COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2016 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

MedStar Harbor Hospital

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HSCRC Community Benefit Reporting Requirements

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

e. The percentage of the hospital's uninsured patients by county. (please provide the source for this data, i.e. review of hospital discharge data);

f. The percentage of the hospital's patients who are Medicaid recipients. (Please provide the source for this data, i.e. review of hospital discharge data, etc.).

g. The percentage of the Hospital's patients who are Medicare Beneficiaries. (Please provide the source for this data, i.e. review of hospital discharge data, etc.)

Table I

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area Zip Codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of Hospital's Uninsured Patients,:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries
157 Source: MHH Finance Department	11,488 *Includes observation patients Source: MHH Finance Department	21225 21230 21061 21227 21060 21122 Source: HSCRC Acute Hospital PSA 2016	Baltimore Washington Medical Center St. Agnes Hospital Mercy Medical Center Source: HSCRC Acute Hospital PSA 2016	1.6% Source: Inpatient hospital discharge data	40.9% *This includes Medicaid HMOs Source: Inpatient hospital discharge data	35.1% *This includes Medicare HMOs Source: Inpatient hospital discharge data

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

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

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

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

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

Some statistics may be accessed from the Maryland State Health Improvement Process, (http://dhmh.maryland.gov/ship/). the Maryland Vital Statistics Administration (http://dhmh.maryland.gov/vsa/SitePages/reports.aspx), The Maryland Plan to Eliminate Minority Health Disparities (2010-2014)(http://dhmh.maryland.gov/mhhd/Documents/Maryland_Health_Disparities_Plan_of_Action_6.10.10.pdf), 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)
Community Health Status Indicators (http://wwwn.cdc.gov/communityhealth)

Table II

Demographic Characteristic	Description	Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	CBISA includes all residents of the hospital's Zip code, 21225 Focus area: Cherry Hill This geographic area was selected due to its high poverty rate and proximity to the hospital, as well as the opportunity to build on longstanding community benefit programs, services and partnerships.	MedStar Health 2015 Community Health Needs Assessment http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf
Median Household Income within the CBSA	Baltimore City - $41,819 Anne Arundel County – $89,031 CBSA (21225) - $37,291 Focus Area (Cherry Hill) - $19,183	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table
Percentage of households with incomes below the federal poverty guidelines within the CBSA	Baltimore City – 19.5% Anne Arundel County – 3.9% CBSA (21225) - 24.5% Focus Area (Cherry Hill) – 47.5%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table 2011 Neighborhood Health Profile: Cherry Hill http://health.baltimorecity.gov/sites/default/files/7%20Cherry%20Hill.pdf

For the counties within the CBSA, what is the percentage of uninsured for each county? 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	Baltimore City – 11.6% Anne Arundel County – 7.0% CBSA (21225) – 13.3%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table
Percentage of Medicaid recipients by County within the CBSA.	Baltimore City – 31.3% Anne Arundel County – 12.1%	2016 Maryland Medicaid eHealth Statistics http://www.chpdm-ehealth.org/mco/index.cfm
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available). See SHIP website: http://dhmh.maryland.gov/ship/SitePages/Home.aspx and county profiles: http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	MD 2017 SHIP Goal -79.8 Baltimore City – 74.1 African American – 72.3 White – 76.8 MD 2017 SHIP Goal – 79.8 Anne Arundel County – 79.8 African American- 78.2 White – 79.9 Cherry Hill – 67.8	2012 - 2014Maryland State's Health Improvement Process (SHIP)http://dhmh.maryland.gov/ship/Pages/home.aspx 2011 Neighborhood Health Profile: Cherry Hill http://health.baltimorecity.gov/sites/default/files/7%20Cherry%20Hill.pdf
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Baltimore City (per 100,000 residents) All Cause Mortality Rate – 1001.7 Cardiovascular Disease Mortality Rate – 300.3 Diabetes Mortality Rate – 29.0 Stroke Mortality Rate – 45.5 Cancer Mortality Rate– 217.1 Anne Arundel County (per 100,000 residents) Heart Disease Mortality Rate – 165.0 Diabetes Mortality Rate – 20.2 Stroke Mortality Rate – 37.6 Cancer Mortality Rate – 166.1	Maryland Vital Statistics Administration 2013 Report Card http://health.baltimorecity.gov/sites/default/files/Health%20Disparities%20Report%20Card%20FINAL%2024-Apr-14.pdf

