HSCRC Community Benefit Reporting Narrative

I. General Hospital Demographics and Characteristics:

1. Table I: Primary Service Area Description:

a. Bed Designation:	b. Inpatient Admissions:	c. Primary Service Area Zip Codes:	d. All other Maryland Hospitals Sharing Primary Service Area:	e. Percentage of Uninsured Patients, by County:	f. Percentage of the Hospital's Patients who are Medicaid Recipients:	g. Percentage of the Hospital's Patients who are Medicare beneficiaries:
115	7610 (Includes Adult and Newborn admissions)	20602 20646 20603 20601 20640 20695	Medstar Southern Maryland Hospital Center (20602)	Charles County: 6.1%	22.5%	41.9%

1.)US Census Bureau, 2010 – 2014 American Community Survey 5-year Estimates
2.) Fiscal Year 2016 Maryland Medicaid e-Health Statistics
3.) Patient Care Analyst CRMC Inpatient Discharge Data

2. Describe the community the hospital serves:

a. Description of Community Benefit Service Area:

The Community Benefit Service Area for the University Of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the six zip codes identified above as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county.

<u>Geography</u>

Charles County is located 23 miles south of Washington, D.C. It is one of five Maryland counties, which are part of the Washington, DC-MD-VA metropolitan area. At 458 square miles, Charles County is the eighth largest of Maryland's twenty-four counties and accounts for about 5 percent of Maryland's total landmass. The northern part of the county is the "development district" where commercial, residential, and business growth is focused. The major communities of Charles County are La Plata (the county seat), Port Tobacco, Indian Head, and St Charles, and the main commercial cluster of Hughesville-Waldorf-White Plains. Approximately 60 percent of the county's residents live in the greater Waldorf-La Plata area. By contrast, the southern (Cobb Neck area) and western

(Nanjemoy, Indian Head, Marbury) areas of the region still remain very rural with smaller populations.

Population

Charles County has experienced rapid growth since 1970, expanding its population from 47,678 in 1970 to 120,546 in the 2000 census and 146,551 in the 2010 census. The current 2016 Census Bureau estimates the population at 156,118 for a 6.1% increase in four years. The magnitude of growth can be seen in the changes in population density. The 1990 census showed that there were 219.4 individuals per square mile, which increased to 261.5 individuals per square mile by 2000, an increase of 19.2%, and to 320.2 individuals per square mile by 2010, an increase of 22.5%.

Transportation

The percent change in the population growth for Charles County has been slightly greater than the change seen in the Maryland population growth. This growth has created transportation issues for the County, in particular for the "development district" in the northern part of the county where many residents commute to Washington D.C. to work. The average work commute time for a Charles County resident is 42.8 minutes which is higher than the Maryland average of 32.0 minutes. Public transportation consists of commuter buses for out-of-county travel and the county-run Van Go bus service for in-county transportation.

Diversity

As the population of the county changes, the diversity of the county also increases. The African American population has experienced the greatest increase. In 2000, African Americans made up 26% of the total Charles County population; by 2014, they comprise 43.8% of the total county population. As of 2014, minorities comprise roughly 54% of the Charles County population. The Hispanic community has also seen increases over the past few years. They now comprise 5.3% of the total county population. This is the one of the highest percentages among the 24 Maryland jurisdictions. Charles County also has one of the largest American Indian/Native American populations in the state of Maryland at 0.8% of the total county population.

The 2015 Charles County gender breakdown is approximately 50/50. Males make up 48.3% of the population, and females make up 51.7% of the county population.

Economy

Employment and economic indicators for the county are fairly strong. The 2010-2014 US Census American Community Survey estimates that 70.4% of the Charles County population is currently in the labor work force. The 2010-2014 5-year estimate for Charles County found that approximately 7.6% of Charles County individuals are living below the poverty level; however, this is lower than the Maryland rate of 10.0%. The Charles County median household income was $91,910, well above the Maryland median household income of $74,149.The diversity of the county is also represented in the business community with 46% of all Charles County businesses being minority-owned firms. This is higher than the State of Maryland at 38%.

Education

Charles County has a larger percentage of high school graduates than Maryland (91.6% vs. 89.0%); however, Charles County has a smaller percentage than Maryland of individuals with a bachelor's degree or higher (26.8% vs. 37.3%).

Housing

There is a high level of home ownership in Charles County (77.9%); however, this is slightly down from the 2010 level (81.8%). The median value of a housing unit in Charles County is similar to the Maryland average ($287,000 vs. $287,500). Home values across Maryland have decreased and Charles County showed a similar downward trend. The average household size in Charles County is 2.86 persons.

Source: 2010-2014 US Census Bureau's American Community Survey 5 year estimates

Life Expectancy

The life expectancy for a Charles County resident, as calculated for 2014, was 79.1 years. This is slightly below the state average life expectancy of 79.8 years.

Source: 2014 Maryland Vital Statistics Report

Births

There were 1,844 births in Charles County in 2015. Charles County represents 44% of the births in Southern Maryland and 2.5% of the total births in Maryland for 2015.

Minorities made up just over half of the babies born in Charles County in 2015 (52%) which is in line with the composition of the county.

Source: 2015 Maryland Preliminary Vital Statistics Report

Health Disparities

Health topics where health disparities are seen for the minority population in Charles County:

Health Topic	Indicator	Rate	Source
Heart Disease Prevalence and Mortality	Rate of ED visits for hypertension per 100,000 population Age-adjusted heart disease mortality rate	White: 109.0 Black: 349.2 White: 173.4 Black: 167.9	Maryland SHIP (Prevalence: HSCRC 2014 and Mortality: 2012-2014 Maryland Vital Statistics Report)
Colon and Rectal Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 36.3 Black: 29.1 White: 13.9 Black: 27.0	2015 Cigarette Restitution Fund Program Cancer Report (2008-2012 rates)
Breast Cancer Incidence	Incidence Rates per 100,000	White: 104.1 Black: 131.6	2015 Cigarette Restitution Fund Program Cancer Report (2008-2012

			rates)
Prostate Cancer Incidence Mortality	Incidence Rates per 100,000 Mortality Rates per 100,000	White: 110.0 Black: 206.7 White: 14.7 Black: 62.1	2015 Cigarette Restitution Fund Program Cancer Report (2008-2012 rates)
Diabetes Prevalence	Unadjusted Diabetes ED Visit Rates by Black or White Race	White: 71.5 Black: 201.9	Maryland 2014 HSCRC per SHIP site
Obesity	Unadjusted % Adults at Healthy Weight	Overall: 30.6 White: 34.1 Black: 25.5	Maryland 2014 BRFSS per SHIP site
STD	Rate of Chlamydia infection for all ages per 100,000 (all ages)	Overall: 462.3 Data not available by race and ethnicity	Maryland STD Prevention Program Level data 2015
Asthma	Rate of ED visits for asthma per 10,000	White-21.4 Black-62.5	HSCRC 2014 Per SHIP Site
Infant Mortality	Infant Mortality Rate per 1,000 births	County Overall: 4.9 White/Not Hispanic: Rate not calculated due to less than 5 deaths Black-8.1	2015 Maryland Infant Mortality Report, Vital Statistics Admin.

1. Fiscal Year 2016 Maryland Medicaid Enrollment by County. Maryland Department of Health and Mental Hygiene and the Hilltop Institute. Available at http://www.chpdm-ehealth.org/index.htm.

2. 2015 Charles County Current Population Survey Data. United States Census Bureau. Available at: www.census.gov.

2. 2014 Maryland Vital Statistics Report and 2015 Maryland Preliminary Vital Statistics Report. Charles County Demographic and Population Data.Maryland Department of Health and Mental Hygiene.Available at www.vsa.maryland.gov.

3. 2010-2014 US Census Bureau, American Community Survey 5 year estimates, Charles County and Maryland. Available at www.census.gov.

4. Maryland State Health Improvement Process Measures. Accessed on October 2016. Available at: http://www.dhmh.maryland.gov/ship/SitePages/Home.aspx.

5. 2015 Maryland Cigarette Restitution Fund Program's Cancer Report. Maryland Department of Health and Mental Hygiene. Available at: http://phpa.dhmh.maryland.gov/cancer/SiteAssets/Pages/surv_data-reports/2015%20CRF%20Cancer%20Report_Final%20(5.2.2016)-updt.pdf.

6. 2015 Chlamydia Infection Rates by Race. Maryland Department of Health and Mental Hygiene.Center for Sexually Transmitted Infection Prevention.

7. 2015 Maryland Infant Mortality Report. Maryland Vital Statistics Administration. Available at: http://www.dhmh.maryland.gov/vsa/AnalyticsReports/2015.pdf.

Table II: Service Area Demographic Characteristics and Social Determinants:

Demographic Characteristic	Description	Source
Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside.	The Community Benefit Service Area for the University of Maryland Charles Regional Medical Center is all 28 zip codes located within the borders of Charles County. This includes the six zip codes identified as the Primary Service Area. The University of Maryland Charles Regional Medical Center is Charles County's only hospital and, as such, serves the residents of the entire county. The zip codes of Waldorf (20601, 20602, 20603), White Plains (20695), and Indian Head (20640) represent the geographic areas where the most vulnerable populations reside in Charles County. The lowest average life expectancy is found in 20640, Indian Head, at 74.7 years. The highest Medicaid enrollment rate was in 20602, Waldorf. The highest percentage of low birth weight babies was in 20695, White Plains. The highest WIC participation rate was in 20602, Waldorf. The WIC participation rate was also high in Indian Head, 20640. The 2006-2011 All-cause mortality for Indian Head was 942.6 per 100,000, above the Maryland state rate. The 2006-2010 heart disease mortality for Indian Head was 232.3, also above the Maryland state rate.	2016 Charles County CHNA 2006-2010 Maryland Vital Statistics 2007-2011 MD Medicaid Program 2006-2010 Maryland Vital Statistics2007-2011 MD WIC Program 2006-2011 Maryland Vital Statistics 2006-2010 Maryland Vital Statistics
Median Household Income within the CBSA	$91,910	2010-2014 US Census *American Community Survey 5 year estimate*
Percentage of households with incomes below the federal poverty guidelines within the CBSA	5.3%	2010-2014 US Census American Community Survey 5 year estimate

For counties within the CBSA, what is the percentage of uninsured for each county? This information may be available using the following links: http://census.gov/hhes/www/hlthins/data/acs/aff.html http://planning.maryland.gov/msdc/American_Community_Survey/2009ACS.shtml	6.1%	2010-2014 American Community Survey 5-Year Estimate
Percentage of Medicaid recipients by County within the CBSA.	15.7%	Fiscal Year 2016 Maryland Medicaid e-Health Statistics: Medicaid Enrollment Rates
Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).	The life expectancy from birth for a Charles County resident as calculated for 2012-2014 was 79.1 years. This is slightly below the state average life expectancy of 79.6 years. White: 79.1 Black: 79.0	2014 Maryland Vital Statistics Report. Charles County Demographic and Population Data. Maryland DHMH
Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).	Age adjusted all-cause death rate for Charles County for 2014 is 623.0 per 100,000 population. White: 809.9 Black: 446.7 Asian/PI: 394.8 Hispanic: 110.0	2014 Charles Co. Death data, 2014 Maryland VSA Report
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)	**Access to healthy food**: • 3 Census tracts with low income and low access to food: 2 in Indian Head and 1 in Waldorf (Both primary service area zip codes) **Transportation:** • Mean travel time to work: 42.8 min **Environmental Factors:** • # of days Air Quality Index exceeds 100: 1.7 • % of children tested who have blood lead levels ≥ 10 mg/dl: 0.20% (2013)(Goal: .177) **Housing:** • Home ownership: 77.9% • Renter occupied housing: 22.1% • Affordable housing: the % of houses sold that are affordable on a median teacher's salary:	USDA 2016, Food Access Research Maps 2010-2014 US Census ACS Maryland SHIP 2010-2014 US Census Data, *American Community Survey* 5 year estimates 2014 Maryland SHIP

	34.4%
	
	Access to Care:
	
	• 70% of Charles County residents travel outside of the county for medical care at some point.
	• % Mothers who received prenatal care 1st trimester ; 67%
	  ○ White/NH: 70.0%
	  ○ Black: 63%
	  ○ Hispanic: 48%
	• Infant Mortality Rate: 5.8 per 1000 live births
	  ○ White/NH: Not calculated due to small case count
	  ○ Black: 8.6
	• Number of federally designated medically underserved areas in Charles County: 6
	  ○ Brandywine
	  ○ Allens Fresh
	  ○ Thompkinsville
	  ○ Hughesville
	  ○ Marbury
	  ○ Nanjemoy
	• Number of physician shortage specialties in Southern Maryland: 28
	
	Physician-to-population ratios in Southern Maryland below the HRSA benchmark for all types of physician
	
	Education:
	
	• 91.6% persons 25+ high school graduates
	• 26.8% persons 25+ bachelor's degree or higher
		2015 Charles County Health Needs Assessment
		
		2014 Maryland SHIP;
		
		2014 Maryland Infant Mortality Report
		
		2014 HPSA Designation
		
		2007 Maryland Physician Workforce Study
		
		2011 MD Workforce Study Health Resources and Services
		
		2010-2014 US Census Bureau's American Community Survey 5 year estimates

Available detail on race, ethnicity, and language within CBSA	**Population**: 156,118 **Sex**: • Female 51.7% • Male: 48.3% **Race and Ethnicity:** • White 47.0% • Black 44.9% • American Indian and Alaska native 0.7%	2010-2014 US Census , *American Community Survey* 5 year estimate

	• Asian alone 3.4% • Native Hawaiian and Other Pacific Islanders 0.1% • Person reporting 2 or more races 3.8% • Hispanic or Latino 5.5% • White not Hispanic 43.2% **Age:** • Persons under 5 years 6.0% • Persons under 18 years 24.5% • Persons 65 years and over 11.5% **Language:** • Language other than English spoken at home: 7.2%	

II. Community Health Needs Assessment (CHNA)

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. 06/30/15

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

   Charles County 2015 CHNA:
   http://www.charlesregional.org/siteassets/pdfs/healthresource/FB42566B-2590-02BA-ECF1AE7380273032.pdf

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

   _ X_Yes Enter date approved by governing body here: 05/26/2015

   ___No

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

   Charles County FY 16-18 Health Improvement Plan:
   http://www.charlesregional.org/siteassets/pdfs/healthImprovementPlanFY2016-2018.pdf

   Charles County FY 16-18 Health Improvement Action Plans:
   http://www.charlesregional.org/health-resources/health-action-plan.cfm?id=2

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?**

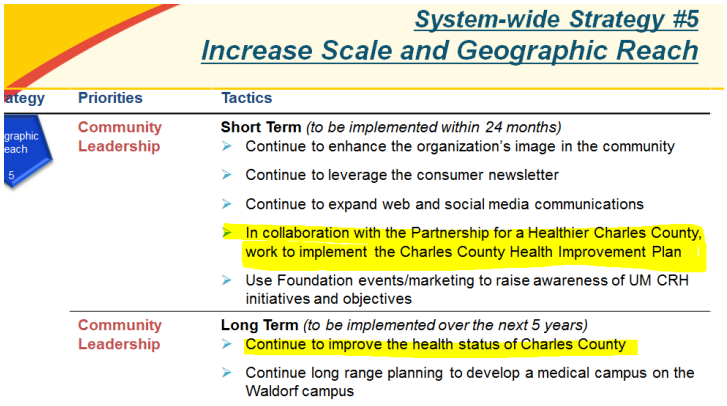
   a. Are Community Benefits planning and investments part of your hospital's internal strategic plan?

