest program – distribute safe sleep kits with education and portable crib to women enrolled in program<br>▪ Mother-Baby, Pediatrics, and ED Units of UM BWMC to supply sleep sacks to target population<br>▪ Supply OB/GYN practices with education materials<br>▪ Community events/health fair outreach<br>▪ Social media postings | ▪ Decrease in infant mortality *(AACO measures)*<br>▪ Increase in number of Stork's Nest participants reporting safe sleep practices at 3 months *(Stork's Nest data)*<br>▪ Number of women enrolled in Stork's Nest who received Safe Sleep education<br>▪ Number of portable cribs distributed<br>▪ Number of attendees at events<br>▪ Number of referrals to community agencies<br>▪ Number of sleep sacks distributed to at risk families<br>▪ Number of social media postings made and engagement recorded | |
|---|---|---|---|---|

## Priority: Health Care Access and Utilization

**Priority Area: Health Care Access and Utilization**

**Goal:** ***Help patients obtain "The Right Care, at the Right Place, at the Right Time" and help eligible patients obtain financial assistance for health care services.***

| Strategy | Target Population | Tactics | Outcome Measures | Resources/Partners |
|---|---|---|---|---|
| Provide education and information to increase community knowledge on where to access the appropriate level of care – Emergency Department, Primary Care, Urgent Care.<br><br>Remain a resource for patients who do not have a usual primary care provider. | Anne Arundel County | ▪ Community events/health fair outreach<br>▪ Lectures<br>▪ Provide educational materials to Emergency Department, in-patient units, Transitional Care Center, and primary care offices<br>▪ Maintain resource lists of local providers and agencies and refer as necessary<br>▪ Expand on the relationship between Transitional Care Center, Emergency Department, and Primary Care services | ▪ Number of participants at events<br>▪ Number of education resources provided<br>▪ Increase in number of new primary care appointments<br>▪ Number of referrals provided | ▪ Anne Arundel County Public Library and Government Agencies<br>▪ Businesses and Chambers of Commerce<br>▪ Chase Brexton Health Care<br>▪ Choice One Urgent Care<br>▪ Health Care and Social Services Providers<br>▪ Healthy Anne Arundel Coalition (HAAC)<br>▪ Maryland Health Care Connection<br>▪ Maryland Health for All<br>▪ Non-profit, Community and Faith-based Organizations<br>▪ University of Maryland Health Advantage |
| Provide education to community on how to access and understand health care benefits, and provide resources as needed.<br><br>Inform patients and family members of UM BWMC's Financial Assistance Policy (FAP). | Anne Arundel County | ▪ Maintain and provide resources for information on Medicaid, Medicare and commercial health insurance – refer to community organizations as necessary (e.g. FQHC, Maryland Health Connection)<br>▪ Make the UM BWMC Financial Assistance Policy available to all patients | ▪ Number of patients assisted with UM BWMC FAP<br>▪ Number of education resources provided<br>▪ Number of community resource referrals<br>▪ Participant feedback<br>▪ Decrease in uninsured Emergency Department visits | |
| Develop community partnerships to increase | Anne Arundel County | ▪ Provide free annual Influenza vaccines | | |

| | | | | |
|---|---|---|---|---|
| access to free/low cost health screenings (e.g. blood pressure, vascular, cancer) and other health care services. | | ▪ Provide community And referrals for follow up care, as needed<br>▪ Provide information on the Anne Arundel County free/reduced fee Dental, Cervical and Breast Cancer Screening Program | | |

