

Appendix 1

The Anne Arundel Medical Center has physician on-call rotations in every specialty for which there may be an emergency or inpatient need. On-call coverage is provided to all patients regardless of insurance status. There are no gaps in availability of any specialty for uninsured or underserved patients. In addition, the hospital has Hospitalist programs in Medicine, Pediatrics, General Surgery, Obstetrics and an Intensivist program. These physicians provide 24-hour in-house coverage for each of these areas for all patients regardless of insurance status. In addition the hospital and many of its physicians support the Anne Arundel County Health Department's REACH Program (Residents Access to a Coalition of Health), which offers access to affordable health services for low-income uninsured individuals in Anne Arundel County.

The Anne Arundel Medical Center continues to operate and support the Outreach Center, a 15 year old community-based, volunteer physician-led health resource center providing approximately 5,000 patient visits for uninsured residents in Anne Arundel County annually. The Outreach Center provides free medical and dental services through a volunteer network of 235 primary and specialty care physicians, 111 dentists, and 30 dedicated clinic volunteers. The Outreach Center is located in the Stanton Community Center in downtown Annapolis where the City of Annapolis provides space rent-free. Anne Arundel Medical Center gives access to its imaging, lab work, operating rooms, nursing support, and staff support with no charge to Outreach Center referred patients. Anne Arundel County Health Department and Mental Health Agency operate clinics within the Outreach Center. Between the medical, dental, and specialty clinics, the Center has 5000 visits each year.

The University of Maryland School of Nursing, Johns Hopkins University School of Nursing, University of Maryland School of Dentistry, and Anne Arundel Community College Physician Assistant Program have formal memorandums of understanding to perform credit-based community health rotations at the Outreach Center for their students.

The hospital collaborates with the County Health Department on the Health Smart Church Program. This grant-funded program provides health education and blood pressure monitoring at minority churches throughout the county. The hospital also collaborates with the County Health Department on the Learn to Live Program. This grant-funded program provides in-person point-of-purchase nutrition education at health department-targeted grocery stores throughout the county.

The Health System's Community Health and Wellness Department partners with the Annapolis and Anne Arundel County Coalition to End Homelessness to organize the County's Homeless Resource Day. The annual March event, now in its second year, assisted approximately 500 of the areas homeless residents to gain access to needed health and human services this past year. The Community Health and Wellness Department recruits healthcare providers from the public and private sectors - other county hospitals, clinics, universities, and colleges to provide healthcare services at the annual event.

Appendix 2

A. Notification of Charity Care and Financial Assistance

1. Public notice and information regarding the Anne Arundel Medical Center's charity care policy shall include the following:
 - a) Annual notice that charity care is provided and the criteria under which it will be provided will be published in the local newspaper, The Capital.
 - b) The notice provided by the United States Department of Health and Human Services regarding medical care for those who cannot afford to pay is posted at the point of admission, the business office, cashier, and emergency room.
 - c) Individual notice is provided to each person seeking service at the time of admission or pre-admission testing.

Appendix 3

Hospital Charity Care Policy

PURPOSE

- To promote access to all medically necessary services regardless of an individual's ability to pay.
- To provide a mechanism for evaluating each family's actual need for hospital financial assistance in lieu of other resources and payers.
- To ensure fair treatment of all applicants and applications.

POLICY

Anne Arundel Medical Center does not deny anyone access to medically necessary services based on ability to pay.

All Uncompensated Care applications shall be submitted to the Financial Counselors for processing. The Financial Counselors will process all applications according to Federal Poverty Guidelines - Category B and in a manner considered fair and equitable to all applicants.

ELIGIBILITY GUIDELINES

INCOME REQUIREMENTS

1. To qualify for the 100% charity allowance the yearly gross family income must not exceed 200% the current poverty income guidelines established by the Department of Health and Human Services.
2. To qualify for the 80% charity allowance the yearly gross family income must not exceed 230% the current poverty income guidelines established by the Department of Health and Human Services.
3. To qualify for the 60% charity allowance the yearly gross family income must not exceed 260% the current poverty income guidelines established by the Department of Health and Human Services.
4. To qualify for the 40% charity allowance the yearly gross family income must not exceed 300% the current poverty income guidelines established by the Department of Health and Human Services.
5. To qualify for the 20% charity allowance the yearly gross family income must not exceed 330% the current poverty income guidelines established by the Department of Health and Human Services.

Anne Arundel Medical Center 2008 Community Benefit Report

The Policy is summarized in the following table:

AAMC - Charity Guidelines Sliding Fee Schedule	
Income Category compared to the Federal Poverty Guideline	Charity Allowance
200% or Below	100%
Up to 230%	80%
Up to 260%	60%
Up to 300%	40%
Up to 330%	20%

Qualification may be calculated by either of the following methods:

- a) Multiplying by four the person's income for the three months preceding the determination of eligibility.
- b) Using the person's actual income for the 12 months preceding the determination of eligibility.

INCOME VALIDATION REQUIREMENTS

1. The process of determining the validity of the reported income may include any one of the following methods:
 - a) Most recent pay stubs preceding the determination.
 - b) Tax Return for the year preceding the determination.
 - c) Statement from the employer.
 - d) Statement from the applicant or spouse as to the lack of income.
 - e) Statement from an interested party having reasonable knowledge of the income status of the applicant, i.e., Anne Arundel Medical Center Patient Accounts Personnel, Social Worker, Clergy or Friend.

DETERMINATION OF ELIGIBILITY

Within two business days of a patient's initial request for charity care services, application for medical assistance, or both, the Financial Counselors will inform the applicant of their probable eligibility.

MEDICAID ELIGIBILITY

Applicants for Uncompensated Care who may qualify for Medicaid or Medical Assistance are required to apply for either Medicaid or Medical Assistance with the appropriate agency. The instruction should be given to the applicant at the time of the request and should be followed-up by the appropriate personnel. The applicant must be approved for Uncompensated Care when applicable and should not be denied or deferred on the basis of potential eligibility for Medicaid

Appendix 4

Hospital Mission Statement

Mission

To enhance the health of the people we serve.

Vision

To be the destination health system in our region.

Core Values

Passion for excellence is at the center of all that we do. The following values aid in this pursuit:

1. Compassion
2. Trust
3. Dedication
4. Quality
5. Innovation

Overarching Goals

1. To reinforce our core values daily
2. To attract and retain the best people
3. To foster collaboration with and among the medical staff
4. To provide excellent facilities, equipment and technology to provide world class quality care
5. To provide needed healthcare services in a financially responsible way
6. To develop a recognized brand in our region

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?
 - 62 inpatient beds
 - 3,725 inpatient admissions
 - 32,841 Emergency Room visits (significant in the services of AGH)
2. Describe the community or communities the organization serves.
 - Describe the geographic community or communities the organization serves.
 - Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet.

Worcester County is the easternmost county located in the U.S. state of Maryland. The county contains the entire length of the state's Atlantic coast line. It is home to the popular vacation resort area of Ocean City. The county is approximately 60 miles long. According to the U.S. Census Bureau, the county has a total area of 695 square miles of which, 473 square miles of it is land and 221 square miles of it is water.

The population is approximately 49,000 residents. According to the 2006 census the median income for a household in the county was \$40,650, and the median income for a family was \$47,293. The per capita income for the county was \$22,505. About **7.20%** of families and **9.60%** of the population were **below the poverty line**, including 17.00% of those under age 18 and 6.40% of those age 65 or over. The median age was 43 years. For every 100 females there were 95.20 males. Nearly one fourth of Worcester County residents are over 65. At Atlantic General our rate of Medicaid and self-pay patients was 7.83% of our revenue in FY08.

In the Worcester County Health Department report from 2005 the age-adjusted mortality rate is 800/100,000 and for the over 64 years of age population it was 4,000/100,000. Information from the same report showed the top three leading causes of death in the county were: #1 cancer, #2 cardiovascular disease, #3 accidents.

The largest concentration of the population is in the northern part of the county where the Ocean City resort area is located and the Berlin/Ocean Pines area; which is a Mecca for retirees who live here full time or divide their time between Maryland and Florida. The population of Ocean City increases by about 100,000 during the tourist season.

3. Identification of Community Needs:
 - a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done.

The hospital is currently working under the Strategic Initiatives which were developed for planning through 2010. Each year, within this framework the hospital makes plans for the upcoming year using the SWOT/GAP analysis model.

The documents used by the hospital to determine community needs are:

- the health assessment publication from the health department, 2005
- Worcester County Local Health Plan, FY 2008
- Tri-county Adolescents Association
- State of Maryland Cancer Registry
- latest census update for income levels regarding provision of resources for financial assistance support
- feedback from area physicians and community members
- questionnaires and evaluations from our community events
- NCR Pricker patient evaluations and feedback

Leadership members from the hospital sit on the boards of many community organizations including:

- the Local Management Board
- Public Safety Net Council
- Child Advocacy Board
- School Board
- YMCA
- Tri County Diabetes Alliance
- Chamber of Commerce of towns throughout the region
- Many Health Department councils

We also have a “Visions for Total Health Advisory Board” comprised of community providers of health related services including traditional as well as integrative health services. Through this committee we can keep our finger on the pulse of the area in which we serve. This committee gives us great feedback on services and programs that are needed, those that are working and those that aren’t. It is through this committee that we put on a major health conference each year which provides health education as well as screenings.

Our auxiliary volunteers are another great resource we use for keeping our pulse on the community. We have over 500 auxillians.

This year we were involved in a planning program for the county sponsored by the area chapter of American Cancer Society. We, along with state and county agencies plus various non-profit groups looked at data provided by a local survey (grant funded project) and state health disparities information to prioritize the disparities in our county. The big areas of need identified were: transportation, access to care, healthier life-styles.

3b. In seeking information about community health needs, did you consult with the local health department?

Yes, members of the hospital staff sit on many committees and boards of the health department. Also there are many members of the health department who sit on

committees within the hospital. We work very closely with our local health department to plan services to meet community needs and decrease the duplication of services.