   __x_Yes

   ____No

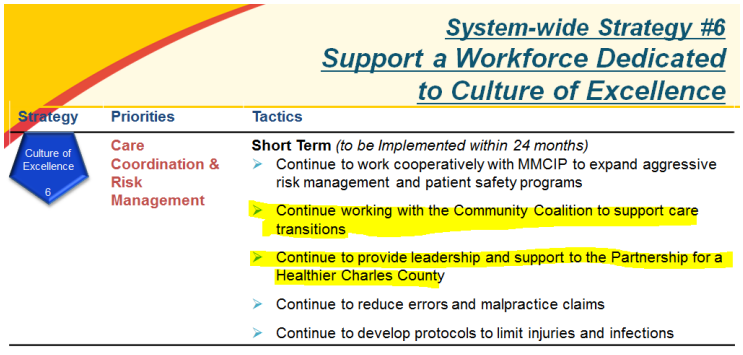
   If yes, please provide a description of how the CB planning fits into the hospital's strategic plan, and provide the section of the strategic plan that applies to CB.

   The Needs Assessment and Health Improvement Plan are included in the overall UM CRMC Strategic Plan which is approved by the Board and directed by Executive Management (Senior Leadership) and implemented by the Community Benefit operations staff through the LHIC.



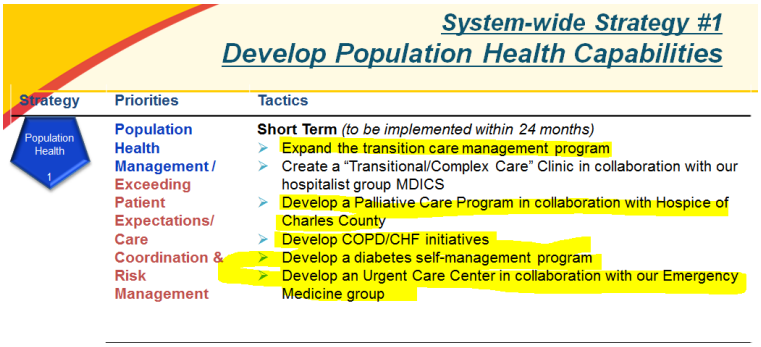
System-wide Strategy #5
Increase Scale and Geographic Reach

ategy	Priorities	Tactics
graphic each 5	Community Leadership	**Short Term** *(to be implemented within 24 months)* ➢ Continue to enhance the organization's image in the community ➢ Continue to leverage the consumer newsletter ➢ Continue to expand web and social media communications ➢ In collaboration with the Partnership for a Healthier Charles County, work to implement the Charles County Health Improvement Plan ➢ Use Foundation events/marketing to raise awareness of UM CRH initiatives and objectives
	Community Leadership	**Long Term** *(to be implemented over the next 5 years)* ➢ Continue to improve the health status of Charles County ➢ Continue long range planning to develop a medical campus on the Waldorf campus



System-wide Strategy #6
Support a Workforce Dedicated to Culture of Excellence

Strategy	Priorities	Tactics
Culture of Excellence 6	Care Coordination & Risk Management	**Short Term** *(to be Implemented within 24 months)* ➢ Continue to work cooperatively with MMCIP to expand aggressive risk management and patient safety programs ➢ Continue working with the Community Coalition to support care transitions ➢ Continue to provide leadership and support to the Partnership for a Healthier Charles County ➢ Continue to reduce errors and malpractice claims ➢ Continue to develop protocols to limit injuries and infections



Source: UM CRMC Three-year Strategic Plan Document

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: Presents plan to Board of Directors; Ensures plan is included in the overall CRMC Strategic Plan
2. _X__CFO: Participates as a member of the Community Benefit Operations Team; Presents Community Benefit Report to Finance Committee of the Board; Identifies Finance Staff to report financial data; Internally audits report; Oversees Population Health Department
3. _X_ Other (please specify)Board of Directors (Governance), Executive Management Group (Resources and direction)

Describe the role of Senior Leadership:

*The UM CRMC Executive Management Group (EMG) consists of the CEO, CFO, CNO, CMO, VP of Planning, VP of Ancillary Services, VP of Human Resources, Site Director for IT, Director for Community Development and Planning and the Foundation Executive Director. This group develops the community benefit strategic plan as part of the annual Strategic Plan planning process. Once the Board has approved the plan, EMG ensures adequate human and capital resources are dedicated to the implementation of the plan. Plan progress and outcomes are reported to EMG. This senior leadership group includes oversight of all clinical and non-clinical areas such as Nursing, Medical Staff, Case Management, Population Health and Ancillary Services. Clinical Leadership ensures participation and resources for data analysis and plan implementation.

ii. Clinical Leadership

1. _x_ Physician Chief Medical Officer
2. _x_ Nurse Chief Nursing Officer
3. _x_ Social Worker CFO (Oversees Case Management)
4. ___Other (please specify)

Describe the role of Clinical Leadership
*(See description of Senior Leadership Role above which includes Clinical Leadership)

iii. Population Health Leadership and Staff

1. _x__ Population Health VP or Equivalent (please list)
   Manager, Population Health Department
2. _x__ Other Population health staff (please list)
   a. Diabetes Educator
   b. Palliative Care Practitioner
   c. Palliative Care Chaplain
   d. Transition Nurse Navigators
   e. Applications Systems Analyst
   f. Community Medicare Nurse Navigator
   g. Population Health Social Worker

Describe the role of Population Health leaders and staff in the community benefit process.

The Population Health (PH) Staff works closely with the Community Benefit Staff and participates in community benefit programs and initiatives such as:

- Participate in the CHNA, health needs prioritization and initiative planning and implementation processes
- PH Manager serves as co-chair of the LHIC Access to Care Subcommittee
- PH staff serve as members of the LHIC subcommittees (i.e., Chronic Disease, Behavioral Health)
- Offer community education and outreach programs on community health improvement initiatives
- Reviews data with CB staff on outcomes of initiatives

iv. Community Benefit Operations

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

1. _x__Individual (please specify FTE) 1.5 Director, Specialist
2. _ x_Committee (please list members)
   Community Benefits Operations Team
   CFO, Erik Boas: Oversees all HSCRC and 990 Reporting; internally audits Community Benefit reports; Allocates resources for CB operations

   Director, Community Development and Planning, Joyce Riggs: Administers CB reporting operations including plan

implementation, collaborates with strategic community partners; Oversees data collection and reporting; provides management for LHIC; Compiles reports

Decision Support Analysts (2) Jermaine Page, Natalie Thomas: Inputs financial data into CB data collection tool for reporting; assists with internal auditing

Revenue Integrity Analyst, Ruth Case: Inputs salary data into CB data collection tool.

Community Outreach Specialist, Amy Zimmerman: Implements community benefit qualifying activities and community outreach programs; Trains departmental CB reporters and manages data collection tool

Epidemiologist, Amber Starn, MPH: Provides data and reporting for CB planning; Monitors and reports outcomes of CB Strategic Plan, Reports SHIP data to CCDOH

3. _X__Department (please list staff)

Community Benefit Reporters: Reporters from each department in the hospital who enter community benefit qualifying occurrences

4. _X__Task Force (please list members)

Local Health Improvement Steering Committee

- Joyce Riggs, UM CRMC
- Amber Starn, Epidemiologist
- Jenn Conte, CC Public Schools
- Linda Smith, College of Southern Maryland
- Local Health Improvement Coalition Subcommittee Chairs
  - Behavioral Health Team: Karen Black, Director, Core Services Agency
  - Access to Care Team: Chrissie Mulcahey, Dir., Health Partners Clinic, Mary Hannah, Manager, Population Health Dept.
  - Chronic Disease Management and Prevention Team: Amy Zimmerman, UM CRMC Community Outreach and Linda Thomas, Dir., Disability Services, CC Dept of Health

5. ___Other (please describe)

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 CFO reviews the report (narrative and spreadsheet) and presents the final report to the Finance Committee of the Board of Directors for approval.

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

The Finance Committee of the Board conducts the review and approval of the report and a summary of key points are presented to the full Board.

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
Charles County Dept. of Health	Dianna Abney, MD	Charles County Health Officer	Executive Committee of LHIC
Charles County Public Schools	Dr. Kim Hill	Superintendent, Charles County Public Schools	Executive Committee of LHIC
College of Southern Maryland	Dr. Brad Gottfried	President	Executive Committee of LHIC
Charles County Dept. of Health	William Leebel	Public Information Officer	Steering Committee of LHIC
Charles County Public Schools	Jennifer Conte	Coordinator of Student Intervention Programs	Steering Committee of LHIC, Co-Chair, Behavioral Health Subcommittee
College of Southern Maryland	Linda Smith	Project Coordinator, Safe Communities	Steering Committee of LHIC
Health Partners Clinic	Chrissie Mulcahey	Director	Chair, Access to Care Subcommittee
Charles County Dept. of Health	Mary Beth Klick	Tobacco Prevention Coordinator	Co-Chair, Chronic Disease Prevention and Management Subcommittee
Charles County Core Services	Karyn Black	Director	Co-Chair, Behavioral Health Subcommittee
Charles County Dept. of Health	Angela Deal	Community Health Educator	Co-chair, Chronic Disease Prevention and Management Subcommittee
Charles County Department of Health	Laura Borawski	Community Outreach Worker	Co-Chair, Chronic Disease Prevention and Management Subcommittee
Partnerships for a Healthier Charles County	Local Health Improvement Coalition		Focus Groups, Health Improvement Plan

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

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.

   Hospital initiatives: See attached Table III

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.

   All 3 priorities outlined in the CHNA are being addressed by UM CRMC either directly (Physician Recruitment), or through partnerships with other organizations (i.e. Chronic Disease Self-Management Program), or through the LHIC, Partnerships for a Healthier Charles County (PHCC) which is co-led and financed by UM CRMC. Where a need is appropriately addressed by another community entity, UM CRMC provides leadership and/or funding through the Charles County Health Improvement Plan and the local health coalition (PHCC) to communicate initiatives, provide financial support and/or assistance or data when needed, and review results (i.e., Substance Abuse, Mental Health).Each LHIC team has developed and implemented strategies specific to their identified priorities and reports back quarterly to the LHIC Steering Committee. The hospital provides support and oversight to the teams as a critical member of the LHIC Steering Committee. The Hospital's Director of Community Development and Planning is the official co-chair to the county LHIC.

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)

Several CRMC community benefit initiatives work toward the population health goals. In fact, where possible, population health goals are used as outcomes for the community benefit initiatives. For example, the Community Coalition/Access To Care Team is an initiative which involves active participation of approximately 30 local health and social service organization which works to improve patient care transitions and reduce readmissions. One major initiative in FY 2016 was to open the Center for Diabetes Education. Other initiatives include opening an Urgent Care Center to increase access to lower acuity health care setting, hiring a transition nurse navigator to assure compliance post discharge and a ED Social Worker to facilitate enrollment in Medicaid and other government programs as well as other community agencies, planning for a Palliative Care program and standing up an inpatient wound healing program.

Charles County has a long history of strong collaboration. The hospital, in partnership with the health department and the local health improvement coalition, conducted one county health needs assessment and developed one county health improvement plan. The county's short, intermediate, and long term health objectives were developed based on the established measures and objectives of the state health improvement process (SHIP).

All community benefits activities and state health improvement process activities for Charles County are tracked by the county epidemiologist, so reports are consistent. The team leaders and participating agencies of the LHIC report each quarter to the epidemiologist. The quarterly reports submitted to SHIP staff are used to complete the hospital's fiscal year community benefits report.

Charles County has received funding from the Maryland Community Health Resource Commission. Funding has been given to the Mobile Integrated Health Program, and Health Partners Inc. These programs and services are aimed at addressing the priorities identified through the CHNA Process. All of the activities funded were contained in the Charles County Health Improvement Plan. The hospital was happy to lend support to all of these funded projects.

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.

2011 Maryland Health Care Workforce Study:

2011 Maryland Health Care Commission (MHCC)'s Physician Workforce Study highlighted the physician workforce in Maryland. This study looked at the HRSA Area Health Resource File for 2009 and 2010 to determine the supply of physicians in Maryland and its regions. Charles County has been included in the Southern Maryland region with Calvert and St Mary's Counties.

As illustrated by the table below, Southern Maryland has physician to population ratios significantly below the HRSA benchmark for all types of physicians.

Table 10: Maryland Supply by Type of Physician and Region, 2009/2010					
	Total	**Primary Care**	**Medical Specialties**	**Surgical Specialties**	**All Other**
Maryland physicians per 1000, residents excluded, with all adjustments					
Baltimore Metro	2.85	0.86	0.48	0.61	0.90
Eastern Shore	1.86	0.62	0.27	0.39	0.57
National Capital	2.25	0.72	0.41	0.48	0.64
Western	2.17	0.73	0.39	0.42	0.63
Southern	1.34	0.53	0.25	0.26	0.30
Total	2.44	0.77	0.42	0.52	0.74
Memo: HRSA baseline, interns excluded, with all adjustments	1.93	0.69	0.27	0.43	0.53
Percent difference from HRSA baseline					
Baltimore Metro	48%	24%	76%	41%	70%
Eastern Shore	-4%	-10%	0%	-11%	8%
National Capital	17%	4%	49%	11%	21%
Western	12%	5%	41%	-4%	19%
Southern	-31%	-24%	-8%	-40%	-43%
Total	27%	11%	54%	19%	39%
Source: Analysis of Maryland 2009/2010 license renewal database, calculations from HRSA 2008, population counts from U.S. Bureau of the Census					

The Maryland physician supply ratios were adjusted to account for variation in average patient-care hours. Even with the adjustment, Southern Maryland continued to see low physician to population ratios. Southern Maryland region had a 26% total physician deficiency versus the HRSA standard. This was the only region in Maryland to have such a significant deficiency. The Southern Maryland region also had physician supply deficiencies for primary care (19%), medical specialties (7%), surgical specialties (34%), and all other physicians (39%). Four out of the five physician supply deficiencies are greater than 10% below the HRSA standard.

Maryland Physician Supply Versus HRSA Standard, All Adjustments					
Region	**Total**	**Primary Care**	**Medical Specialties**	**Surgical Specialties**	**All Other**
Entire State	27%	11%	54%	19%	39%
Baltimore Metro	44%	21%	69%	40%	66%
Eastern Shore	4%	0%	8%	-2%	13%
National Capital	18%	4%	56%	8%	23%
Western	20%	12%	48%	3%	29%
Southern	-26%	-19%	-7%	-34%	-39%
Key: Green = >10%, Yellow = -10% to 10%, Red = <-10%					

Note: Positive percentage indicates supply in excess of HRSA Standard, and negative percent indicates a supply deficit compared to the HRSA Standard. Southern: Charles, Calvert, and St Mary's Counties

Study implications for Southern Maryland from the 2011 Maryland Physician Workforce Study include:

Residents are likely to travel out of area for care:

- Physicians in Southern Maryland provide about 67% of Medicare beneficiary's total Medicare physician care. Residents receive 14% of physician care in Mont/PG counties and 12% in out-of-state (probably DC)

Table 14: Intrastate Travel for Care, Medicare Fee-for-Service Part B Beneficiaries, 2009

Maryland Residents, Physician Services Spending Per Capita

	Physician Location							
Beneficiary Residence	Baltimore Metro	Eastern Shore	National Capital	Western	Southern	Out of state	Total	% of spending in own region
Baltimore Metro	$ 2,503	$ 12	$ 56	$ 23	$ 7	$ 74	$ 2,675	94%
Eastern Shore	$ 299	$ 1,712	$ 26	$ 6	$ 2	$ 318	$ 2,362	72%
National Capital	$ 159	$ 4	$ 2,335	$ 15	$ 73	$ 595	$ 3,181	73%
Western	$ 121	$ 8	$ 101	$ 1,834	$ 3	$ 224	$ 2,290	80%
Southern	$ 182	$ 4	$ 378	$ 6	$ 1,806	$ 316	$ 2,692	67%

Source: Analysis of Medicare 5% sample limited data set standard analytic files and denominator file, 2009

- Southern Maryland physicians are as likely as physicians overall to participate in Medicaid/Medicare and to accept new patients.