## Priority: Healthy and Safe Social Environments

<table>
<tr><td colspan="5">Priority Area: Healthy and Safe Social Environments<br><br>Goal: Increase social support to youth and young adults.</td></tr>
<tr><th>Strategy</th><th>Target Population</th><th>Tactics</th><th>Outcome Measures</th><th>Resources/Partners</th></tr>
<tr>
<td>Provide education and information on the importance of healthy social and physical relationships.<br><br>Explore opportunities to partner with community organizations to educate youth on life skills topics (e.g. social media and its influence on social skills, body image, bullying, gang violence, and suicide).<br><br>Promote education, information, and resources on adverse childhood experiences (ACEs).</td>
<td>Anne Arundel County, emphasis on youth and young adults under the age of 25 years and those who work with this population. Emphasis on North and West County, and individuals of health disparities.</td>
<td>▪ Community events/health fair outreach<br>▪ Participation on community boards (e.g. YWCA)<br>▪ Continued expansion of the S.A.F.E. program<br>▪ Lectures<br>▪ Provide resources on ACEs trainings held locally</td>
<td>▪ Number of attendees at events<br>▪ Number of education resources provided<br>▪ Increase in number of ED visits requiring S.A.F.E. Program<br>▪ Decrease in suicide related ED visits (AACO DOH measures)<br>▪ Decrease in suicide related Deaths among youth (AACO measures)<br>▪ Decrease in domestic violence (AACO measures)<br>▪ Participant feedback</td>
<td rowspan="2">▪ Anne Arundel County Public Library, Public Schools, and Government Agencies<br>▪ Anne Arundel County Head Start<br>▪ Anne Arundel County Partnership for Children, Youth and Families<br>▪ Community of Hope, Brooklyn Park<br>▪ Health Care, Behavioral Health and Social Services<br>▪ Healthy Anne Arundel Coalition (HAAC)<br>▪ Judy Center at Hilltop Elementary<br>▪ Non-profit, Community, and Faith-based Organizations<br>▪ Safe Sitter, Inc.<br>▪ The Family Tree<br>▪ The Parenting Center at Anne Arundel Community College<br>▪ Y of Central Maryland<br>▪ YWCA of Annapolis and Anne Arundel County</td>
</tr>
<tr>
<td>Provide support to parents and/or guardians of young children.</td>
<td>Anne Arundel County, emphasis on those caring for young children age zero to five.</td>
<td>▪ Expand on partnership opportunities with the Judy Center at Hilltop Elementary<br>▪ Provide educational classes (e.g. Mom’s Morning Out) to help guardians positively manage stress and discipline children, limiting screen time and learn basic health care information for themselves and their child(ren)</td>
<td>▪ Number of attendees at events<br>▪ Number of education resources provided<br>▪ Participant feedback</td>
</tr>
</table>

| | | | | |
|---|---|---|---|---|
| Provide support to community organizations and school youth programs. | Anne Arundel County | ▪ Provide support for school STEM programs<br>▪ Participation in homeless youth programs<br>▪ Participation in youth development programs<br>▪ Continued support of advocacy efforts and other initiatives related to social determinants of health<br>▪ Provide Safe Sitter and Safe@Home classes | ▪ Number of attendees at events<br>▪ Number of youth enrolled in classes<br>▪ Number of youth mentored | |
| Provide support to reduce gun violence in the local community. | Anne Arundel County | ▪ Participate in the County's Gun Violence Prevention Task Force<br>▪ Participation in preparedness drills and training activities | ▪ Leadership participation in the task force<br>▪ Number of drills/training activities | |

## Section 4: Community Benefit Annual Reporting

UM BWMC and UMMS also produce an annual report to the community on our community health improvement activities. This report is available on UM BWMC's web site at: https://www.umbwmc.org/community-benefit. Paper copies of this report are also distributed throughout the community. Are we still doing the community health improvement report?

Each December, UM BWMC submits an annual report on our community benefit activities and financial investments to the Maryland Health Services Cost Review Commission, a state regulatory agency. This report includes an accounting of community benefit activities conducted by the hospital and a narrative which supplements the financial report. The major community benefit categories covered in the report include: community health services, health professions education, mission-driven health services, research, cash and in-kind contributions, community building activities, community benefit operations and charity care/patient financial assistance. This agency also provides feedback to each hospital on how they can enhance their community benefit activities and reporting. The community benefit reports from each Maryland hospital are posted online by Maryland Health Services Cost Review Commission at http://www.hscrc.state.md.us. We also report our community benefit activities to the federal Internal Revenue Service on the IRS Form 990, Schedule H.