Access to healthy food, transportation and education, housing quality and exposure to environmental factors that negatively affect health status by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources) See SHIP website for social and physical environmental data and county profiles for primary service area information: http://dhmh.maryland.gov/ship/SitePages/measures.aspx	**By County within the CBSA** Percent of Zip codes in county with a healthy food outlet : Baltimore City – 48.89% Anne Arundel County – 44.19 State of Maryland – 40.4% Percentage of working age people who use public transportation: Baltimore City – 18.22% Anne Arundel County – 3.2% State of Maryland – 8.8% National – 4.7% Percentage of adults (25+) with a college degree: Baltimore City – 27.5% Anne Arundel County – 37.4% State of Maryland – 37.1% Number of days with maximum ozone concentration over the National Ambient Air Quality Standard: Baltimore City – 20 Anne Arundel County - 19 State of Maryland – 11.7 Homeownership Rate: Baltimore City – 47.15 Anne Arundel County – 74.03 State of Maryland – 67.1 **Cherry Hill (focus area within CBSA)** Supermarket Proximity (estimated travel time to nearest supermarket by car (in min) 7.0; by bus (in min) 32.0. Percent of residents 25 years and older with a college degree or more – 6.8%	Maryland State's Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/Pages/home.aspx
Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions.	CBSA (Zip Code 21225 which includes the Brooklyn, Brooklyn Park, Cherry Hill, and Pumphrey neighborhoods) Total population – 33,091 White – 16,623	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.

http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	African American – 15,100 Asian – 1,106 Indian and Alaska Native – 519 Native Hawaiian and Other Pacific Islander – 49 Other Race – 1,365 Language Only English - 91.5% Other than English - 8.5% Cherry Hill Total population – 9,285 White -225 African American - 8,810 Two or more races -185 Hispanic or Latino - 40 American Indian or Alaska native - 20 Asian - 25 Native Hawaiian or other Pacific Islander -15	gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_S1601&prodType=table 2011 Neighborhood Health Profile: Cherry Hill http://health.baltimorecity.gov/sites/default/files/7%20Cherry%20Hill.pdf

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

   __X__Yes
   ____No

   Provide date here. 06/30/2015

   If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).
   http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf

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

   _X_Yes 06/17/2015
   ___No

   If you answered yes to this question, provide the link to the document here.
   http://ct1.medstarhealth.org/content/uploads/sites/16/2014/08/MedStar_CHNA_2015_FINAL.pdf
   (pg. 20-23)

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

      _X__Yes
      ___No

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

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

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

i. Senior Leadership

1. _X__CEO
2. _X__CFO
3. _X__Other (please specify)

Describe the role of Senior Leadership.

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

ii. Clinical Leadership

1. _X__Physician
2. _X__Nurse
3. _ __Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

MedStar Harbor Hospital's clinical leaders are represented on the hospital's senior leadership team through the chief nursing officer and the vice president of medical affairs. Additionally, other clinicians serve on the hospital's Advisory Task Force (see iv 4).

iii. Population Health Leadership and Staff

1. ____ Population health VP or equivalent (please list)
2. ____ Other population health staff (please list staff)

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

iv. Community Benefit Operations

1. ___Individual (please specify FTE)
2. ___Committee (please list members)
3. _X__Department (please list staff)
   a. Community Relations Manager (1FTE)

b. School Resource Coordinator (1FTE)
c. Nurse Educator (1 FTE)
d. General Clerk (1FTE)

4. _X__Task Force (please list members)
5. ___Other (please describe)

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

The Community Relations Manager oversees all community benefit programming, planning and reporting.