4. Please list major needs identified through the process explained #3.

- Access to care, not enough physicians locally
- Mental health services
- Transportation to appointments, testing and treatments
- Specialty services
- Diabetes

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

As mentioned previously the hospital leadership developed, in 2005 the 5 year strategic plan for the institution. Within this framework we set organizational goals each year. Because our leadership is so involved in the community through serving on boards we have a good idea of community health needs. We also have Primary Care offices throughout our primary and secondary markets which give us a first hand look at community needs. We have 193 physicians on our medical staff which gives input.

Through the SWOT/Gap model the medical staff, hospital leadership, and management determine the needs we feel most need to be addressed that year. Each individual in management and leadership develops individual and department goals and senior leadership of the hospital determines the hospital's annual goals. It is through this process that the community benefit goals are determined.

Community Benefits is addressed by every department in the hospital and all participate on some level. There is a Community Benefits Committee, with members from each department, which oversees the process. The Community Education Department provides oversight to the Community Benefits Committee and Visions Advisory Board (see question 3) as well as all hospital departments regarding community benefits.

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

Yes, there are community benefit programs initiatives which address all the above mentioned needs:

- Access to care, not enough physicians locally
- Specialty services

AGH is always recruiting new physicians. During this year we acquired **3** primary care providers, **4** nurse practitioners, **2** ophthalmologists, **1** new neurologist as well as granting admitting privileges to other community physicians. The targeted recruitment specialties for next year are: endocrinology, anesthesia, ENT, urology and primary care.

Another way we are addressing access to care is through our physician's appointment line. This is a central number where a patient can call to schedule an appointment with any AGH physician. If their usual provider cannot see them that day they will be given an appointment with another provider and their records will be temporarily transferred to assure continuity of care.

The behind the scenes process which makes this process attainable is our electronic medical record system. This is a service which less than 7% of physician offices across the country can offer. We began the process this year of putting all patient records in our Atlantic General Health System offices into electronic format. This means they can be accessible to the physician at any of the outpatient offices or in the hospital for emergency room and inpatient admissions.

- Mental health services

Several members of our hospital staff are involved in the Worcester County Public Safety Net Council. This council is made up of: public health personnel, social services, crisis services, law enforcement, judicial system, the detention system and community affiliates. The purpose of this council is to address the mental health needs in the county. In addressing the mental health needs there will be less unnecessary hospitalizations and ER visits as well as needless incarcerations and judicial services.

As a result of this council existing mental health services are coordinated throughout the county are being promoted to the residents. A web site has been launched, <http://worcester.md.networkofcare.org> where people can access many resources for information, education and resources. Also helping to meet the mental health needs AGH is expanding one of our existing outpatient buildings, Atlantic Health Center (AHC). This expansion will house a new outpatient mental health program, including counselors and a psychiatrist.

- Transportation to appointments, testing and treatments

In providing a step in the solution to the transportation issue faced across our county we are ever increasing services throughout the area. In our county, as well as in most rural areas, people are reluctant to travel outside their immediate locale to get health services. Realizing this we believe an important part of providing care is to take as many services as possible into the communities we serve. As mentioned before we have acquired 3 primary care physicians and 4 nurse practitioners this year, increasing the number of patient visits that we can

accommodate in our primary care offices. We have also increased our lab and imaging services offered in our most distant community in the county. Part of our goals for FY08 was to increase the offering of health screenings and education to the distant areas of the county. We have added 3 hypertension clinics in those communities each month. We have also offered additional health fairs (with screenings) and education to area churches in those communities.

- Diabetes

Our Diabetes Education Department continues to offer diabetes education and counseling to our residents. In addition they participate in many health fairs, 2 community support groups and teaching classes through the health department. As mentioned before in the AHC expansion the Diabetes Education Department will be enlarging to include space for additional education and counseling services.

Two additional programs which we sponsor to address these and other community health needs is the Visions for Total Health Conference and the AARP Health Fair. Between the 2 events we served approximately 800 residents last year. At these events we provide free lab screenings for cholesterol, glucose and prostate. At these events there is health education on various topics as well as other screenings such as blood pressure, diabetes, stroke, pulmonary, body mass index, fitness and bone density. All services are free to the attendees.

7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major Community Benefit program initiatives.

1a. - Name of initiative: Visions for Total Health conference

b. Year of evaluation: 2006 and 2007

c. Nature of evaluation: participant satisfaction survey

d. Result of evaluation: Location and time of year for the conference was changed. It was moved from the busy tourist season in Ocean City to the fall (after the season) into the local high school. This change allowed us to serve the local community better and resulted in a higher attendance and increase in satisfaction according to the participant surveys.

2a. - Name of initiative: target minority group to recruit 250 participants into stroke risk program

b. Year of evaluation: FY 2008

c. Nature of evaluation: perform stroke risk questionnaire and blood pressure screening and registering for follow up through American Heart Association.

d. Result of evaluation: worked with the Stroke Center to provide screenings/registration/education in various venues resulted in registration of more than 250 participants into the program.

3a. – Name of initiative: Living Well Chronic Disease Self Management Program

b. Year of Evaluation: FY 2008

c. Nature of evaluation: comparison data of problems of daily life associated with chronic disease

d. Result of evaluation: of the 25 participants attending the program there was a self-reporting decrease of 30% to 50% in problems of daily life associated with chronic disease.

8. 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.

The number one determined specialty gap in services in our county is mental health providers. There is one full time psychiatrist for the nearly 50,000 residents. Because many of those, in need of mental health services, end up in the emergency department at the hospital it is a drain on the system. Problems that could be handled appropriately on an outpatient mental health basis end up becoming physical problems resulting in emergency room visits and hospital admissions or social problems resulting in arrests or incarcerations.

Another gap in specialty physicians is endocrinology. The diabetes rate in Worcester County is 14%, double the national rate. In this area, not even in this county, there is one endocrinologist. This puts a large burden on the primary care doctors, and diabetes programs to educate and manage diabetic patients. Because of lack of services many residents must go out of the eastern shore area for diabetic care and many go untreated or minimally managed.

In the northern part of the county the hospital has a walk-in site that treats patients and charges on a sliding fee schedule. In the next county to the southwest there is a similar medical service clinic (not run by AGH). This does somewhat serve the southern part of

the county but because of the rural nature of our area and the lack of comprehensive public transportation there is still a need for more such services.

Appendix 1

1. Describe your Charity Care Policy

Dedicated financial counselors help those who are uninsured or underinsured, with few resources on which to rely, navigate the options that may be available to them, including the available Maryland Medicaid programs. If no other financial avenues are available to a patient, he or she may apply for financial assistance for those services deemed medically necessary. We base our financial assistance on 200 percent of the poverty level guidelines set by the federal government. Financial Assistance is available to all patients who qualify. This year, Atlantic General Hospital and Health System dedicated just over \$1 million to this program.

The Charity Care information is in a brochure which can be found in all public waiting areas of the hospital and health system sites. We also run articles in our newsletters that are distributed in the homes of all residents in the county and service areas. Through the Case Management and Patient Financial Services Departments those in need are determined and guided through the process as described above.

Appendix 2

Attach Financial Assistance Policy

Appendix 3

2. Describe the hospital's mission, vision, and value statements.

Our President and CEO Michael Franklin, FACHE, recently said it best in an "On Call" article, "Achieving our Vision "To be the leader in promoting access to healthcare services..." and our Mission"...to improve individual and community health" means we must continue to courageously address issues that plague all communities, and create solutions for our community. More people are being diagnosed with chronic conditions, which can lead to a decline in the quality of life and is causing the exponential climb in healthcare costs experienced by families. While the incidence of chronic care is trending up, people are also living longer and are much more active longer. How do we help those

families who live in our community manage the health care needs of 3 and 4 simultaneous generations? Such issues affecting the future of the quality of life in our community require strong leadership and foresight from those who have the responsibility for ensuring that these threats are curtailed.” (“On Call”, Fall 2008).

In summary our Vision, Mission and Values are to provide quality healthcare to the residents of the area and to improve their lives through education, service and care of their health needs. Our patients are in the center of our values through: personalized attention, financial accountability, our respect, kindness, integrity, honesty, trust, education, meeting community needs, teamwork, partnerships and patient safety.

Appendix 4

[Attach Policy A-53](#)

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM

POLICY AND PROCEDURE

TITLE: FINANCIAL ASSISTANCE POLICY

DEPARTMENT: ADMINISTRATION/FINANCE

Effective Date: 10/22/97 Number: 9

Revised: 10/9/99,
10/15/04
01/02/05
09/12/05
03/01/07 Pages: _____

Reviewed: 6/25/01,7/9/01,
7/9/02,7/9/04

Signature:

Vice President of Finance

Director of Patient Financial Services

POLICY:

It is the policy of Atlantic General Hospital/Health System to provide services without charge to all eligible persons who are unable to pay according to the Hospital's guidelines. Atlantic General's Financial Assistance program is granted after all other avenues have been explored, including payment arrangements or government financial assistance. A distinction is made between financial assistance and bad debts. Financial Assistance is amounts due the Hospital from patients not having the income or resources necessary to meet their responsibility to pay for their health care services within an appropriate length of time. Bad debts are amounts due from patients who are able, but unwilling to pay.

Financial Assistance will be available to all patients without discrimination on the grounds of race, color, national origin, creed.

1. AGH bases Financial Assistance on 200% of the Federal poverty guidelines (Exhibit A). Only income and family size will be considered in approving applications for Financial Assistance. Financial Assistance can be applied to all outstanding balances at the time of approval.
2. A patient can be eligible for Financial Assistance in a catastrophic medical situation when medical liabilities are greater than 10% of the annual income.