Table 13: Acceptance of Medicaid and Medicare Patients, by Region				
	Medicaid		Medicare	
Region	% of practices accepting Medicaid	Of those, % accepting new Medicaid patients	% of practices accepting Medicare	Of those, % accepting new Medicare
Percent of physicians				
Baltimore Metro	80%	88%	85%	94%
Eastern Shore	89%	90%	91%	94%
National Capital	61%	85%	79%	93%
Western	80%	85%	86%	91%
Southern	86%	86%	89%	93%
Total	75%	87%	84%	94%
Percent difference from state average				
Baltimore Metro	6%	1%	2%	1%
Eastern Shore	18%	4%	8%	1%
National Capital	-19%	-2%	-6%	-1%
Western	6%	-3%	2%	-3%
Southern	15%	-1%	6%	0%
Total	0%	0%	0%	0%
Source: Maryland license renewal survey, 2009/2010				

***Maryland Health Workforce Study Phase 2 Report, January 2014*:**

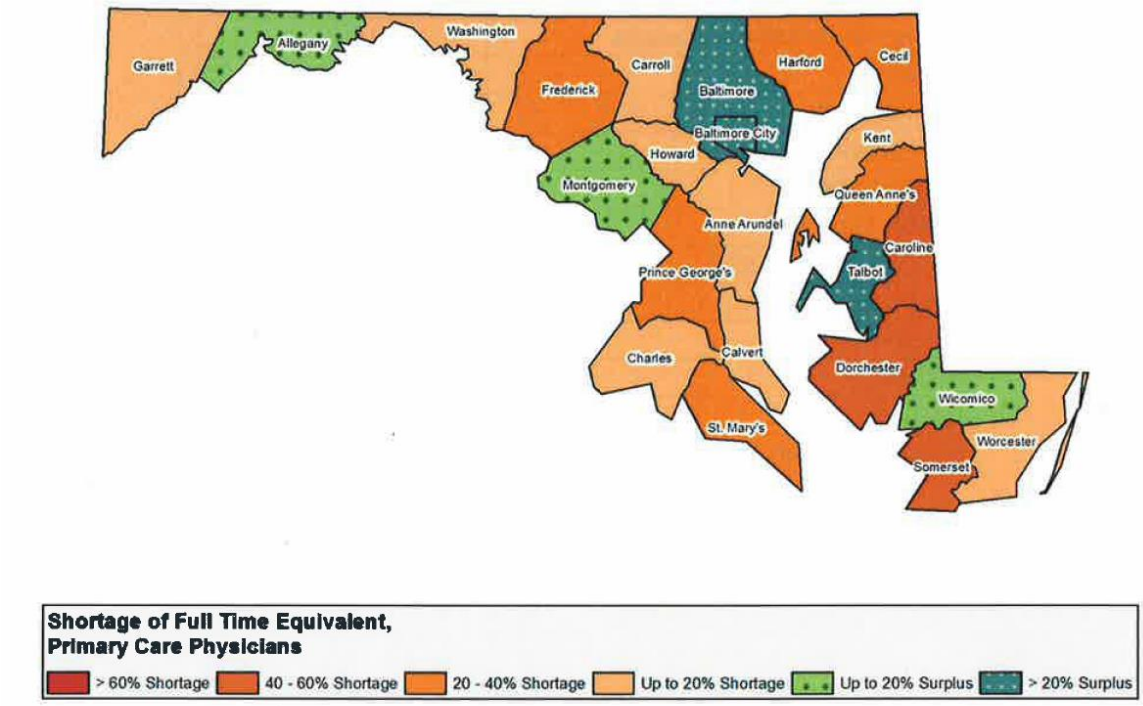
In January 2014, the Maryland Health Care Commission (MHCC) released a second report detailing Phase 2 of the Maryland Health Workforce Study. This study assessed health workforce distribution and the adequacy of supply. Using funding from the Robert Wood Johnson Foundation, the MHCC was able to study the Maryland healthcare workforce on the state and jurisdictional level. Phase II presents estimates of current supply and demand for health professions designated by MHCC as high priority in supporting Maryland's transition to health reform, and for which data were readily available for estimating supply and demand. These professions included primary care specialties and psychiatrists. Current supply estimates were also presented for psychologists, social workers, counselors, physician assistants, pharmacists, registered nurses, and dentists.

Demand modeling: Estimates of the current demand for healthcare providers were developed using the IHS Healthcare Demand Micro-simulation Model. The major components of this model include: 1. A population database that contains characteristics and health risk factors for a representative sample of the population

in each Maryland count; 2. Equations that relate a person's characteristics to his or her demand for healthcare services by care delivery setting; and 3. Staffing patterns that convert demand for healthcare services to demand for full time equivalent (FTE) providers.

In Charles County, the primary care physician FTE demand is greater than the primary care FTE supply (7.4 vs. 6.1). There is an 18% shortfall in the primary care services supply to fulfill the current demand. Charles County falls in the "Up to 20% Shortage Area" for primary care physician supply. See Map 1 below.

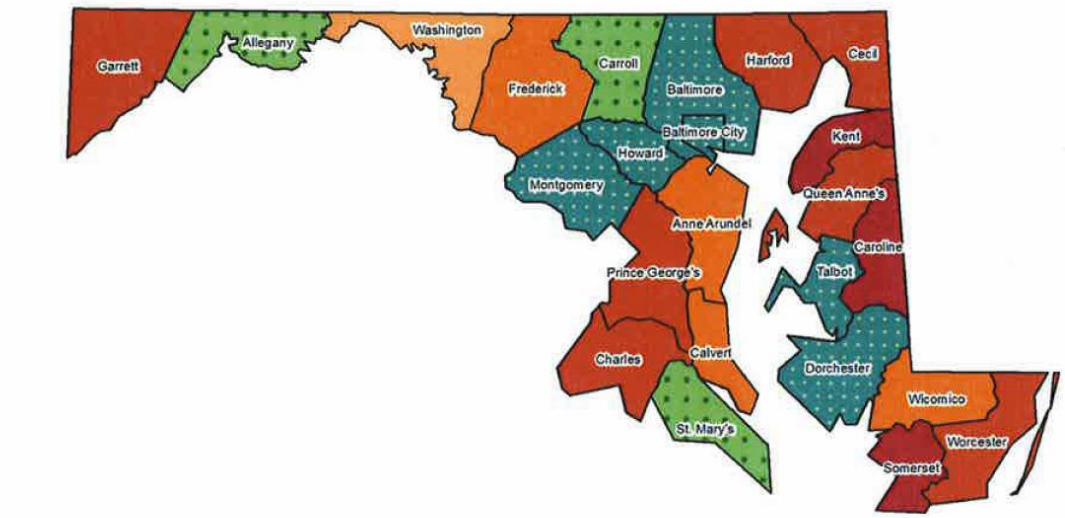
Map 1: Maryland County-Level Adequacy of FTE Primary Care Physician Supply

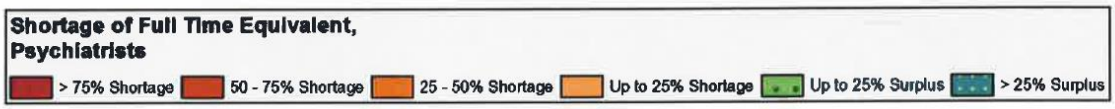


The FTE per 10,000 supply rates for professional counselors, social workers, and psychologists in Charles County is much lower than the rates for Maryland. The Charles County FTE rate for physician assistants is the only rate that came close to the Maryland state supply rate.

The demand for psychiatrists in Charles County is much higher than the county supply for psychiatry. Charles County has a shortage between 50-75% of full time equivalent psychiatrists. See Map 2 below.

Map 2: Maryland county-Level Adequacy of FTE Psychiatrist Supply





2011 County Physician/Nurse Specialty Data:

The US Department of Health and Human Services' Health Resources and Services Administration publishes information on the number of physicians and nurses by speciality for each state. 2011 data on the number of pediatricians, nurse practitioners, nurse midwives, general surgeons, general practitioners, OBGYN's, internal medicine physicians, and family medicine practitioners were compiled for Maryland and its jurisdictions. Specialities where Charles County is in lower half of the Maryland jurisdictions include OBGYN, nurse practitioners, and general surgeons.

***Primary Care Physicians Ratio*:**

Access to care requires not only financial coverage, but also access to providers. While high rates of specialist physicians have been shown to be associated with higher, and perhaps unnecessary utilization, sufficient availability of primary care physicians is essential for preventive and primary care, and when needed, referrals to appropriate specialty care. Using data from the Area Health Resource File and the American Medical Association, the County Health Rankings were able to provide 2012 primary care physician ratios for all United States counties. For 2012, the Charles County primary care physician ratio was 2035:1. Primary Care Physicians (PCP) is defined as the ratio of the population to total primary care physicians. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The 2012 Charles County PCP ratio is almost twice as high as the Maryland state ratio of 1131:1.

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
Hospital-Based Physicians	Due to the significant physician shortage in the Southern region, UM CRMC does not have adequate pool of community physicians to provide 24 hour professional and administrative services for many required specialties. Contracts with these physicians and groups are needed to provide 24 hour services for patients regardless of their insurance status or ability to pay and make it necessary for UM CRMC to assure that Contractor receives fair market value compensation for the services it is rendering to or for the benefit of Hospital.
Non-Resident House Staff and Hospitalists	N/A
Coverage of Emergency Department Call	As a result of the prevailing physician shortage (southern Maryland has the highest number of physician specialty shortages in the state); the University of Maryland Charles Regional Medical Center has an insufficient number of specialists within the medical staff. In all of these areas there are not enough physicians to care for patients including uninsured and underinsured in the hospital. Therefore, subsidies are paid to the physicians to provide on call coverage for the Emergency Department and patient care departments.
Physician Provision of Financial Assistance	N/A
Physician Recruitment to meet Community Need	Southern Maryland had the highest percentage of physician shortages of all of the regions in Maryland (89.9%). To address the shortage, the University of Maryland Charles Regional Medical Center hired both a Chief Medical Officer and Physician Recruiter and Liaison who are working to successfully attract and retain physicians to the community. Private practice within the community is preferred, but the hospital will employ those physicians when necessary. The recruitment strategy plan was to increase primary care and specialty providers by at least seven (7) by FY 2016. The result was a recruitment of 7 new providers during that

	period.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	N/A

Table III: Initiative I: Access to Care

Identified Need	MD Health Commission reports that 83 physician specialties are in shortage in So MD. Using data from the Area Health Resource File and the American Medical Association, the County Health Rankings were able to provide 2012 primary care physician ratios for all United States counties. For 2012, the Charles County primary care physician ratio was 2035:1. Primary Care Physicians (PCP) is the ratio of the population to total primary care physicians. Primary care physicians include non-federal, practicing physicians (M.D.'s and D.O.'s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The 2012 Charles County PCP ratio is almost twice as high as the Maryland state ratio of 1131:1. There is a federally designated mental health professional shortage area for the entire county. It is reported that there are 3 full-time equivalent non-federal mental health professionals practicing in Charles County. Charles County received a score of 12 out of 25. There is a federally designated primary care professional shortage area for Southern Charles County. They report that there is one full-time equivalent primary care professional providing ambulatory patient care in the designated area. The Southern Charles County census tracts of 8511, 8512, 8513.01, and 8513.02 are included in the designated HPSA area. Charles County received a score of 13 out of 25. There are 6 population areas in Charles County with MUA/MUP designation. There is one medically underserved population (MUP) in Charles County. An MUP is a group of people who face economic, cultural, or linguistic barriers to health care. In Charles County, the MUP is located in the Brandywine Service Area. This population is a government MUP, which means it was designated at the request of a State Governor based to documented unusual local conditions and barriers to accessing personal health services. In addition to the MUP, there are 5 medically underserved areas (MUA) in Charles County. Medically Underserved Areas may be a whole county or a group of contiguous counties, groups of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services. Those areas include: Medically Underserved Area (MUA): Score 51.97 • District 4, Allens Fresh • District 5, Thompkinsville • District 9, Hughesville Medically Underserved Area: Score 61.25 • District 10, Marbury

Table III: Initiative I: Access to Care

	• District 3, Nanjemoy *Maryland Health Workforce Study Phase 2 Report, January 2014*: In Charles County, the primary care FTE demand is greater than the primary care FTE supply (7.4 vs. 6.1). There is an 18% shortfall in the demand for primary care services. Charles County falls in the up to 20% shortage area for primary care physician supply. The 2012 Charles County preventive hospital stay rate was 71 per 1000 Medicare enrollees and is higher than the Maryland state average rate of 54 per 1000 Medicare enrollees. Some decreases have been seen for Charles County since 2008; however, the Charles County rate has consistently been above the state and national rates. Yes, this was identified through the CHNA process.
Hospital Initiative	<u>Initiatives:</u> A. Enhance county capacity to provide recruit and retain health care providers. B. Increase awareness of county health services in the Community C. Increase the health literacy of Charles County residents. D. Address transportation barriers through new and innovative approaches.
Total Number of People within the Target Population	152,864 (County Population as reported in CHNA)
Total Number of People Reached by the Initiative	1150 encounters at community events attended by the Access to Care Team. 9963 patient visits at Urgent Care Center.
Primary Objective of the Initiative	***A. Enhance county capacity to provide recruit and retain health care providers.*** 1. Recruit additional health care providers and specialists to the county through the University of Maryland Charles Regional Medical Center. 2. Increase access to primary care, urgent care and other lower acuity health care settings. 3. Establish a committee to review and advocate for federal designations of medically underserved areas/populations and health professional shortage areas and to review physician enticements such as incentives and reimbursements. ***B. Increase awareness of county health services in the Community*** 1. Expand Population Health initiatives that address the entire population of the county (designated CBSA) and move people from a high risk category toward lower risk. 2. Develop an awareness campaign surrounding appropriate setting of care: primary care, urgent care, emergency department, and 911. 3. Engage community stakeholders in the monthly Community Coalition meetings to share and gather information on services available.