The School Health Resource Coordinator plans and executes all outreach through the Healthy Schools Healthy Families Program.

The Nurse Educator coordinates the hospital's diabetes prevention program.

The General Clerk staffs many outreach act ivies to ensure event runs smoothly.

Task Force Members:

Name	Organization
Antigone Vickery	Director, Office of Assessment, Planning and Response, Anne Arundel County Department of Health
Aruna Chandran, MD, MPH	Chief of Epidemiology, Baltimore City Health Department
Brent Flickinger	Southern District Planner, Baltimore City Department of Planning
Michael Middleton	Chairperson, Cherry Hill Community Coalition
Cathy McClain	Executive Director, Cherry Hill Trust
Will Sebree	Community Outreach Advocate, Family Health Centers of Baltimore
Tracey Garrett	President, Friendship Academy at Cherry Hill Elementary/Middle School
Kerunne Ketlogetswe, MD	Cardiologist, MedStar Harbor Hospital
Ned Carey	Chief Administrative Officer of the Maryland Aviation Administration

David Hager, MD	Chairman, Dept. of Emergency Med, MedStar Harbor Hospital
Luis Rivera-Ramirez, MD	Endocrinologist, MedStar Harbor Hospital
Leslie Hughan	Community Relations Manager, MedStar Harbor Hospital
Calvert Moore	School Health Resource Coordinator, MedStar Harbor Hospital
Jill Johnson	Vice President of Operations, MedStar Harbor Hospital
Robert Dart, MD	Primary Care Physician, MedStar Harbor Hospital

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

Spreadsheet __X___yes _____no
Narrative __X___yes _____no

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

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

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

Spreadsheet __X___yes _____no
Narrative __X___yes _____no

If no, please explain why.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

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

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

Organization	Name of Key Collaborator	Title	Collaboration Description
Cherry Hill Community Coalition	Michael Middleton	Chair	Provided meeting time to us to conduct the survey
Cherry Hill Trust	Cathy McClain	Chair	Provided meeting time to conduct the survey as well as helped distribute the survey
Northeast High School	Jackie Dunn	Signature Facilitator	Provided an opportunity for community members to participate in the

			survey
Arundel Elementary/Middle School	Rochelle Machado	Principal	Provided space and time for a community input session
Cherry Hill Elementary/Middle School	Tracey Garrett	Principal	Provided space and time for a community input session

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

_____yes __X___no

Although there is a member of the hospital who co-chairs a subcommittee within the LHIC.

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

__X___yes _____no

- Community Relations Manager

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

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

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

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

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

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

f. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative? (please be sure to include the actual dates, or at least a specific year in which the initiative was in place)

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

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

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

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

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

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

Table III – Initiative I

<table>
<tr><td>Identified Need</td><td>Chronic disease prevention and management
Top health conditions most seen in the community (n=277) (MedStar Harbor Hospital Community Health Needs Assessment, 2015).
53% of respondents report obesity/overweight
45% of respondents report diabetes
23% of respondents report heart disease
Maryland State Health Improvement Planning data shows
Percentage of adults who are obese
Maryland—28%
Anne Arundel County—28%
Baltimore City—33%
Diabetes age-adjusted deaths per 100,000
Maryland—20
Anne Arundel County—22
Baltimore City—30
Heart disease age-adjusted deaths per 100,000
National—202
Maryland—199
Anne Arundel County—174
Baltimore City—286</td></tr>
<tr><td>Hospital Initiative(s)</td><td>Education Seminars and Preventative Screenings
The initiative provides healthy cooking demonstration classes and educational talks to residents in ZIP code 21225. The program also provides free monthly blood pressure screenings and facilitates diabetes support groups for participants and their families.</td></tr>
<tr><td>Primary Objective</td><td>Reduce the incidence, prevalence and risk factors contributing to chronic diseases within the CBSA ZIP code 21225.</td></tr>
<tr><td>Single or Multi-Year Initiative Time Period</td><td>Multi-Year
FY13-ongoing</td></tr>
<tr><td>Key Partners in Development and/or Implementation</td><td>American Heart Association Teaching Kitchen; MedStar Visiting Nurse Association; Asbury Town Neck United Methodist Church; Living Word Seventh Day Adventist Church; Davidsonville United Methodist Church; Empowering Believers Church of the Apostolic Faith; Jenkins Memorial Church; John Wesley United Methodist Church; Metropolitan United Methodist Church; Mt. Zion United Methodist Church (Magothy); Mt. Zion United Methodist Church (Laurel); New Life Fellowship International Ministry; Pasadena United Methodist Church; St. John Lutheran Church; St. John's United Methodist Church.</td></tr>
</table>

