COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2015 Community Benefit Reporting

Health Services Cost Review Commission
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BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. Please list the following information in Table I below. For the purposes of this section, "primary services area" means the Maryland postal ZIP code areas from which the first 60 percent of a hospital's patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all acute care hospitals by the HSCRC. (Specialty hospitals should work with the Commission to establish their primary service area for the purpose of this report).

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:[1]	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
384 Licensed Beds for FY15[2]	25,380	21401 21403 21037 21114 21409 21012 20715 21146 21122 21113 21666 20716 21061 21054 21032 20774	Harbor Hospital Center, Baltimore Washington Medical Center, Johns Hopkins Hospital, University of Maryland Medical Center, Laurel Regional Hosp., Prince George's Hospital Center, Holy Cross Hospital, Doctors Community Hospital, UM Rehab & Ortho Inst.	8.2% Uninsured [3]	There were 65,636[4] Medicaid MCO recipients enrolled in August 2015 in Anne Arundel Co., 12% of the County population. AAMC Emergency Room patients from Anne Arundel County with Medicaid totaled over 15,000 in FY15. This accounts for 27% of all AAMC outpatient ER visits from Anne Arundel County. Medicaid Inpatients to AAMC totaled approx.1,900 in FY15 or 12% of AAMC inpatients from Anne Arundel Co.[5]

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

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

[1] Maryland HSCRC
[2] Maryland Health Care Commission FY15 Licensed Bed Report
[3] Anne Arundel County "Building Partnerships for a Healthier Community", Report Card of Community Health Indicators, May 2015
[4] http://www.md-medicaid.org/mco/index.cfm
[5] AAMC internal patient data

The 2013 CHNA was a collaborative effort produced from the LHIC (Healthy Anne Arundel Coalition). In partnership with UM-BWMC, the Anne Arundel County Department of Health and Anne Arundel Medical Center, the CBSA was determined to be Anne Arundel County since that is the demographic area the partners collectively serve. The description below describes the CBSA and the pockets of need that currently exist.

Anne Arundel County ("the County") is defined as the Community Benefit Service Area since sixty-five percent of inpatient discharges (over 16,000 in FY15) come from the County. The discharged patients from A. A. County were comprised of 81.8% White and 18.2% non-white. The 2015 County demographics are as follows: 70.2% White, 15.8% Black, 7.2 % Hispanic, 3.8 % Asian, 0.3 % Native American, and 2.9 % are other races. [6] [The 2016 draft CHNA provides a better explanation of the CBSA based on vulnerable patient populations, geography and social determinants of health. However, at the time of the FY2015 Community Benefits Report submission, the 2016 CHNA is not complete and it is currently in draft form].

General Demographics

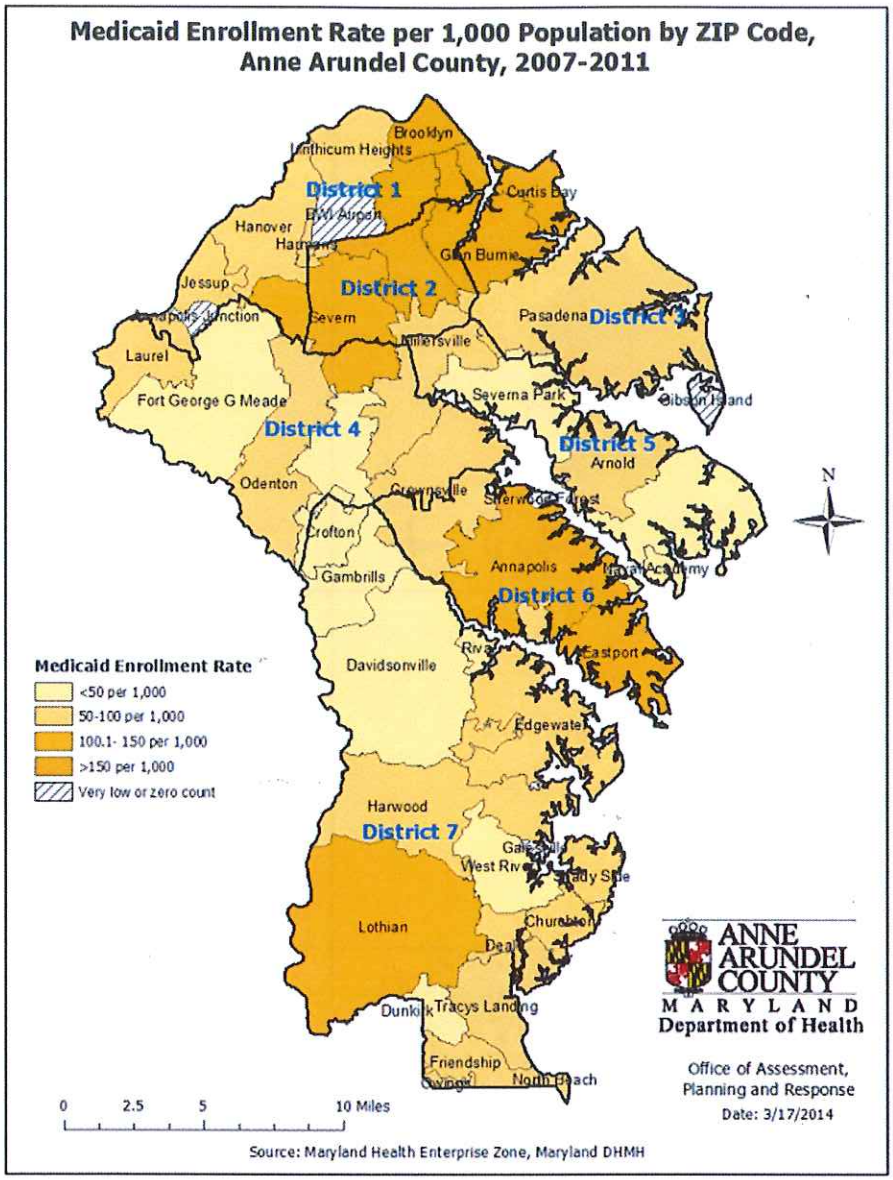
While the County ranks overall favorably as compared to the State with regard to income, housing, and health insurance coverage. Specifically, the median household income (HHI) in the County is $87,430 as compared to Maryland $73,538.[7] The median HHI by race is as follows: White HHI $94,204, Black HHI $70,474, and Hispanic HHI $66,831. The County Report Card (2015) indicates that 4.3 percent of families/6.39 percent of individuals are living below the poverty level. The average unemployment rate for the civilian labor force for the County, January, 2015 is 5.1 percent. Furthermore, 12 percent of Black county residents and 15.3 percent of Hispanic/Latino residents live in poverty. This is compared to 4.6 percent among the County's White residents. There is significant disparity between races as it pertains to HHI and poverty levels.

Disparity

The poverty rates and Medicaid enrollment rates are concentrated geographically. The north and south portions of the County have higher rates of poverty and Medicaid enrollment (Maps 1, 2). Portions of Annapolis (21401 and 21403 zip codes) also have higher rates of poverty and Medicaid enrollment. There is a section of the 21401 zip code, in which the Hospital is located, which has been identified by the State as a designated "Health Enterprise Zone" (HEZ). Furthermore, these zip codes have distinct areas where residents suffer significant health disparities that are compounded by common social determinants of health such as reduced access to health care, limited transportation, low literacy levels, and high rates of crime. Approximately 33 percent of Annapolis rental units are public housing or receive a public subsidy to provide housing to low and moderate income households, as defined by HUD.