3. Approvals can remain active for one year from date of application provided all information is reaffirmed. If information has changed at time of reaffirmation a new application must be submitted for approval. Medicare deductibles can be included on a previous application if service is within the same benefit year. All information must be reaffirmed.
4. Patients are not eligible for Financial Assistance if the account is for workers compensation, litigation, or the balance is pending an estate settlement.

PROCEDURES

1. Self pay patients or balances after insurance.
 - a) It is the responsibility of the Patient Financial Services Associate to determine that all available resources (Medical Assistance, private funding, family members, credit cards and /or payment arrangements) have been exhausted.
 - b) The Patient Financial Services Associate will have the patient or representative of the patient complete a Financial Assistance Application. (Exhibit B) Applications may be accepted from the patient by telephone. The Associate documents on the signature line the application was verbal.
 - c) Update the accounts to payer code PCHA (pending charity), plan code PCHA when application is completed by the patient or mailed to the patient or patient representative.
 - d) If supporting documentation is not returned within 30 days, this automatically disqualifies the patient for Financial Assistance. Only in extraordinary circumstances will this time frame be waived. Additionally, the payer code PCHA must be removed.
 - e) If a patient returns to the hospital for services within the year approval period all information must be reaffirmed by completing the questionnaire attached to the CHAR payer code in the AS400. For inpatient and surgery claims, patients must be reevaluated for Medical Assistance and notes posted on the accounts.
 - f) Approval procedures remain for re-affirmations. (See Section 4)
2. Medical Assistance Pending Accounts
 - a) Once it is determined the patient is not eligible for Medical Assistance and payment arrangements cannot be made, the PFS Associate will have the patient complete a Financial Assistance Application. Applications may be accepted from the patient by telephone. The Financial Counselor or PFS Associate documents on the signature line the application was verbal.
 - b) Notes must be put in the system indicating the reason the patient was unable to obtain Medical Assistance or make payment arrangements.
 - c) If the patient completes an application at time of service, the PFS Associate forwards the application to either the Collection Specialist until a decision is made on Medical Assistance.
 - d) If patient has applied for Medical Assistance and been approved, our Financial Assistance should be removed from payer except in the case of PAC, then CHAR stays as primary payer.
3. Application Requirements
 - a) Family size – a family unit is defined all exemptions filed on the income tax return filed for the individual filing the application whether or not they were the individual filing the return or listed as a spouse or dependent. For homeless persons or in the event that a

- b) Income – Income is to be determined for the **entire family unit**. It should be supplied for the twelve months preceding the request or for the three months preceding the request. If 3 months is used, multiply the 3 month annual income by four to calculate the annual income. Income must be verified through a recent pay stub **and** the previous years' tax return. The annual income or the annualized income will be compared to 200% of the Federal Poverty Guidelines (Exhibit A) to determine eligibility. If anyone in the family unit owns a business, the net income from the business will be used for the calculation. If anyone in the family unit owns a business, current information must be submitted for business income and expenses. If current income and expenses are not available, the previous year tax return 1040 and Schedule C must be submitted.
 - c) For each family member receiving unearned income the following must be submitted with the application.
 - 1) Proof of Social Security Benefits
 - 2) Proof of Disability Benefits
 - 3) Proof of Retirement/Pension Benefits
 - 4) Proof of Veterans Benefits
 - 5) Proof of Child Support.
 - d) If anyone in the family unit is not working or has unreported income a signed notarized statement must be provided by the individual or a letter from a Government Agency that is providing financial information indicating the amount of the unreported income and/or the employment status.
 - e) After the application is received the Collection Specialist reviews the application and if eligible completes the Approval of Financial Assistance Form. (Exhibit D) If the **patient** is eligible the Collection Specialist forwards the application for approval. Prior to sending the application for approval the Collection Specialist will EVS to insure the patient does not have Medicaid.
 - f) A decision will be rendered within 15 working days of receipt of a completed application.
 - g) The Collection Specialist notifies the patient of the decision for Financial Assistance in writing (Exhibit E or F).
4. Approval
- a) The Collection Specialist completes the Approval of Financial Assistance Form (Exhibit D) and refers the form for the following authorized signatures:

Less than \$2,000	Director of Patient Financial Services
\$2,000 - \$5,000	CFO/Vice President of Finance
Over \$5,000	CEO/President
 - b) After the Financial Assistance Application has been approved, the Collection Specialist allowances off the appropriate amount to procedure code: 1031098
 - c) The Collection Specialist documents the system and indicates the patient was approved for Financial Assistance and the date of approval.
 - d) The Collection Specialist updates all accounts with payer code CHAR (Financial Assistance), plan code CHAR, and enters the effective and termination date of the Financial Assistance on the payer screen. Collection Specialist must be sure the history account has the payer code CHAR listed.

- e) The Collection Specialist monitors accounts using a worklist identifying all accounts where CHAR is secondary and the primary insurance has paid.
- f) Financial Assistance approvals and supporting documentation will be filed by month and maintained for a period of ten years.
- g) Once applications are approved the Collection Specialists forward the applications with supporting documentation to the General Clerk for storage and retention.
- h) The General Clerk balances the Financial Assistance Allowances to the monthly TRANSMTH01 report and provides the report to the Manager for review. The General Clerk files the TRANSMTH01 report showing transaction code 1031098 with the monthly Financial Assistance approvals.

5. Reaffirmation

- a) If the patient presents for any additional services during the year approval period, the Registrar pulls forward the payer information and payer code CHAR will be present. Registrar verifies the approval dates are within the range of the approval period. The registrar affirms whether or not the patient's information has remained the same. If the information is the same then the registrar will answer "Y" to the reaffirmation question on the payer screen. If information has changed or date of service is outside the approval period, the patient must reapply for Patient Financial Assistance.
- b) Once the CHAR payer code is on the account the system will automatically write off the balance at time of billing to code 1031098. The Collection Specialist reviews daily the automatic contractual write off report (PBRP110-001) to insure that the reaffirmation questionnaire is completed on the payer screen, and the account date of service is within the effective/termination dates of the 180 day approval period. If the questionnaire has not been answered the Collection Specialist must contact the patient. If CHAR is secondary on the account the Collection Specialist reverses the automatic write off pending outcome of primary payer.
- c) To complete the reaffirmation, Section 4 must be followed and the Reaffirmation form (Exhibit C) must be completed for all accounts greater than \$2000. For accounts less than \$2000 the Collection Specialist must complete the Patient Financial Assistance confirmation (Exhibit G) indicating all information has been confirmed and forward to the Director of Patient Financial Services for approval.

ATLANTIC GENERAL HOSPITAL/HEALTH SYSTEM
POLICY AND PROCEDURE

TITLE:	MISSION STATEMENT, STATEMENT OF VALUES, AND ETHICAL COMMITMENT
DEPARTMENT:	ADMINISTRATION

Effective Date:	<u>5/93</u>	Number:	<u>A-53</u>
Revised:	<u>5/00, 11/00, 5/95</u> <u>5/97, 11/01, 11/02</u>	Pages:	<u>Two (2)</u>
Reviewed:	<u>9/99, 5/00, 11/00</u> <u>10/01, 11/01, 11/02</u> <u>6/06</u>		
Signature:			

President/CEO

APPROVAL DATE:

11/1/01
Board of Directors

POLICY:

It is the policy of Atlantic General Hospital/Health System to maintain a Mission Statement, Statement of Values, and Ethical Commitment for the organization. This will be reviewed annually by the leadership and Board of Directors with approved changes made and communicated. The Mission Statement will be posted prominently throughout the organization.

Atlantic General Hospital and Health System

VISION

To be the leader in promoting access to healthcare services for the residents and visitors of Worcester County and the surrounding region.

MISSION

To provide quality care, personalized service and education to improve individual and community health.

VALUES

These values serve as the foundation for achieving our mission.

- ◆ *Dedication to patient safety*
- ◆ *Respect and kindness*
- ◆ *Community commitment*
- ◆ *Honesty, integrity, and trust*
- ◆ *Personalized attention*
- ◆ *Partnership and teamwork*
- ◆ *Financial accountability*
- ◆ *Continued learning and improvement*

These values are honored in all we do for our patients, visitors, medical staff, associates, partners and volunteers.

Ethical Commitment

To conduct ourselves in an ethical manner that emphasizes a basic community service orientation and justifies the public trust.

BWMC FY08 COMMUNITY BENEFIT REPORT

1. Baltimore Washington Medical Center is a 298 licensed bed facility with 19,018 inpatient admissions in FY08.

2. Anne Arundel County is compact but diverse, including within its borders the state's capital and its largest airport, 400 miles of tidal shoreline, and long strips of farmland and other sparsely populated territory. The demographics are just as diverse: military personnel from Fort Meade, a suburban working class and all contribute to the population of just over 500,000. The complex mixture places Anne Arundel among the highest jurisdictions in the state in affluence and average age of its residents.

BWMC Primary Service Area

Zip Code	City
21060	Glen Burnie
21061	Glen Burnie
21122	Pasadena
21144	Severn
21225	Brooklyn Park
21226	Curtis Bay

BWMC South Service Area

Zip Code	City
21012	Arnold
21032	Crownsville
21054	Gambrills
21108	Millersville
21114	Crofton
21401	Annapolis
21402	Annapolis
21146	Severna Park

BWMC West Service Area

Zip Code	City
21090	Linthicum
21113	Odenton
20755	Ft. Meade
21240	BWI
21227	Elkridge/Arbutus
21076	Hanover

Demographic Characteristics (2006 Estimates)

Total Population	509,300
Median Household Income (2006 inflation adjusted \$)	\$79,950
Families below poverty level	2.7%

Data Source: American Community Survey, U.S. Census Bureau; Maryland State Data Center, Maryland Department of Planning.

	Life Expectancy (Years)
Male	75.8
Female	79.7
White	78.0
White Male	76.0
White Female	80.0
Black	74.7
Black Male	73.6
Black Female	76.1
Overall Average	77.7

Data Source: Division of Health Statistics, Maryland Department of Health and Mental Hygiene (MD DHMH).

