COMMUNITY BENEFIT NARRATIVE REPORTING INSTRUCTIONS

Effective for FY2016 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore MD 21215

MedStar St. Mary's 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
91 Source: Hospital Finance	Total Inpatient admissions – 8972 Newborns – 1280 Total admits minus newborns – 7692 Source: Hospital Finance	20653 20659 20650 20619 20636 Source: HSCRC Acute Hospital PSA 2016	none	3.5% Source: Hospital Inpatient/observation admissions	12.3% Source: Hospital inpatient admissions	36.8% Source: Hospital Inpatient Admissions

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 residents of St. Mary's County Focus area: Lexington Park, zip code 20653	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	St. Mary's County - $99,428 Lexington Park - $73,847	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	St. Mary's County – 5.1% Lexington Park – 11.6%	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
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	St. Mary's County – 7.6% Lexington Park -8.9%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

Percentage of Medicaid recipients by County within the CBSA.	St. Mary's County – 15.6%	2016 Maryland Medicaid Health 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 St. Mary's County – 79.3 African American – 76.9 White – 79.5	2014 Maryland State's Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/Pages/home.aspx
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	St. Mary's County (per 100,000 residents): Mortality Rate – 752	Maryland Vital Statistics Annual 2014 Report Card http://dhmh.maryland.gov/vsa/Documents/14annual_revised.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** Percentage of Low income persons with limited/low access to a supermarket or large grocery store St. Mary's County – 21.6% Mean travel time to work: St. Mary's County – 29.7 minutes Percentage of Adults (25+) with a college degree: St. Mary's County – 30.1% State of Maryland 37.1% Annual Number of days with maximum ozone concentration over the National Ambient Air Quality Standard: St. Mary's County – 17	2011USDA Economic Research Service http://www.ers.usda.gov/data-products/food-access-research-atlas/download-the-data.aspx 2014 Maryland State's Health Improvement Process (SHIP) http://dhmh.maryland.gov/ship/Pages/home.aspx 2016 County Health Rankings and Roadmaps http://www.countyhealthrankings.org/app/maryland/2016/rankings/st-marys/county/outcomes/overall/snapshot

Available detail on race, ethnicity, and language within CBSA. See SHIP County profiles for demographic information of Maryland jurisdictions. http://dhmh.maryland.gov/ship/SitePages/LHICcontacts.aspx	**St. Mary's County** Demographics Total population – 110,350 White – 85,737 Hispanic – 4,648 Black or African American - 15,559 American Indian and Alaska Native – 274 Native Hawaiian and Other Pacific Islander - 33 Asian –2,668 Two or more races – 3,537 Language Speak only English – 93.0% Speak a language other than English – 7.0% **Lexington Park** Total population –24,481 White – 14,780 Hispanic – 1,623 Black or African American - 6,723 American Indian and Alaska Native –132 Native Hawaiian and Other Pacific Islander - 29 Asian –1,029 Two or more races –1,221 Language Speak only English – 90.2% Speak a language other than English – 9.8%	U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

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. 6/30/2015

   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 6/17/2015
   ___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. 17-19)

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) CMO/COO

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

ii. Clinical Leadership

1. __x_Physician
2. __x_Nurse
3. ___Social Worker
4. ___Other (please specify)

Describe the role of Clinical Leadership

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

iii. Population Health Leadership and Staff

1. ____ Population health VP or equivalent (please list)
2. __x__ Other population health staff (please list staff)
    a. Director of Population and Community Health

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

The Director of Population and Community Health leads the hospital community benefits program as well as the population and community health functions that do not count toward community benefit. The department consists of administrative support, supervisor who also writes and manages grants, RN care coordinators,

program coordinators, as well as community and clinical health educators. Safety net primary care services also fall under this umbrella.

iv. Community Benefit Operations

1. ___Individual (please specify FTE)
2. ___Committee (please list members)
3. _x__Department (please list staff)
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 Director of Population and Community Health along with the Finance Director and Analysts are responsible for community benefits programming and reporting.

The Operations Specialist oversees the day to day operations of Health Connections and the Hospital's Community Health Department.

The Department Secretary serves as the Community Benefits Data Coordinator.

The Data Analyst collects program data and enters it in CBISA for reporting.

The Finance Lead calculates financial data and collects subsidies.

The Program Coordinator oversees Chronic Disease programs and events.

Various educators provide services to community members through programming.