UM BWMC staff regularly report on the status of community benefit activities to the medical center's Community Benefit Board and the Board of Directors, as detailed in the Community Benefit Operations and Oversight portion of this document.

## Section 5: Conclusion

UM BWMC's mission is to provide the highest quality health care services to the communities we serve. The keyword for our community benefit work is communities. We extend our services beyond the hospital walls and outside of our campus through partnerships with organizations throughout our community. UM BWMC is proud to be a leader in helping to connect community members with the medical, behavioral and social resources necessary to help them lead healthier lives.

UM BWMC, true to our mission, will always provide high-quality and compassionate health care services. However, it is our hope that our community benefit programs will help people lead healthier lives so that they can avoid repeat visits to the Emergency Department and prevent admissions to the hospital. As part of our commitment to provide the highest quality of health care services to the communities we serve, UM BWMC is working to ensure patients can receive the right care, at the right place and at the right time. As such, our programs strive to provide information and resources in both hospital and community settings.

As the health care landscape in Maryland and the United States places an increased emphasis on keeping people healthier and out of the hospital, UM BWMC is poised to be a leader in promoting population health through our community benefit activities. We are able to successfully address that challenge due to our strong relationships within the health care system and throughout our community. UM BWMC collaborates with patients, families, community and faith-based organizations, government agencies, health care and social service providers, businesses and others to respond to the needs of our community. We look forward to the continued engagement of our community and the development of new relationships in the successful implementation of this plan.

For more information about our community benefit activities, please visit https://www.umbwmc.org/community-benefit, send an email to bwmcpr@umm.edu or call 410-553-8103. Should we keep this contact information or switch to your contact information?

## Appendix A: Financial Assistance Policy Summary

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

It is the policy of UM BWMC to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance.

UM BWMC publishes the availability of Financial Assistance on a yearly basis in local newspapers and posts notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability is also sent to patients with patient bills. Signage in key patient access areas is available. A Patient Billing and Financial Assistance Information Sheet is provided before discharge and is available to all patients upon request.

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

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

For more information about UM BWMC's Financial Assistance Policy, visit umbwmc.org/financial-assistance or call: 410-821-4140.

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

**PLEASE NOTE:**

1. We treat all patients needing emergency care, no matter what they are able to pay.

2. Services provided by physicians or other providers may not be covered by the hospital Financial Assistance Policy. You can call 410-821-4140 if you have questions.

**How We Review Your Application**

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

1. Your income or your family's total income is low for the area where you live, or

2. Your income falls below the federal poverty level if you had to pay for the full cost of your hospital care, minus any health insurance payments.

**PLEASE NOTE:**

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

**How To Apply For Financial Help**

1. Fill out a Financial Assistance Application form.

2. Give us all of your information to help us understand your financial situation.

3. Turn the application form into us.

**PLEASE NOTE:**

The hospital must screen patients for Medicaid before giving financial help.

**Other Helpful Information**

1. You can get a free copy of our Financial Assistance Policy and Application form:
    - Online at www.umbwmc.org/financial-assistance
    - In person at the Patient Accounts Department — UM Baltimore Washington Medical Center, 301 Hospital Drive, Glen Burnie, Maryland 21061
    - By mail: call 410-821-4140 to request a copy
2. You can call the Financial Assistance Department if you have questions or need help applying. You can also call if you need help in another language. Call: 410-821-4140.