In FY08, there were 153,886 patient registrations at Baltimore Washington Medical Center. Of these registrations, 13,080, or 8.5% were uninsured.

3. Baltimore Washington Medical Center utilizes the Anne Arundel County Department of Health Report Card of Community Health Indicators to direct community outreach activities each year. This report card is issued by the Anne Arundel County Department of Health and reviewed by BWMC each year. The May 2007 Report Card was utilized to direct FY08 community outreach efforts.

BWMC maintains a strong relationship with the Anne Arundel County Department of Health, meeting on a regular basis to review and discuss various community health programs and initiatives. Additionally, on-going work in the community and with community organizations, including participation on committees and advisory councils, allows for continuous communication and often provides new ideas and opportunities for BWMC to maximize community outreach efforts.

4. The Anne Arundel County Department of Health Report Card of Community Health Indicators allows BWMC to research, develop and implement programs that are beneficial to the community. The major community needs identified in the May 2007 report card were heart disease, cancer, stroke and infant mortality.
5. To ensure that the community's most pressing health care issues are addressed, BWMC created the Board Community Mission Committee in 2007. This committee reviews the Anne Arundel County Department of Health Report Card of Community Health Indicators annually. Comprised of select BWMC board members, BWMC foundation board members, BWMC administration and community outreach staff, the committee oversees the hospital's community benefit mission and determines which community needs will be addressed through community benefit activities each year.
6. Infant Mortality/Stork' Nest

Prenatal care is essential to increasing chances of positive pregnancy outcomes. BWMC's Stork's Nest is an incentive-based prenatal education program to encourage pregnant women to have a healthy pregnancy, giving their babies the best opportunity for a healthy beginning. The program is made up of six-class sessions, focusing on everything from nutrition, exercise and stress in pregnancy to how to bathe and diaper a newborn. Participants receive points for each class they attend, as well as physician visits and healthy behaviors. Participants can then use those points to purchase baby items at BWMC's outreach center in Arundel Mills, including infant clothing, strollers, car seats, diapers, feeding supplies, portable cribs and first aid supplies.

Women can continue to earn points after their babies are born by taking them to well baby check-ups and making sure they receive immunizations on time.

Participants can use the points until their babies are one year old.

Any pregnant woman in Anne Arundel County is eligible to participate in Stork's Nest, but the program's emphasis is on engaging pregnant women who do not receive regular prenatal care and are at an elevated risk for having a low birth weight or premature birth – potential causes of infant mortality.

In FY09, BWMC plans to expand Stork's Nest to eight-classes. In partnership with the Anne Arundel County Department of Health, additional topics to be covered will include early parenting, Shaken Baby Syndrome, safe sleeping and Sudden infant death syndrome (SIDS).

Heart Disease/Day of Dance

Day of Dance is an annual event held each February in recognition of National Heart Month to celebrate the benefits of dance and exercise in the prevention of heart disease. Participants have the opportunity to try various dance styles, enjoy dance demonstrations and participate in free health screenings such as cholesterol,

blood pressure and body mass index. Educational information on heart disease, cancer and diabetes is also available.

Heart Disease/Day of Dance continued

BWMC also offers several informative heart healthy talks each year and blood pressure screenings each month at various locations in the community.

Stroke

As a Primary Stroke Center, BWMC offers a monthly stroke support group that serves as a resource for patients who are recovering from a stroke or who are at high risk for having a stroke. Additionally, each May in recognition of Stroke Awareness Month, BWMC sponsors Stroke Awareness Day to promote stroke prevention and to educate those at high risk about prevention, warning signs and the treatment of stroke. Informative talks on stroke prevention are offered each year at a variety of locations throughout the community.

Vascular Screenings

The Maryland Vascular Center at BWMC offers free monthly vascular screenings to community. These potentially life-saving screenings for carotid artery disease, abdominal aortic aneurysms and peripheral arterial disease (PAD) are offered to community members age 50 or older who have one of the following risk factors: hypertension, diabetes, family history of vascular disease, high cholesterol or who smokes.

Cancer

Cancer is the leading cause of death in Anne Arundel County with incidence and mortality rates of lung, colorectal, breast and prostate at or above the state average. In an effort to encourage early detection, Baltimore Washington Medical Center offers cancer screenings (i.e. prostate and skin) to the community each year. Monthly cancer support groups for breast and prostate cancer are also offered. Informative talks on cancer prevention, early detection, treatment options, etc. are offered each year at a variety of locations throughout the community. BWMC works with area churches and community groups to disseminate information about cancer screenings and events to better reach at risk populations.

7. Program Evaluation

1a. Name of initiative: Day of Dance Post Event Survey

1b. Year of evaluation: 2008 (May)

1c. Nature of evaluation: A three-month follow-up event survey was mailed to 2008 Day of Dance attendees. Participants were asked to rate their satisfaction with various components of the event (location, dance styles showcased and health screenings offered). Participants were also asked about lifestyle and lifestyle changes as a result of information they gained from Day of Dance.
BWMC will utilize survey feedback and comments to improve Day of Dance in 2009.

1d. Result of evaluation: Approximately 50% of the Day of Dance post event surveys were returned to BWMC. Results are summarized in the table below:

Event location	78% satisfied
Dance styles showcased	70% satisfied
Screenings offered	68% satisfied
Likely to make a lifestyle change as a result of information obtained at event	62% indicated 'yes'
Overall satisfaction with event	80%

2a. Name of initiative: Prostate Screening Follow-Up

2b. Year of evaluation: 2008 (June)

2c. Nature of evaluation: Prostate results from both the PSA blood test and the digital exam (DRE) are reviewed by the screening physicians. Follow-up letters are mailed to all screening participants. This letter contains screening results and if indicated, the recommended follow-up such as scheduling an appointment with a physician. Additionally, all abnormal screenings are followed-up with a phone call from BWMC's Tate Cancer Center outreach and education coordinator. During this call, the coordinator verifies that the participant received and understands the screening results. The outreach and education coordinator is also able to link the participant with an appropriate physician if the participant has not already selected one. The coordinator also follows up by phone 6-8 weeks later to determine if the participant is receiving appropriate care.

Additionally, overall screening results are collated and trended by BWMC's cancer outreach and education coordinator.

- 2d. Result of evaluation: 169 men participated in the prostate screening offered at BWMC on June 25, 2008. It was determined that 31 men had abnormal findings (abnormal PSA, DRE or both). This represents approximately 18% of participants. Attempts were made to contact the 31 men - the outreach coordinator was successful in reaching 21 participants. (10 participants did not return our calls). 21 participants have or will receive two follow-up phone calls from the outreach coordinator during the 12 month post-screening period. To date, prostate cancer has been confirmed in four participants being followed.
8. While Anne Arundel County is generally not considered underserved, there is a significant portion of the population surrounding BWMC that houses an underserved, uninsured and indigent population.

Baltimore Washington Medical Center does offer a Financial Assistance program to serve those patients who are treated at the medical center, uninsured and do not qualify for any federal or state assistance programs (Medicaid, REACH, etc). In order to qualify, patients need to fill-out an application to qualify for full-coverage of their medical care.

OB/GYN Services

Baltimore Washington Medical Center does not operate a hospital-based obstetrics program, however a \$117 million expansion project is almost complete and includes an eight-story patient tower, a new women's health center and an expanded emergency department. An 18-bed obstetrics program will be part of the women's center, which will also include a comprehensive outpatient center that offers well-woman check-ups and prenatal care; case managers; and education about parenting and infant care. BWMC will provide a state-of-the-art obstetric and gynecologic care program with diagnostic testing and clinical support services for the community, including the underserved population regardless of insurance status or ability to pay.

Additionally, BWMC continues to maintain a relationship with People's Community Health Centers. People's operates two health centers in BWMC's service area, one located in Brooklyn Park and the other in Severn. They provide high-quality, comprehensive medical, dental, and neonatal health care to all, regardless of the ability to pay or insurance status.

Appendix 1

Baltimore Washington Medical Center's Financial Assistance Policy is established to assist patients in obtaining financial aid when it is beyond their financial ability to pay for services rendered.

A patient's inability to obtain financial assistance does not, in any way, preclude the patient's right to receive and have access to medical treatment at Baltimore Washington Medical Center.

Baltimore Washington Medical Center informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state or local government programs or under the hospital's financial assistance policy in the following manner:

- BWMC posts its financial assistance policy and financial assistance contact information in all admission areas, the emergency room and all other outpatient areas throughout the facility.
- BWMC discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and employs dedicated staff on-site to assist patients with qualification for such programs.
- A copy of BWMC's financial assistance policy is included in the patient handbook that is provided to each patient upon admission.
- An abbreviated statement referencing BWMC's financial assistance policy, including a phone number to call for more information, is run annually in the local newspapers (Maryland Gazette and Capital).

Financial Assistance Policy

POLICY

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A patient's inability to obtain financial assistance does not, in any way, preclude the patient's right to receive and have access to medical treatment at Baltimore Washington Medical Center.

RESPONSIBILITY

Vice President of Finance

PROCEDURE

The following guidelines will be used to determine eligibility for uncompensated care.

1. All patients shall be eligible for financial assistance provided they meet the necessary criteria.
2. Financial assistance will be given without regard to age, race, creed or sex.
3. Application for charity care should be made as soon as possible in the admissions process; however, an application may be taken at any time on active or bad debt accounts.
4. The appropriate medical center personnel will determine if a patient is eligible for financial assistance. In making this determination, the current Federal Poverty Income Guidelines will be used as a base guide.
5. Determination of probable eligibility for financial assistance will be determined within two business days after initial submission of the Financial Assistance Application.
6. If it is determined that the patient may be eligible for other third-party coverage, including Maryland Medical Assistance, this determination must be made before charity care can be considered. Charity care would always be the resolution of last resort.