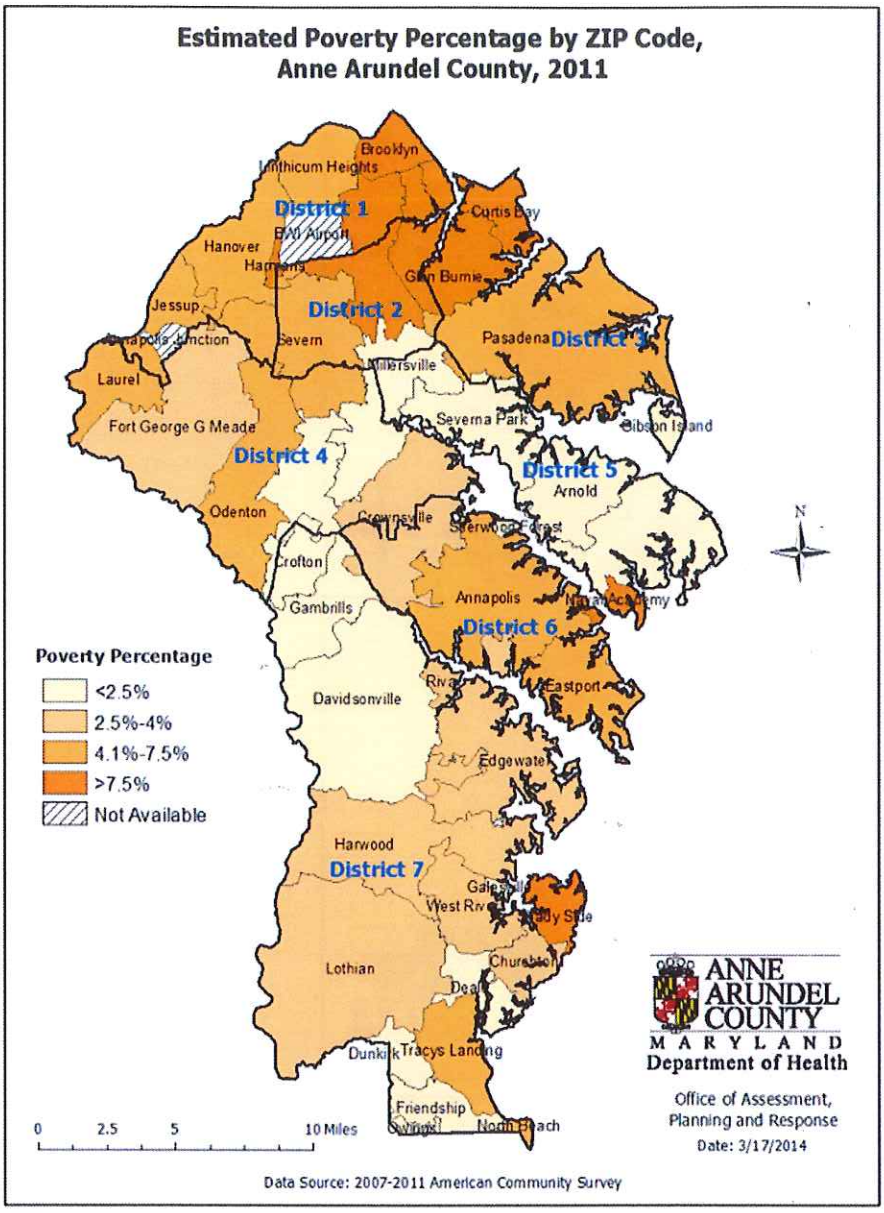
[6] Nielsen, Inc.

[7] Anne Arundel County Health Report Card, 2015



[8] **Map 1**

[8] Anne Arundel County Department of Health (2014). Anne Arundel County Health Data By Councilmanic Districts and ZIP Codes



[9] **Map 2**

Growing Populations

The Hispanic population has experienced the most growth among all population groups in the County. Hispanic residents increased from 3.7 percent to 6.6 percent between 2007 and the 2013[10]. It is projected that the Hispanic population will continue to grow an additional 22.4% over the next 5 years. A growing immigrant population contributes to this growth. However, this exponential growth complicates access to care. Many Hispanics do not speak English and are not insured. Therefore, sliding scale programs must exist as well as increase availability of

[9] Anne Arundel County Department of Health (2014). Anne Arundel County Health Data By Councilmanic Districts and ZIP Codes

[10] U.S. Census Bureau, American Community Survey, 2013

culturally sensitive, bilingual primary care providers are needed to meet the health needs of this population.

The population of the residents who are 65 and older in the County is expected to grow 24.5 percent over the next five years.[11] County patients with Medicare made up 43% of County inpatient admissions at AAMC in FY15. Because two out of every three older Americans have multiple chronic conditions[12], this age group is another priority of AAMC's community health initiative.

Geography

There are significant differences between North and South portions of Anne Arundel County that affect the health of the residents. The southern half of the County (south of Annapolis) is primarily zoned "Residential Agricultural," per Anne Arundel County Department of Planning and Zoning[13], and it is considered a rural area. Southern Anne Arundel County accounts for only 11.5% of the County's total population.[14] This area is served by one federally-qualified health center in the Owensville/West River community. Since it is rural and has one clinic, access to care is a significant need.

The northern half of the County is primarily urban and suburban as it sits adjacent to Baltimore City. There is a greater minority population in the northern half of the county in addition to a greater Medicaid population. Thus, access to care is also an issue. (See Map 3 above for additional clarity.)

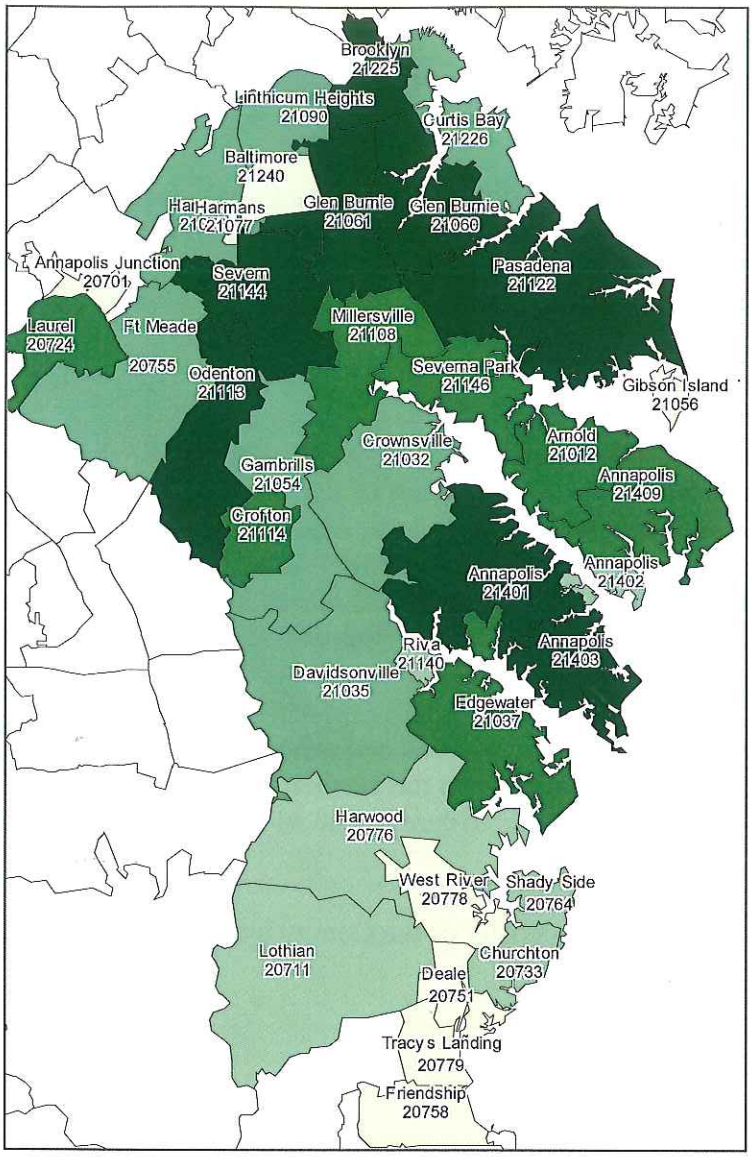
The map below shows the population density of the County by zip code boundary.

[11] Nielsen, Inc. 2014 county level demographic data

[12] http://www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf

[13] http://www.aacounty.org/PlanZone\

[14] Nielsen, Inc. 2014 population estimates



Map 3

Transportation

An inadequate public transportation system in the County is a barrier for employment and healthcare. The County is situated along the western shore of the Chesapeake Bay and consists of a series of peninsulas which makes a comprehensive public transportation system too expensive to maintain.[15] As a result, there are not adequate local bus lines to service many areas of the County. South County has only three bus stops in the Edgewater area which leaves a great portion of southern Anne Arundel County without public transportation. Public transportation is in need of additional routes. As a result, only 3.3 percent of Anne Arundel County residents utilize public transportation to get to work.[16] Annapolis does operate a growing transit system, but it does not serve areas outside of the city. There ae a few connections wuth eth County bus

[15] Anne Arundel County Local Health Plan 2011
[16] Nielsen, Inc. 2014 county level demographic data

service to sites such as the Casino at Arundel Mills and Fort Meade. The lack of public transportation is a significant issue throughout the County, since residents are limited in employment and access to healthcare.[17]

Conclusion

Secondary data for the County reveals higher socio-economic groups with higher income, education level and housing as compared to the State. The majority of residents also have health insurance. But, income and health disparity exists in the northern and southern sections of the County as well as Annapolis. The Hispanic population and the senior/ aging population are growing quickly. Transportation is a barrier to healthcare and employment. AAMC has focused its community benefit work within the 21401 (HEZ) and 214-3 zip codes due to the apparent disparity and the hospitals' location.