## Appendix B: Sample Community Benefit Partner List

**Anne Arundel County Government Agencies, Schools and Coalitions**

- Anne Arundel Community College
- Anne Arundel County Conquer Cancer Coalition
- Anne Arundel County Co-Occurring Disorders Steering Committee and Change Agent Committee
- Anne Arundel County Crisis Response
- Anne Arundel County Department of Aging and Disabilities
- Anne Arundel County Department of Health
- Anne Arundel County Department of Recreation and Parks
- Anne Arundel County Department of Social Services
- Anne Arundel County Drug and Alcohol Council Workgroup
- Anne Arundel County Executive's Office
- Anne Arundel County Fetal and Infant Mortality Review Team and Community Action Team
- Anne Arundel County Fire Department – Emergency Medical Services Division
- Anne Arundel County Head Start
- Anne Arundel County Mental Health Agency, Inc.
- Anne Arundel County Overdose Review Team
- Anne Arundel County Partnership for Children, Youth and Families
- Anne Arundel County Police Department
- Anne Arundel County Public Libraries
- Anne Arundel County Public Schools
- Anne Arundel County State's Attorney's Office
- Community of Hope, Brooklyn Park
- Healthy Anne Arundel Coalition
- Maryland Division of Early Childhood
- Maryland University of Integrative Health

**Non-profit, Community and Faith-based Organizations**

- American Cancer Society
- American Diabetes Association
- American Heart Association
- American Lung Association
- American Red Cross
- Arundel Community Development Services, Inc.
- Assistance League of the Chesapeake
- Boys and Girls Clubs of Annapolis and Anne Arundel County
- Burgers and Bands for Suicide Prevention
- Catholic Charities of Anne Arundel County
- Chesapeake Arts Center
- Churches including Abundant Life Church, Asbury Methodist Church, Brooklyn Community Methodist Church, Harundale Presbyterian Church, Heritage Community Church, Fresh Start Church

(Freetown), Light of the World Family Ministries, St Bernadette Parish (Severn), St Paul Lutheran Church, The Church at Severn Run, and others

- Community Foundation of Anne Arundel County
- Cribs for Kids
- Fort Meade Alliance
- Glen Burnie Improvement Association and other local neighborhood groups
- Greater Baybrook Alliance
- Hands of Hope
- Leadership Anne Arundel
- March of Dimes, Maryland Chapter
- National Alliance for the Mentally Ill, Anne Arundel County Chapter
- Partners in Care
- Safe Sitter, Inc.
- Severna Park Community Center
- The Family Tree
- The Arc Central Chesapeake Region
- United Black Clergy
- United Way of Central Maryland
- Y of Central Maryland
- YWCA of Annapolis and Anne Arundel County
- Zeta Phi Beta Sorority, Inc.

**Health Care, Behavioral Health and Social Service Providers**

- Choice One Urgent Care
- Federally Qualified Health Centers
    - Chase Brexton Health Care
    - Total Health Care
- Hospice of the Chesapeake
- Hospitals
    - Anne Arundel Medical Center
    - MedStar Harbor Hospital
    - University of Maryland Medical System Hospitals
- Maryland Health Care Connection
- Primary Care, Behavioral Health and Specialist Providers
    - Advanced Radiology
    - CVS Minute Clinics
    - University of Maryland Medical Group
- The Coordinating Center
- University of Maryland Health Advantage

**Businesses and Chambers of Commerce**

- Annapolis and Anne Arundel County Chamber of Commerce
- Arnold and Severna Park Chamber of Commerce
- Arundel Mills Mall
- BWI Partnership
- NAACP Anne Arundel County
- Northern Anne Arundel County Chamber of Commerce
- Pasadena Business Association
- Uber Health
- West County Chamber of Commerce

*Note: This list includes existing and planned collaborations

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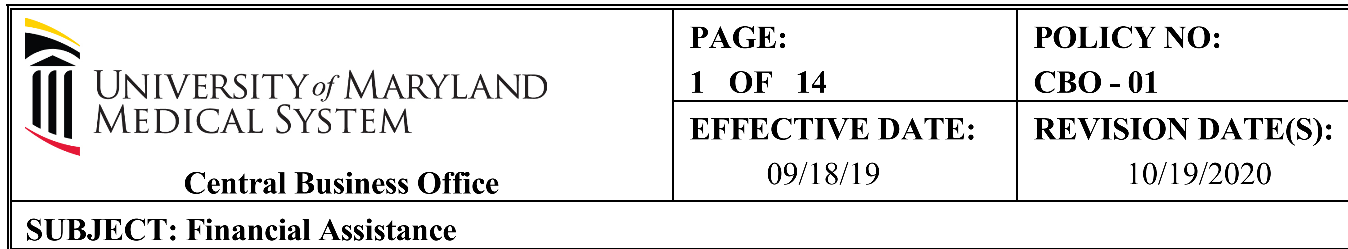
[i] Maryland Health Services Costs Review Commission, FY18 Community Benefit Reporting Guidelines and Standard Definitions