Table III: Initiative I: Access to Care

	4. Inform primary care providers, insurance companies, and emergency department staff on how to educate their patients on true emergencies and appropriate setting for their level of care. Also educate those providers on community resources and available services. 5. Attend community events and programs to provide information on available county health services. ***C. Increase the health literacy of Charles County residents.*** 1. Develop a health literacy video and document checklist for educating providers 2. Develop or find a certified "Health Literacy" training and recruit volunteers, including the faith-based community, our trusted community leaders. 3. Increase the county's capacity to implement evidence-based community health worker models which can provide culturally competent, individualized case management, patient navigation, and health education. ***D. Address transportation barriers through new and innovative approaches.*** 1. Explore the possibility of a buddy system to help elderly patients to get to appointments and to check in on each other. 2. Continue to pursue new medical transportation options and possible grant funding for a collaborative project between Volunteer EMS and local limo company.
Single or Multi-Year Initiative Time Period	Multi-year initiative (2011-present)
Key Partners in Delivery	University of Maryland Medical System, Partnerships for a Healthier Charles County, Health Partners, Inc, Maryland Community Health Resource Commission, Charles County Department of Health, Greater Baden Medical Center, United Way, University of Maryland Charles Regional Medical Center Community Coalition, Emergency Management Associates
Impact/Outcome of Hospital Initiative	***The end measures for all access to care team activities are:*** 1. Physician Recruitment and Retention: Increase the number of Charles County physicians by 7 providers. 2. Unnecessary Hospital Utilization: Reduce the Charles County preventable hospital stay rate from 71 per 1000 Medicare enrollees to 69 per 1000 Medicare enrollees. Source: County Health Rankings ***The intermediate measures for all access to care team activities are:*** 1. How long since you visited a doctor for a routine check up (BRFSS) 2. Percent of Medicaid adolescent who have had a well child visit in the last year (SHIP) 3. Southern Maryland Physician Supply vs. HPSA standards (MHCC

Table III: Initiative I: Access to Care

	Maryland Health Care Workforce Study) 4. Primary Care Provider Supply/Demand Rates per 10,000 population (2012 MD Physician Workforce Study) 5. Expansion or changes in the Federally designated health shortage professional area designations for primary care and mental health and medically underserved areas 6. Decrease in County and Zip Code Inpatient Hospitalization Rates (HSCRC) 7. Decrease in County and Zip Code ED Outpatient Visit Rates overall and for mental health, addictions, hypertension, asthma, diabetes, congestive heart failure (HSCRC and SHIP) 8. Increase resident satisfaction with the health care they receive (BRFSS) 9. Decrease the percentage of people who report that there was a time in the past 12 months when they could not receive the medical care they needed or when they did not have health insurance (BRFSS). 10. Increase the percentage of residents who report that they can see a doctor when they needed one (BRFSS) 11. Decrease the percentage of residents who report delaying getting medical care due to transportation (BRFSS) 12. Reduce the Charles County hospital readmission rate Process measures include: Number of providers recruited Number of committees established Number of team members recruited to the committee Number of meetings held Number of stakeholders in attendance Number of designation changes reviewed Number of designation changes needing advocacy Number of banners developed Number of flyers developed Number of flyers disseminated Number of events attended Number of new members recruited Number of meetings held Number of providers educated Number of MCO's educated Number of presentations given Number of events attended Number of flyers or information disseminated Number of trainings developed Number of presentations given Number of people trained on Health Literacy Number of community health worker models created, developed, or planned Number of new programs initiated for CHW Number of partners involved in transportation issues Number of new collaborations established for transportation Number of new transportation programs developed

Table III: Initiative I: Access to Care

	Number of people served in new transportation programs Number of grants application submitted to address transportation
Evaluation of Outcome	In Year 1 of implementation, only process measures are available for reporting. Some of the programs in the plan have not yet been initiated, therefore, their numbers will be zero. They are either in the planning stages or have not yet been explored. ***A. Enhance county capacity to provide recruit and retain health care providers.*** 1. Recruit additional health care providers and specialists to the county through the University of Maryland Charles Regional Medical Center. A total of 7 health care providers were recruited in FY16. 2. Open Urgent Care Center to increase access for lower acuity patients in a more appropriate setting. The Urgent Care was opened in September 2015 and there have been 9960 patient visits in FY 16. 3. Establish a committee to review and advocate for federal designations of medically underserved areas/populations and health professional shortage areas and to review physician enticements such as incentives and reimbursements. This initiative was not addressed in FY16. It will be explored in Years 2 and 3 of the plan. Number of committees established: 0 Number of team members recruited to the committee: 0 Number of meetings held: 0 Number of stakeholders in attendance: 0 Number of designation changes reviewed: 0 Number of designation changes needing advocacy: 0 ***B. Increase awareness of county health services in the Community*** 1. Expand Population Health initiatives that address the entire population of the county (designated CBSA) and move people from a high risk category toward lower risk. A Manager for Population Health Department was hired and a strategic plan developed in coordination with community benefit operations staff and CC health improvement plan outcomes. Transition Nurse Navigators were hired to reach initiatives and participate on LHIC teams. The LHIC subcommittee Access to Care is co-chaired by the Population Health Manager.

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	Staff members hired: Department Manager and 2 transition nurse navigators 2. Develop an awareness campaign surrounding appropriate setting of care: primary care, urgent care, emergency department, and 911. A communications campaign was developed by the University of Maryland Charles Regional Medical Center to explain the appropriate usage of urgent care and the ED. Educational information was developed on when to use the ED vs. Urgent care vs. primary care. Digital media, print and social media were employed to educate the public. Additionally, the team was able to develop a first line community resource guide that provides quick information and contacts for community and health resources in the county. It is also being made into a rack card and distributed in FY 17. Number of rack cards distributed: 20,000 Number of campaign PSA's: 7 Number of page views/downloads on website: 1,581 Number of Facebook views: 5844 Number of Facebook Interactions: (Share, Like, Comment) 207 2. Engage community stakeholders in the monthly Community Coalition meetings to share and gather information on services available. The University of Maryland Charles Regional Medical Center's Community Coalition voted to become the Access to Care Team of the Partnerships for a Healthier Charles County. They have assumed the action plan of the team and have broken down into 3 working groups to address the topics specified in the action plan. Number of new members recruited: 40 Number of meetings held: 12 3. Inform primary care providers, insurance companies, and emergency department staff on how to educate their patients on true emergencies and appropriate setting for their level of care. Also educate those providers on community resources and available services. This is the next step in this initiative and will be developed and implemented in Years 2 and 3 of the plan. Number of providers educated: 0 Number of MCO's educated: 0

Table III: Initiative I: Access to Care

	Number of presentations given: 0 4. Attend community events and programs to provide information on available county health services. The Access to Care Team is involved in the community and has information available at many community events including Community Resource Day and the Charles County Fair. Number of community event attended: 24 Number of encounters at community events: 1150 ***C. Increase the health literacy of Charles County residents.*** 1. Develop a Health Literacy Education Campaign including a video with a post test survey after viewing and health literacy checklist for health providers developing documents for patients. The video and checklist are available on the hospital's intranet site. 2. Develop or find a certified "Health Literacy" training and recruit volunteers, including the faith-based community, our trusted community leaders. The Health Literacy working group is still working on this initiative. This has yet to develop the training. Number presentations made showing video to community groups and health care providers: 5 Number of people reached through presentations: 164 Number of trainings developed: 0 3. Increase the county's capacity to implement evidence-based community health worker models which can provide culturally competent, individualized case management, patient navigation, and health education. Number of community health worker models created, developed, or planned: 1 training for Community Health Workers is currently being planned for Charles County. We are exploring opportunities for funding at this time. Number of new programs initiated for CHW: 0 ***D. Address transportation barriers through new and innovative approaches.*** 1. Explore the possibility of a buddy system to help elderly patients to get to appointments and to check in on each other. 2. Continue to pursue new medical transportation options and possible grant funding for a collaborative project between Volunteer EMS and local limo company. The transportation working group has developed some new partnerships

Table III: Initiative I: Access to Care

	and has been able to work on 2 grant applications in Year 1. They plan to use funding to conduct a study of current transportation options and to develop new opportunities to work within our current systems to improve transportation options for county residents. Number of partners involved in transportation issues: 10 Number of new collaborations established for transportation: 1 Number of new transportation programs developed/planned: 1 Number of people served in new transportation programs: 0 Number of grants application submitted to address transportation: 2	
Continuation of Initiative	Initiatives will continue in the next fiscal year.	
Expense: Total Cost of Initiative and What amount is restricted grants/direct Offsetting Revenue	A. Total Cost of Initiative • Physician Recruitment and Loan Guarantee $ 170,314 • Urgent Care $ 708,081 • Pop. Health Manager (25%) $24,874 • 2 RN Navigators $62,141 • Staff time for Access to Care Meetings and Community Events- $11,456 Total Cost- $976,866	B. Direct Offsetting Revenue from Restricted Grants

Table III: Initiative 2: Cancer

Identified Need	Cancer is the leading cause of death in Charles County. In 2014, a total of 240 deaths occurred in Charles County from cancer, representing 25% of the total county deaths. Charles County had a 2007-11 Colon and Rectal Cancer incidence rate of 40.9 per 100,000. This was slightly higher than the Maryland state average rate of 39.3. Incidence rates were higher for Charles County men than Charles County women (53.4 vs. 31.9). Charles County African Americans had a similar colon and rectal cancer incidence rate to Charles County Whites (40.6 vs. 38.8). The 2007-2011 Charles County colon and rectal cancer mortality rate of 19.4 per 100,000 is higher than the Maryland state average rate of 16.0 and the other Southern Maryland counties (17.3 for Calvert and 14.8 for St Mary's County). Charles County males were more likely to die from colon and rectal cancer than Charles County females (29.9 vs. 13.3). 2007-2011 Charles County colon and rectal cancer mortality rates for African Americans were higher than the rates for Charles County Whites (30.5 vs. 16.6). Yes, this was identified through the CHNA Process. Due to the disparities seen for both colorectal cancer incidence and mortality for Charles County men and the disparity in colorectal cancer mortality for Charles County African Americans, the University of Maryland Charles Regional Medical Center, along with the members of the Chronic Disease Prevention Team, decided to focus efforts on educating the most vulnerable populations on the need for colorectal cancer screening
Name of Initiative	Colorectal Cancer Initiatives: 1. Increase Community Outreach & Education surrounding colon and rectal health 2. Engage men in the community to discuss the barriers and challenges associated with colon and rectal cancer screening and needed health care services. 3. Establish a referral system with county providers and other county agencies to community resources and programs for Colorectal Cancer screening and follow-up.
Total Number of People within the target population:	Because our focus is on the prevention of the disease and not just the treatment and survival after disease onset, we choose to target the whole county. The 2015 Charles County population was 156,118.
Total Number of People reached by this initiative:	4330

Table III: Initiative 2: Cancer

Primary Objective of the Initiative:	***1. Increase Community Outreach & Education surrounding colon and rectal health*** *i. Implement Colorectal Cancer Education Campaign at County Fair utilizing inflatable colon, educational items and fun "booty call" dance.* Metrics: A. Schedule the use of the Inflatable Colon at a minimum of 1 community event each year B. Develop 1 new awareness campaign surrounding colorectal cancer screening using visual aids, education, form boards, etc. C. Develop a pre and post test for administration during colorectal cancer education at the Inflatable Colon. D. Purchase 1 new colon and prostate model and 1 poster of the human body with organs. E. Educate community members on the anatomy of the colon, rectum, and prostate using the Inflatable Colon, the organ models, and the anatomy poster. F. Develop a community awareness using 19 white shirts and 1 blue shirt as a visual statistics of colorectal cancer prevalence. G. Develop and print 1 Colonoscopy Screening resource list and information (simple) H. Conduct community education on colon and rectal health at 5 community events each year. *ii. Develop strategies and materials to assist with health literacy surrounding the colon and rectum and the guidelines for appropriate screening and referral.* Metrics: A. Utilize existing and purchase additional 2 visual teaching tools of the colon and other body functions. B. Develop simplified educational materials on the anatomy and health of the colon and prostate. C. Take new strategies and teaching tools "on the road" to a minimum of 5 cancer outreach venues each year. ***2. Engage men in the community to discuss the barriers and challenges associated with colon and rectal cancer screening and needed health care services.*** *i. Conduct focus groups with men aged 50+ to determine why they did or why they have not had a colonoscopy.* Metrics: A. Develop 1 list of culturally appropriate focus group questions B. Determine at least 2 culturally competent and objective individuals to serve as focus group facilitators. C. Establish and Purchase incentives and materials to promote participation in focus groups D. Recruit men to participate who represent a diverse sampling of the county population including various regions of Charles County, ages, and all races/ethnicities.

Table III: Initiative 2: Cancer

	E. Schedule 3 -4 focus groups F. Compile responses recorded during focus groups and establish some conclusions and themes that surfaced during the discussions. G. Develop new programs and awareness campaigns that target the barriers and challenges that were established during the focus group discussions. ***3. Establish a referral system with county providers and other county agencies to community resources and programs for Colorectal Cancer screening and follow-up.*** i. *Develop an educational program geared toward increased county providers' capacity to refer patients to county Colorectal Cancer programs and screenings.* *ii. Educate county agencies and community organizations on the resources available in the county for colorectal cancer screening and follow-up.* Metrics: A. Conduct 1 educational presentation on colorectal cancer screening and follow-up resources and the county's cancer team action plan to county providers at the Charles County Medical Society meeting. B. Conduct 1 educational presentation on colorectal cancer screening and follow-up resources and the county's cancer team action plan to county agencies and community organizations at a Partnerships for a Healthier Charles County meeting. C. Conduct 1 educational presentation on colorectal cancer programming and resources and the county's cancer team action plan to providers at the University of Maryland Charles Regional Medical Center Department of Medicine Meeting. D. Establish a referral system among county providers to the Colorectal Cancer Program. E. Determine the feasibility of establishing a standardized screening history form that can be incorporated into electronic health records.
Single or Multi-Year Initiative Time Period	Multi-Year (2011 to present)
Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, PHCC Cancer Team, Charles County Department of Health, Charles County Medical Society, Charles County NAACP
Impact/Outcome of Initiative	Process measures were tracked to determine the number of individuals educated on cancer risk factors and screening practices. We also tracked the number of encounters and community events aimed at raising awareness of issues surrounding cancer and the need for screening and early intervention. Impact measures included an analysis of cancer incidence and mortality rates for Charles County overall and site specific. Rates are compared to

Table III: Initiative 2: Cancer

	determine if county level are different from the state average rate and to determine if racial disparities are present.
Evaluation of Outcome	***Process:*** 1. Colorectal Cancer Education and Awareness: The Cancer Team used the Charles County Fair Friday as the location for a colorectal cancer education and awareness event. The Charles County Department of Health brought the inflatable colon (funded by UM Charles Regional Medical Center in 2014) and set up in the center of the fairgrounds. People had the opportunity to walk through the colon and talk with Cancer Team members about colon and rectal health and colonoscopies for screening. The team also designed and printed out signs on the importance of colon and rectal cancer screening. Team members walked all around the fair that day with their signs. One of the main themes was 1 in 20 will be diagnosed with colorectal cancer. 19 cancer team members wore white shirts. One member, who is a colorectal cancer survivor, wore a light blue shirt that said "Ask me why I wear blue." To draw attention to the inflatable colon, the screening signs, and the information table, the Cancer Team did a "booty call" dance in the afternoon. It was a fun opportunity to get people engaged and talk to them about the importance of colorectal cancer screenings. There were a total of 550 encounters at this community event. The inflatable colon also visited the Charles County Government Employee Fair in October 2015. There were a total of 100 encounters at this event. University of Maryland Charles Regional Medical Center offered a Colorectal Cancer Forum in February with panel 4 physicians – a gastroenterologist, surgeon, radiation oncologist and oncologist. We planned and promoted the event however we had to cancel the event due to lack of participation. The Team will consider offering this at a better date and time for the public. Number of Community Events attended: 39 Number of people in attendance at events: 4310 Number of people educated at events: 581 Number of Forum attendees: 0 In addition, all local physician practices are visited on a regular basis to ensure that they are stocked with brochures regarding the colorectal cancer screening program at the health department. 2. Focus Groups: The team worked hard on organizing Men's Focus Groups on Colon Health: developing a set of questions, date/location,

Table III: Initiative 2: Cancer

	arranging for a male facilitator, and determining a gift card incentive. The first focus group was canceled due to lack of sign ups. The team will regroup and think of new and innovative ideas to recruit men to the focus groups. Number of Focus groups conducted in FY16: 0 3. Establishment of a screening referral system: In Spring 2016, the Charles County Department of Health was awarded a mini planning grant to work with 2 health systems to develop and implement a referral system for colorectal cancer screening. The goal of the program was to increase colorectal cancer referral and screening rates among those 2 practices. The LHIC Chronic Disease and Cancer Team provided planning and support for the project. It was established that the CRC screening rate at Practice 1 was 7% and at Practice 2 was 2%. Each practice was given models to use when educating their patients on colorectal cancer and the need for screening. System level changes were made to increase referrals to those aged 51-75. Both practices developed process maps and formalized policies on colorectal cancer screening. One practice added a provider reminder system into their EHR to prompt the provider to educate and refer eligible patients for screening. Additionally, a presentation was given to physicians at one of their regularly scheduled MedChi Meetings, the local medical society. They were educated on available resources for cancer screening as well current recommendations for screening. Number of referral systems developed and initiated: 2 Number of provider reminder system initiated with a practice EHR: 1 Number of presentations given to 20 physicians attending the Charles County Medical Society meeting, Med Chi: 1 Impact: 1*. Decrease the 2007-2011 Charles County colon and rectal cancer mortality rate from 19.4 per 100,000 to 18.0 per 100,000 (10% reduction) Source: 2014 Maryland CRF Cancer Report* Update: The 2008-2012 Charles County colon and rectal cancer mortality rate was 17.2 per 10,000. This is lower than our goal set at 18.0 per 100,000 population.
Continuation of Initiative	Initiatives will continue to expand current initiatives and develop new ideas to increase our education among the most vulnerable populations.