Advisory Task Force Members:

Name/Title	Organization
Mary Leigh Harless-Board Member (ATF Chairperson)	MedStar St. Mary's Hospital
Christine Wray – President	MedStar St. Mary's Hospital
Stephen Michaels, MD – Chief Operating/ Medical Officer	MedStar St. Mary's Hospital
Ric Braam - Chief Financial Officer	MedStar St. Mary's Hospital
Vacancy – Chief of Nursing Officer	MedStar St. Mary's Hospital
Lori Werrell – Director, Population and Community Health	MedStar St. Mary's Hospital
Holly Meyer - Director of Marketing	MedStar St. Mary's Hospital
Dr. Avani Shah	Community Physician/Chief of Staff
Kathleen O'Brien	Walden Sierra
Ella Mae Russell	Department of Social Services
Lori Jennings Harris	Department of Aging and Human Services
Meena Brewster, MD – Health Officer	St. Mary's County Health Department
Barbara Thompson – Board member	Hospital Board Member

Nathaniel Scroggins	Minority Outreach Coalition member
Jane Sypher – Board Member	Hospital Board Member
Colenthia Malloy	Greater Baden Medical Center
Dr. Fahmi Fahmi	MedStar St. Mary's Hospital, Primary Care
Dr.Connor Lundegran	Chief of Staff
Tracey Harris	College of Southern Maryland
Jenna Mulliken	Healthy St Mary's Partnership

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:

___x__Other hospital organizations
___x__ Local Health Department
___x__ Local health improvement coalitions (LHICs)
___x__ Schools
___x__ Behavioral health organizations
__ x__Faith based community organizations
__ x__ Social service organizations

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

Organization	Name of Key Collaborator	Title	Collaboration Description
Walden Sierra	Kathleen O'Brien	Executive Director	Assist with survey and focus group participation and selection of final areas of focus Provided data
Department of Social Services	Ella Mae Russell	Director	Assist with survey and focus group participation and selection of final areas of focus
Department of Aging and Human Services	Lori Jennings-Harris Maryellen Kraese Cynthia Brown	Director Prevention Coordinator Core Service Agency	Assist with survey and focus group participation and selection of final areas of focus

	Alice Allen	Senior Centers	
The Healthy St Mary's Partnership	Jenna Mulliken	Health Improvements Coordinator/Health Planner	Assist with survey and focus group participation and selection of final areas of focus Provided data
Greater Baden Medical Services	Colenthia Malloy	Executive Director	Assist with survey and focus group participation and selection of final areas of focus
Health Department	Dr. Meena Brewster, MD, MPH	Public Health Officer	Assist with survey and focus group participation and selection of final areas of focus Provided data

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

___x__yes _____no

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

__x___yes _____no

- Vice President served as Co-Chair until her departure;CMO/COO newly elected chair for 2017
- Director Population and Community Health, co-chairs the Access to Care team
- Chronic Disease Program Coordinator, co-chairs the Healthy Eating Active Living Team
- Alcohol and Opiod Misuse Program Coordinator, is a member of the Behavioral Health Team
- Director Behavioral Health is a member of the Behavioral Health Team

- Director Population and Community Health is a member of the Tobacco Free Living team

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 donation?

Table III – Initiative I

Identified Need	Access to Care: Physician Shortage and Health Disparities ▪ The 2015 Community Health Needs Assessment (CHNA) for MedStar St. Mary's Hospital (MSMH) outlines Access to Care as a primary concern for the residents of St. Mary's County. Data supporting the 2015 CHNA reflects disparity in physician and dental shortages, affordability for services and emergency department visits. Many of these data points exceeded the state averages. Emergency Department visits for Chronic diseases, including diabetes, high blood pressure and asthmas exceeded the state averages; ▪ The Patient-provider ratio exceeds the state average for both physicians as well as for dental services (2829:1 and 2369:1 respectively) This also leads to St. Mary's County being designated as a Health Care Provider Shortage area; ▪ As it relates to affordability, 10% of St. Mary's County adult residents stated they were unable to afford to see a doctor within the past year.
Hospital Initiative	Increase access to primary care providers/services by securing new providers; Infuse services to the southern portion of the county- a designated Health Care Provider Shortage area in an effort to decrease health disparities. Description: MSMH has seen an increase in emergency department (ED) visits for chronic diseases (diabetes, high blood pressure, and asthmas) which are higher than the state average. Many patients do not have a designated Primary Care Physician so they are resigned to utilizing the emergency department for what would normally be a standard medical appointment had they had access to a provider. In an effort to eliminate the misuse of ED services, MSMH has partnered with the Greater Baden Medical Services Inc. (the Federally Qualified Health Center FQHC for this region) to serve residents and non-residents of the HEZ.
Primary Objectives	1) Increase the number of Primary Care Physicians in St. Mary's County with a primary focus on areas identified as a Health Care Provider Shortage Area, such as the Health Enterprise Zone (HEZ). Metrics: MedStar St. Mary's Hospital's continues to utilize the services of the Care Coordinators and Neighborhood Wellness Advocates. The Care Coordinators and Neighborhood Wellness Advocates make contact with patients who have been discharged from the emergency department within 72 hours of their release. During this contact, CCs and NWAs review their plan of care, determine the need for additional referrals and answer questions the patient and their caregiver may have. This includes connecting the patient with a Primary Care Physician, transportation services, and any other social service-based agency. Additional Metrics: Where some patients may be un/underinsured, Neighborhood Wellness Advocates (NWAs) will assist in completing applications for supportive programs such as the Affordable Care Act, securing Veteran's Benefits and Social Security benefits where applicable. Transportation services may also be available for those clients residing the HEZ through their shuttle route as well as specialty