[ii] Chronic lower respiratory diseases include chronic obstructive pulmonary disease and asthma.



| UNIVERSITY of MARYLAND MEDICAL SYSTEM<br>Central Business Office | PAGE:<br>1 OF 14 | POLICY NO:<br>CBO - 01 |
|---|---|---|
| | EFFECTIVE DATE:<br>09/18/19 | REVISION DATE(S):<br>10/19/2020 |
| SUBJECT: Financial Assistance | | |

**KEY WORDS: Financial Assistance**

**OBJECTIVE/BACKGROUND:**

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

**APPLICABILITY:**

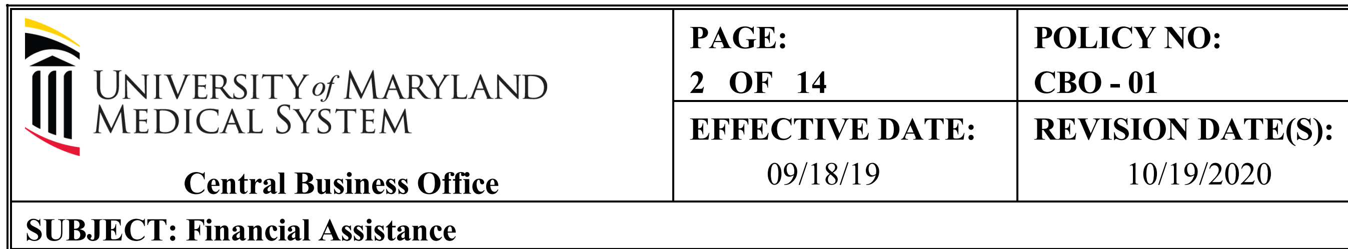
***<u>PROGRAM ELIGIBILITY</u>***

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

**Specific exclusions to coverage under the Financial Assistance Program:**

<u>The Financial Assistance Program generally applies to all emergency and other medically necessary care provided by each UMMS hospital; however, the Financial Assistance Program does not apply to any of the following:</u>

1. Services provided by healthcare providers not affiliated with UMMS hospitals (e.g., durable medical equipment, home health services).
2. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, or Workers Compensation), are not eligible for the Financial Assistance Program.
   a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.




3. Cosmetic or other non-medically necessary services.
4. Patient convenience items.
5. Patient meals and lodging.
6. Physician charges related to the date of service are excluded from this UMMS financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.
   a. A list of providers, other than the UMMS hospital itself, delivering medically necessary care in each UMMS hospital that specifies which such as providers are not covered by this policy (as well as certain such providers that are covered) may be obtained on the website of each UMMS Entity.

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

1. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Medical Center due to insurance plan restrictions/limits.
2. Refusal to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.
3. Refusal to divulge information pertaining to a pending legal liability claim.
4. Foreign-nationals traveling to the United States seeking elective, non-emergent medical care.

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

Unless they meet Presumptive Financial Assistance Eligibility criteria, patients shall be required to submit a complete Financial Assistance Application (with all required information and documentation) and determined to be eligible for financial assistance in order to obtain financial assistance. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application before receiving non-emergency medical care unless they meet Presumptive Financial Assistance Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

Those with income up to 200% of Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care (“MD DHMH”) are eligible for free care. Those between 200% to 300% of MD DHMH are eligible for discounts on a sliding scale, as set forth in Attachment A.