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

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

[17] http://www.aacounty.org/Partnership/Resources/2012_AA_County_Needs_Assessment.pdf

Table II

Community Benefit Service Area (CBSA) population and demographic characteristics	Total Population: 563,973[18] Male: 49.5 % Female: 50.5% Average Age: 38.9 Years Percent of Total Population by Age: 0 – 4 Years: 6.1% 5 – 17 Years: 16.3% 18 – 64 Years: 63.7% 65+ Years: 13.8%
Median Household Income within the CBSA	$92,505[19]
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Families Below Poverty Level[20] 4.3%, a 0.3% increase since last year Individuals Below Poverty Level 6.3%, a 0.4% increase from last year.
Please estimate the percentage of uninsured people by County within the CBSA This information may be available using the following links: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html; http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	8.2% Uninsured [21]
Percentage of Medicaid recipients by County within the CBSA. Source: http://www.md-medicaid.org/mco/index.cfm	In FY15, an average of 69,318 residents or 12.3% were eligible for Medicaid
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	79.8 yrs. with race disparities[22] White 79.9 yrs. Black 77.8 yrs.
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available). http://dhmh.maryland.gov/vsa/Documents/13annual.pdf , Table 39A, Table 50	Mortality Rate (all races, all causes): 727.3/100,000 (age-adjusted) White 803.9 Black 520.3 Hispanic 96.5 Mortality Rates of Chronic Lower Respiratory Disease: 38.5

[18] Nielsen, Inc. 2015 county level demographic estimates
[19] Ibid.
[20] A. A. County Report Card of Community Health Indicators, May 2015
[21] Anne Arundel County "Building Partnerships for a Healthier Community", Report Card of Community Health Indicators, May 2015
[22] Md. Vital Statistics Annual Report 2013, Table 7, http://dhmh.maryland.gov/vsa/Documents/13annual.pdf

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. http://dhmh.maryland.gov/ship/SitePages/measures.aspx	Approximately 69,000 (or 12% of) Anne Arundel County residents live in an area categorized as a food desert by the USDA. • 30 % of students are eligible for free and reduced price meals[23] • 8.9% of county populations is food insecure • 7.4% county population are participants in SNAP (Supplemental Nutrition Assistance Program) • 11% residents are in poor or fair health • Physical inactivity is at 21% • Excessive drinking is at 19% • 12.3% of County students not graduating high school.[24]
Available detail on race, ethnicity, and language within CBSA. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	Race (NH = non-Hispanic) White, NH: 70.2% Black, NH: 15.8% Hispanic: 7.2% Asian, NH: 3.8% American Indian, NH: 0.1% Other, NH: 2.8%
Education http://quickfacts.census.gov/qfd/states/24/24003.html	Pop. 25+ without H.S. Diploma 9.3% Pop. 25+ Bachelor's or above 37.1%
Tobacco Use – SHIP Objective http://dhmh.maryland.gov/ship/SitePages/Home.aspx http://www.marylandbrfss.org/[25]	The percentage of adolescents who used any tobacco product in the last 30 days is 17.7% Adults currently smoke 18.7% White 16.3% Black 13.3%
Obesity: Body Mass Index (BMI) of 30 or more Overweight: BMI of 25 to 29.9 http://www.marylandbrfss.org/	Total Adults: Overweight by BMI 37.5% Obese by BMI 33.0% White: Overweight 36.9%, Obese 29.8% Black: Overweight 34.5%, Obese 47.0%

[23] Johns Hopkins Center for a Livable Future The Maryland Food System Mapping Resource, http://mdfoodsystemmap.org/

[24] http://www.countyhealthrankings.org/app/home#/maryland/2013/anne-arundel/county/outcomes/overall/snapshot/by-rank

[25] 2014 Data obtained directly from BRFSS Coordinator at Maryland DHMH

http://dhmh.maryland.gov/ship/SitePages/Home.aspx (accessed 10/28/15)	Children with Obesity 12.1%
Asthma – SHIP Objective http://dhmh.maryland.gov/ship/SitePages/Home.aspx	Rate of ED visits for asthma per 10,000 population, 45.4 with disparities: White 24.8 Black 112.0 Hispanic 31.2
Heart Disease – SHIP Objective http://dhmh.maryland.gov/vsa/Documents/13annual.pdf Table 50 Hypertension – SHIP Objective http://dhmh.maryland.gov/ship/SitePages/Home.aspx http://www.marylandbrfss.org/	Mortality Rate: 165.0/100,000 (age-adjusted) Rate of ED visits for hypertension: 183.6/100,000 All races 106.5/100,000 Whites 511.2/100,000 Blacks Total County: 3.6% told by a doctor they had an MI White 4.1% Black 3.1%
Cancer – SHIP Objective http://phpa.dhmh.maryland.gov/cancer/SiteAssets/SitePages/surv_data-reports/2014%20CRF%20Cancer%20Report.pdf Mortality Rates: Tables 10, 19, (2007-2011) Incidence Rates: Tables 8, 17, 62 (2007-2011)	Mortality Rate all cancer sites (age-adjusted): 183.4/100,000 which is above the State rate of 175.8/100,000 White 186.4; Black 182.9 Age-adjusted Cancer Incidence Rates all cancers: Total Rate: 479.2 (Male 538.3/ Fem 434.6) Whites 485.0; Blacks 450.6 Hispanics 284.3 (2011 only) Lung & Bronchus Incidence Rates (age-adjusted): Total Rate: 68.7/100,000 (Male 76.5/Fem 63.0) Whites 71.5; Blacks 54.2 Mortality rate: 55.2 (Male 65.6/Fem 47.6) Whites 57.9 Blacks 41.9 Melanoma Incidence Rates: Total Rate: 32.4 (Male 43.2/Fem 24.0) Whites: 37.1 (other races unavailable) Mortality Rate: 3.5/100,000 (Male 6.0/

	Fem 1.6)
Diabetes – SHIP Objective http://dhmh.maryland.gov/ship/SitePages/Home.aspx http://www.marylandbrfss.org/	Rate of ED visits for diabetes per 100,000 population Total: 187.3 with great disparities: White-132.3 Black-368.9 Hispanic-62.6 9.1% of County have a Diabetes diagnosis (excludes pregnancy) White 8.7% Black 14.5%
Co-occurring disorders http://dhmh.maryland.gov/ship/SitePages/Home.aspx SHIP Objective http://www.marylandbrfss.org/	Incidence Rate of suicide = 9.4/100,000 Incidence Rate of drug induced deaths = 15.3/100,000; ED visits for addictions-related conditions 1541.3/100,000 ED visits for a mental health conditions 4509.9/100,000 population. Alcohol: Binge Drinkers 29.8% White 28.9% Black 35.1% Chronic Drinkers 6.8% White 7.5% Black 3.2%
Infant Mortality/ Low Birth Weight – SHIP Objective Source: Maryland Vital Statistics 2014 report, published September 2015 http://dhmh.maryland.gov/vsa/Documents/imrrep14_draft%201.pdf	Infant Mortality Rate/1,000 live births: Total 5.7 White-3.8 Black-12.7 Hispanic 7.7 Low Birth Weight: Total 7.5% White- 6.7% Black- 12.9% Asian- 9.0% Hispanic-7.7%
Access to primary care physicians from www.countyhealthrankings.org	Ratio of Population to Primary Care Physicians is 1,430:1

II. COMMUNITY HEALTH NEEDS ASSESSMENT

The FY2013 CHNA identified seven issues that affect county residents: obesity, co-occurring disorders, cancer incidence and mortality (lung and melanoma cancers), chronic disease (heart disease and diabetes), health care services for the under- and uninsured, health inequities that vary by race, and awareness of existing services. AAMC in collaboration with its LHIC is currently conducting the FY2016 CHNA (anticipated completion is January, 2016). Therefore, for the purposes of this report, AAMC is using information from the FY2013 CHNA.