Table III: Initiative 2: Cancer

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative Colorectal Cancer Education and Awareness $ 1,045 Colorectal Cancer Forum $ 4,382 Total: $5427	B. Direct offsetting revenue from Restricted Grants

Table III: Initiative 3: Chronic Disease Prevention and Management

Identified Need	Heart disease is the second leading cause of death for Charles County residents. Heart disease accounts for approximately 1/4 of the county deaths each year. The 2014 rate of ED visits for hypertension per 100,000 population is higher in blacks (349.2) than whites (109.0). This is a priority measure with the Maryland State Health Improvement Process. The 2012-2014 death rate for people in Charles County with diabetes mellitus 26.6 per 100,000 people. This is highest among the other So MD counties and higher than the state average (2014 MD Vital Statistics Report). Approximately 13.3% of CC adults report having diabetes (2014 MD BRFSS). Emergency Department visit rates due to diabetes show a disparity among Charles County African Americans. The same is true for Maryland African Americans. Therefore, this priority has been established by the Maryland State Health Improvement Process. Yes, this was identified through the CHNA process.
Name of Hospital Initiative	<u>Initiatives:</u> Increase evidence based chronic disease self management by hospitals and primary care providers. Link health care-based efforts with community prevention activities.
Total number of people within the target population	Approximately 35% of the county population has either hypertension or diabetes. They are our target population for this initiative. Target population: 54641
Total number of people reached by the initiative	1239
Primary Objective of the Initiative	***1. Promote the University of Maryland Charles Regional Medical Center's increased efforts to provide free and low cost chronic disease and diabetes education to the community.*** Number of people participating in the Outpatient Diabetes Self Management Training Program Number of people educated in the free Diabetes class Number of new programs developed Pre and Post data of diabetes education participants Number of people participating in Gentle Movement and Relaxation Yoga Therapy for People with Chronic Conditions (i.e. COPD, Diabetes, Stroke) ***2. Implement the Stanford Chronic Disease Self Management Program, utilizing many community agencies and partners.*** Number of education sessions held

Table III: Initiative 3: Chronic Disease Prevention and Management

	Number of partners assisting with sessions Number of participants educated through CDSMP Pre and Post data of CDSMP participants ***3. Increase the capacity of primary care providers to implement screening, prevention and treatment measures for hypertension and diabetes in adults through QI methods and other training approaches.*** Number of participating physician practices Percent of patients with their hypertension under control Percent of patients with their diabetes under control ***4. Link health care-based efforts with community prevention activities.*** Number of referral forms established for county providers to refer to community resources and programs Number of chronic disease resource directories developed for use by county providers and health systems Number of physician referrals to diabetes classes Number of physician referrals to CDSMP classes Number of hospital physician referrals to the Quitline through Fax to Assist Number of physician referrals to health department smoking cessation classes Number of health department dental clinic patients referred to community resources Number of community events attended for outreach
Single or Multi-Year Initiative Time Period	Multi-year Initiative (2012-present)
Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, PHCC Chronic Disease Prevention Team, Charles County Department of Health, Health Partners, MedStar Shah Group, the Western Family Medical Center

Table III: Initiative 3: Chronic Disease Prevention and Management

Impact/Outcome of Hospital Initiative	Process measures are tracked to determine the number of new programs established and the number of participants in those programs. The diabetes program conducts pre and post tests to examine increases in diabetes knowledge. Impact data examined includes diabetes prevalence and mortality rates for Charles County. Additionally, BRFSS data on co-morbidities and diabetic complications are examined to see if county diabetics are under control.
Evaluation of Outcome	Process Measures: ***1. Promote the University of Maryland Charles Regional Medical Center's increased efforts to provide free and low cost chronic disease and diabetes education to the community.*** Conduct free or low cost diabetic education in the county. The University of Maryland Charles Regional Medical Center is providing free diabetes education classes to the public bi-monthly. The goal is to collect data on participants and become recertified by ADA. Most recently, the University of Maryland Charles Regional Medical Center opened the Center for Diabetes Education. Services include: Individual evaluation and diabetes instruction Group education classes Blood sugar meter training Insulin instruction Injection training Diabetes nutrition instruction Diabetes weight management Diabetes during pregnancy Diabetes Self-Management Education for: Adults with Type 1 Diabetes Adults with Type 2 Diabetes Women with Gestational Diabetes (Diabetes During Pregnancy) The Center opened in FY 17 with planning and recruitment costs in FY 16. Number of patients participating in free diabetes education class: 88 Pre/Post Free Diabetes Education Class Test Scores

Date	# of Attendees	Pre	Post	%Change
July 2015	6	78%	100%	22%
August 2015	4	80%	100%	20%
September 2015	6	80%	100%	20%
October 2015	9	80%	100%	20%
November 2015	2	*	*	*
December 2015	14	69%	100%	40%
January 2016	9	84%	100%	16%
February 2016	13	85%	100%	15%
March 2016	5	84%	100%	16%
April 2016	6	*	*	*
May 2016	8	88%	100%	12%
June 2016	6	*	*	*
Totals	88	80.89%	100%	20%

Table III: Initiative 3: Chronic Disease Prevention and Management

2. Implement the Stanford Chronic Disease Self Management Program, utilizing many community agencies and partners.

The University of Maryland, Health Partners, the Charles County Department of Health, and Shah Associates had staff trained in the Chronic Disease Self Management Program (CDSMP) in June 2015. Classes began in January 2016. A total of 3 CDSMP classes were conducted in FY16 with a total of 27 participants completing the class. 4 staff members from the health department and hospital were trained in the hypertension module of the CDSMP and one class was conducted in FY16.
Data collected by MAC.

Number of workshops: 3

Average participants per workshop: 12.0
Number of participants: 36
Number who completed 4 or more sessions: 27 of 35 (77%)
Number who are support persons: 12 (33%)

Gender	Count	Percent
Female	29	81%
Male	7	19%

*(Note: *Total can be greater or less than 100% due to multiple ethnicities, insurances, conditions and rounding)*

Ethnicity	Count	Percent
White/Caucasian	15	47%
Black or African American	13	41%
Hispanic/Latino	1	3%
Asian or Asian American	1	3%
Hawaiian Native or Pacific Islander	1	3%
Other	1	3%
Unknown/No Response	6	excluded

Type of Insurance	Count	Percent
Private	24	60%

Table III: Initiative 3: Chronic Disease Prevention and Management

Medicare	9	22%
Medicaid	3	7.5%
Other	4	10%
Unknown/No Response	6	excluded

Private Insurance	Count	Percent
BC/BS	13	62%
United	3	14%
Kaiser	1	5%
Aetna	1	5%
Other	3	14%
Unknown/No Response	1	excluded

Chronic Condition	Count	Percent
Hypertension	12	16%
Diabetes	11	15%
Arthritis	9	12%
Cancer	9	12%
Chronic Pain	8	11%
Lung Disease	4	5%
MS	3	4%
Osteoporosis	2	3%
None	6	8%
Other	11	15%

Condition Count	Count	Percent
Multiple chronic conditions	20	56%
One chronic condition	10	28%
No chronic conditions	6	17%

People in Household	Count	Percent
2	10	34%
3	5	17%
1	5	17%
4	4	14%

5	3	10%
6	2	7%
Unknown/No response	7	excluded

Education	Count	Percent
Some college or tech school	13	43%
College 4 years or more	12	40%
High school grad or GED	5	17%
Unknown/No Response	6	excluded

County	Count	Percent
Charles	36	100%

3. Increase the capacity of primary care providers to implement screening, prevention and treatment measures for hypertension and diabetes in adults through QI methods and other training approaches.

The Charles County Department of Health, in partnership with the University of Maryland Charles Regional Medical Center, Health Partners Inc, the Western County Family Medical Center, and Medstar Shah Medical Group implemented a program to address community-clinical linkages for the improvement of health outcomes among patients with diabetes and hypertension. All participating health systems were given hypertension and A1C models to educate patients on their disease conditions. The partners also created a referral form that included all community resources to help the patient address their chronic condition along with ideas for self management of their disease processes. A total of 209 patients were educated and given a referral form with information on community resources through this program. All patients receiving a referral were followed up by phone 1 week later in determine if they had followed the instructions on their referral form. Those who needed help in registering for a class were assisted at that time.

Location of Referrals:

Program	# of referrals
8-week tobacco cessation class, Charles County Department of Health	36
Better Breathers Support Group, University of Maryland Charles Regional Medical Center	3

Table III: Initiative 3: Chronic Disease Prevention and Management

Living Well Chronic Disease Self Management Program, Health Department and all Health Systems participating	98
Heart Healthy Eating, University of Maryland Charles Regional Medical Center	91
Diabetes Education, University of Maryland Charles Regional Medical Center	77
Diabetes Education, MedStar Shah Medical Group	28
Healthier Hearts Support Group, University of Maryland Charles Regional Medical Center	6
Weight Management Class, University of Maryland Charles Regional Medical Center	76
The Alive! Online Program	73
Improve Medication Adherence	97
Self Monitor blood pressure	113

Outcomes at follow-up:

Outcome of Follow Up Call	**Number of Responses**
Completed the referred services	8
Called or contacted the referred services	2
Still planned to complete the referred services	33
Were educated on the benefits of the service	41
Did nothing	2
Were unable to contact	71

4. Link health care-based efforts with community prevention activities.

The Chronic Disease Prevention Team developed a resource guide last fiscal year and revised it to fit the needs of the community and improved the document to focus on chronic disease prevention, treatment and self management. It will also include community resources and self management tools. Tools include logs for blood pressure and glucose, a physician and medication list, and more.

Number of resource guides disseminated in the community: 1000

Impact Measures:

Diabetes Mortality:

1. Reduce the Charles County diabetes emergency department visit rate from 208.7 per 100,000 to the Maryland rate of 205.0 per 100,000. Source: 2013 Maryland HSCRC data from SHIP website

Table III: Initiative 3: Chronic Disease Prevention and Management

	Hypertension ED Visit Rate: *Reduce the Charles County hypertension emergency department visit rate from 308.1 per 100,000 to 305 per 100,000 (1% reduction) Source: 2013 Maryland HSCRC data from SHIP website*	
Continuation of Initiative	Initiatives will continue in the next fiscal year since increases have been seen in the county's diabetes prevalence and disparities in hypertension and diabetes ED visit rates for African Americans.	
A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative • Staff time to teach free diabetes classes $ 4,793.00 • Planning, supplies, staff time for Chronic Disease Self- Management Program $23,057 • Recruitment and planning costs for diabetes education center $114,118 • Staff time Community Linkages for Diabetes and Hypertension Improvement $ 5,029 Total: $146,997	B. Direct offsetting revenue from Restricted Grants • A $5000 stipend for this project was received from DHMH

Table III: Initiative 4: Mental Health

Identified Need	12.7% of Charles County BRFSS respondents reported that they have been diagnosed with an anxiety disorder (2014 BRFSS). 13.7% of Charles County BRFSS respondents reported that they have been diagnosed with a depressive disorder (2014 BRFSS). The 2012-2014 Charles County suicide rate was 10.5 per 100,000 population, above the state level. Mental Health ED Visit Rate: 3045.8 per 100,000. CC White rate: 3907.5, CC AA rate: 2675.8, CC Asian rate: 410.8, CC His rate: 352.7. Mental Health ED rate has increased from 2535.6 in 2010 to 3045.8 in 2013. Charles County has a Mental Health Professional Shortage Area for the entire county. 3 providers are needed. ED Visit Rates have been identified as a priority measures through the Maryland State Health Improvement Process. Yes, this was identified as a need through the CHNA Process.
Name of Hospital Initiative	Initiative: Engage and educate all segments of the community on behavioral health to promote resources, to reduce stigma, and to increase awareness.
Number of people within the target population	12% anxiety prevalence: approximately 17586 people 14% depression prevalence: approximately 20517 people Target population: 17586+20517=38,103
Number of people served by the initiative	3258
Primary Objective of the Initiative	***Engage and educate all segments of the community on behavioral health to promote resources, to reduce stigma, and to increase awareness.*** *1. Expand the Mental Health First Aid training in the Charles County Public Schools and in the general community and work collaboratively with the Charles County Public School to implement Lauren's Law:* The Charles County Core Service Agency has been training school personnel, local law enforcement, first responders, and other community members on Mental Health First Aid. The Charles County Public Schools had a staff member trained as a trainer. This staff members trained all school counselors, principals, and other interested staff. Mental Health First Aid is a well-known and evidence-based program to help community members to identify the signs and symptoms of mental health disorders and how to mitigate situations.