***Presumptive Financial Assistance***

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

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

m. Bankruptcy, by law, as mandated by the federal courts
n. St. Clare Outreach Program eligible patients
o. UMSJMC Maternity Program eligible patients
p. UMSJMC Hernia Program eligible patients

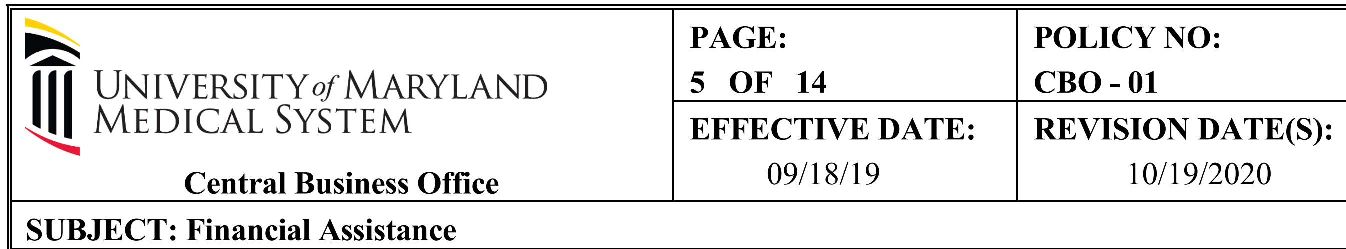
**Specific services or criteria that are ineligible for Presumptive Financial Assistance include:**

a. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

**POLICY:**

This policy was approved by the UMMS Executive Compliance Committee (ECC) Board on October 19, 2020. This policy applies to the following hospital facilities of the University of Maryland Medical System ("UMMS hospitals"):

- University of Maryland Medical Center (UMMC)
- University of Maryland Medical Center Midtown Campus (MTC)
- University of Maryland Rehabilitation & Orthopaedic Institute (UMROI)
- University of Maryland St. Joseph Medical Center (UMSJMC)
- University of Maryland Baltimore Washington Medical Center (UMBWMC)
- University of Maryland Shore Medical Center at Chestertown (UMSMCC)
- University of Maryland Shore Medical Center at Dorchester (UMSMCD)
- University of Maryland Shore Medical Center at Easton (UMSME)
- University of Maryland Charles Regional Medical Center (UMCRMC)
- University of Maryland Upper Chesapeake Health (UCHS)
- University of Maryland Capital Region Health (UM Capital)




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

UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any) and admissions areas, as well as the Billing Office. Notice of availability will also be sent to the patient with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge, and it (along with this policy and the Financial Assistance Application) will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas. This policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency.

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

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

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

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

This policy was adopted for University of Maryland Shore Medical Center at Chestertown (UMSMCC) effective September 1, 2017.

This policy was adopted for University of Maryland Shore Medical Center at Dorchester (UMSMCD) effective September 1, 2017.

This policy was adopted for University of Maryland Shore Medical Center at Easton (UMSMCE) effective September 1, 2017.

This policy was adopted for University of Maryland Charles Regional Medical Center (UMCRMC) effective December 2, 2018.

This policy was adopted for University of Maryland Upper Chesapeake Health (UCHS) effective July 1, 2019

This policy was adopted for University of Maryland Capital Region Health (UM Capital) effective September 18, 2019

**PROCEDURE:**

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.

2. When possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial

assistance. Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both.

d. If a patient submits a Financial Assistance Application without the information or documentation required for a final determination of eligibility, a written request for the missing information or documentation will be sent to the patient. This written request will also contain the contact information (including telephone number and physical location) of the office or department that can provide information about the Financial Assistance Program and assistance with the application process.
e. The patient will have thirty (30) days from the date this written request is provided to submit the required information or documentation to be considered for eligibility. If no data is received within the 30 days, a letter will be sent notifying the patient that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case by submitting the missing information or documentation 30 days after the date of the written request for missing information/documentation.
f. For any episode of care, the Financial Assistance Application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.
g. Individual notice regarding the hospital's Financial Assistance Policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

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

If a patient submits both a copy of their most recent Federal Income Tax Return and a copy of their most recent pay stubs (or other evidence of income), and only one of the two documents indicates eligibility for financial assistance, the most recent document will dictate eligibility. Oral submission of needed information will be accepted, where appropriate.