<table>
<tr><td></td><td>services. The specialty service provides door to door services 3 days per week for those who cannot get to a local bus route by virtue of their medical condition or public transportation limitations (no wheel chair lift, no bus route near their client's home, etc.).

At the end of fiscal year 2016, the Mobile Dental Clinic (aka Dental van) was in the process of finalizing a service agreement with a Dentist and his assistant. The dental van will offer services in the HEZ for clients who are un/underinsured. These services will be offered one time per week in the beginning with a later determination of increasing service hours in FY 2017.</td></tr>
<tr><td>Single or Multi-year initiative</td><td>This has been an ongoing, multi-year initiative that will continue into FY 2017. As the HEZ grant comes to a close in FY 2017, services will be transferred to other agencies to serve clients in the medical shortage areas and beyond.</td></tr>
<tr><td>Key Partners in Development and/or Implementation</td><td>Key partners for Access to Care are as follows:

▪ Greater Baden Medical Services, Inc.
▪ Health Enterprise Zone Partner Organizations
▪ St. Mary's County Health Department
▪ St. Mary's County Department of Social Services
▪ Three Oaks Homeless Shelter (Medical respite program)
▪ Health Share
▪ Calvert Healthcare Solutions (a Navigator Entity)</td></tr>
<tr><td>How were outcomes evaluated</td><td>Outcomes continue to be evaluated by tracking the impact of programs/services offered to the community.
- Number of new physicians
- Number of transportation services provided</td></tr>
<tr><td>Outcomes (Include process and impact measures)</td><td>Outcome measures include but are not limited to:

▪ Number of new physicians hired to work at MSMH in reporting year 6 new physicians in FY16.
▪ Transportation services provided in the Health Enterprise Zone (FY 2016):
Shuttle service
<table>
<tr><th>Quarter</th><th>Ridership</th><th>HEZ Residents</th><th>1 offs</th></tr>
<tr><td>Jul-Sept</td><td>1,836</td><td>1,413</td><td>29</td></tr>
<tr><td>Oct-Dec</td><td>2,664</td><td>2,210</td><td>4</td></tr>
<tr><td>Jan-Mar</td><td>1,693</td><td>1,340</td><td>6</td></tr>
<tr><td>Apr-Jun*</td><td>500</td><td>339</td><td>0</td></tr>
<tr><td>W.A.R.M</td><td>464</td><td>646</td><td>-</td></tr>
<tr><td>Totals</td><td>7,961</td><td>6,180</td><td>64</td></tr>
</table></td></tr>
</table>

<table>
<tr><td></td><td colspan="2">Specialty service
<table><tr><th>Quarter</th><th>Scheduled Rides</th><th>Cancel/No Show</th><th>Rides</th></tr><tr><td>Jul-Sept</td><td>147</td><td>23/5</td><td>119</td></tr><tr><td>Oct-Dec</td><td>60</td><td>3/1</td><td>57</td></tr><tr><td>Jan-Mar</td><td>306</td><td>26/31</td><td>249</td></tr><tr><td>Apr-Jun</td><td>167</td><td>32/1</td><td>134</td></tr><tr><td>Total</td><td>533</td><td>60/33</td><td>440</td></tr></table>
Beginning in fall of 2016, we will begin tracking utilization of Uber Central by patients who are identified as in need of transportation assistance.</td></tr>
<tr><td>Continuation of Initiative</td><td colspan="2">This initiative will progress into FY 2017.</td></tr>
<tr><td>A. Total Cost of initiative for current fiscal year
B. What amount is restricted grants/direct offsetting revenue</td><td>A. Total Cost of initiative for current fiscal year

$1,335,462.00</td><td>B. What amount is restricted grants/direct offsetting revenue