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

   X Yes
   ____No

   Provide date here. 01/13/13 (mm/dd/yy)
   The next edition of the CHNA is in process and publication will be January, 2016.

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

   http://www.aahs.org/community/
   http://aahealth.org/pdf/chna-final-report.pdf

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

   _X__Yes 11/ 8/13 (mm/dd/yy) Enter date approved by governing body here:
   ___No

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

   http://www.aahs.org/community/pdfs/Plan2013-2015.pdf

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

      X Yes
      ___No

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

AAMC uses a strategic planning process that categorizes 39 initiatives into 5 strategic goal areas (Quality, Community Health, Workforce, Growth, and Finance). Senior leadership, clinical leadership and administrative leadership identify opportunities for growth and health improvement through planning retreats, meetings, and data analysis. These initiatives are chosen based on their ability to have significant impact on the care of patients and the community we serve to improve health, increase quality, reduce costs, and strengthen workforce. Leaders identify Community Benefit through the strategic initiatives and report the data and information to Department of Community Health Improvement for collection and analysis. Community Health tracks the data and reports monthly to leadership through the True North Metrics process.

There are other initiatives that will impact community benefit: Expand care in the community via clinics (Community 2.1.1); establish a health equity focus related to access (Community 2.1.2), conduct the CHNA (Community 2.1.3), implement an outpatient diabetes program (Community 2.2.1), expand palliative care program (Community 2.2.2), implement out-patient care coordination (Community 2.2.3) , develop partial hospitalization program for psychiatry (Growth 4.2.4).

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

i. Senior Leadership

1. X_CEO
2. X_CFO
3. X_Other (please specify) Chief Medical Office, Chief Operations Officer, Chief Nursing Officer, Chief Strategy Officer, President of the Foundation.

As senior leaders, they are involved in driving the process as described in 1a.

ii. Clinical Leadership

1. X_Physician
2. X_Nurse
3. ___Social Worker
4. X_Other (please specify) Health educators and Registered Dietitians

Clinical chairs, nursing leaders, and community health department staff also have significant input into the process described in 1a.

iii. Community Benefit Operations

1. X_Individual (please specify FTE)

2. X_Committee (please list members)
3. X_Department (please list staff)
4. ___Task Force (please list members)
5. ___Other (please describe)

A group of educators across the service lines (cancer prevention/ smoking cessation, women's health, Pathways/ substance use prevention, dietitians, community health nurses, and health educators meet monthly through the Community Education and Outreach Committee. This group reports regularly on past activities and future opportunities for community education and outreach. They identify populations and geographic areas in need and topics of interest. This group is responsible for implementing many of the community benefit activities across the organization.

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

Spreadsheet	__X___yes	_____no
Narrative	__X___yes	_____no

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

Senior leadership reviews and approves the narrative and spreadsheet prior to submission to the HSCRC. The Strategic Planning Sub-Committee of the Board of Trustees completes the review of the narrative and spreadsheet in January (the month after submission). The spreadsheet is included as part of the financial audit process that the hospital undergoes annually and 990 Form submission to the IRS annually.

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

Spreadsheet	___X__yes	_____no
Narrative	___X__yes	_____no

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

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

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

NOTE: The organizations listed below are all members of the LHIC. A separate entry for the LHIC is not included. HAAC was the responsible body for organizing, contracting services, and coordinating the CHNA process for AAMC and UM-BWMC. These individuals/ organizations provided oversight to the process.

Organization	Name of Key Collaborator	Title	Collaboration Description
Anne Arundel County Department of Health	Angela Wahkweya Jinelene Chan	Health Officers	Lead in CHNA collaboration
UM-BWMC	Kathy McCollum & Kim Davidson	COO Director of Community Health	Partner in conducting CHNA
AAMC	Michelle Harder Christine Crabbs	Data Analyst Manager, Community Health	Partner in conducting CHNA
Anne Arundel County Mental Health Agency	Adrienne Mickler	Executive Director	Partner in Conducting CHNA
Anne Arundel Department of Aging	Pam Jordan	Director	Provided input
Anne Arundel County Office of the County Executive	Yveola Peters	Community	Assisted with identifying/promoting focus groups
Light of the World Ministries	Pastor Sheryl Menendez	Pastor/Office of Minority Health Liaison	Assisted with identifying focus group participants

In addition to the LHIC, the CHNA was guided by participants in the data collection process Five focus groups were held at various locations throughout Anne Arundel County in August and September 2012. Focus Groups topics addressed Mental & Behavioral Health, Access to Health Care, and Nutrition & Physical Activity. Each session lasted approximately two hours and was facilitated by trained staff from the consultant. In total, 55 people participated in the focus groups. Participants were recruited through local health and human service organizations and public news releases. In exchange for their participation, attendees were given a $50 gift card at the completion of the focus group.

With regard to the key informant surveys, 121 online questionnaires were completed during July and August 2012. Study participants represented a variety of sectors including public health and medical services, non-profit and social organizations, children and youth agencies, faith-based organizations, and the business community. It is important to note that the number of completed surveys and limitations to the sampling method yield results that are directional in nature. Results reflect the perceptions of some community leaders, but may not necessarily represent all community leaders within Anne Arundel County.

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

Christine Crabbs, Director of Community Health Improvement is Co-Chair of the LHIC (i.e., Healthy Anne Arundel Coalition).

___X__yes _____no

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

See above.

__X___yes _____no

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

1. Please use Table III, to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence based initiative and how the results will be measured (what are the short-term, mid-term and long-term measures? Are they aligned with measures such as SHIP and all-payer model monitoring measures?), time allocated to each

initiative, key partners in the planning and implementation of each initiative, measured outcomes of each initiative, whether each initiative will be continued based on the measured outcomes, and the current FY costs associated with each initiative. Use at least one page for each initiative (at 10 point type). Please be sure these initiatives occurred in the FY in which you are reporting. Please see attached example of how to report.

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

a. 1. Identified need: This includes the community needs identified by the CHNA. Include any measurable disparities and poor health status of racial and ethnic minority groups. Include the collaborative process used to identify common priority areas and alignment with other public and private organizations.
2. Please indicate whether the need was identified through the most recent CHNA process.

b. Name of Hospital Initiative: insert name of hospital initiative. These initiatives should be evidence informed or evidence based. (Evidence based initiatives may be found on the CDC's website using the following link: http://www.thecommunityguide.org/) (Evidence based clinical practice guidelines may be found through the AHRQ website using the following link: www.guideline.gov/index.aspx)

c. Total number of people within the target population (how many people in the target area are affected by the particular disease being addressed by the initiative)?

d. Total number of people reached by the initiative (how many people in the target population were served by the initiative)?

e. Primary Objective of the Initiative: This is a detailed description of the initiative, how it is intended to address the identified need, and the metrics that will be used to evaluate the results.

f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?

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

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

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

i. Evaluation of Outcome: To what degree did the initiative address the identified community health need, such as a reduction or improvement in the health indicator? Please provide baseline data when available. To what extent do the measurable results indicate that the objectives of the initiative were met? There should be short-term, mid-term, and long-term population health targets for each measurable outcome that are monitored and tracked by the hospital organization in collaboration with community partners with common priority areas.

These measures should link to the overall population health priorities such as SHIP measures and the all-payer model monitoring measures. They should be reported regularly to the collaborating partners.

j. Continuation of Initiative: What gaps/barriers have been identified and how did the hospital work to address these challenges within the community? Will the initiative be continued based on the outcome? What is the mechanism to scale up successful initiatives for a greater impact in the community?

k. Expense:
A. What were the hospital's costs associated with this initiative? The amount reported should include the dollars, in-kind-donations, or grants associated with the fiscal year being reported.
B. Of the total costs associated with the initiative, what, if any, amount was provided through a restricted grant or donation?