4. In addition to qualifying for Financial Assistance based on income, a patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses based on the Financial Hardship criteria discussed below. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.
   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.
      i. If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
      ii. If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
         1. A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.

5. Once a patient is approved for Financial Assistance, Financial Assistance coverage is effective for the month of determination and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Assistance eligibility period further into the past or the future on a case-by-case basis. If additional healthcare services are provided beyond the eligibility period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

6. Account balances that have not been paid may be transferred to Bad Debt (deemed uncompensated care) and referred to an outside collection agency or to the UMMS hospital's attorney for legal and/or collection activity. Collection activities taken on behalf of the hospital by a collection agency or the hospital's attorney may include the following Extraordinary Collection Actions (ECAs):
   a. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.
   b. Commencing a civil action against the individual.

c. Placing a lien on an individual's property. A lien will be placed by the Court on primary residences within Baltimore City. The hospital will not pursue foreclosure of a primary residence but my maintain its position as a secured creditor if a property is otherwise foreclosed upon.
d. Attaching or seizing an individual's bank account or any other personal property.
e. Garnishing an individual's wage.

7. ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 120 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 30 days prior to commencement of the ECA. This written notice will indicate that financial assistance is available for eligible individuals, identify the ECAs that the hospital (or its collection agency, attorney, or other authorized party) intends to obtain payment for the care, and state a deadline after which such ECAs may be initiated. It will also include a Patient Billing and Financial Assistance Information Sheet. In addition, the hospital will make reasonable efforts to orally communicate the availability of financial assistance to the patient and tell the patient how he or she may obtain assistance with the application process. A presumptive eligibility review will occur prior to any ECA being taken. Finally, no ECA will be initiated until approval has been obtained from the CBO Revenue Cycle. UMMS will not engage in the following ECAs:
    a. Selling debt to another party.

    b. Charge interest on bills incurred by patients before a court judgement is obtained

8. If prior to receiving a service, a patient is determined to be ineligible for financial assistance for that service, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

9. A letter of final determination will be submitted to each patient who has formally submitted an application. The letter will notify the patient in writing of the eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for the determination. If the patient is determined to be eligible for assistance other than free care, the patient will also be provided with a billing statement that indicates the amount the patient owes for the care after financial assistance is applied.

10. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds will be issued back to the patient for credit balances, due to patient payments, resulting from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.

11. If a patient is determined to be eligible for financial assistance, the hospital (and/or its collection agency or attorney) will take all reasonably available measures to reverse any ECAs taken against the patient to obtain payment for care rendered during the financial assistance eligibility window. Such reasonably available measures will include measures to vacate any judgment against the patient, lift levies or liens on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

12. Patients who have access to other medical coverage (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.

13. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.

14. The Financial Assistance Program will accept all other UMMS hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.

15. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.

16. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.

a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

***Financial Hardship***

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

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

1. Their medical debt incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship.

For the patients who are eligible for both, the Reduced Cost Care under the primary Financial Assistance criteria and also under the Financial Hardship Assistance criteria, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital will grant the reduction in charges, which is balance owed that is greater than 25% of the total annual household income.

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

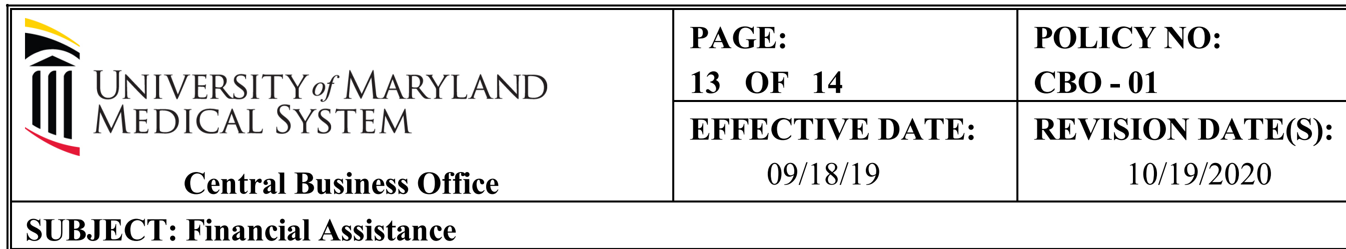
Medical Debt is defined as out of pocket expenses for the facility charges incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and/or UM Capital for medically necessary treatment.