$722,000</td></tr>
</table>

Table III- Initiative II

Identified Need	Behavioral Health The 2015 Community Health Needs Assessment (CHNA) for MedStar St. Mary's Hospital (MSMH) outlines behavioral health-related services as an area of need coupled with improving behavioral health outcomes. Just as with physician and dental disparity, psychiatric services and/or providers are limited within the county. The CHNA for St. Mary's County outlines the following: ▪ St. Mary's County has a 906:1 patient-provider ratio compared to state level patient to provider data of 502:1 ▪ Only 75% of adults in St. Mary's County report "Good" mental health ▪ Increase in ED visits for behavioral health conditions jumped from 4,607/100,000 to 5,009/100,000 in 2013 ▪ Age-Adjusted suicide rate in the county is 12/100,00 compared to the state at 9/100,000 ▪ While below the state average, the county has a 476/100,000 Domestic Violence rate (based on those reporting DV incidences).
Hospital Initiative	Increase access to behavioral health related services and improve behavioral health outcomes
Primary Objectives	1) Recruitment of an outpatient psychiatrist to serve the residents of, or those seeking services within St. Mary's County. Description: Along with Primary Care and Dental providers, St. Mary's County has a shortage of Behavioral Health providers including but not limited to Psychiatric services. The Behavioral Health Patient to provider ratio for St. Mary's County is 906:1, nearly double the state patient provider ratio of 502:1. Metrics: MSMH has contracted with AxisHealth, Behavioral Health services program to provide psychiatric services. Through this agreement, a full time psychiatrist has begun to serve the residents of St. Mary's County. Additionally, Dr. Gill has recruited PAs to provide additional hours to those needing services. This has gone from a two-day per week operation to now a full, 40-hour per week service located in our Primary Care office located in the Greater Lexington Park Health Enterprise Zone. MSMH also regularly tracks resources of available services in the community that may be new or have added additional providers and/or group services to meet the need of the community. These resources are available to medical staff when creating a discharge plan.
Single or Multi-year initiative	This is an ongoing, multi-year initiative that will continue into FY 2017.
Key Partners in Development and/or Implementation	Community partners include but are not limited to: ▪ Behavioral Health Action Team (BHAT) ▪ Community-Based Behavioral Health Entities; ▪ Domestic Violence Coordinating Council;

<table>
<tr><td></td><td colspan="2">▪ St. Mary's County Core Services Agency;
▪ St. Mary's County Department of Social Services;
▪ St. Mary's County Health Department;
▪ Three Oaks Homeless Center</td></tr>
<tr><td>How were outcomes evaluated</td><td colspan="2">Outcomes were evaluated based on the increased number of service providers in the region.</td></tr>
<tr><td>Outcomes (Include process and impact measures)</td><td colspan="2">Outcome measures, specific to programs include but are not limited to:

▪ Number of behavioral health specialists hired/Contracted with MSMH; - FY 2016: Contract with Axis Health to provide Psychiatric services
▪ Increased access to behavioral health services in St. Mary's County; Interventionist added to Health Enterprise Zone (an employee of Walden Sierra Behavioral Health Services) in April 2016. She will conduct Home Visits and community events specific to the HEZ clientele. The Interventionist will conduct SBIRTS assessment to clients she encounters. Data will begin to be tracked starting in July 2017.
▪ Reduction of emergency department visits and readmissions related to behavioral health conditions

FY 2016 Quarter 3 data:
• 17,721 ED patients served:
• 195 Mental Health related encounters;
• 35 suicidal ideations
Future Quarter data will be made available at a later date

▪ ED Diversion program began in December 2015. Since its beginning, 17 patients with mental health needs were diverted to community based programs such as Anchor versus being admitted to the hospital for service that can be received in the community.</td></tr>
<tr><td>Continuation of Initiative</td><td colspan="2">This ongoing initiative will continue into 2017.</td></tr>
<tr><td>C. Total Cost of initiative for current fiscal year
D. What amount is restricted grants/direct offsetting revenue</td><td>A. Total Cost of initiative for current fiscal year
$478,665.00</td><td>B. What amount is restricted grants/direct offsetting revenue

$0</td></tr>
</table>

Table III – Initiative III

Identified Need	Chronic Disease The 2015 Community Health Needs Assessment (CHNA) for MedStar St. Mary's Hospital (MSMH) has identified Chronic Diseases as an area in need of improvement. Chronic Disease, for the purposes of this report, includes heart disease/stroke, diabetes, obesity and Alzheimer's. One of the major impacts of the physician shortage is the increase in patients coming to the emergency department for what could be addressed through their Primary Care Physician's office. The CHNA for St. Mary's County outlines the following specific to Chronic Disease: ▪ The rate of emergency department visits due to hypertension in St. Mary's County is 284/100,000 people, compared to the stated at 246/100,000 ▪ Prevalence of high blood pressure in St. Mary's County is at 30%, high cholesterol is at 41% ▪ The County's Medicare population has a higher prevalence of diabetes and chronic kidney disease as compared to the Medicare population at a national level ▪ Diabetes prevalence is noticeably higher among Hispanics (35%) and African American (15%) populations ▪ Obesity prevalence is St. Mary's County is highest among Hispanics (47%), followed by African Americans (39%) and Whites (32%) ▪ Alzheimer's is the 6th highest cause of death in St. Mary's County ▪ Hospitalization rates related to Alzheimer's disease and/or dementia is disproportionately higher for certain ethnic groups compared to the county average
Hospital Initiative	Improve population health outcomes for St. Mary's County through targeted chronic disease prevention and management programming.
Primary Objectives	1) Develop support groups and educational programming for Alzheimer's disease and dementia. Description: There are community-based Alzheimer Support groups in locations that are generally serving residents in a managed care environment (Assisted living, nursing homes, long-term care, etc.). These groups are part of the fee they pay to reside in these long-term care facilities/homes. As a result, there are limited Alzheimer's and/or dementia support groups serving "Non-residential" citizens in St. Mary's County. Metrics: MSMH began operation of a monthly support group focusing on Alzheimer's and memory impacting diseases. Guest speakers attend the class as well as offering the peer-to-peer support component. This support group is ongoing and will consider expanding times and locations in FY 2017. 2) Expand classes such as the National Diabetes Prevention Program (NDPP) and the Chronic Disease Self Management program (CDSMP). Description: These programs have been offered to work-place groups as well as