Table III Initiative I - Obesity

a. 1. Identified Need 2. Was this identified through the CHNA process?	Obesity is the number one health need in the County. 67.3% of are overweight or obese according to the 2015 Anne Arundel County Report Card. 12.1% of children and adolescents are obese (SHIP Data). Yes this was identified through the CHNA process.	
b. Hospital Initiative	Support LHIC Obesity Prevention Committee Community Health Talks on Healthy Eating and Exercise at Targeted Populations,	
c. Total Number of People Within the Target Population	22% of 556,348 (total population of Anne Arundel County) are under the age of 18 = 122,397 children and adolescents in the County 433,951 adults	
d. Total Number of People Reached by the Initiative Within the Target Population	771 adults and adolescents attended 36 healthy eating and fitness talks 871 adults and adolescents received individual nutrition appointments with an RD	
e. Primary Objective of the Initiative	Increase access to appropriate nutrition education to increase knowledge about obesity, healthy foods and the importance of exercise.	
f. Single or Multi-Year Initiative –Time Period	Multi year	
g. Key Collaborators in Delivery of the Initiative	AAMC Registered Dietitians and Health Educators, Anne Arundel County Public Schools, Seeds for Success, Housing Authority of the City of Annapolis, faith based organizations,	
h. Impact/Outcome of Hospital Initiative?	AAMC believes that the lectures increased awareness. Provided education to nearly 1,550 individuals who would not have received it.	
i. Evaluation of Outcomes:	There has not been a change in the obesity epidemic in the County. Rates remained unchanged at 66%.	
j. Continuation of Initiative?	Yes, obesity is a national epidemic and it will take years to impact the rates.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 96,587	B. Direct Offsetting Revenue from Restricted Grants $39,108

Table III Initiative II - Co-Occurring

a. 1. Identified Need 2. Was this identified through the CHNA process?	Co-Occurring Disease (Mental Health & Substance Abuse) ED visits for Substance Use Disorders (S.H.I.P Data) is 1541.3/100,000and it is above the MD 2017 goal. ED Rate for Mental Health Disorders (S.H.I.P Data) is 4509/100,000 and it is above the MD2017 goal. The suicide rate in the County is 9.4/100,000 which is also above the MD2017 goal. Yes this was identified through the CHNA process.	
b. Hospital Initiative	1. Open Out-patient Mental Health Clinic 2. Referral for Recovery program 3. Family Wellness Retreats for families seeking sobriety 4. No- cost services for recovery for substance abuse 5. Substance Abuse Prevention Programs for school aged children	
c. Total Number of People Within the Target Population	See data described above. AAAMC is addressing the need for urgent and immediate care to the most vulnerable patients affected by mental health and substance abuse.	
d. Total Number of People Reached by the Initiative Within the Target Population	1. 2174 encounters (opened October, 2014) 2. 280 encounters 3. 250 encounters 4. 2 beds open 365 days/year for detox and recovery 5. 194 schools/ 10,000 encounters	
e. Primary Objective of the Initiative	#1, 4 in b. Reduce the burden of mental health and substance abuse in the County. #2 Provide immediate access to mental health providers to urgent need patients #3 – On-going weekend retreats to support families affected by substance abuse #5 – Prevent children from using/ abusing substances	
f. Single or Multi-Year Initiative –Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Participating Hospital Staff (AAMC), Anne Arundel County Public School Staff, Anne Arundel County Department of Health, Anne Arundel County Department of Juvenile Justice, Anne Arundel County Courts	
h. Impact/Outcome of Hospital Initiative?	These are new initiatives for FY15. Their impact has not been realized.	
i. Evaluation of Outcomes:	See above.	
j. Continuation of Initiative?	Yes, mental health and substance abuse are significant needs in the County.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 1,194,956	B. Direct Offsetting Revenue from Restricted Grants C. $100,000

Table III Initiative III–Cancer

a. 1. Identified Need 2. Was this identified through the CHNA process?	Cancer: Lung cancer mortality rate is 55.2/100,000 compared to MD at 47.7/100,000 Melanoma mortality rate is 3.5/100,000 compared to MD 2.6/100,000 *Data pulled from the Anne Arundel County Report Card 2015* Yes, these two types of cancers were specifically identified through the CHNA process.
b. Hospital Initiative	1. Smoking cessation program (in-patient, out-patient and community) to reduce the smoking rates in the County and provide prevention programs as well. 2. Train other health providers in smoking cessation 3. Lung CT screening program for adults who meet lung cancer screening criteria 4. Melanoma awareness programs with children and adolescents
c. Total Number of People Within the Target Population	18% of adults and 17.7% of adolescents smoke according to the S.H.I.P measures.
d. Total Number of People Reached by the Initiative Within the Target Population	1,417 encounters in smoking cessation programs 30 attendees in trainings 202 healthy Lung screenings 250 encounters for melanoma education
e. Primary Objective of the Initiative	Decrease the number of adult and adolescent smokers. Increase the number of former smokers who get screened for lung cancer before symptoms arise. Increase the awareness in adolescents and children as to the risk factors for melanoma (prevention)
f. Single or Multi-Year Initiative –Time Period	Multi Year
g. Key Collaborators in Delivery of the Initiative	Participating Hospital Staff (AAMC), Healthy Anne Arundel Coalition, American Cancer Society, Anne Arundel County Public Schools, Faith based organizations, physician groups, and the Housing Authority of the City of Annapolis
h. Impact/Outcome of Hospital Initiative?	21% cessation rate at one year post intervention 9 Lung CT Findings It is difficult to assess the prevention efforts at the melanoma presentations.
i. Evaluation of Outcomes:	The Smoking cessation program has a long established history with proven results and 21% cessation rate. The lung screening program has been effective at finding approximately 5% of discoverable lung cancers at an early stage to decrease morbidity form the disease.
j. Continuation of Initiative?	Yes, the adult smoking rate continues to decrease from 19.0% to 18% over the last year. Smoking rates for adolescents has remained flat. Lung cancer incidence and mortality has reduced from 81.8/100,000 to 68.7/100,000 and 61.9/100,000 and 55.2/100,000 respectively between 2013 and 2015.

k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting	A. Total Cost of Initiative $ 182,283	B. Direct Offsetting Revenue from Restricted Grants n/a

Table III Initiative IV Chronic Disease & Disparity

a. 1. Identified Need 2. Was this identified through the CHNA process?	Chronic Disease, specifically Diabetes and Heart Disease. Mortality rates for diabetes and heart disease in the County (20/100,000 and 165/100,000) are similar to that of the state (20/100,000 and 167/100,000). However, there is significant disparity between races in the County. ED rates for uncontrolled diabetes are for Whites 132.3/100,000 and for Blacks 368.9/100,000. ED rates for uncontrolled hypertension is 106.5/100,000 for Whites and 511.2 for Blacks. Yes this was identified through the CHNA process.	
b. Hospital Initiative	Smoking cessation (see Initiative III for Cancer) Blood pressure Screening and Monitoring Program/ Cholesterol screenings Vascular health screening program Heart health and Diabetes education programs	
c. Total Number of People Within the Target Population	See above for data.	
d. Total Number of People Reached by the Initiative Within the Target Population	Blood pressure screening and monitoring program encounters = 616 encounters Cholesterol screenings – 8,109 encounters Vascular health screenings – 2093 encounters Heart health talks – 290 encounters Diabetes classes - 80 encounters	
e. Primary Objective of the Initiative	Create awareness about chronic disease and risk factors for heart disease and diabetes to motivate participants to seek on-going preventive care.	
f. Single or Multi-Year Initiative –Time Period	Multi-year	
g. Key Collaborators in Delivery of the Initiative	AAMC nurses, Anne Arundel County Public Schools, faith based organization, for – profit businesses, County Executive's office, health department, Annapolis City, AACC	
h. Impact/Outcome of Hospital Initiative?	The purpose of screenings is to identify risk factors and provide earlier access to care. AAMC reached 10,572 individuals to screen for heart disease risk and provide education.	
i. Evaluation of Outcomes:	Screening for disease does not lengthen life, but it can have a tremendous impact on morbidity, according to the CDC. The American Heart Association recommends that patients know their numbers to reduce morbidity from heart disease.	
j. Continuation of Initiative?	Yes, chronic disease remains to be a significant health need in the County.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 534,056	B. Direct Offsetting Revenue from Restricted Grants n/a