Once a patient is approved for Financial Hardship Assistance, coverage will be effective for the month of the first qualifying date of service and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Hardship eligibility period further into the past or the future on a case-by-case basis according to their spell of illness/episode of care. It will cover the patient and the eligible family members living in the household for the approved reduced cost and eligibility period for medically necessary care.

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

***Appeals***

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




**ATTACHMENTS:**

# ATTACHMENT A

## Sliding Scale – Reduced Cost of Care

| 2020 Federal Poverty Limits (FPL) and Maryland Dept of Health & Mental Hygiene (DHMH) Annual Income Eligibility Limit Guidelines | | | UMMS 100% Charity | UMMS 90% Charity | UMMS 80% Charity | UMMS 70% Charity | UMMS 60% Charity | UMMS 50% Charity | UMMS 40% Charity | UMMS 30% Charity | UMMS 20% Charity | UMMS 10% Charity |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Equals Up to 200% of MD DHMH Annual Income limits | Equals Up to 210% of MD DHMH Annual Income limits | Equals Up to 220% of MD DHMH Annual Income limits | Equals Up to 230% of MD DHMH Annual Income limits | Equals Up to 240% of MD DHMH Annual Income limits | Equals Up to 250% of MD DHMH Annual Income limits | Equals Up to 260% of MD DHMH Annual Income limits | Equals Up to 270% of MD DHMH Annual Income limits | Equals Up to 280% of MD DHMH Annual Income limits | Equals Up to 290% of MD DHMH Annual Income limits |
| House-hold (HH) Size | 2020 FPL Annual Income Elig Limits | 2020 MD DHMH Annual Income Elig Limits | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: | If your total annual HH income level is at or below: |
| Size | Up to | Up to | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max | Up to Max |
| 1 | 12,490 | **$17,620** | $35,240 | $37,002 | $38,764 | $40,526 | $42,288 | $44,050 | $45,812 | $47,574 | $49,336 | $52,859 |
| 2 | 16,910 | **$23,797** | $47,594 | $49,974 | $52,353 | $54,733 | $57,113 | $59,493 | $61,872 | $64,252 | $66,632 | $71,390 |
| 3 | 21,330 | **$29,974** | $59,948 | $62,945 | $65,943 | $68,940 | $71,938 | $74,935 | $77,932 | $80,930 | $83,927 | $89,921 |
| 4 | 25,750 | **$36,167** | $72,334 | $75,951 | $79,567 | $83,184 | $86,801 | $90,418 | $94,034 | $97,651 | $101,268 | $108,500 |
| 5 | 30,170 | **$42,344** | $84,688 | $88,922 | $93,157 | $97,391 | $101,626 | $105,860 | $110,094 | $114,329 | $118,563 | $127,031 |
| 6 | 34,590 | **$48,521** | $97,042 | $101,894 | $106,746 | $111,598 | $116,450 | $121,303 | $126,155 | $131,007 | $135,859 | $145,562 |

*All discounts stated above shall be applied to the amount the patient is personally responsible for paying after insurance reimbursements.

*Amounts billed to patients who qualify for Reduced-Cost of Care on a sliding scale (or for Financial Hardship Assistance) will be less than the amounts generally billed to those with insurance (AGB), which in Maryland is the charge established by the Health Services Cost Review Commission (HSCRC). UMMS determines AGB by using the amount Medicare would allow for the care (including the amount the beneficiary would be personally responsible for paying, which is the HSCRC amount; this is known as the "prospective Medicare method".

**Effective 7/1/20**

**POLICY OWNER:**

UMMS CBO

**APPROVED:**

Executive Compliance Committee Approved Initial Policy: 09/18/19
Executive Compliance Committee Approved Revisions: 10/19/2020