	on a quarterly basis at the hospital. Community screenings are offered through the Million Hearts ® initiative in our Primary Care office, located in the Health Enterprise Zone as well as through community-based wellness events. Once patients are identified they are welcome to attend these multi-week programs which will assist the patient in how to manage their chronic disease. Metrics: While workplace groups have not been as well attended as originally hoped, community-based programming is ongoing and regularly operates. Through the Million Hearts ® initiative, many clients are screened and referred for services specific to their identified chronic disease. Future groups in 2017 may be offered at alternate locations if registration requirements are met (programs like NDPP require a minimum number of registrants to maintain fidelity to the program). 3) Participate on the monthly Health Eating Active Living (HEAL) team of the Healthy St. Mary's Partnership. Description: Healthy Eating and Active Living are essential in the prevention and control of chronic diseases like diabetes, cancer, heart disease, and high blood pressure. These chronic diseases contribute to the leading causes of death nationally and here in St. Mary's County. By focusing on healthy eating and maintaining a physically active lifestyle, residents can help prevent these chronic diseases (and many other conditions) as well as the complications associated with them. When communities focus on strategies to support healthy eating and active living for their residents, they improve population health and minimize the financial burden associated with chronic diseases. Metrics: Monthly meetings are hosted at MSMH with multiple community partners. During the monthly meetings, agencies work to promote programs, create policies specific to wellness and healthy lifestyles, share ideas about "What works" in gaining community buy in and how to assist others in promotion of community initiatives.
Single or Multi-year initiative	This is a multi-year community-wide initiative that will continue into 2017
Key Partners in Development and/or Implementation	Community partners include but are not limited to: ▪ St. Mary's County Government ▪ St. Mary's County Recreation and Parks ▪ St. Mary's County Tennis Association ▪ Run Fit Kidz ▪ St. Mary's County Department of Aging and Human Services ▪ Million Hearts ▪ Healthiest Maryland Businesses ▪ Southern Maryland Agricultural Development Commission ▪ College of Southern Maryland ▪ More to Explore-St. Mary's County
How were outcomes evaluated	This outcome will be evaluated by tracking community participation, policy implementation and overall improvement in community wellness as collected in future surveys, assessments, and any other data collection outlets.
Outcomes (Include	Outcomes specific to programs include but are not limited to:

<table>
<tr><td>process and impact measures)</td><td colspan="2">▪ Expand Alzheimer's support groups to local community-based programs such as Assisted Living facilities, Nursing Homes, Senior centers, etc.
• FY 2016: Start up of Alzheimer's Support Group
• 6 meetings offered between January –June 2016
• Average attendance at meetings: 5 participants
▪ Increase attendance to Alzheimer's Support groups by 40% in 2017
• In the first 6 months of operation, average attendance was 5 people for this hospital-based group
▪ Reduce the number of hospital readmissions related to HEZ clients
• FY 2015: 28 HEZ readmissions
• FY 2016: 57 HEZ readmissions*</td></tr>
<tr><td>Continuation of Initiative</td><td colspan="2">This initiative will be ongoing through 2017.</td></tr>
<tr><td>E. Total Cost of initiative for current fiscal year
F. What amount is restricted grants/direct offsetting revenue</td><td>A. Total Cost of initiative for current fiscal year

$150,632.00</td><td>B. What amount is restricted grants/direct offsetting revenue

$16,267.00</td></tr>
</table>

**The increase in raw number of HEZ readmits is attributable to multiple factors however the overall HEZ readmission rate continues to trend below the risk adjusted hospital rate and the hospital continues to show decreases in the readmission rate based on comparison base years.*