Table III Initiative V – Access to Care

a. 1. Identified Need 2. Was this identified through the CHNA process?	Individuals who need access to primary care. 81.9% of County residents report that they seek regular care from a Primary care provider. This is lower than the MD 2017 goal of 83%. Yes this was identified through the CHNA process.	
b. Hospital Initiative	Community Clinics for low cost primary and dental care, regardless of insurance status.	
c. Total Number of People Within the Target Population	Approximately 8-9% of the County is uninsured (Anne Arundel County Report Card 2015). In addition, there are un-documented immigrants who live here and require care as well. This number cannot be determined.	
d. Total Number of People Reached by the Initiative Within the Target Population	Primary care encounters – 10,312 Dental care encounters - 581	
e. Primary Objective of the Initiative	Provide access to quality affordable healthcare to uninsured and underinsured and reduce ED usage for uncontrolled chronic disease.	
f. Single or Multi-Year Initiative –Time Period	Multi Year	
g. Key Collaborators in Delivery of the Initiative	Community Clinics at Anne Arundel Medical Center staff, Anne Arundel County Department of Health, Center of Hope (Centro De Ayuda), MCHRC, City of Annapolis, Department of Social Services	
h. Impact/Outcome of Hospital Initiative?	At the time of submission of this report, AAMC is trying to determine the effect of the clinics on reducing re-admissions and or PAU for primary care diagnosis.	
i. Evaluation of Outcomes:	8-9% of residents in the County do not have health insurance. The Clinics are a safety net for those individuals as well as undocumented immigrants.	
j. Continuation of Initiative?	Yes, access to affordable primary care is necessary to improve health outcomes. AAMC is committed to the underserved population who need access to sliding scale fee clinics.	
k. Total Cost of Initiative for Current Fiscal Year and What Amount is from Restricted Grants/Direct Offsetting Revenue	A. Total Cost of Initiative $ 915,398	B. Direct Offsetting Revenue from Restricted Grants n/a

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

   The CHNA did describe other determinants of health such as transportation and health care affordability. AAMC has been committed to provide sliding scale fee primary care in its two clinics located on Forest Dr. and on Glenwood St. in Annapolis. A small dental care clinic is located in the Stanton Center in Annapolis. Healthcare affordability, in general, is not a concept that AAMC can address solely. AAMC does remain diligent to expand low cost primary care and dental services.

   The need to improve dental health was also mentioned in the CHNA. In FY14, a local dentist expanded hours to care for underserved patients. Free and low cost dental care was provided to residents who do not have access to dental care. The wait list for preventive dental care has decreased, but it still remained a concern. In FY15, AAMC developed a policy to provide dental care to individuals who are underinsured or may not fit the category for no-cost dental care. Dental hygienists were hired through a grant to the clinic to address these needs and provide preventive dental care.

   Public transportation is not in the scope of services that AAMC can provide as a hospital.

   While the CHNA mentioned these determinants, it did not include them in the final analysis and conclusions. In FY14, AAMC had initiatives underway to address cancer, substance abuse, chronic disease, services for under- and uninsured and healthcare disparities. The FY14-15 Implementation Plan does include programs to address all health needs indicated in the CHNA.

2. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health? (see links below for more information on the State's various initiatives)

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

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

- Increase life expectancy

AAMC focuses on prevention of disease. As a result, we provide over 160 health talks and health fairs (1,465 hours and community benefit $48,60, flu shot clinics (2,500 vaccines provided and $71,000 community benefit), blood pressure and cholesterol screenings (8,500 hours and community benefit $258,710), vascular screenings (community benefit $65,000) that advise and guide community members to better health.

- Prevention Quality Indicator (PQI) Composite Measure of Preventable Hospitalization

AAMC provides on-going Living Well with Diabetes in partnership with the Anne Arundel County Departme.t of Aging (Community Benefit $7,100). A newly established Diabetes program started FY16, so additional care plans, standard orders, and staff education will be provided to reduce re-admissions from diabetes. In FY17, a diabetes navigator will be hired to manage patients from in-patient to out-patient to prevent re-admissions. AAMC has a pediatric nurse navigator (grant funded, no community benefit associated with this initiative) to work with high risk children to prevent asthma admissions. Another care manager works with adults to manage post-discharge patients who have COPD and CHF. Often patients who are admitted through the ED do not have primary care physicians. AAMC established 2 clinics for primary care to better manage hypertension, establish follow up patients, etc (Community Benefit $915,000).

- Reduce the % of adults who are current smokers

AAMC has provided community based smoking cessation programs to adults for nearly 20 years. Working in conjunction with the Anne Arundel County Department of Health, patients enrolled in programs may receive free nicotine replacement medicines if they qualify. Counselors see inpatients, out-patients, and provide classes. See Table III, Initiative III for data on smoking cessation encounters.

- Reduce the % of youth using any kind of tobacco product

AAMC's smoking cessation initiative also provides counseling to adolescents who smoke. IN addition, AAMC participates with the Anne Arundel County Department of Health and the Anne Arundel County School system to provide free anti-smoking talks to students (40 hours, $1600 community benefit). The encounters for adolescents enrolled in smoking cessation are included in increase life expectancy above and Table III, Cancer.

- Increase the % vaccinated annually for seasonal influenza

AAMC vaccinates all 4,800 employees, 1,100 physicians, vendors, patients and visitors to the campus. Not all of this is community benefit, but 2500 vaccinations were provided to the community at large for a total community benefit of $71,000.

- Increase the % of children with recommended vaccinations

AAMC supports this initiative, but we see the community pediatric practices focused on this work. AAMC will print information guides in our Magazine to help parents understand the need for immunizations and the schedule.

- Reduce new HIV infections among adults and adolescents

- Reduce diabetes-related emergency department visits

AAMC opened an out-patient Diabetes Center in un-regulated space on July 1, 2015. The demonstrated need was evident based on the ED visits for uncontrolled diabetes. See Table 2 for information. More information and data will be included in the FY16 Community Benefit Report.

- Reduce hypertension related emergency department visits

AAMC began community based nurse clinics in FY14 to respond to this need, and create awareness in the community. Access to the underserved community is provided within 1 day for individuals to seek care to control their hypertension. See Table III, Initiative 4 and 5 for encounters.

- Reduce the % of children who are considered obese

See Table III, Initiative 1, Obesity.

- Increase the % of adults who are at a healthy weight

See Table III, Initiative 1, Obesity.

- Reduce hospital ED visits from asthma

AAMC has a pediatric nurse navigator (grant funded, no community benefit associated with this initiative) to work with high risk children to prevent asthma admissions.

- Reduce hospital ED visits related to behavioral health

See Table III, Initiative 2, Co-Occurring disorders for Community Benefit programs description.

- Reduce Fall-related death rate

A care manager works with high risk patients to ensure they are safe upon discharge. In FY15, AAMC contracted with the Coordinating Center to provide home base care management for high risk for re-admission patients (Community Benefit ?).

I. PHYSICIANS

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

According to the 2015 County Health Rankings, Maryland fares better at a 9 percent rate of insured residents as compared to Maryland (12 percent) and the US (11 percent). However, access to primary care and other specialties is worse in Anne Arundel County as compared to Maryland and the US. In fact, the patient to primary care physician ratio in Anne Arundel (1430:1) is worse than in Maryland (1045:1) and the U.S. benchmark (1131:1) meaning that more individuals are seeking care from fewer providers. This shortage results in seriously limited access to primary care in parts of our Community Benefit Service Area. Building primary care access is essential to the Hospital's strategic plan, Vision 2020. Increased accessibility and coordinating health care increased the focus on prevention and improving the population health of our CBSA.

Access to mental health providers and dentists is also worse in Anne Arundel County as compared to Maryland and the US. According to the 2015 County Health Rankings, the ratio of mental health providers to patients is 718:1 as compared to Maryland (502:1) an d the US (386:1).

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

The ED physician group is an external organization that AAMC contracts with to provide 24 hour care in the Emergency Room. AAMC reimburses them for their charity care and their call coverage. Our ED serves 93,475 patients per year and this subsidy ensures that patients have access to high quality physician care.

There are many physician specialties that are in high demand and are necessary to address the needs outlined in the CHNA. AAMC's physician recruitment efforts included 2 endocrinologists and a nurse practitioner to develop an out-patient diabetes program. A medical oncologist to reduce wait times for cancer patients. Twelve family practice/ internal medicine physicians and nurse practitioners were recruited to meet the shortage of primary care in the County. There were 5 OB/GYN providers recruited to meet the demand. The health department closed their low cost clinics for undocumented women and AAMC took on an additional 200 deliveries per year and the related pre-natal care. Four psychiatrists and mental health providers were recruited to address the demand for mental health and substance abuse.

II. APPENDICES

To Be Attached as Appendices:

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

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

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

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

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

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

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

Appendix 1

AAMC's Financial Assistance Policy

Description

The Financial Assistance Signage is conspicuously displayed in English & Spanish in the Emergency Department, Cashiering & Financial Counseling.