Appendix 2 continued

PROCEDURE continued

7. A specific amount of financial aid will be established annually in the medical center's operating budget. This amount shall not exceed the maximum limitation for financial assistance as established by the Health Services Cost Review Commission.
8. Baltimore Washington Medical Center reserves the right to modify this financial assistance policy depending on the availability of such charity allowances as established by the Health Services Cost Review Commission or subsequent governing bodies, or by the medical center itself.

ORIGINATOR

Senior Vice President and Chief Operating Officer

REVIEW CYCLE

3 Years

Appendix 3

Throughout the past four decades, Baltimore Washington Medical Center has evolved into a comprehensive medical center, offering the highest quality of care to the community. Through hiring and retaining outstanding people, BWMC provides exceptional service to patients and visitors. Highly trained physicians and associates and state-of-the-art technology complement treatment capabilities while maintaining a focus on service and quality at every level of the organization.

VISION STATEMENT

Outstanding People, Exceptional Service,
Uncompromising Quality

MISSION STATEMENT

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

Bon Secours Baltimore

2008 HSCRC Community Benefit Report - Appendices Summary Overview

- As a member of the Catholic health ministry, **Bon Secours Baltimore Health System, Inc. (BSBHS)** is called to live the teachings and promises of Jesus. The community benefit services provided by BSBHS include programs and partnerships working to improve access to health care and the quality of life and holistic health of the communities served.

QUALITATIVE DESCRIPTION OF COMMUNITY BENEFIT

1. Description of the Community Served

BSBHS exists to benefit the people living in the communities it serves. The communities served by BSBHS are in west, north and southwest Baltimore, where nearly one-third of the city's total population resides. Dominated by the elderly, women and children, BSBHS' service area includes stable, thriving neighborhoods as well as many neighborhoods facing basic social challenges in the areas of housing, employment, education and health.

2. Description of Organization and Services Provided

The Mission of BSBHS is to help people and communities to health and wholeness by providing compassionate, quality health care and being *good help* to all in need in west Baltimore with special concern for the poor and dying, in response to the Gospel mandate and healing ministry of Jesus Christ and the Catholic Church.

The organizational Vision is that "By the year 2010, the BSBHS will be recognized as a health care leader. Our healing ministry will be expressed through services to the west Baltimore community that include focused acute and ambulatory care, community outreach, and health education programs that are focused, innovative, financially sustainable and in collaboration with others. Quality and compassionate care will continue to be our hallmark."

BSBHS provides a full range of services and programs in response to community needs and interests including: Acute Care, Cardiology, Case Management, Wound Care, Community Health Screenings, Critical Care, Emergency Care, Diagnostic Services, Employment Services, Family Support Center, Financial Education, Infectious Disease Care, Laboratory Services, Mammography, Neurology, Nuclear Medicine, Ophthalmology, Orthopedics, Parish Nurse Services, Pastoral Care, Perioperative Services, Pharmacy, Physical Therapy, Podiatry, Psychiatry, Pulmonary Services, Primary Care, Renal Dialysis, Senior and Family Housing, Smoking Cessation, Social Work, Substance Abuse Treatment, Surgery, a Wellness and Fitness Center, Vascular Services and the Women's Resource Center.

3. Charity Care/Patient Financial Assistance Policy

BSBHS is committed to ensuring access to health care services for all. As a health care provider, BSBHS treats all patients, whether insured, underinsured or uninsured, with dignity, respect and compassion throughout admission, delivery of services, discharge and billing and collection processes. BSBHS addresses the needs of the uninsured by providing free or reduced fees on hospital services, community outreach efforts to assist with Medicaid and SCHIP enrollment, and free community-based preventive and primary care services.

BSBHS proactively screens to identify individuals and their families who may qualify for federal, state or local health insurance programs or the Bon Secours Patient Financial Assistance Program (“FAP”). Potentially eligible patients are referred to the Patient Financial Assistance Department for assistance in completing the documentation required to establish eligibility in, and apply for, government insurance programs or the FAP. Patients are responsible for providing the information necessary to complete the documentation.

The FAP aids uninsured patients who do not qualify for government-sponsored health insurance and who communicate their inability to pay for their medical care. The FAP provides 100% financial assistance to uninsured patients with annual family incomes at or below 200% of the Federal Poverty Guidelines (“FPG”), as adjusted by the Medicare geographic wage index for each community served to reflect that community’s relative cost of living (“Adjusted FPG”).

For uninsured and underinsured patients with annual family incomes greater than 200% of the Adjusted FPG, the FAP offers a reduction to the amount of the full charges for medically necessary services through a community service adjustment (“CSA”). The CSA is market adjusted and based on the payment discount received by other health care payers doing business in the community. For these patients, the FAP also sets a maximum annual family payment liability to ensure that no family suffers a catastrophic financial burden to receive necessary health care services. Based on research conducted by the Tax Foundation, the maximum annual family liability is based on a sliding scale determined by the family income and size. The standard sliding scale is adjusted by the Medicare geographic wage index of each community served to reflect that community’s relative cost of living. All patients are eligible for a Prompt Pay Discount. In addition, a variety of other potential payment options are available.

This patient financial assistance policy is communicated to patients verbally upon registration and through visible postings of the policy and brochures in common areas throughout the hospital.

4. Collection Policy

Any collection attorneys or agencies used by BSBHS commit to follow BSBHS’ value-based procedures, including, without limitation, its Code of Conduct, in pursuit of estates, garnishments and judgments for non-payment.

5. Description of All Other Community Benefit (except Community-Building Activities)

For BSBHS, creating an option for the poor and disadvantaged cannot be simply providing free or discounted services to those who come to our health care facilities in crisis without financial means to pay. Our call to live the teachings and promises of Jesus requires that we nurture the growth of individual and community capacities and create opportunities for each individual to assume a meaningful role in defining and pursuing holistic well being, peace, and hope. Our call requires that we be a prophetic voice for just and equitable public policies that ensure access to basic human goods for all people.

As part of Bon Secours Health System, Inc., BSBHS’ commitment to social and economic justice is integrated into the fabric of the organization through its Strategic Quality Plan and its common vision of a healthy community. Our vision of a healthy community is embodied in the following statements. “A healthy community is a good place to live for all residents. The rich diversity of cultures and capacities of the community are celebrated and mobilized, with a particular concern for the poor, marginalized and dying, to create physical and social environments that promote families, nurture youth and support senior citizens. Individuals have the opportunity to fully participate in defining holistic well being and assuming responsibility for the development of their innate potential.”

“Community Benefit” is not just a *program* within BSBHS, but rather a constitutive dimension of its mission and history. From its beginnings in 1881 providing health care and support in neighbors’ homes, to the establishment of its first hospital in 1919, to its comprehensive neighborhood revitalization initiative in the 21st Century – BSBHS has been an integral part of the community life of West Baltimore.

Community Based Clinical Services

BSBHS community based clinical services include the Community Institute of Behavioral Services which provides a variety of clinical and community based behavioral health services; the Imani Center which provides primary and specialty care to persons affected by HIV/AIDS; health screenings at no charge at various sites throughout the community; and free transportation to and from medical appointments for the elderly and disabled;

Health Care Support Services:

Tele-Heart is a disease management program for persons diagnosed with congestive heart failure and hypertension serving almost 5,400 persons in FY 08.

Community Benefit Operations/Financial and In-Kind Contributions

The Bon Secours of Maryland Foundation provides oversight and administration of BSBHS Community Benefit operations as well as providing operating support to the Operation ReachOut Southwest coalition and contributions to local community groups.

6. Description of Community Building Activities

Community Building is a strategic initiative of BSBHS. This initiative encompasses long term, collaborative relationships in which service organizations engage and empower the members of a defined geographic community to support them in improving their quality of life and holistic health.

Since 1995, BSBHS has worked closely with the Operation ReachOut Southwest (OROSW) community to create projects, programs and work plans that are leading to the realization of OROSW’s vision: to make southwest Baltimore a community of choice for current and new residents.

Over the past few years, OROSW and BSBHS have partnered to make tremendous strides in building programs and projects that are improving the quality of life for the residents of southwest Baltimore. This has been accomplished by building off the strengths of the community, listening and responding to what residents say they need, and hiring talented people to implement the projects.

The *Homebuyer's Club* is an educational peer-supported process that helps build responsible homeownership by providing participants with information that along with their own determination and self sacrifice enables them to become homeowners and improve their quality of life.

Our Money Place (OMP) – combines the services of the Security Plus Federal Credit Union, a local check casher, OROSW and BSBHS. Since opening in 2003, OMP has offered savings accounts, market rate loans, low cost check-cashing, debt remediation and retirement planning to help residents reduce non-asset building debt and increase personal wealth.

Youth Employment and Entrepreneurship Program helps high school age youth learn job readiness, financial literacy and leadership skills and then access part time and summer jobs. YEPEP also helps youth develop career plans and get into post-secondary education. The program follows alumni still involved who attend college.

Clean & Green turns vacant lots into attractive green spaces and consistently maintains them at a community-wide scale.

Career Development Program offers job readiness, placement and retention services where, after a four week intensive classroom experience, clients are followed for three years and helped to move up the company ladder, obtain more education as needed, get out of debt and learn basic money management skills. The ultimate goal is for a person to financial self-sufficiency.

Family Support Center helps young parents obtain a GED and get into college while providing developmental child care and parenting classes. Children (birth to age 4) receive developmental child care while their parents are in class or in training. In addition provides In-Home-Intervention services.

Women's Resource Center is a drop-in Center for homeless women or women at risk for becoming homeless providing crisis intervention, hospitality services and domestic violence counseling.

Home Improvement Grants Program offers recoverable grants up to \$10,000 to homeowners to make needed home repairs. If the homeowner stays in the house for at least five years, the funds do not need to be repaid. If the homeowner moves prior to five years, s/he must repay the loan on a pro-rata basis.

BSBHS also renovates row houses and constructs apartment buildings where low-income families and seniors can find safe and affordable housing in what had been dangerous, abandoned and drug-ridden properties.