Table III – Initiative IV

Identified Need	Substance Abuse The 2015 Community Health Needs Assessment (CHNA) for MedStar St. Mary's Hospital (MSMH) has identified Substance Abuse as an area of concern for residents of the county. For the purposes of this Assessment, "Substance Abuse" will also include Alcohol, Tobacco and Opioid abuse. The CHNA identifies the following areas specific to Substance Abuse as areas of need: ▪ Percentage of adult smokers in St. Mary's county is at 20.9% ▪ Binge drinking is highest amongst adults under the age of 45 (34%) and males (27%) ▪ 24% of adults in the county report binge drinking within 30 days of this survey, compared to 17% of adults at a statewide level ▪ Addiction-related visits to the emergency department exceeded the statewide average as well as the goal set by the local health department.
Hospital Initiative	While MedStar St. Mary's Hospital is approaching each of the substance abuse subcategories differently, the overarching initiative is to reduce tobacco use, alcohol abuse and drug overdoses in St. Mary's County.
Primary Objectives	1) Decrease number of youth who report alcohol use 2) Decrease number of youth and young adults who report binge drinking Description: MedStar St. Mary's Hospital staff chair the Community Alcohol Coalition (CAC) for St. Mary's County. Through community outreach efforts, the CAC creates and disperses mass mailings of postcards, billboards, social media postings, and newspaper ads supporting the "Don't be that guy!", "Don't be a party to underage drinking" and the "Can you afford it?" messages. Metrics: MSMH partners with several community organizations to promote the above listed messages not only through their agencies but on a community-wide effort. The CAC advertises via numerous media outlets. Through this initiative, adults of legal purchasing age are reminded of the costs associated with supplying alcohol to underage persons. Additionally, through the partnership with the Alcohol Beverage Board and the St. Mary's County Licensed Beverage Association, the CAC offers incentives to establishments that strictly enforcing carding of all patrons. Metrics: Several types of media to promote the message around binge drinking can be found throughout the county in various formats. Through a Facebook Page, Snapchat activities, Twitter postings, along with newspaper advertisements, and billboards that are seen as you enter and exit the northern boundary of the county share the message of the type of consumer one should not be. These messages are intended to shed light on the binge drinking, even among adults.

	These advertisements reflect irresponsible persons who are passed out, have been colored on, or present as "foolish" based on their intoxication. 3) Decrease unauthorized use of prescription medications throughout the county Description: Through the work done with the Maryland Strategic Prevention Framework process for Overdose Prevention (MSPF), MSMH will partner on various community outreach efforts that will address unlawful use of prescription drugs. Events include medication take back events that are hosted in partnership with local law enforcement and social service-based agencies within the county. Metrics: By increasing the level of education to the community on proper medication use, storage and disposal methods, to local prescribers on proper prescribing techniques as well as the utilization of the Prescription Drug Monitoring Program (PDMP) we, as a community, will see a decrease in the amount of patients entering to the emergency department for drug overdose/ improper use of prescription medications. Within one year of program implementation we expect an: ▪ Increase from 24.9% to 35% in the perception of respondents who have seen information about the dangers of prescription opioids at their doctors' offices; ▪ Increase the number of CDS eligible prescribers registered with PDMP from 64 to 70; ▪ Increase the number of PDMP-enrolled CDS prescribers who use the system during a six-month period from 51.5% to 55%; ▪ Increase education and awareness of safe storage methods for prescription opioids from 34.7% to 39.7%; ▪ Increase education and awareness of proper disposal methods for prescription opioids from 52.6% to 56.6% 4) Increase the number of staff who are trained in the Fax to Assist enrollment process Description: MSMH staff, specifically respiratory, have been trained in making a referral to the Maryland Quit line/Fax to Assist in an effort to encourage patients to quit their tobacco usage whether it is cigarettes or chewing tobacco. Metrics: The amount of staff trained at the hospital will increase. Additionally, as the program moves to an electronic referral process that is seemingly more streamlined, staff will be educated on how to initiate this process for the benefit of the patient.
Single or Multi-year initiative	Alcohol: Multi Year Initiative Renewed in 2015 for five years; Tobacco: Multi-Year Initiative- Offers continued support to community and