Financial Assistance Policy as well as a printable Uniform Financial Assistance application is posted on the AAMC website.

English/Spanish table top tents display this information at every patient entry point and it is included in each patient guide located in the inpatient rooms.

Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.

The financial assistance application is available at all registration points – but in particular the Emergency Department

A brochure "What you need to know About Paying for Your Health Services" is available at every patient access point. The brochure was developed by Patient Financial Services with guidance from Public Relations. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish. Also, it is posted on AAMC's website.

It is mandatory that all inpatients receive the "What you need to know about paying for your health services" brochure as part of the admission packet.

Informational "business cards" are available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital Financial Counseling office for assistance.

Appendix II

AAMC's Financial Assistance Policy

Changes since the ACA

Given the January 1, 2014, Affordable Care Act implementation and Medicaid Expansion many individuals are eligible for Medicaid coverage or may purchase medical benefits through the National Health Care Exchange.

The hospital's financial counseling workflow has been redesigned to promote enrolling patients for Medicaid. AAMC employs 3 Financial Advocates certified by the State of Maryland to complete Hospital Presumptive Eligibility applications for immediate temporary Medicaid coverage as well as the full long term Medicaid applications.

Appendix III

SEE FOLLOWING PAGE

	Patient Financial Services – Hospital Financial Assistance, Charity Care, Billing & Collection Policy
Dates Previously Reviewed/Revised: **Newly Reviewed By:** **Effective Date: December 1, 1997** **Review Date: August 15, 2012** **F&A Committee Approval: September 21, 2012** **Board of Trustees Approval: September 27, 2012**	**Owner:** Director of Patient Financial Services Reviewed (date & initials): _____
Approver Title: Chief Financial Officer _____ Approval Signature	

Scope: Anne Arundel Medical Center

Policy Statement:
To promote access to all for medically necessary services regardless of an individual's ability to pay, to provide a method of documenting uncompensated care and to ensure fair treatment of all applicants and applications

Purpose:
- To assure the hospital communicates patient responsibility amounts in a fair and consistent manner.
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices, effective June 1, 2009
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To define the hospital's decision making process for referral for collection or legal action.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices, effective June 1, 2009

Hospital Financial Assistance Communications
- The Financial Assistance Signage is conspicuously displayed in English & Spanish in the Emergency Department, Cashiering & Financial Counseling.
- Financial Assistance Policy as well as a printable Uniform Financial Assistance application is posted on the AAMC website.
- English/Spanish table top tents display this information at every patient entry point and it is included in each patient guide located in the inpatient rooms.
- Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.
- The financial assistance application is available at all registration points – but in particular the Emergency Department.

- A brochure "What you need to know About Paying for Your Health Services" is available at every patient access point. The brochure was developed by Patient Financial Services with guidance from Public Relations. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish. Also, it is posted on AAMC's website.
- It is mandatory that all inpatients receive the "What you need to know about paying for your health services" brochure as part of the admission packet.
- Informational "business cards" are available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital Financial Counseling office for assistance.
- Hospital Patient Financial Service staff receive extensive training on the revenue cycle and are incentivized to obtain AAHAM Technical (CPAT) certifications to demonstrate their expertise in billing and revenue cycle requirements.

Charity Care

- Determination of Probable Eligibility: Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.
- AAMC provides 100% charity to individuals with household income at or below 200% of the US Poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.
- AAMC provides 100% charity to individuals enrolled in the Medicaid Primary Adult Care program and other means tested State & Local programs.
- AAMC provides a sliding fee scale for individuals with household income at or below 330% of the US poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.
- AAMC provides financial assistance not only to the uninsured but to patients with a demonstrated inability to pay their deductibles, copayments and balance after insurance.
- The hospital excludes assets such as the patient's primary home, method of transportation and cash assets less than $15,000.
- For all income levels, AAMC will take into account special circumstances such as the amount of the bill compared to income and cumulative impact of all medical bills.
- AAMC developed an initiative with the A.A. County Department of Health to help provide free prenatal diagnostic testing for uninsured unregistered immigrants. These individuals are not eligible for any Medicaid program.
- AAMC participates with an Anne Arundel County specific program (REACH) administered through the AA County Department of Health to provide free care to low income uninsured or under-insured individuals (below 200% of the US Poverty Guideline). These individuals come to AAMC on an elective basis and are prescreened by the local Department of Social Services.
- Diagnostic and Treatment services are provide free of charge to referrals from the AAMC Outreach Free Clinic initiative located in downtown Annapolis.
- Payment plans, Interest Free

<u>Billing</u>

Patient Statement of Charges:

- A Summary Bill of charges, formally referred to as the Uniform Summary Bill is mailed to every inpatient within 15 days of discharge from the hospital. This contains information on the insurance company billed as well as how to contact the Patient Financial Services office for questions or assistance.
- Uninsured patients receive this Summary as well
- Each bill for outpatient services includes detail charge information on the first request for payment.
- At any time, the patient may request a copy of their detailed itemized bill.
- The HSCRC required Patient Billing Information sheet data is printed on the Uniform Summary Bill and the back of all patient billing statements.
- A representative list of services and charges is available to the public on the hospital's website and in written form. The website will be updated quarterly with the most recent average charge per case for each of the services.
- Requests and inquires for current charges for specific procedures/services will be directed to the ACP Financial Coordinator or if applicable the specific department Financial Coordinator. The Coordinator will communicate with the patient and the patient's provider of care to provide the best possible estimate of charges. Using the CPT code, service description and/or other supply/hospitalization time charge estimates are based on, a) review of the charge master for the CPT code/service description, and/or b) review of cost of similar surgical procedures/treatments/hospital stays. The patient will be informed cost quotes are estimates and could vary based on the actual procedure(s) performed, supplies used, hospital stay/OR time & changes in HSCRC rates. If the Coordinator requires guidance or additional information to provide the estimate he/she will contact the Reimbursement Department. Every effort will be made to respond to the request for charges within 2 business days depending on information needed to fulfill the patient's request.

Patient Balance Billing:

- From the point in which it is known that the patient has a balance for which they are responsible the hospital begins billing the patient to request payment.
- Each patient receives a minimum of 3 requests for payment over a 90 day period.
- Each patient bill includes contact information for financial assistance and states where to call to request a payment plan.
- Each bill informs the patient they may receive bills from physicians or other professionals.
- Short and Long term interest free payment plans are available. The hospital takes into account the balance of the bill and the patient's financial circumstances in determining the appropriate agreement.
- Should the patient contact Patient Financial Services Customer Service unit regarding inability to pay – financial assistance is offered and the financial assistance screening process begins.

Collection Agency process:

- If there is no indication from the patient or a representative that they cannot pay and no attempt at payment or reasonable payment arrangements is made, the account is referred to a collection agency.

- The collection agency referral would typically occur between 90 – 110 days from the first request to the patient to pay assuming the patient made no attempt to work out payment arrangements or indicated financial need.
- The final statement to the patient communicates the account will be referred to an external agency if the balance is not satisfied.

Collections

- The Director of Patient Financial Services oversees the hospital's business relationship with the Collection Agency.
- AAMC does not utilize a credit reporting bureau.
- AAMC does not charge interest to patients
- The collection agency performs a financial checkpoint before taking the next step to legal action.
- AAMC staff reviews each case before being referred for legal action
- The collection agency is educated on how to make referrals to AAMC's financial counseling department for individuals indicating they have an inability to pay.
- The collection agency will establish payment arrangements in compliance with AAMC's interest free commitment.
- As a last resort, AAMC will file suit for collection of debts.
- If the court makes judgment in the hospitals favor – a formal legal credit mark referred to as a "judgment" is placed on an individual's credit and remains intact for 10 years. Once the full payment is made the patient may request that the judgment reflects as satisfied on the credit rating.
- AAMC will file suit against estates and in some cases, when appropriate, trust funds.
- AAMC does actively enforce a lien against an individual's primary home.

Approved by CFO
Bob Reilly

Appendix IV

SEE FOLLOWING PAGE

Thank you for choosing Anne Arundel Medical Center for your health care needs. We understand this can be a challenging time for our patients, and we know that the financial aspect of hospitalization sometimes can be confusing.

To take the confusion out of the payment process, our Patient Financial Services Team is available to help you understand your hospital bill. We also can help you with payment options, including whether you are eligible for financial assistance through federal and state programs. We can answer general questions about the manner in which your insurance company processed your bill.