<table>
<tr><td>How were the outcomes evaluated?</td><td colspan="2">Number of classes held
Number of encounters
Demographic information of participants</td></tr>
<tr><td>Outcomes (Include process and impact measures)</td><td colspan="2">Nine community events (cooking demonstrations and educational talks)
102 community screenings (blood pressure, glucose and vision)
Began offering the National Diabetes Prevention Program
1,173 encounters
In FY16, 67 percent of program participants gained new knowledge.</td></tr>
<tr><td>Continuation of Initiative</td><td colspan="2">Yes</td></tr>
<tr><td>A. Total Cost of Initiative for Current Fiscal Year
B. B. What amount is Restricted Grants/Direct offsetting revenue</td><td>A. Total Cost of Initiative $17,703</td><td>B. Direct offsetting revenue from Restricted Grants $0</td></tr>
</table>

Table III – Initiative II

Identified Need	Cancer Screening and Prevention • 32% (n=277) of survey respondents report cancer as a top issue seen in the community (MedStar Harbor Hospital Community Health Needs Assessment, 2015). • At MedStar Harbor Hospital, breast cancer treatment is the third most costly charity care service (MedStar Harbor Hospital Charity Care Analysis, 2013). • Maryland State Health Improvement Plan data shows: o Cancer deaths per 100,000 persons ▪ National—181 ▪ Maryland—182 ▪ Anne Arundel County—183 Baltimore City—233 *The Healthy People 2020 goal is 161
Hospital Initiative(s)	Colorectal Cancer & Breast Cervical Cancer Program In partnership with the Baltimore City Health Department, MedStar Health has been named the exclusive subcontractor providing free lifesaving colorectal cancer screening for eligible Baltimore City residents. Helping to reduce colorectal health disparities among high-risk populations, this partnership further enhances MedStar Health's continued commitment to protecting the community from the second leading cause of cancer deaths in Maryland.
Primary Objective	To increase cancer knowledge and access to prevention and screening services.
Single or Multi-Year Initiative Time Period	Multi-Year FY 2013 - ongoing
Key Partners in Development and/or Implementation	American Cancer Society, Healthy Anne Arundel, Allen Center for Seniors, Brooklyn Park Senior Center, Cherry Hill Senior Center, Curtis Bay Senior Center, Locust Point Senior Center, Family Health Centers of Baltimore

How were the outcomes evaluated?	Number of women who receive breast cancer screening (Baltimore City Health Department)	
Outcomes (Include process and impact measures)	Colorectal cancer program served nearly 265 people and the Breast & Cervical Cancer Program provided outreach services to more than 701 women. Held two cancer screening events, serving 15 people.	
Continuation of Initiative	Yes	
C. Total Cost of Initiative for Current Fiscal Year D. B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $180,462	B. Direct offsetting revenue from Restricted Grants $483,965