	community stakeholders; Opioid Crisis: Multi-Year Initiative which began in January of 2016 (anticipated 2016-2019)
Key Partners in Development and/or Implementation	Partners include but are not limited to the following, based on subcategory: **Alcohol** ▪ St. Mary's County Department of Social Services ▪ St. Mary's County Health Department ▪ College of Southern Maryland ▪ Community Members (Parents and Youth) ▪ Minority Outreach Coalition ▪ NAS PAX River ▪ Southern Maryland News Net ▪ St. Mary's County Sheriff's Office ▪ St. Mary's County Alcohol Beverage Board ▪ St. Mary's County Department Government ▪ St. Mary's County License Beverage Association ▪ St. Mary's County Public Schools ▪ St. Mary's County Treatment and Prevention Office ▪ Walden Behavioral Health, Inc. **Tobacco:** ▪ St. Mary's County Department of Social Services ▪ St. Mary's County Health Department ▪ St. Mary's County Sheriff's Office ▪ St. Mary's County Department of Aging and Human Services ▪ St. Mary's County Public Schools ▪ St. Mary's County Treatment and Prevention Office **Opioid Crisis:** ▪ St. Mary's County Department of Social Services ▪ St. Mary's County Health Department ▪ St. Mary's County Public Schools ▪ National Alliance on Mental Illness (NAMI) ▪ On Our Own St. Mary's ▪ Parents Affected By Addiction ▪ Pathway's Inc. ▪ Private Therapists ▪ St. Mary's County Sheriff's Office ▪ St. Mary's County Government ▪ St. Mary's County Drug Court ▪ St. Mary's County Treatment and Prevention Office ▪ St. Mary's Department of Juvenile Services ▪ Walden Inc.
How were outcomes evaluated	For alcohol reduction efforts the following surveys are utilized for tracking alcohol consumption: ▪ Youth Risk Behavior Survey (YRBS)

	▪ National Survey on Drug Use and Health (NSDUH) ▪ Maryland Young Adult Survey on Alcohol (MYSA) For tobacco reduction: ▪ Youth Risk Behavior Survey (YRBS) ▪ Tobacco Survey ▪ # of referrals to Fax-To-Assist Line For substance use: ▪ Youth Risk Behavior Survey (YRBS) ▪ National Survey on Drug Use and Health (NSDUH) ▪ Maryland Public Opinion Survey on Opioids
Outcomes (Include process and impact measures)	Outcomes specific to programs include but are not limited to: ▪ There is a reported 20.9% Smoking Prevalence among adults in St. Mary's County; Among youth, 15.6% of St. Mary's County youth smoked in the past 30 days of the survey time period, compared to the state level of 8.7%. Efforts to utilize the Fax To Assist programming are ongoing. The fax to assist program has recently transitioned to an online format that no longer requires a staff member to be trained on the program, they simply can assist with the online referral. Due these circumstances the outcome of increasing staff was not necessary for the program to continue. An online link along with additional information about smoking cessation courses are shared with consumers that are interested in receiving assistance in their efforts to quit their tobacco habit. Additionally every patient discharged from MedStar St. Mary's Hospital that has disclosed their tobacco usage habits to clinical staff are receives education about the program in their discharge paperwork. If the patients consent to work with community-based care coordinators, the referral follow up can be tracked. If not, there is no way to track beyond those receiving information whether they are engaging in services. ▪ Continue Community Alcohol Coalition activities for public policy advocacy and social awareness of underage and binge drinking measurable outcomes cannot be determined at this time due to insufficient data. The Youth Risk Behavior Survey (YRBS) is compiled every 3 years. As a result, the current data available speaks to 2014 youth between the ages of 13-18. According to the 2014 YRBS, 31.9% of St. Mary's County consumed alcohol within 30 days of the survey completion compared to the state level at 26.1%. Binge drinking amongst adults younger than 45 is at 34% in St. Mary's County. The data below exhibits the efforts the Community Alcohol Coalition has made to encourage a decrease of use in youth and young adults that report underage or binge drinking. Coalition Activities have continued 1,268,964 Billboard Impressions 115,856 Bus Wrap Impressions 15 Outreach events Community Events (Health Fairs and County Fair etc.)

<table>
<tr><td></td><td colspan="2">Responsible Alcohol Service Training’s

12 Coalition Meetings
36 Partnership Meetings

- Attend Monthly Alcohol Beverage Board Meetings (on agenda)
- Attend Monthly License Beverage Association Meetings (on agenda)
- Attend Monthly Behavioral Health Action Team Meetings

11,899 *Total Facebook Reach (7.55% increases in FY15 impressions of organic non-paid ads)

▪ Lead the Maryland Strategic Prevention Framework process for overdoes prevention
▪ Participated in the monthly Tobacco Free Living Action Team of the Healthy St. Mary’s Partnership (12 meetings attended by Health Connections Staff)
▪ Participated in Drug Take-Back events hosted in partnership with local law enforcement agencies:

929,033 Pills Collected 60% increase from FY15
669 controlled patches
148 controlled liquids
20 Scheduled Take back events</td></tr>
<tr><td>Continuation of Initiative</td><td colspan="2">Initiatives focusing on alcohol (binge and underage drinking), Tobacco use and drug abuse (prescribed and illicit) will continue into 2017.</td></tr>
<tr><td>G. Total Cost of initiative for current fiscal year
H. What amount is restricted grants/direct offsetting revenue</td><td>A. Total Cost of initiative for current fiscal year
Quit Kits $1000.00
Staff Training - $500.00
Support staff - $14,560</td><td>B. What amount is restricted grants/direct offsetting revenue:</td></tr>
</table>

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.