Table III: Initiative 4: Mental Health

	Number of people trained in Mental Health First Aid Number of school personnel trained in Youth Mental Health First Aid *2. Behavioral Health Provider in ED: Contract with Calvert Memorial Hospital to bring Behavioral Health trained provider to improve access and appropriate treatment for patients in the ED with mental health or substance use disorders.* Number of patient visits: *3. Promote the KNOW Mental Health NO Stigma campaign in Charles County. Create a county awareness campaign to educate the general public on the definition of behavioral health.* Other presentations held to educate on mental health: 2 1. Number of presentations Out of the Darkness Walk: The second Southern Maryland Out of the Darkness Walk was held in September 2014 in Port Tobacco, MD. The event was well attended and exceeded fundraising goals for suicide prevention efforts. Number of people participating: Community Awareness Events to raise awareness of mental health and substance use disorders: The events raise awareness and provide information and resources to those who may be in need of treatment for one or both of those disorders. Number of events: Number of encounters at events: *3. Increase county capacity to screen and refer patients using the Screening and Brief Intervention and Referral for Treatment (SBIRT) model.* SBIRT Training for ED and Primary Care Providers: The Behavioral Health Team has met with staff from the St Mary's County Health Department and Walden Sierra to begin discussions on establishing an SBIRT training and tracking system for Charles County providers. Number of SBIRT trainings held: 0 Number of people trained in SBIRT: 0 Number of agencies using SBIRT: 2 *4. Crisis Intervention Training:*

Table III: Initiative 4: Mental Health

	Crisis response: Established contract with provider to provide follow up response to referrals of individuals with mental illness by law enforcement officers. Crisis Intervention Training: Nothing concrete in Charles County in FY16. Finally got some buy in and dedicated staff in the summer of FY17, so will have more to report soon. Plan to hold first regional training in May 2017.
Single or Multi-Year Initiative Time Period	Multi-year (2012 to present)
Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, PHCC Behavioral Health Team, Charles County Core Service Agency, Vesta Inc, Freedom Landing, NAMI Southern Maryland , Charles County Public Schools, College of Southern Maryland, American Foundation for Suicide Prevention
Impact/Outcome of the Hospital Initiative	Process measures will track the number of people educated in mental health first aid, the number of community events hosted, and the number of people attending in community events. Impact measures: Long Term Measures: Reduce the Charles County mental health emergency department visit rate from 3045.8 per 100,000 to 3015 per 100,000 (1% reduction). Source: 2013 Maryland HSCRC data from SHIP website Intermediate Measures: Increase the proportion of adults and children with diagnosed mental health disorders from 12.2% to 13% (anxiety disorders) and from 10.4% to 11% (depressive disorders). (BRFSS) Increase the number of public mental health treatment admissions and increase clients who report being very satisfied with treatment from 19.9% in 2015 to 25% (PMHS OMS). Increase persons with co-occurring substance abuse and mental health disorders who receive treatment for both from 382 in FY14 to 420 (10% increase). (Crystal Report MARS0002 for Dual Diagnosis with SMI/SED). Increase the number of people receiving treatment for abuse or dependence of opiates and/or illicit drugs in the past year by 5%.

Table III: Initiative 4: Mental Health

Evaluation of Outcome	***Engage and educate all segments of the community on behavioral health to promote resources, to reduce stigma, and to increase awareness.*** *1. Expand the Mental Health First Aid training in the Charles County Public Schools and in the general community and work collaboratively with the Charles County Public School to implement Lauren's Law:* The Charles County Core Service Agency has been training school personnel, local law enforcement, first responders, and other community members on Mental Health First Aid. The Charles County Public Schools had a staff member trained as a trainer. This staff members trained all school counselors, principals, and other interested staff. Mental Health First Aid is a well-known and evidence-based program to help community members to identify the signs and symptoms of mental health disorders and how to mitigate situations. Number of people trained in Mental Health First Aid: 96 Number of school personnel trained in Youth Mental Health First Aid: 141 *2. Behavioral Health Provider in ED: Contract with Calvert Memorial Hospital to bring Behavioral Health trained provider to improve access and appropriate treatment for patients in the ED with mental health or substance use disorders.* Number of patient visits: *3. Promote the KNOW Mental Health NO Stigma campaign in Charles County. Create a county awareness campaign to educate the general public on the definition of behavioral health.* <u>Other presentations held to educate on mental health:</u> 2 1. safeTALK Presentation: 19 in attendance 2. Traumatic Brain Injury and Substance Use and Domestic Violence Presentation: 29 in attendance <u>Out of the Darkness Walk</u>: The second Southern Maryland Out of the Darkness Walk was held in September 2014 in Port Tobacco, MD. The event was well attended and exceeded fundraising goals for suicide prevention efforts. Number of people participating in the suicide prevention and awareness walks: 473 <u>Community Awareness Events</u> to raise awareness of mental health and substance use disorders: The events raise awareness and provide information and resources to those who may be in need of treatment for one or both of those disorders.

Table III: Initiative 4: Mental Health

	Number of community events hosted: 8 Number of encounters at community events: 2500 *3. Increase county capacity to screen and refer patients using the Screening and Brief Intervention and Referral for Treatment (SBIRT) model.* SBIRT Training for ED and Primary Care Providers: The Behavioral Health Team has met with staff from the St Mary's County Health Department and Walden Sierra to begin discussions on establishing an SBIRT training and tracking system for Charles County providers. Number of SBIRT trainings held: 0 Number of people trained in SBIRT: 0 Number of agencies using SBIRT: 2 *4. Crisis Intervention Training:* Crisis response: Established contract with provider to provide follow up response to referrals of individuals with mental illness by law enforcement officers. Crisis Intervention Training: Nothing concrete in Charles County in FY16. Finally got some buy in and dedicated staff in the summer of FY17, so will have more to report soon. Plan to hold first regional training in May 2017. No performance metrics to report in Year 1. Impact Measures: *Reduce the Charles County mental health emergency department visit rate from 3045.8 per 100,000 to 3015 per 100,000 (1% reduction). Source: 2013 Maryland HSCRC data from SHIP website* No updates are available since Fy16 is Year 1 of implementation.
Continuation of Initiative	Initiatives will continue in next fiscal year. This priority has been identified as a priority in the 2015 CHNA Process.

Table III: Initiative 4: Mental Health

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative • Staff time for Case Management $ 108 • Subsidy to Behavioral Health Provider: $269,448 Total: $269,556	B. Direct offsetting revenue from Restricted Grants

Table III: Initiative 5: Mobile Integrated Healthcare

Identified Need	From 1/1/15-11/30/15, a total of 20 patients made at least 20 visits or more to the University of Maryland Charles Regional Medical Center Emergency Department. They accounted for a total of 643 visits. That is an average of 32 visits per patient. Visit counts ranged from 20 visits to 124 visits per patient in the 11 month time frame. The majority of the patients had either Medicaid (55%) or Medicare (35%) as their primary health insurance. Managing their conditions in the primary care and home setting could lead to a reduction in hospital visits and a needed reduction in the 30-day readmissions rate to avoid penalties. Most of the high utilizers were discharged to their homes for self care after they have been treated in the acute hospital setting. The most commonly reported reasons for their visits included pain, shortness of breath/trouble breathing, chest pain, and behavioral health conditions. These patients could greatly benefit from community resources to help them self manage their disease processes and how changes to the home can improve their health. A second analysis of ED utilization was conducted in December 2015 using the time frame January 1-November 30, 2015. The criteria for inclusion were any patient with 20 or more visits to the emergency department during the specified time period. The data was queried by the transition nurse case manager using the HSCRC database. From January 1, 2015 through November 30, 2015, a total of 20 patients made at least 20 visits or more to the University of Maryland Charles Regional Medical Center Emergency Department. They accounted for a total of 643 visits. That is an average of 32 visits per patient. Visit counts ranged from 20 visits to 124 visits per patient in the 11 month time frame. The majority of the patients had either Medicaid (55%) or Medicare (35%) as their primary health insurance. The average number of visits among patients with Medicaid was 25 visits per patient. The average number of visits among patients with Medicare was 82 visits per patient. Managing their conditions in the primary care and home setting could lead to a reduction in hospital visits and a needed reduction in the 30-day readmissions rate to avoid penalties. Most of the high utilizers were discharged to their homes for self care after they have been treated in the acute hospital setting. The most commonly reported reasons for their visits included pain, shortness of breath/trouble breathing, chest pain, and behavioral health conditions. These patients could greatly benefit from community resources to help them self manage their disease processes and how changes to the home can improve their health. Access to Care was identified in the CHNA process as a priority for Charles County. The Charles County Mobile Integrated Healthcare

Table III: Initiative 5: Mobile Integrated Healthcare

	Project was planned and developed to address this priority and decrease the unnecessary and over-utilization of the hospital as well as emergency medical services transport.
Hospital Initiative	Mobile Integrated Healthcare: Reduce Emergency Department (ED) utilization and Emergency Medical Services (EMS) transports among high utilizers by linking them with care coordination and community health services.
Total Number of People within the Target Population	152,864 (County Population as reported in CHNA)
Total Number of People Reached by the Initiative	None at this point. The program is still in the development phase. It will begin Fall 2016.
Primary Objective of the Initiative	

Major Action or Step:	*Deliverable:*
Hold meetings of the MIH committee to start implementation of MIH project.	Monthly in the beginning and quarter after program has been implemented.
Hire a paramedic, nurse practitioner, and 2 community health workers.	4 total staff hired
Establish contact with hospital high utilizers each year and educate them on the program. Recruit and maintain contact with hospital high utilizers	30 hospital high utilizers educated 10 hospital utilizers recruited and engaged
Establish contact with EMS high utilizers and educate on the program. Recruit 5 EMS high utilizers as participants	20 EMS high utilizers educated 5 EMS high utilizers recruited
Establish contact with community agency referrals and educate on program. Recruit community agency referrals as participants	20 community agency referrals educated 5 community agency referrals recruited
Conduct initial team visits within 24-48 hours of discharge	80% of all initial home visits within 24-48 hours
Give people the tools to manage disease processes	# of people receiving this service
Improve the safety of the home through environmental scan and subsequent education	# of home safety inspections conducted
Connect people to a primary care provider or re-connect them to their primary care provider	75% of participants connected with PCP

Table III: Initiative 5: Mobile Integrated Healthcare

	Educate on appropriate use of the emergency department and emergency medical services	# of people receiving this service
	Link individuals to social services and transportation to prevent barriers to access	# of people receiving this service
	Connect them to specialists for disease processes	# of people receiving this service
	Maintain communication with participants through the community health workers to ensure they are engaged and have needed services.	# of phone calls # of visits
	Conduct subsequent home visits by MIH team when needed.	# of subsequent home visits
Single or Multi-Year Initiative Time Period	Multi-year initiative	
Key Partners in Delivery	University of Maryland Medical System, Partnerships for a Healthier Charles County, Health Partners, Inc, Maryland Community Health Resource Commission, Charles County Department of Health, Charles County Emergency Medical Services	
Impact/Outcome of Hospital Initiative	*Primary Long Term Outcome:* A reduction in the hospital readmission rate to the Medicare all cause, all payer readmission rate of 10.39%. The indicator for Primary Outcome is the University of Maryland Charles Regional Medical Center 30-day readmission rate. Rates are calculated by calendar year and have been adjusted to remove planned admissions. The Measurement Tool for Primary Outcome Indicator is the University of Maryland Charles Regional Medical Center PAU Analytical Report. Sources of data are from the Maryland Health Services Cost Review Commission and the Chesapeake Regional Information Systems for our Patients (CRISP). *Secondary Long Term Objective Outcome:* A 10% reduction in the EMS transport rate due to less usage among high utilizers for non-emergent transport. The indicator for Secondary Outcome is the Charles County Department of Emergency Services transport rate. The Measurement Tool for Primary Outcome Indicator is Charles County Department of Emergency Services Electronic Health Record System. The data would be queried by the department's quality assurance officer. **Intermediate Objectives will include:** -Recruit 10 hospital high utilizers to participate in the program (5 in the first half of Year 1 and 5 in the second half of Year 1) -Recruit 5 EMS high utilizers to participate in the program	

Table III: Initiative 5: Mobile Integrated Healthcare

	-Recruit 5 participants to the program from partnering community agencies (Community Services, Social Services, AERS, etc) -Increase the number of participants who visit their primary care providers twice a year for routine care -Increase health literacy by educating participants on prevention/management of their disease processes -Decrease the number of Emergency Department visits/911 System calls among participants by 25% in Year 1 -Decrease the average number of ED visits among high utilizers from 32 to 24 visits per patient. -Work with hospital finance department to determine cost savings related to decrease hospital and ED usage among participants Process measures have been outlined for each objective in the primary objective section above.	
Evaluation of Outcome	The Charles County Department of Health, in collaboration with the University of Maryland Charles Regional Medical Center and Charles County Department of Emergency Services, applied for funding from the Maryland Community Health Resource Commission to initiate the Charles County Mobile Integrated Healthcare Project. University of Maryland Charles Regional Medical Center co-funded this project with Maryland Community Health Resource Commission for the three year period. Funding was received in Spring 2016 with a tentative start date for Fall 2016. This program is in the planning phase and will begin in early FY17. Therefore, there are no outcomes and performance measures to report at this time.	
Continuation of Initiative	This project has been in the planning phase. The three-year grant funding from the hospital began in FY 2016 and the Maryland Community Health Resource Commission funding will begin in FY 2017.	
Expense: Total Cost of Initiative and What amount is restricted grants/direct Offsetting Revenue	A. Total Cost of Initiative • $50,000 from the hospital in FY16	B. Direct Offsetting Revenue from Restricted Grants

Table III: Initiative 5: Mobile Integrated Healthcare

Table III: Initiative 6: Obesity

Identified Need	Prevalence of overweight in HS students: 17% overall, Hispanic (25%) and AA (18%) more likely to report being overweight. Obese: 12% overall Hispanic (13%) and AA (13.5%) more likely to report being obese. Adults: 72.1% overweight or obese Charles County has the second lowest percentage of adults at a healthy weight (27.9%). CC AA less likely to be at a healthy weight (24.8%) than CC Whites (31.7%). The percentage of children who are obese and the percentage of adults at a healthy weight have both been identified as priorities through the Maryland State Health Improvement Process. Yes, this was identified through the CHNA process.
Hospital Initiative	Initiatives: 1. Increase access to healthy foods 2. Enhance the built environment to support active living 3. Create a 'Community of Wellness' through community engagement
Total Number of People within the Target Population	72.1% of the Charles County adults (18+) are either overweight or obese: 83,791 29% of CC HS students (15-19 years) are overweight or obese: 1689 Target population: 1689+83791=85,480
Total Number of People Reached by this Initiative	11500
Primary Objective of the Initiative	***1. Establish, Re-establish, and enhance programs to educate the community on healthy foods such as the Grow It, Eat It Program, Refresh, and the Master Gardener Program.*** Number of partners Number of schools participating Number of students educated through the program Number of new community gardens established **2.** ***Support county businesses in their adoption of policy changes for nutrition and physical activity strategies. Support and promote worksite (and/or community) wellness and/or group exercise programs and activities i.e. Parks and Recreation.*** Number of businesses enrolled in Maryland Healthiest Businesses **3.** ***Support walking groups that encourage community-wide organized physical activity, social support, and enhanced access to local facilities.***

Table III: Initiative 6: Obesity

	Number of people participating Number of organizations partnering **4. *Increase the membership of the Chronic Disease Prevention Team to enhance their abilities to reach the general population and the underserved communities.*** Number of new members Number of meetings held
Single or Multi-Year Initiative Time Period	Multi-Year Initiative (2012-present)
Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, Charles County Department of Health, The Judy Centers, Charles County Community Services, College of Southern Maryland, University of Maryland Extension Office, Charles County Public Schools, Maryland Healthiest Businesses Initiatives, Community Transformation Grant
Impact/Outcome of Hospital Initiative?	Process measures on number of individuals reached through health education and preventive screenings, number of encounters at community events, number of schools involved in school-based programs, number of stores participating in Healthy Stores initiatives, number of businesses recruited for Maryland Healthiest Businesses. Outcome measures evaluate any reduction in childhood obesity percentages for the county using WIC data for the 2-5 year old population and the Youth Risk Behavior Survey data for children aged 13-18 years. The Behavioral Risk Factor Surveillance System is used to determine any reductions in adult obesity percentages.
Evaluation of Outcomes	Process: Multiple events and initiatives were implemented. These include: Youth Triathlon: The University of Maryland Charles Regional Medical Center, in collaboration with the Charles County Department of Health and Charles County Parks and Rec, hosted a youth triathlon in July 2015 at North Point High School. Number of youth triathlon participants: 125 Community 5K: The University of Maryland Charles Regional Medical Center, in collaboration with the Charles County Department of Health and Charles County Parks and Rec, hosted a community 5K in October 2015 at La Plata High School. They also offered blood pressure screening and stroke prevention at this event. Number of Community 5K participants: 59 Charles County Fair: The Chronic Disease Prevention Team hosts a table

Table III: Initiative 6: Obesity

	each year at the Charles County Fair on Fair Friday. The Charles County Public Schools are closed on Friday to allow the school children to attend the fair. This is a great opportunity to reach these children and their families. They provide apples as a healthy alternative to traditional fair food. They also play a game with the children and teach them facts about nutrition in order to "win" their apple. They had a total of 1000 encounters at the fair. Maryland Healthiest Businesses: The Charles County Department of Health, with support from the University of Maryland Charles Regional Medical Center, received a worksite wellness readiness grant from the Maryland Healthiest Businesses. Businesses who enroll will receive help to complete the CDC Worksite Wellness Scorecard. Once weaknesses and gaps are identified, the businesses are given resources and recommendations on how they can make changes to their current wellness policies and how to become healthier worksites. Number of businesses enrolled in Healthiest Maryland Businesses: 35 Number of employees educated on worksite wellness through initiative: 11500 <u>Impact:</u> 2013 YRBS Obesity Rate: 12.3%. This shows progress from our baseline percentage of 13.3%. We are still working toward our goal of 11.2%. The percentage of Charles County residents who are overweight or obese continues to rise from 70.6% in 2010 to 72.1% in 2013. 2013 BRFSS results showed a decrease in the number of Charles County residents who are at a healthy weight from 29.4% in 2010 to 27.9% in 2013. The Charles County percentage (27.9%) remains below the state average of 35.8%.
Continuation of Initiative	Initiatives will continue in next fiscal year.