Table III – Initiative III

Identified Need	Children and Family Wellness Healthy Children learn better. Individuals with higher levels of education attainment have better health outcomes. One of the Baltimore City Department of Health goals, as reported in the Healthy Baltimore 2015 Report, is to promote healthy children and adolescents. Baltimore City Health Indicators: Indicator: Decrease rate of infant mortality by 10% Baseline: 13.4 per 1,000 live births Target: 12.1 per 1,000 live births Indicator: Increase rate of school readiness by 15% Baseline 67% Target 77.1%
Hospital Initiative(s)	Healthy Schools Healthy Family Program An innovative approach to health care designed to strengthen the entire Cherry Hill community. Working directly with Cherry Hill school students, their families, and educators and staff, the program provides and facilitates courses, seminars and activities that teach healthy lifestyle choices, diet, hygiene, self esteem and more. Programs and seminars include: • Anger management (six week course) • Asthma • Hand Hygiene • Healthy Eating • Personal Hygiene • Medication Safety • Sexually Transmitted Infection prevention (six week course)
Primary Objective	To promote healthy habits and healthy behaviors among students age 4 to 15 and their families.
Single or Multi-Year Initiative Time Period	Multi-Year 2013- ongoing
Key Partners in Development and/or Implementation	Friendship Academy at Cherry Hill Elementary/Middle School, Dr. Carter G. Woodson Elementary/Middle School, Arundel Elementary/Middle School, It's About the Kids Education Organization, Kaiser Permanente Educational Theatre, American Heart Association, Cherry Hill Coalition, EndSide Out, Baltimore City Health Department

How were the outcomes evaluated?	Number of classes held Number of encounters Surveys Pre-test versus Post-test Personal stories	
Outcomes (Include process and impact measures)	In FY16, the Healthy Schools Healthy Families Program held 33 education classes and 22 special program classes to students and 13 parent seminars. The school resource nurse conducted 8 home visits. The program had more than 3,000 encounters with students, and nearly 1,000 encounters with parents and school staff. Collectively, we saw an increase in knowledge. Personal stories also confirmed positive results. Approximately 135 surveys were completed and approximately 630 pre/post test were completed. Of those who attended our parent seminars, 85 percent found the programs to be helpful.	
Continuation of Initiative	Yes	
E. Total Cost of Initiative for Current Fiscal Year F. B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative $150,930	B. Direct offsetting revenue from Restricted Grants $0

Issue	Evidence	Explanation	Lead
Alcohol Addiction	49% (n=277) of CHNA participants identified alcohol addiction as a health condition most seen in our community (MedStar Harbor Hospital Community Health Needs Assessment, 2015). The Baltimore City Health Department identified reducing drug and alcohol abuse as a priority area. Within Baltimore City, the hospital admission rate for alcohol-related disorders is 396/100,000 persons, as reported in the Healthy Baltimore 2015 Interim Status Report. Anne Arundel County Department of Health 3-Year Strategic Plan also reports the percentage of adults who regularly consume alcohol and who binge drink exceeds both the state and national averages.	The hospital does not have the expertise to have a leadership role in these areas. When possible, the hospital will support stakeholders by contributing to initiatives and participating in conversations on the topics – particularly as they relate to health status and health outcomes.	Family Health Centers of Baltimore, Baltimore City Health Department, Healthy Anne Arundel
Heroine/Opiod Addiction	30% (n=277) of the CHNA participants identified heroine/opioid addiction as a health condition most seen in our community (MedStar Harbor Hospital Community Health Needs Assessment, 2015). The Baltimore City Health Department identified reducing drug and alcohol abuse as a priority area. Within Baltimore City, the admission rate for drug-related disorders is 324/100,000 persons, as reported in the Healthy Baltimore 2015 Interim Status Report.		Family Health Centers of Baltimore, Baltimore City Health Department, Healthy Anne Arundel
Affordable Child Care	38% (n=277) of the CHNA participants identified affordable		United Way of Central Maryland, Churches

	child care as a service most needed in our community (MedStar Harbor Hospital Community Health Needs Assessment, 2015).		
Affordable Housing	35% (n=277) of the CHNA participants identified affordable housing as a service most needed in our community (MedStar Harbor Hospital Community Health Needs Assessment, 2015).		United Way of Central Maryland, Cherry Hill Development Corporation

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

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

   In alignment with the State's population health strategy, the goals of the community benefit initiatives were to promote health and wellness and improve health knowledge and behaviors among communities and populations disproportionately affected by highly prevalent diseases and conditions. According to Maryland's State Health Improvement Process, 30% of all deaths were attributed to heart disease and stroke. MHH's primary focus from fiscal year 2016 – 2018 is to implement evidence-based interventions that address chronic disease, specifically targeting heart disease, cancer, diabetes and obesity; and child and family wellness. In effort to reduce the incidence, prevalence and risk factors contributing to chronic diseases, the hospital offers a walking program that will focus on increasing physical activity.