7. Tax Exemption Criteria

BSBHS has an open medical staff with privileges available to all qualified physicians. In 2008 the health system was led in its mission to serve the community by a governing board that included 14 members, 10 of whom are representative of the community.

8. Annual Report to the Community

BSBHS annually develops a report to the community, explaining the various community benefit services and programs that exist. This report also includes the annual financial commitment of the local system to the community, detailing monetary contributions for government sponsored healthcare shortfall, community benefit programs and charity care at cost. This reported is published to the public each year on or around January 24th, commemorating Foundation Day of the Sisters of Bon Secours.

Bon Secours Baltimore Health System

Gaps in Availability of Specialist Providers

Across the country, the vast majority of specialist providers rely upon reimbursement from Medicare, Medicaid, Managed Care, and patients to provide financial support for their practices. For hospitals such as Bon Secours that primarily serve in low-income, urban poor areas, however, the opportunities for specialists to be compensated through these vehicles are extraordinarily low. Consequently, if these specialist providers were to attempt to provide the needed health care services for these hospitals through only the support of “paying” patients, they would quickly be forced to close their practices or move to a community with far more favorable payor mix.

For a hospital like Bon Secours to continue to support the community with the varied specialist providers necessary for a full-service medical/surgical hospital with Emergency and Surgical Services, some manner of support is required to ensure the provision of that professional specialist medical care. With nearly 50% of the patient population presenting as Charity, Self-Pay (Bad Debt), and Medicaid, specialist physicians serving patients at Bon Secours are simply unable to cover their costs.

In particular, the primary shortages in availability, absent some form of financial support, come in the form of ED, ICU, and Surgical regular physician staffing, in addition to the “on-call” coverage necessary to support 24-hour services in these areas. **As a result, in Bon Secours’ submitted FY2008 HSCRC Annual Filing, the “Part B” support provided by the hospital as indicated in the “UR6” Schedule totals \$14.3 million.** For a hospital the size of Bon Secours, this is a significant outlay of support that is necessary to provide the specialist care required to compassionately and equitably care for our patients.

Therefore, real and significant “gaps” in the availability of specialist providers in this community currently exist, which currently is only being filled via this support from the hospital. These gaps are currently being filled in the following specialist areas:

- ED coverage (approx. \$3.9 million)
- Anesthesia (approx. \$1.7 million)
- Medical/Surgical “House Coverage” (approx. \$1.2 million)
- OR on-call coverage (approx. \$1.0 million)
- Intensive Care (approx. \$0.6 million)
- Psych (approx. \$0.5 million)
- Radiology (approx. \$0.6 million)
- Pathology/Lab
- Vascular
- Hemodialysis
- Other Sub-Specialties

In addition to these gaps that are currently filled via subsidy, relatively unmet specialist needs for both the uninsured and insured within our facility include ENT Specialists, limited G.I. (Gastrointestinal Specialists), Neurologists, Urologists and Endocrinologists.

Bon Secours Baltimore Health System

Description of Charity Care Policies

Bon Secours Baltimore Health System (BSBHS) is committed to ensuring access to health care services for all. As a health care provider, BSBHS treats all patients, whether insured, underinsured or uninsured, with dignity, respect and compassion throughout admission, delivery of services, discharge and billing and collection processes. BSBHS addresses the needs of the uninsured by providing free or reduced fees on hospital services, community outreach efforts to assist with Medicaid and SCHIP enrollment, and free community-based preventive and primary care services.

BSBHS proactively screens to identify individuals and their families who may qualify for federal, state or local health insurance programs or the Bon Secours Patient Financial Assistance Program ("FAP"). Potentially eligible patients are referred to the Patient Financial Assistance Department for assistance in completing the documentation required to establish eligibility in, and apply for, government insurance programs or the FAP. Patients are responsible for providing the information necessary to complete the documentation.

The FAP aids uninsured patients who do not qualify for government-sponsored health insurance and who communicate their inability to pay for their medical care. The FAP provides 100% financial assistance to uninsured patients with annual family incomes at or below 200% of the Federal Poverty Guidelines ("FPG"), as adjusted by the Medicare geographic wage index for each community served to reflect that community's relative cost of living ("Adjusted FPG").

For uninsured and underinsured patients with annual family incomes greater than 200% of the Adjusted FPG, the FAP offers a reduction to the amount of the full charges for medically necessary services through a community service adjustment ("CSA"). The CSA is market adjusted and based on the payment discount received by other health care payers doing business in the community. For these patients, the FAP also sets a maximum annual family payment liability to ensure that no family suffers a catastrophic financial burden to receive necessary health care services. Based on research conducted by the Tax Foundation, the maximum annual family liability is based on a sliding scale determined by the family income and size. The standard sliding scale is adjusted by the Medicare geographic wage index of each community served to reflect that community's relative cost of living. All patients are eligible for a Prompt Pay Discount. In addition, a variety of other potential payment options are available. This patient financial assistance policy is communicated to patients verbally upon registration and through visible postings of the policy and brochures in common areas throughout the hospital.


BSBHS is required to adhere to the system-wide Patient Financial Assistance/Charity Care Policies. These policies have been attached for your information and use ("*Appendix 3*").

These policies and procedures are communicated and made available to patients in a wide variety of ways:

- At each point of registration, there are signs advising patients that Bon Secours has financial assistance available if they are unable to pay their bills. In addition, brochures are given to patients summarizing the policy, along with the financial assistance application.
- At time of discharge, patients are identified who may demonstrate a lack of coverage. For those patients, assistance is provided in conjunction with a Social Worker to have the appropriate physician complete a medical disability form (402 B), as appropriate. This information is then provided to the outside firm Hospital Support Services, who assists Bon Secours patients with applying for and securing enrollment in the State Medicaid program.
- In each billing letter, Bon Secours has paragraph that advises patients that, if paying their balance in full is not possible, to please call our toll-free Customer Service Center. At that time, Bon Secours' extended payment plan will be explained to them, as well as the patient Financial Assistance Program, as noted above.

**BON SECOURS HEALTH SYSTEM, INC.
Marriottsville, Maryland**

Policy/Procedure

Topic: Patient Financial Assistance	Policy No.: BB-10	Date: 8/6/2008 Rev:
Area: Patient Financial Services	Page 1 of 2	Approved by:  BSHSI Board of Directors

PURPOSE

Bon Secours Health System, Inc. (“BSHSI”) is committed to ensuring access to needed health care services for all. BSHSI treats all patients, whether insured, underinsured or uninsured, with dignity, respect and compassion throughout the admissions, delivery of services, discharge, and billing and collection processes.

POLICY

BSHSI proactively screens to identify individuals and their families who may qualify for federal, state or local health insurance programs or the Bon Secours Patient Financial Assistance Program (“FAP”). Potentially eligible patients are referred to BSHSI’s Patient Financial Services Department for assistance in completing the documentation required to establish eligibility in, and apply for, government insurance programs or the FAP. Patients are responsible for providing the information necessary to complete this documentation.

The FAP aids uninsured patients who do not qualify for government-sponsored health insurance and who communicate their inability to pay for their medical care. The FAP provides 100% financial assistance to uninsured patients with annual family incomes at or below 200% of the Federal Poverty Guidelines (“FPG”), as adjusted by the Medicare geographic wage index for each community served to reflect that community’s relative cost of living (“Adjusted FPG”).

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served to reflect that community's relative cost of living.

All patients are eligible for a Prompt Pay Discount when the patient balance owed is paid in full within thirty days or other designated period of time. In addition, a variety of other potential payment options are available to patients and their families through the FAP including, but not limited to, a monthly payment plan, loan program and single payment after their insurance company has paid its portion.

Any collection attorneys or agencies used by BSHSI will commit to follow BSHSI's value-based procedures, including, without limitation, its Code of Conduct, in pursuit of estates, garnishments and judgments for non-payment of debt.

PROCEDURES

This policy is implemented pursuant to the Patient Financial Assistance – Implementing Procedures Policy, approved by the Executive Management Team which addresses, at a minimum, the following:

- Communication and Education regarding Financial Assistance
- Determination of Insurance and Financial Status
- Financial Counseling
- Discounted Services
- Billing and Collection
- Payment Options
- Program Enrollment Assistance
- Patient Financial Assistance Program
- Accountability and Monitoring
- State Requirements, as applicable
- Definitions

Compliance with this policy is monitored by Internal Audit. Regular reports will be made to the Executive Management Team, and at least annually to the BSHSI and Local System Boards.

**Bon Secours Health System, Inc.
System-Wide Policy Manual**

TOPIC: Patient Financial Assistance Services	POLICY NO.: CYC-01 / FAP0025 and E5101	DATE: September 1999 REVISED: May 15, 2008
AREA: Patient Financial Services Patient Financial Assistance	APPROVED BY: Rich Statuto	

Policy

The Bon Secours Health System (“BSHSI”) exists to benefit people in the communities served. Patients and families are treated with dignity, respect and compassion during the furnishing of services and throughout the billing and collection process.

To provide high quality billing and collection services, standard patient financial assistance services and procedures are utilized. These services and procedures address the needs of patients who have limited financial means and are not able to pay in part or in full for the services provided without undue financial hardship (excluding cosmetic or self pay flat rate procedures).

Procedures

The standard patient financial assistance services and procedures are organized as follows.

<u>Procedure</u>	<u>Policy Section</u>
Communication and Education of Services	• 1
Preliminary Determination of Insurance and Financial Status	• 2
Financial Counseling	• 3
Prompt Pay Discounts	• 4
Billing and Letter Series	• 5
Payment Options	• 6
Program Enrollment Assistance	• 7
Patient Financial Assistance Program	• 8
Pursuit of Non Payment	• 9
Accountability and Monitoring	• 10
State Requirements and Policy Revisions	• 11

Definitions

- Charity – “the cost of free or discounted health and health related services provided to individuals who meet certain financial (and insurance coverage) criteria” as defined the Catholic Health Association of the United States.