Table III: Initiative 6: Obesity

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative • Staff time for Youth Triathlon and Community 5K $ 288.00 • Staff time $383.00 • Cost of apples $159.00 Total: $830	B. Direct offsetting revenue from Restricted Grants

Table III: Initiative 7: Substance Use Disorders

Identified Need	Adults: Charles County Behavioral Risk Factor Surveillance System (BRFSS) data 4% adults chronic alcoholics; 18% binge drinking in past month; Adult National Survey of Drug Use and Health(NSDUH): Southern Maryland Regional Data: 51% have used alcohol in past month (18-25); 10.5% have abused prescription drugs in last yr (18-25 yrs). Youth Tobacco and Risk Behavior Survey (YTRBS): 61% of HS students have used alcohol; 36% of youth have used marijuana; 11% of youth have used cocaine; 20% youth have abused prescription drugs/heroin Addictions related ED visit rate: 1200.4 per 100,000. CC White 1500, CC AA rate 1122.8, CC Hispanic 261.2. CC rate has increased from 868.6 in 2010 to 1200.4 in 2013. Drug-induced death rate: 11.2 per 100,000, CC White 17.3. ED visit rates for addictions-related conditions and drug-related death rates are established measures from the Maryland State Health Improvement Process. Yes, this was identified as a need through the CHNA Process.
Name of Hospital Initiative	<u>Initiative:</u> Increase county capacity to provide services and treatment for opioid use and overdose.
Number of people within the target population	Approximately half of Charles County adults have consumed a substance in the past month: 73,276. 61% of HS Students surveyed reported they had consumed a substance in the past month. 61% of CC population 15-19 years: 3553 Target Population: 3553+73276=77279
Number of people reached by the initiative within the target population	11780
Primary Objective of the Initiative	***1. Engage and educate all segments of the community on behavioral health to promote resources, to reduce stigma, and to increase awareness.*** <u>Community Events</u>: Residents are educated on behavioral health at community events such as the county fair and Community Resource Day.

Table III: Initiative 7: Substance Use Disorders

	Number of community events attended: Number of encounters at community events: Drug-free events: Project Graduation is run each year as a drug free alternative for Charles County graduating seniors. Number of students attending Project Graduation: Online Newsletter: The College of Southern Maryland has continued using the Student Health 101 online newsletter to educate all students on health issues, including smoking cessation, the dangers of binge drinking, stress, sleep, and other health conditions. Number of online newsletters sent to college students on alcohol, smoking, and health Number of students receiving the newsletters Opiate Awareness Campaign: Number of awareness campaigns initiated: Community Presentation: Number of presentations: Number of participants educated: ***2. Increase county capacity to provide services and treatment for opioid use and overdose.*** Charles County Prescription Drug Take Back Program : This program was developed through a partnership of University of Maryland Charles Regional Medical Center, Charles County Government, the Governor's Office of Crime and Prevention and 6 local privately owned pharmacies to provide safe, convenient and responsible means to dispose of all medications. The program did not start until FY 17 however planning for the project began in FY 16. Train county agencies and community members on Naloxone distribution: Number of Naloxone trainings conducted: Number of citizens trained in Naloxone administration: SBIRT Training for ED and Primary Care Providers: The Behavioral Health Team has met with staff from the St Mary's County Health Department and Walden Sierra to begin discussions on establishing an SBIRT training and tracking system for Charles County providers.

Table III: Initiative 7: Substance Use Disorders

	Number of SBIRT trainings held: Number of people trained in SBIRT: Number of agencies using SBIRT:
Single or Multi-Year Initiative Time Period	Multi-year (2012 to present)
Key Collaborators in Delivery	University of Maryland Charles Regional Medical Center, PHCC Behavioral Health Team, Charles County Department of Health, College of Southern Maryland, Charles County Substance Abuse Advisory Coalition, Charles County Sheriff's Office, Citizens for Substance Free Youth, Charles County Public Schools, Charles County Commissioners, Walden Sierra
Impact/Outcome of Hospital Initiative?	Process measures will track the number of community events hosted, and the number of people attending in community events, etc. to determine if we have met the goals and expectations set by those programs. All performance measure tracked throughout the year. Impact measures: New Maryland Youth Risk behavior survey data was released in May 2014. Data on 30-day use and binge drinking were examined to determine if any reductions can be seen. Additionally, the CORE Alcohol and Drug Survey was conducted at the College of Southern Maryland to determine if any changes have been made in binge drinking levels and in perceptions of harm and acceptance for binge and underage drinking. SMART data (all individuals receiving substance use disorder treatment through a publicly funded program) will be tracked for increases in the number of people receiving treatment for opiates and illicit drugs. Enhanced communication between the health department and hospital case managers will help to track the number of hospital staff using SBIRT and the number of people they refer to the health department for substance use treatment from the ED.
Evaluation of Outcome	***1. Engage and educate all segments of the community on behavioral health to promote resources, to reduce stigma, and to increase awareness.*** <u>Community Events</u>: The PHCC Behavioral Health Team and the Charles County Substance Abuse Advisory Coalition attended community events in order to educate the community and parents about the dangers of underage drinking and the consequences of providing alcohol to minors. Some events include: the Charles County fair, Homeless Resource Day, and the Living Healthy and Drug Free in Charles County Awareness Day. Number of community events attended: 15 Number of encounters at community events: 8175

Table III: Initiative 7: Substance Use Disorders

	Drug-free events: The Charles County Public Schools, in partnership with the Charles County Sheriff's Office, the Charles County Commissioners, and the Charles County Substance Abuse Advisory Coalition, held the 29th annual Project Graduation for all Charles County graduating seniors. The event is a drug and alcohol free celebration held after the high school graduation nights. Seniors and their guests are presented with information on the dangers of underage drinking. The Charles County Substance Abuse Advisory Coalition also held its annual fishing derby to get children outdoors and talk to them about safety and being drug-free. Number of students attending Project Graduation: 1575 Online Newsletter: The College of Southern Maryland has continued using the Student Health 101 online newsletter to educate all students on health issues, including smoking cessation, the dangers of binge drinking, stress, sleep, and other health conditions. Number of online newsletters sent to college students on alcohol, smoking, and health: 7 Number of students receiving the newsletters: 1500 Opiate Awareness Campaign: An awareness campaign was conducted in the county using ads on VanGo buses (county public transit system). In November 2015, three bus ads with the tagline "Opiates kill" and another regarding prescription drug abuse were placed on county transit buses that circulate the county. The ads ran for a 90 day period and will be seen throughout the county. Number of awareness campaigns initiated: 1 Community Presentation: In April 2016, the College of Southern Maryland, in collaboration with the Charles County Substance Abuse Advisory Coalition, held a presentation titled What's New in the Drug World. The landscape of adolescent substance abuse is a forever changing phenomenon. This training provided up-to-date information and guidance that can be used by professionals as well as parents to equip them with knowledge to work with youth. Participants learned recent drug trends as it relates to adolescent substance abuse from opiates, to vaping, and cannabis. This class discussed current statistical data related to adolescent substance abuse trends and work to identify patterns to focus on. The presentation objectives included: 1. Increase awareness of current trends in adolescent substance abuse. 2. Learn and review drug slang terminology. 3. Identify substance abuse patterns. Number of participants attending this event: 100

Table III: Initiative 7: Substance Use Disorders

	2. Increase county capacity to provide services and treatment for opioid use and overdose. <u>Train county agencies and community members on Naloxone distribution</u>: Number of Naloxone trainings conducted: 35 Number of citizens trained in Naloxone administration: 430 <u>SBIRT Training for ED and Primary Care Providers</u>: The Behavioral Health Team has met with staff from the St Mary's County Health Department and Walden Sierra to begin discussions on establishing an SBIRT training and tracking system for Charles County providers. The University of Maryland Charles Regional Medical Center's Emergency Department is very interested in being trained and implementing this initiative in this fiscal year. The team will continue its focus on this initiative in Years 2 and 3. The Center for Children, the county's mental health provider for children, and Greater Baden Medical Center, the county's FQHC, have begun screening their patients using SBIRT at all of their clinic locations. The team will continue its focus on this initiative in the coming months. Number of SBIRT trainings held: 0 Number of people trained in SBIRT: 0 Number of agencies using SBIRT: 2 <u>Other Activities not yet addressed in Year 1</u>: -Recruit county providers who are trained at prescribing Suboxone. - Promote and support the Charles County Sheriff's Office Prescription Take Back Program. Impact Measures: 1*. Reduce the Charles County addictions-related emergency department visit rate from 1200.4 per 100,000 to 1188 per 100,000 (1% reduction) Source: 2013 Maryland HSCRC data from SHIP website* This is Year 1 of the implementation plan; therefore, an update is not yet available for our long term objective.
Continuation of Initiative	Initiatives will continue in next fiscal year.

Table III: Initiative 7: Substance Use Disorders

A. Total Cost of Initiative for Current Fiscal Year B. What amount is Restricted Grants/Direct offsetting revenue	A. Total Cost of Initiative • Cost of planning time and bags for pharmacies $10,860	B. Direct offsetting revenue from Restricted Grants

Appendix I
HSCRC Community Benefit Report FY 2016
Financial Assistance Policy Description
University of Maryland Charles Regional Medical Center (UM CRMC)

UM CRMC posts its charity care policy, or a summary thereof, as well as financial assistance contact information in admissions areas, emergency rooms, business offices and other areas of the facility where eligible patients are likely to present. The policy is posted in the local paper twice each year. Additionally, the policy and plain language version are available on the hospital's public website.

The FAP is written in a culturally sensitive and at an appropriate reading level. It is available in English and Spanish. All Patient Access Customer Service Staff have training in the financial assistance process.

During the intake or discharge process or when there is contact regarding a billing matter, if a patient discloses financial difficulty or concern with payment of the bill, the patient is provided with FAP information. A packet with the application, criteria and a documentation checklist is provided. Assistance completing the application is available. Additionally, assistance is provided for patients or their families in qualification and application of government benefits, Medicaid and other state programs. Once an application is processed and if it is deemed incomplete, a letter is sent to the patient requesting the missing or incomplete items. Patients may call the Call Center or come into the Patient Access Office for assistance.

New Financial Assistance Policy Changes Pursuant to the ACA

ACA Health Care Coverage Expansion Description

Since implementation of the Affordable Care Act's (ACA) Health Care Coverage Expansion Option became effective on January 1, 2014, there has been a decrease in the number of patients presenting to the hospital in either uninsured and/or self-pay status. Additionally, the ACA's Expansion Option included a discontinuation of the primary adult care (PAC) which has also reduced uncompensated care. While there has been a decrease in the uncompensated care for straight self-pay patients since January 1, 2014, the ACA's Expansion Option has not completely eradicated charity care as eligible patients may still qualify for such case after insurance.

The following additional changes were also made to the hospital's financial assistance policy pursuant to the most recent 501(r) regulatory requirements:

1. **LANGUAGE TRANSLATIONS**
    a. Requirement: The new 501(r) regulations lowered the language translation threshold for limited English proficient (LEP) populations to the lower of 5% of LEP individuals in the community served/1000-LEP individuals. University of Maryland Charles Regional Medical Center translated its financial assistance policy into the following languages: Spanish
2. **PLAIN LANGUAGE SUMMARY**
    a. Requirement: The new 501(r) regulations require a plain language summary of the FAP that is clear, concise, and easy for a patient to understand. University of Maryland Charles Regional Medical Center created a new plain language summary of its financial assistance policy in addition to its already-existing patient information sheet.

3. **PROVIDER LISTS**
    a. Requirement: The new 501(r) regulations require each hospital to create and maintain a list of all health care providers (either attached to the FAP or maintained as a separate appendix) and identify which providers on that list are covered under the hospital's FAP and which providers are not. University of Maryland Charles Regional Medical Center maintains that list which is available for review.

Hospital	FAP Language Translations
UM Baltimore Washington Medical Center	English; Spanish; Korean
UM Charles Regional Medical Center	English; Spanish
Mt. Washington Pediatric Hospital	English; Spanish; French; Chinese
UM Shore Regional Health	English; Spanish
UM St. Joseph Medical Center	English; Spanish; French; Russian; Chinese; Korean; Vietnamese; Tagalog
University of Maryland Medical Center	English; Spanish; French; Chinese
UMMC-Midtown Campus	English; Spanish; French; Chinese
UM Rehabilitation & Orthopaedic Institute	English; Spanish; French; Russian; Chinese; Korean; Vietnamese; Tagalog
UM Upper Chesapeake Health	English; Spanish

TITLE: GUIDELINES FOR THE FINANCIAL ASSISTANCE PROGRAM

POLICY NUMBER: AD-0150

EFFECTIVE: January, 1999 LAST REVISED: May, 2016

POLICY:

1. This policy applies to University of Maryland Charles Regional Medical Center (UM CRMC). UM CRMC is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.

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

3. UM CRMC will publish the availability of Financial Assistance on a yearly basis in the local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Signage in key patient access areas will be made available. A Financial Assistance Information Sheet will be provided to patients receiving inpatient services, and a Financial Assistance Information Sheet made available to all patients upon request.

4. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

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

6. Account(s) will be written off to bad debt and assigned to a collection agency generally between 90 - 120 days from the date of discharge and after communication with the customer has failed to produce a plan to liquidate the account(s). With approval from the Patient Accounts Department, Extraordinary Collection Actions (ECAs) may be taken on accounts that have not been disputed or are not on a payment arrangement. These actions will occur no earlier than 120 days from submission of first bill to the patient and will be preceded by notice 30 days prior to commencement of the action. Availability of

financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

7. UM CRMC staff/designee will pursue all collection activities available for the purpose of collecting amounts legally due and owed to include the following:

- Dunning
- Suit
- Exercise of liens
- Wage attachments

PROCEDURE:

I. Program Eligibility

A. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, UM CRMC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. UM CRMC reserves the right to grant Financial Assistance without formal application being made by our patients.