VI. PHYSICIANS

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

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

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

Table IV – Physician Subsidies

Category of Subsidy	**Explanation of Need for Service**
Hospitalist	MedStar Harbor Hospital provides physicians (hospitalists) for patients who do not have primary care providers handling their stay. Our community includes many low-income and minority families who have this requirement. The community needs for these services are being met, and a negative margin is generated.
Women's and Children's Services	Physician practices provide healthcare services for obstetrics and gynecology. A negative margin is generated. A large number of our patients receiving these services are from minority and low income families. Prenatal care is provided. Ob-Gyn coverage is provided 24 hours a day. Preventive measures and improvement of the patient's health status are achieved. The services address a community need for women's health and children's services for lower income and minority families.
Psychiatric Services	MedStar Harbor Hospital absorbs the cost of providing psychiatric supervision for the Emergency Department on a 24-7 basis. If these services were not provided, patients would be transported to another facility to receive them. The community needs are being met and commitment to patients is exhibited by providing

	these services.

VII. APPENDICES

To Be Attached as Appendices:

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

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

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

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

VII. APPENDICES

Appendix I
Financial Assistance Policy

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

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

Appendix II
Financial Assistance Policy Changes

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

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

Appendix III
Financial Assistance Policy

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

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

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

Scope

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

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

Definitions

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

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

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

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

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

Responsibilities

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

2. MedStar Health believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. The charity care, financial assistance, and periodic payment plans available under this policy will not be available to those patients who fail to fulfill their responsibilities. For purposes of this policy, patient responsibilities include:
   2.1 Completing financial disclosure forms necessary to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.
   2.2 Working with the facility's financial counselors and other financial services staff to ensure there is a complete understanding of the patient's financial situation and constraints.
   2. 3Completing appropriate applications for publicly-funded healthcare programs. This responsibility includes responding in a timely fashion to requests for documentation to support eligibility.
   2. 4 Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.
   2 .5 Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.
   2.6 It is the responsibility of the patient to inform the MedStar hospital of their existing eligibility under a medical hardship during the 12 month period.

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

4. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. **PRESUMPTIVE ELIGIBILTY**

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

8 MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS

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

9. PAYMENT PLANS

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

10 BAD DEBT RECONSIDERATIONS AND REFUNDS

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

Exceptions

1 PROGRAM EXCLUSION

MedStar Health's financial assistance program excludes the following:

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

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

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

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

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

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

Explanation And Details/Examples
N/A

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

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

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

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

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

Appendix IV
Patient Information Sheet

MARYLAND HOSPITAL PATIENT INFORMATION SHEET

HOSPITAL FINANCIAL ASSISTANCE POLICY

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

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

PATIENTS' RIGHTS

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

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

PATIENTS' OBLIGATIONS

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

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

CONTACTS:

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

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

For Information about Maryland Medical Assistance

Contact your local Department of Social Services

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

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

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

F-400 (6/21/10) (INDD)

Appendix V
Mission, Vision, Value Statement

Mission
MedStar Harbor Hospital is committed to always providing a quality, caring experience for our patients, our communities, and those who serve them.
Quality, Caring and Service
These are the sentinel guideposts for MedStar Harbor, forming the foundation for the hospital's journey from good to great.
Our Patients and Communities
Our patients are our primary reason for existence. They are at the heart of our mission. Our communities are comprised of our employees, our physicians, other caregivers, and the residents of the areas we serve.
Vision
The Trusted Leader in Caring for People and Advancing Health.
Values

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

Attachment A

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

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