Issue	Evidence	Evidence	Lead
Affordable housing	Only 40% of units are sold affordable on median teacher salary, compared to the state average of 53% (MDP 2013, Maryland SHIP report). 49% of survey respondents cite affordable housing as a need in our community (MedStar St. Mary's Hospital Community Health Needs Assessment, 2015).	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.	Housing Authority, County Government, Planning and Zoning
Better jobs	36% of survey respondents cited better jobs as a need in our community (MedStar St. Mary's Hospital Community Health Needs Assessment, 2015).		County Government, Economic Development, Private Sector
Affordable child care	33% of survey respondents cited affordable childcare as a need in our community (MedStar St. Mary's Hospital Community Health Needs Assessment, 2015).		County Government

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)

   The 39 indicators on the SHIP are used during the CHNA process and are tracked and analyzed when updated. They form the basis of the work of our LHIC and are used as a basis for deciding appropriate partnerships and grant opportunities for the hospital.http://public.tableau.com/shared/CT3GJWZDB?:display_count=yes

   MARYLAND STATE HEALTH IMPROVEMENT PROCESS (SHIP)
   http://dhmh.maryland.gov/ship/SitePages/Home.aspx
   COMMUNITY HEALTH RESOURCES COMMISSION http://dhmh.maryland.gov/mchrc/sitepages/home.aspx

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.

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**
Emergency and Trauma Services	The hospital contracts with individual physicians and physician groups to ensure the needs of the uninsured/underserved populations are met by providing subsidies for the coverage of emergency department calls. Including on-call specialists for the Emergency Department for certain surgical specialties. If these specialties were not available the patient would have to go to be admitted to another facility.
Other (Hospitalist)	Hospitalists provide most hospital care due to physician shortage except for select practices.
Hospital Outpatient Services	Accessibility to Primary Care services is crucial to the health and wellness of the population. In order to promote healthy lifestyles and a focus on awareness of one's health. The PCC provides these services to many patients who utilize public transportation to obtain health services by being located on MSMH's campus. The lack of Primary Care in our service area would lead to a decrease in health and life quality in the community which would eventually translate to increased hospital utilization.
Women's and Children's Services	Many areas in the MSMH service area include underinsured or uninsured patients. With the hospital being the only health network in the area, it is crucial for MSMH to maintain the services provided for women in the community.
Behavioral Health	The hospital absorbs the cost of providing psychiatric and behavioral health supervision for

	the Emergency Department on a 24/7 basis. If these services were not provided, patients would be transported to another facility offering this service.

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).

VIII. APPENDICES

Appendix I

Financial Assistance Policy

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

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

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

Appendix II
Financial Assistance Policy Changes

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

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

Appendix III
Financial Assistance Policy

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

Policy

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

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

Scope

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

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

Definitions

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

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

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

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

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

Responsibilities

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

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

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

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

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

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

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

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

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

4. **ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.6 Medical Hardship Reduced-Care Sliding Scale Levels:

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

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

6.1 Patients may obtain an application for Financial Assistance Application:

6.1.1 On Hospital websites

6.1.2 From Hospital Patient Financial Counselor Advocates

6.1.3 By calling Patient Financial Services Customer Service

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

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

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

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

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

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

7. PRESUMPTIVE ELIGIBILTY

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

7.1.1 Maryland Primary Adult Care Program (PAC)

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

8 MEDSTAR HEALTH FINANCIAL ASSISTANCE APPEALS

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

9. PAYMENT PLANS

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

10 BAD DEBT RECONSIDERATIONS AND REFUNDS

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

Exceptions

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

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

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

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

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

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

Explanation And Details/Examples
N/A

Requirements And Guidelines For Implementing The Policy
N/A

Related Policies
N/A

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

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

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

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

Appendix IV

Patient Information Sheet

Patient Information Sheet

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

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

PATIENTS' RIGHTS

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

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

If you do not qualify for Medical Assistance, or financial assistance, you may be eligible for an extended payment plan for your hospital medical bills.

If you believe you have been wrongfully referred to a collection agency, you have the right to contact the hospital to request assistance. (See contact information below).

PATIENTS' OBLIGATIONS

MedStar St. Mary's Hospital believes that its patients have personal responsibilities related to the financial aspects of their healthcare needs. Our patients are expected to:

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

Contacts

Call 301-475-6039 with questions concerning:

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

FOR INFORMATION ABOUT MARYLAND MEDICAL ASSISTANCE

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

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

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

The patient information sheet is also available in Spanish.

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

Mission

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

Vision

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

Values

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

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