- Income – The total family household income includes, but is not limited to earnings, unemployment compensation, Social Security, Veteran’s Benefits, Supplemental Security Income, public assistance, pension or retirement income, alimony, child support and other miscellaneous sources.
- Bad Debt – An account balance owed by a patient or guarantor that can afford to pay, but has refused to pay, which is written off as non-collectable.
- Baseline – 200% of the Federal Poverty Guidelines (“FPG”) – utilized by all BSHSI Local Systems to determine eligibility for the Patient Financial Assistance Program.
- Medical Eligibility Vendor/Medical Assistance Advocacy - Advocacy vendor contracted by BSHSI to screen patients for government programs and BSHSI Financial Assistance.
- Patient Financial Assistance Program – A program designed to reduce the patient balance owed provided to patients who are uninsured and underinsured and for whom payment in full or in part of the financial obligation would cause undue financial hardship.
- Prompt Pay Discount – A discount on the patient balance owed if paid within thirty (30) days of billing.
- The Tax Foundation Special Report – Guidelines for calculating the patient balanced owed for individuals participating in the Patient Financial Assistance Program, which identifies the percent income set aside for savings and medical expenses. The source is “A Special Report from the Tax Foundation”; dated November 2003, document number 125.
- Community Service Adjustment (“CSA”) – A reduction in total charges to an account, which reflects an offset to the cost of healthcare to our uninsured patients and families.
- Uninsured – Patients who do not have any insurance and are not eligible for federal, state or local health insurance programs.
- Local System Champion (“LSC”) – The individual appointed by the Local System CEO to assist in the education of staff and monitor compliance with this policy.
- Head of Household (“Guarantor”) – The individual listed on tax return as “Head of Household”. This will be the individual used for tracking Family Annual Liability.
- Household Family Members (“Dependents”) – Individuals “residing” in household which are claimed on the tax return of the Head of Household (Guarantor).

Communication and Education of Services	POLICY NO. CYC-01/FAP_0025 Section 1
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- 1.1 All BSHSI representatives that have contact with patients regarding financial status are responsible for advising patients of the BSHSI Patient Financial Assistance Services Program.
- 1.2 Standard signs and brochures are prepared by BSHSI Patient Financial Services for limited customization (name and logo) by each Local System. Signs and brochures are available in English and Spanish. Each Local System is responsible for having the signs and brochures translated into the other dominant languages spoken in the respective community in a manner that is consistent with the English version.
- 1.3 A brochure and education on its content are provided to each patient upon registration. Signs and brochures are predominantly displayed in patient registration, customer service, waiting and ancillary service areas.
- 1.4 Brochures and education on the content are provided to physicians and their staff.

- 1.5 Changes to the brochure or signs are prepared by BSHSI Patient Financial Services and distributed to each Local System Director of Patient Financial Service for immediate use. All brochures must be approved by BSHSI Patient Financial Services and reviewed for Medicare and Medicaid compliance.
- 1.6 The LSC is responsible to ensure that all community service agencies are provided information regarding the BSHSI Patient Financial Services practices. It is recommended that this be done in a forum that is interactive.
- 1.7 Training, education and resources on the Patient Financial Assistance Services Policy and Procedures is provided to each Local System CEO, VP of Mission, Director of Patient Financial Services and the Local System Champion and staff, as needed, to ensure consistency in deployment and policy administration.
- 1.8 Accommodations will be made for non-English speaking patients.

Preliminary Determination of Insurance and Financial Status	POLICY NO. CYC-01/FAP_0025 Section 2
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- 2.1 The Patient Access Staff, including Registration and Medical Eligibility Vendor/Medical Assistance Advocacy, screen all patients to identify individuals and their families who may qualify for federal, state or local health insurance programs or the Patient Financial Assistance Program (see section 8 of this Policy). Potentially eligible patients are referred to Patient Financial Services for financial counseling.
- 2.2 Although proof of income is requested for consideration of the Patient Financial Assistance Program some Local System DSH regulations may require proof of income. Such regulations will be handled on a case-by-case basis.
- 2.3 Automatic charity assessment and credit checks for accounts greater than \$5,000 will be considered.

Financial Counseling	POLICY No. CYC-01/FAP_0025 Section 3
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- 3.1 Patient Financial Services Staff, including the Patient Access Staff, is responsible for assisting patients and their families in determining eligibility and applying for federal, state and local insurance programs and/or for the Patient Financial Assistance Program. If applicable, referral for debt counseling is made. Information will be made available at all patient access locations, including 24-hour emergency departments.
- 3.2 A standard financial information worksheet is used to collect and document the patient's insurance and financial status. The standard worksheet is reviewed as needed, but at least annually, by the BSHSI Director of Patient Financial Services. Any changes to the standard work sheet are communicated to each Local System Director of Patient Financial Services and Local System Champion for immediate use.

- 3.3 Patient cooperation is necessary for determination. If patient does not provide the financial information needed to determine eligibility for the Patient Financial Assistance Program, the patient will be given the opportunity for a Prompt Pay Discount.
- 3.4 All uninsured patients are provided a Community Service Adjustment, at the time of billing.
- 3.5 All BSHSI locations will have dedicated staff to assist patients in understanding charity and financial assistance policies.

Prompt Pay Discounts	POLICY NO. CYC-01/FAP_0025 Section 4
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- 4.1 All patients are eligible for a 10% Prompt Pay Discount when the patient balance owed is paid in full within thirty (30) days of the bill date. Patient is responsible for deducting the 10% prompt pay discount at the time of payment.
- 4.2 The Local System Director of Patient Financial Services is responsible for ensuring compliance with all state laws and regulations regarding discounts for health care services.

Billing and Letter Series	POLICY NO. CYC-01/FAP_0025 Section 5
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- 5.1 A standard letter series is used to inform the patient of the patient balance owed and the availability of the Patient Financial Assistance Program. (See BSHSI Patient Financial Services Policy No C1217.)
- 5.2 The BSHSI Director of Patient Financial Services or designee reviews as needed, but at a minimum on an annual basis, the standard letter series. Any changes to the standard letter series are communicated to each Local System Director of Patient Financial Service or designee and Local System Champion for immediate use.
- 5.3 A distinct letter series is used for the Patient Financial Assistance Program to inform the patient of eligibility status and the patient balance owed. (See BSHSI Patient Financial Services Policy No. C313.)
- 5.4 The BSHSI Director of Patient Financial Services or designee reviews as needed, but at a minimum on an annual basis, the distinct letter series for Patient Financial Assistance Program. Any changes to the distinct letter series are communicated to each Local System Director of Patient Financial Service or designee and Local System Champion for immediate use.
- 5.5 It is the policy of BSHSI to provide notification to a patient at least thirty (30) days before an account is sent to collection. Written notice can be included with the bill.

Payment Options	POLICY NO. CYC-01/FAP_0025 Section 6
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- 6.1 A variety of payment options are available to all patients and their families.

- **Monthly Pay Plan** - Patient pays the patient balance owed over an eight-month period with a minimum monthly payment of \$50. In the State of New York, the monthly payment shall not exceed ten percent (10%) of the gross monthly income of the patient. A patient may receive a monthly payment due reminder or choose an automatic check debit or credit card payment method.
- **Loan Program** - Assistance in obtaining a low-cost retail installment loan with an independent finance company is provided if the patient is not able to pay the patient balance owed within eight months of the billing date.
- **Single Payment** – Patients may choose to wait to pay the patient balance owed until after their insurance company has paid its portion. The patient balance owed is due within thirty (30) days of the billing date.

6.2 The Patient Financial Services staff documents the payment option selected by the patient in the financial information system.

6.3 Payments will be applied in the following order, unless otherwise directed by the LS DPFS:

- In accordance with remittance advice or EOB
- As directed by the patient/guarantor

In the absence of the above two points...

- The most current account

This approach mitigates issues with the handling of Family Annual Liability and reduces expense to the organization.

Program Enrollment Assistance	POLICY No. CYC-01/FAP_0025 Section 7
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7.1 The Medical Eligibility Vendor/Medical Assistance Advocacy screens referred patients for eligibility for the following programs (this list is not inclusive of all available programs) :

- SSI Disability / Federal Medicaid
- State Medicaid
- Local/County Medical Assistance Programs
- State-Funded Charity Programs
- BSHSI Patient Financial Assistance Program

7.2 The Medical Eligibility Vendor/Medical Assistance Advocacy assists the patient in completing and filing application forms for all programs for which the patient may be eligible, including the BSHSI Patient Financial Assistance Program.

7.3 The Medical Eligibility Vendor/Medical Assistance Advocacy forwards the completed Patient Financial Assistance Program application form (and any documentation) to Patient Financial Services for processing.

7.4 Patients should be encouraged to apply for financial assistance as soon as possible, and in the State of New York, Patients will have at least ninety (90) days from date of discharge or date of service to apply for financial assistance

and at least twenty (20) days to submit the completed application (including any state or federally required documentation)

- 7.5 Certain government programs may require proof of income.
- 7.6 Patients without US citizenship presenting as uninsured will be eligible for the CSA however they must also be screened for available programs and/or referred to an international case firm (as determined by the Local System).
- 7.7 Insured patients without US citizenship must be referred to an international case firm (as determined by the Local System) for processing.