Specific exclusions to coverage under the Financial Assistance program may include the following:

1. Services provided by healthcare providers not affiliated with UM CRMC (e.g., home health services).

2. Patients whose insurance denies coverage for services due to patient's noncompliance of insurance restrictions, rules and access (e.g., insurance requires use of capitated facility and patient was non-compliant; therefore claim was denied), are not eligible for the Financial Assistance Program.

    a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made considering medical and programmatic implications.

3. Unpaid balances resulting from cosmetic or other non-medically necessary services.
4. Patient convenience items.
5. Patient meals and lodging.
6. Physician charges related to the date of service are excluded from UM CRMC's financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.

B. Patients may become ineligible for Financial Assistance for the following reasons:

1. Refusal to provide requested documentation or providing incomplete information.
2. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to UM CRMC due to insurance plan restrictions/limits.
3. Failure to pay co-payments as required by the Financial Assistance Program.
4. Failure to keep current on existing payment arrangements with UM CRMC.
5. Failure to make appropriate arrangements on past payment obligations owed to UM CRMC (including those patients who were referred to an outside collection agency for a previous debt).
6. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.
7. Refusal to divulge information pertaining to legal liability claim.

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

D. Patients who indicate they are financially unable to pay an outstanding balance(s) shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance (See Section II below) eligibility criteria. If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership.

E. Standard financial assistance coverage amounts will be calculated based upon 200-300% of income, and hardship will be calculated based on hardship guidelines as defined by federal poverty guidelines and follows the sliding scale.

II. Presumptive Financial Assistance

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

1. Active Medical Assistance pharmacy coverage.
2. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums).
3. Homelessness.
4. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs.
5. Maryland Public Health System Emergency Petition patients.
6. Participation in Women, Infants and Children Programs ("WIC")
7. Food Stamp eligibility.
8. Maryland eligibility Family Planning Only.
9. Eligibility for other state or local assistance programs.
10. Patient is deceased with no known estate.
11. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.

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

1. Purely elective procedures (e.g., Cosmetic procedures) are not covered under the program.

III. Medical Hardship

A. Patients falling outside of conventional income or presumptive Financial Assistance criteria are potentially eligible for bill reduction through the Medical Hardship program.

1. Medical Hardship criteria is State defined:
   a. Combined household income less than 500% of federal poverty guidelines.
   b. Having incurred collective family hospital medical debt at UM CRMC exceeding 25% of the combined household income during a 12-month period. The eligibility period is 12-month from the date that the Medical Hardship application was approved.
   c. The medical debt includes co-payments, co-insurance, and deductibles.

B. Patient balance after insurance:

1. UM CRMC applies the State established income, medical debt and time frame criteria to patient balance after insurance applications.

C. Coverage amounts will be calculated based upon zero - 500% of income as defined by federal poverty guidelines and follows the sliding scale below:

ATTACHMENT I

Sliding Scale

FINANCIAL ASSISTANCE – INCOME GUIDELINES

Size of Family Unit	FPL Income	% of Federal Poverty Level Income - 2016											
		Up to 200%	Up to 210%	Up to 220%	Up to 230%	Up to 240%	Up to 250%	Up to 260%	Up to 270%	Up to 280%	Up to 300%	300% - 500%	
		Standard Financial Assistance - % of Reduction in Charges										Medical Hardship	
		100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	Patient Responsibility is 25% of Income	
1	11,880	23,760	24,948	26,136	27,324	28,512	29,700	30,888	32,076	33,264	35,640	35,640	③ 59,281
2	16,020	32,040	33,642	35,244	36,846	② 38,448	40,050	41,652	43,254	44,856	48,060	48,060	79,940
3	20,160	40,320	42,336	44,352	46,368	48,384	50,400	52,416	54,432	56,448	60,480	60,480	100,598
4	24,300	48,600	51,030	53,460	55,890	58,320	60,750	63,180	65,610	68,040	72,900	72,900	121,257
5	28,440	① 56,880	59,724	62,568	65,412	68,256	71,100	73,944	76,788	79,632	85,320	85,320	141,916
6	32,580	65,160	68,418	71,676	74,934	78,192	81,450	84,708	87,966	91,244	97,740	97,740	162,574
7	36,730	73,460	77,133	80,806	84,479	88,152	91,825	95,498	99,171	102,844	110,190	110,190	183,650
8	40,890	81,780	85,869	89,958	94,047	98,136	102,225	106,314	110,403	114,492	122,670	122,670	204,450

For families with more than 8 persons, add $4,160 for each additional person.

Patient Income and Eligibility Examples:

Example #1	Example #2	Example #3
- Patient earns $59,500 per year - There are 5 people in the patient's family - The % of potential Finance Assistance coverage would equal 90% (they earn more than $56,680 but less than $59,724)	- Patient earns $39,000 per year - There are 2 people in patient's family - The % of potential Financial Assistance coverage would equal 50% (they earn more than $38,448 but less than $40,050)	- Patient earns $58,000 per year - There is 1 person in the family - The balance owed is $20,000 - This patient qualifies for Hardship coverage, owed 25% of $59,281 ($14,821)

FPL = Federal Poverty Levels

D. If determined eligible, patients and their immediate family are certified for a 12-month period effective with the date on which the reduced cost medically necessary care was initially received.

E. Individual patient situation consideration:

1. UM CRMC reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.
2. The eligibility duration and discount amount is patient-situation specific.
3. Patient balance after insurance accounts may be eligible for consideration.
4. Cases falling into this category require management level review and approval.

F. In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance programs, UM CRMC is to apply the greater of the two discounts.

G. Patient is required to notify UM CRMC of their potential eligibility for this component of the financial assistance program.

IV. Asset Consideration

A. Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient responsibility without causing undue hardship. Individual patient financial situation such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are reviewed.

B. Under current legislation, the following assets are exempt from consideration:

1. The first $10,000 of monetary assets for individuals, and the first $25,000 of monetary assets for families.
2. Up to $150,000 in primary residence equity.
3. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement, account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans. Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.

V. Appeals

A. Patients whose financial assistance applications are denied have the option to appeal the decision.

B. Appeals can be initiated in writing.

C. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

D. Appeals are documented. They are then reviewed by the next level of management above the representative who denied the original application.

E. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.

F. The escalation can progress up to the Chief Financial Officer who will render a final decision.

G. A letter of final determination will be submitted to each patient who has formally submitted an appeal.

VI. Procedures

A. UM CRMC will provide a trained person or persons who will be responsible for taking Financial Assistance applications in Patient Access and Patient Accounts. These staff can be Financial Counselors, Billing Staff, Customer Service, etc.

B. Every possible effort will be made to provide financial clearance prior to date of service. The financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

1. Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.
2. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
3. UM CRMC will not require documentation beyond that necessary to validate the information on the Financial Assistance Application.
4. Applications initiated by the patient will be tracked, worked and eligibility determined within 30 days of receipt of completed application. A letter of final determination will be submitted to each patient that has formally requested financial assistance.
5. Incomplete applications/missing documentation will be noted in patient's account, and original documents will be returned to patient with instruction to complete and return for processing.

C. In addition to a completed Financial Assistance Application, patients may be required to submit:

1. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable).
2. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.
3. Proof of social security income (if applicable).
4. A Medical Assistance Notice of Determination (if applicable).

5. Proof of U.S. citizenship or lawful permanent residence status (green card).
6. Reasonable proof of other declared expenses.
7. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
8. Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted.

D. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UM CRMC guidelines.

1. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.

   a. If the patient does qualify for financial clearance, appropriate personnel will notify scheduling department who may then schedule the patient for the appropriate service.
   b. If the patient does not qualify for financial clearance, appropriate personnel will notify the scheduling staff of the determination and the non-emergent/urgent services will not be scheduled.
   c. A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.

E. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination up to three (3) years prior and the following three (3) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. Payments made for care received during the financial assistance eligibility window that exceed the patient's determined responsibility will be refunded if that amount exceeds $5.00.

F. The following may result in the reconsideration of Financial Assistance approval:

1. Post approval discovery of an ability to pay.
2. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to UM CRMC.

G. Patients with three (3) or twelve (12) months certification periods have the responsibility (patient or guarantor) to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

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

UNIVERSITY OF MARYLAND CHARLES REGIONAL MEDICAL CENTER

TITLE: **GUIDELINES FOR THE FINANCIAL ASSISTANCE PROGRAM**

FUNCTION: Administrative

POLICY NUMBER: AD-0150

ISSUE DATE: 01/99

REVIEW/REVISED DATE:

Revised: 04/00	Revised: 05/01	Revised: 06/02
Revised: 07/03	Revised: 01/04	Revised: 11/04
Revised: 04/06	Revised: 05/07	Revised: 05/08
Revised: 04/10	Revised: 03/11	Revised: 02/12
Revised: 02/13	Name Change: 07/13	Revised: 03/14
Revised: 02/15	Revised: 02/16	Revised: 05/16

APPROVED BY:

Shelley Culhane
Chair, Board of Directors

Date

Noel Cervino
President & CEO

Date

Erik Boas
Sr. Vice President, Finance/CFO

Date

NOTE: This policy was previously LD-004 (as of 04/10).

Disclosure Statement

Effective July 1, 2013, the name of Civista Health, Inc. was changed to University of Maryland Charles Regional Health, Inc. and the name of Civista Medical Center, Inc. was changed to University of Maryland Charles Regional Medical Center. For purposes of all Policies and Procedures, these new names are now operational and any inadvertent mention of Civista Health, Inc. or Civista Medical Center is now incorrect.

The shared drive is the official location for Organizational Policies and Procedures for University of Maryland Charles Regional Medical Center. The original of this Organizational Policy and Procedure document with required signature is available for review during regular business hours by contacting the Information Technology Department at 301-609-4495. University of Maryland Charles Regional Medical Center reserves the right to update or modify all policies, procedures, and forms at any time and without prior notice, by posting the revised version on this drive. **NOTE:** To ensure the integrity of these documents, each page is either scanned or converted and placed on this drive as a duplicate of the original.

APPENDIX IV

Contact Information

If you feel your rights have been violated in any way, please contact Performance Improvement immediately by calling 301-609-4310.

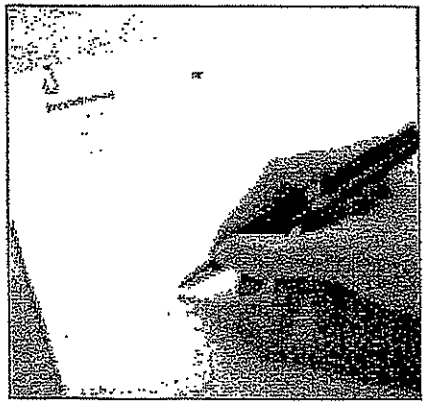
Contact & Phone Numbers:

For customer service in Billing, the hours of operation are 8:30am–4:00pm, Monday through Friday. We can be reached at 301-609-4400.

Patient Financial Services:
301-609-4400

Maryland Medical Assistance
800-284-4510

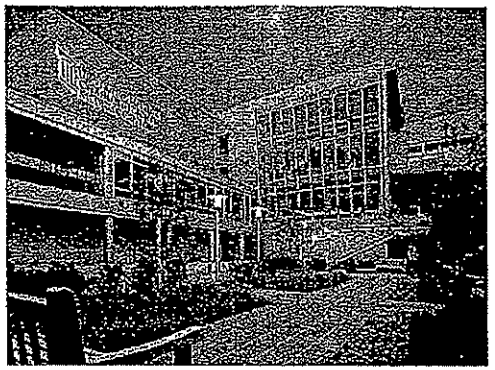
Department of Labor, Licensing and Regulation
301-645-8742



5 Garrett Ave.
PO Box 1070
La Plata, MD 20646
Phone: 301-609-4000
www.charlesregional.org

UNIVERSITY of MARYLAND
CHARLES REGIONAL
MEDICAL CENTER

PATIENT INFORMATION



Patient's Rights & Obligations

You have the right to:

1. Receive care and treatment at this hospital despite the ability to pay.
2. Receive consideration and respect by the staff during every phase of your care.
3. Be treated with dignity, respecting your spiritual, cultural, and personal values and beliefs.
4. Have respect for your privacy and for the confidentiality of information about you and your medical condition.
5. Be involved in decisions affecting your health care and well-being.
6. Know the name of the physician responsible for directing and coordinating your care as well as the names of other hospital caregivers.
7. Be informed about procedures and treatment and to refuse treatment as permitted by law.
8. Have questions answered about your condition and course of treatment.
9. Expect the health care professionals will accept and act upon your reports of pain and will provide education and resources available relating to pain management.
10. Be informed of available resources for resolving disputes, grievances, and conflicts.
11. Receive a written bill stating the Medical Center's charges.

You have the responsibility to:

1. Provide, to the best of your ability, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
2. Ask questions and request clear explanations of your care treatments and service in order to make informed decisions.
3. Follow the care, treatment, and service plan developed.
4. Be responsible for the outcomes if you do not follow the care, treatment and service plan provided to you.
5. Provide a copy of your advance directives power of attorney or domestic partnership affidavit if you have created such documents, to those responsible for your care while you are in the hospital.
6. Know and follow hospital rules and regulation, showing respect and consideration for other patients and individuals providing your health care.
7. Meet the financial commitments made with Civista Medical Center.
8. Inform Civista Medical Center as soon as possible if you believe that any of your rights have been or may be violated. You may do this at any time by calling the Office of the President at 301-609-4265 or Performance Improvement at 301-609-4310.

Hospital billing can be confusing. We hope that this brochure answers some of the questions that you may have regarding billing.

Physician Billing

You will receive multiple bills for your visit to the emergency room; as well as multiple bills for outpatient/inpatient services. Charles Regional Medical Center will submit a bill to you or your insurance company for our facility charges and/or the "technical" portion of the services. Your physician, surgeon, anesthesiologist, pathologist, radiologist, cardiologist, and Emergency Department physician will bill you separately for their professional services. Please contact them directly with your billing questions.

Emergency Medical Associates
240-686-2310

Radnet
301-438-5000

New Bridge Anesthesia
Anesthesia
301-638-4400

ABEO (Pathology Billing).
240-566-1603

Charles Regional Medical Center understands that patients may be faced with a difficult financial situation when they incur medical bills that are not covered by insurance. We encourage every patient and family to pursue all available programs that may be offered through the local Department of Social Services.

Financial Assistant

Charles Regional Medical Center can offer financial assistance to our patients who are denied state assistance. Please speak with a Customer Service Representative to determine if you may be eligible for either full or discounted services under this program. You may also contact a Customer Service Representative at 301-609-4400 for further information. Our financial aid programs will only apply to your hospital bills, and again, we encourage you to contact the Department of Social Services for assistance in paying your medical bills.

6 Garrett Ave.
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APPENDIX V

UNIVERSITY of MARYLAND
CHARLES REGIONAL HEALTH

OUR MISSION

University of Maryland Charles Regional Health exists to always provide excellent patient care as measured by the population's health, clinical outcomes, patient satisfaction and cost effectiveness.

OUR VISION

University of Maryland Charles Regional Health will remain the premier place to receive care and the premier place to provide care.