We have prepared this brochure to help answer the most commonly asked questions about billing. If your specific question is not listed here, please contact 443-481-6500 Monday – Friday between 8:30 a.m. and 4:00 p.m.

Patient Financial Services Resources

Our Financial Counseling team is located at the Medical Park Campus, 2001 Medical Parkway, Annapolis, Maryland.

You may make an appointment to meet with a financial coordinator by calling:

Financial Assistance 443-481-1401

Medical Assistance application 443-481-1401

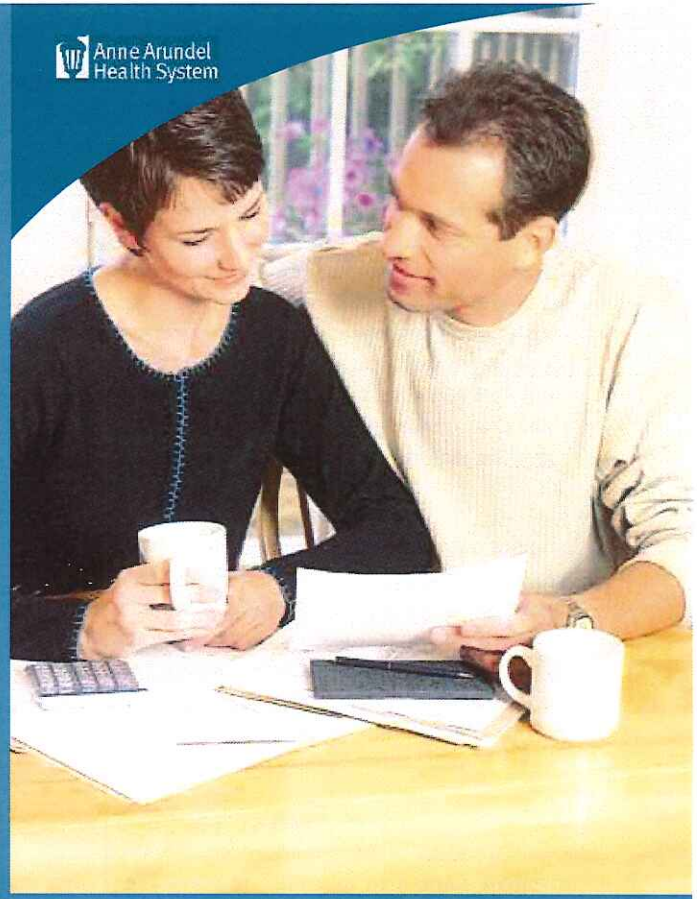
Payment Arrangements 443-481-1401

If you have received a bill and have questions or wish to discuss payment arrangements you may call:

Questions about your bill 443-481-6500

Payment Arrangements..... 443-481-6500

Anne Arundel Health System



Patient Billing Information Q&A

Patient Billing Information Q&A

What is included in my hospital bill?

Your bill from Anne Arundel Medical Center is for services you receive from nurses, social workers, dietitians, therapists and other staff. It also includes charges for your room, meals, linens, supplies, medications, diagnostic tests and supervised professional services, such as those of respiratory and physical therapists.

What is not included in my hospital bill?

You will be billed separately by your physicians, consulting physicians, and surgeons for services they provide to you. These services are NOT included in your hospital bill. Each physician who cares for you will send you a separate bill for services they provided. This includes physicians who may have treated you in the Emergency Department; those you may never see, including physicians who interpret diagnostic studies, such as X-rays, EKGs, and certain laboratory specimens; and anesthesiologists, staff pediatricians or internal medicine physicians who may have treated you during your stay.

How does health insurance billing work?

When you receive services at Anne Arundel Medical Center, we will bill your health insurance provider on your behalf. To do this, and to assure the hospital is paid for services provided to you, we need a copy of your insurance card. We must supply complete and accurate information to your health plan, including your full name, address, phone number, date of birth, and Social Security number. Incomplete or incorrect information could mean a denial from your insurance provider. You could be held responsible for the balance of the invoice when an insurance provider delays, denies, or makes partial payment. Your insurance company may also require that you make your co-payment at the time of service.

If you cannot or will not provide complete insurance and subscriber information Anne Arundel Medical Center cannot submit your bill to your insurance company. If that is the case, you will be a "self pay" patient and we will ask you for a deposit for services. All cosmetic services and services not deemed medically necessary by your insurance company must be paid in full and in advance of the service.

What if I Have a Managed Care or HMO Plan?

If you have a managed care or HMO plan and you are admitted to our emergency room, your plan may require you to contact your local office to obtain authorization for your admission within 24 hours of an emergency admission. Your health insurance card should provide you with your plan's telephone number. Anne Arundel Medical Center staff will attempt to contact your insurance plan with notification of your inpatient admission. Most HMO plans require you to obtain a referral or authorization for certain non-emergency services. Anne Arundel Medical Center will help you obtain the authorization.

Many HMOs require you to receive diagnostic services such as laboratory tests and X-rays at a designated provider, not at the hospital's outpatient department.

What if my visit involves worker's compensation?

If we do not receive worker's compensation information from you or your employer you will be responsible for your bill. It is important that you provide your medical insurance benefit information as well, so any required authorizations or other steps to ensure coverage are followed. This will assist in protecting you and the hospital financially should worker's compensation deny payment. We need a copy of the denial in order to bill your insurance.

What if my visit is due to a motor vehicle accident?

Anne Arundel Medical Center does not bill auto insurance providers. MVA patients are responsible for payment of services provided. It is important that you provide your medical insurance benefit information as well, so any required authorizations or other steps to ensure coverage are followed. This will assist in protecting you and the hospital financially should the auto insurance deny payment. We need a copy of the denial in order to bill your insurance.

What does Medicare Cover?

"Medical Necessity" is a term used by Medicare to describe the services Medicare feels are "reasonable and necessary" for the treatment or diagnosis of an illness or injury. In most cases Medicare provides payment for "medically necessary" services. If your physician prescribes a service that may not be covered by Medicare you will be asked to sign an Advance Beneficiary Notice before service is provided stating that Medicare is not likely to pay for the service. By signing this form you agree to be responsible for payment.

What are my options under Medicare?

If you have an Advance Beneficiary Notice you can sign it and agree to pay for the services yourself or you can refuse the service or treatment. If you refuse the service or treatment, we encourage you to talk with your physician about options that would be covered under Medicare. You have the right to appeal a Medicare decision of non-coverage. If you would like to file an appeal or have other Medicare-related questions, please call the Medicare Beneficiary Hotline at 1-800-633-4227.

What if I can't pay on time?

We understand that certain circumstances may make it difficult for you to pay your bill on time. However, if your account becomes past due, Anne Arundel Medical Center will take action to recover the amount owed. Please call 443-481-6500 between the hours of 8:30 a.m. – 4:00 p.m., Monday through Friday, to discuss your circumstances. We want to help you protect your credit.

What if I am unable to pay any portion of my bill?

If you are unable to pay your bill we can help you apply for state and federal programs that may pay all or a portion of your bill. Please call 443-481-1401 for assistance. Anne Arundel Medical Center offers financial assistance for those who do not qualify for state or federal programs but meet certain federal poverty guidelines. Also, you may be eligible for a partial reduction on the amount you owe.

For more information about patient financial services resources and telephone numbers, see the back of this brochure.

Appendix V

SEE FOLLOWING PAGE

About AAMC

▶ About Us

▶ Leadership

443-481-1000

Find Us

Facebook

Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, MD 21401
(443)481-1000

Mission & Vision

Our Mission and Vision

Mission: To enhance the health of the people we serve
Vision 2020: Living Healthier Together

Our Corporate Values

COMPASSION
It happens in a hundred different ways every day. An encouraging word for a patient. Empathizing with a family. Making a co-worker's day a little smoother. Compassion is at the heart of our mission.

TRUST
This is the foundation of our culture -- patients and families putting their trust in us.

DEDICATION
Caring for patients requires selflessness and teamwork. We are thousands of people in jobs of every description all committed to the same goals.

QUALITY
Quality means meeting the high standards of excellence we expect of each other and that our patients deserve. Together we achieve better outcomes and experiences.

INNOVATION
Since our founding in 1902, we have been at the forefront of advancements in technology and patient care to benefit the people of our communities.

DIVERSITY
We benefit and draw strength from our differences. Diversity is our daily experience, a journey - not a destination.

COLLABORATION
In partnership with many, we work together toward our vision: *living healthier together*.

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