Patient Financial Assistance Program	POLICY No. CYC-01/FAP_0025 Section 8
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- 8.1 The Patient Financial Assistance Program assists uninsured and underinsured patients who are not able to pay in part or in full the account balance not covered by their private or government insurance plans without undue financial hardship.
- 8.2 The standard minimum income level to qualify for 100% charity through the Patient Financial Assistance Program is an income equal to or less than 200% of the Federal Poverty Guidelines. BSHSI will not include Patient's assets in the application process.
- 8.3 Individuals above the 200% of the Federal Poverty Guidelines can be found eligible for partial assistance. Determination of a patient's maximum annual liability considers the patient's income and size. The patient balance owed is calculated using the formula illustrated in the Tables below..
- 8.4 In New York, when a patient is above 200% but less than or equal to 250% of the Federal Poverty Guidelines, the hospital shall apply a graduated scale not to exceed the maximum that Medicare, Medicaid, the charge from a third party payor, or the charge from the BSHSI hospital as adjusted by the CSA, whichever is more generous.
- 8.5 In New York, when a patient is equal to or above 251% of the Federal Poverty Guidelines, the hospital shall collect no more than the greater of the amount that would have been paid for the same services by Medicare, Medicaid, or the "highest volume payor, or the charge from the BSHSI hospital as adjusted by the CSA, whichever is more generous.

UNINSURED ONLY:

Note: This Table Does Not Address New York Patients.

Step I	<p>[Charges] x [Community Service Adjustment] = Adjusted Account Balance Owed</p> <p><u>Uninsured patients ONLY</u> will receive an "account" balance reduction / Community Service Adjustment (CSA). The reduction is market adjusted and will insure that patient's will never pay 100% of charges. The patient is still fully responsible for their Annual Liability after FAP (Steps II & III below).</p>
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	<p>NOTES: The Community Service Adjustment applies to the balance due on individual accounts.</p> <p>a) If patient is approved for financial assistance they are responsible for each adjusted account balance owed amount until they meet their annual family liability.</p> <p>b) If patient is not approved for financial assistance, they are responsible for each adjusted account balance owed without an annual threshold.</p>
Step II	$[Household\ Income] - [Federal\ Poverty\ Guidelines,\ Adjusted\ for\ Family\ Size] = Adjusted\ Household\ Income$
Step III	$[Adjusted\ Household\ Income] \times [The\ Tax\ Foundation\ \% \text{ which identifies the amount of Household Income Spent for Medical Expenses}] = Patient/Family\ Maximum\ Annual\ Liability$ <u>Once the annual liability is met any balances thereafter will be processed as 100% charity (see section 8.6).</u>
Step IV	As applicable, $[Patient\ Balance\ Owed] - [10\% \text{ Prompt Pay Discount}] = Discounted\ Patient\ Balance\ Owed.$
Step V	As patients become eligible for FAP the CSA will be reversed and processed as a charity adjustment.

UNDERINSURED ONLY:

Note: This Table Does Not Address New York Patients.

Step I	$[Household\ Income] - [Federal\ Poverty\ Guidelines,\ Adjusted\ for\ Family\ Size] = Adjusted\ Household\ Income$
Step II	$[Adjusted\ Household\ Income] \times [The\ Tax\ Foundation\ \% \text{ which identifies the amount of Household Income Spent for Medical Expenses}] = Patient/Family\ Maximum\ Annual\ Liability$ <u>Once the annual liability is met any balances thereafter will be processed as 100% charity (see section 8.6).</u>
Step III	As applicable, $[Patient\ Balance\ Owed] - [10\% \text{ Prompt Pay Discount}] = Discounted\ Patient\ Balance\ Owed$
Step IV	As patients become eligible for FAP the CSA will be reversed and processed as a charity adjustment.

8.6 The BSHSI Director of Patient Financial Services prepares and distributes updates to the Federal Poverty Guidelines, The Tax Foundation Average % and the respective Local

System Cost of Service Adjustment as a part of the annual Strategic Quality Plan and Budget Guidelines process. The Local System Champion is responsible to ensure Guidelines are followed.

- 8.7 Patient Financial Services determines and documents the patient's eligibility for the Patient Financial Assistance Program and notifies the patient. The letter of approval/denial is mailed to the patient within ten (10) working days after receipt of the application and supporting documentation.
- 8.8 Patients determined to be eligible for Patient Financial Assistance Program retain eligibility for a period of twelve (12) months from the date of approval. At the end of those twelve (12) months, the patient is responsible for reapplying for eligibility for the Patient Financial Assistance Program.
- 8.9 Services provided as a result of an accident are subject to all legal instruments required to ensure third party liability payment, even if these instruments are filed after the initial eligibility for the Patient Financial Assistance Program has been approved. If third party coverage exists, BSHSI will collect the balance owed from the third party payer.
- 8.10 Application can be made on behalf of the patient by the following parties, including but not limited to:
 - Patient or guarantor
 - Faith community leader or representative
 - Physician or other health care professionals
 - Member of the Administration

8.9 Validated denial of coverage will be considered as uninsured and will be provided CSA.

Pursuit of Non-Payment	Policy No. CYC-01/FAP_0025 Section 9
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- 9.1 No collection efforts are pursued on any pending Patient Financial Assistance Program account.
- 9.2 Any collection attorneys working on behalf of BSHSI are NOT authorized to attach bank accounts and in no case file body attachments. BSHSI collection attorneys follow BSHSI's value-based procedures in the pursuit of estates, garnishments and judgments for non-payment of debts. In no event will BSHSI ever put a lien on a patient / guarantor's primary residence.
- 9.3 In New York, BSHSI payment plans will not contain an accelerator or similar clause under which a higher rate of interest is triggered by a missed payment.
- 9.4 Each Local System uses a reputable collections attorney for the processing of legal accounts.
- 9.5 The Local System Director of Patient Financial Services is responsible for reviewing balances of \$5,000 and greater to confirm that all appropriate actions have been taken

prior to the patient balance being written off to Bad Debt or sent for suit. Policy allows for the Local Systems to be more stringent in their practices with respect to authorization levels.

- 9.6 As State requirements permit, deceased patients with no estate or patients that have been discharged through a Chapter 7 bankruptcy are automatically qualified for 100% charity write off.
- 9.7 All collection-type vendors are required to comply with the BSHSI Code of Conduct.

Accountability and Monitoring	Policy No. CYC-01/FAP_0025 Section 10
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- 10.1 Reports on the program status are issued monthly, as part of current patient financial services/ revenue cycle reporting, to each Local System CEO, CFO, VP of Mission, Director of Patient Financial Services, Local System Champion and staff and others as defined.
- 10.2 The indicators used to monitor the program are:
 - Main Indicators:
 - Bad Debt as % of Gross Revenue
 - Charity Care as % of Gross Revenue
 - Monitoring Indicator: Reduction to % of accounts/dollars in bad debt that have been reclassified to charity.
- 10.3 The Local System CEO is the responsible person to insure applicable standardization of implementation and compliance with the integrity of the program on an ongoing basis.

State Requirements and Policy Revisions	Policy No. CYC-01/FAP_0025 Section 11
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- 11.1 Due to the ever-changing environment and current proposed legislation it will be necessary to revise this policy as appropriate.
- 11.2 It may be necessary to address certain State requirements within this policy to insure compliance with applicable laws and regulations.
- 11.3 Maryland State Only Regulations
 - The Maryland HSCRC (Health Service Cost Review Commission) requires all Maryland hospitals to use the Uniform Financial Assistance Application form beginning January 1, 2006.
- 11.4 New York State Only Requirements:
 - Appeals Process for Re-Consideration of a Denied Application – All patients that have been denied have the right to appeal by contacting the New York business office at 800-474-3900. .

- The following are the reporting requirements by the hospital:
 - A report on hospital costs incurred and uncollected amounts in providing services to the uninsured and under insured, including uncollected co insurance and deductible amounts.
 - The number of patients, organized by zip code, who applied for financial assistance, and the number of patients by zip code whose applications were approved and whose applications were denied.
 - The amount reimbursement received from the Hospital Indigent Care Pool.
 - The amount spent from charitable funds, trusts or bequests established for the purpose of providing financial assistance to eligible patients as defined by such trusts or bequests.
 - If local social services district in which the hospital is located permits the hospital to assist patients with Medicaid applications, the number of Medicaid applications the hospital helped patients complete, and the number approved and denied.
 - The hospital's losses resulting from providing services under Medicaid.

Prepared by/Title: Becky Cary, Uninsured Manager, PFS

Signature/Date: _____

Reviewed by/Title: Joe Rapoza, Jr., Associate VP of Operations for Integrated CBO's

Signature/Date: _____

Approved by/Title: George Dantona VP, Revenue Cycle Services, HSO

Signature/Date: _____

Related Policies & Procedures; Notes; Controls:

Revision Date:
(Use if Revised.)

Review Date:
(Use if Reviewed
No Changes.)

		May 1, 2006
		April 18, 2008
Nick Dawson	Additions for New York State	April 24, 2008
Nick Dawson	Additions for Maryland State	June 4 th 2008

Filename: BC

E5101

Date: September, 1999

BON SECOURS BALTIMORE HEALTH SYSTEM

MISSION

The Mission of the Bon Secours Baltimore Health System is to help people and communities to health and wholeness by providing compassionate, quality health care and being *good help* to all in need in West Baltimore, with special concern for the poor and dying, in response to the Gospel mandate and healing ministry of Jesus Christ and the Catholic Church.

VISION

By the year 2010, the Bon Secours Baltimore Health System will be recognized as a health care leader. Our healing ministry will be expressed through services to the West Baltimore community that include focused acute and ambulatory care, community outreach, and health education programs that are focused, innovative, financially sustainable and in collaboration with others. Quality and compassionate care will continue to be our hallmark.

VALUES

At the heart of the Mission and Vision of Bon Secours Baltimore Health System are these eight **CORE VALUES**:

RESPECT--We treat all people well because all people have dignity.

JUSTICE--We support, protect and promote the rights of all individuals and we have a special concern for the rights of the poor and the dying.

INTEGRITY--We are honest in our dealings and our behavior is consistent with our thoughts, feelings and actions.

STEWARDSHIP--We are dedicated to the responsible and creative utilization of our resources to assure the continuance of our mission.

INNOVATION--We continually search within ourselves and our partnerships for new ways to profoundly improve our services and life in the surrounding communities.

COMPASSION--We experience and express empathy with the life situations of others.

QUALITY--Quality is continually improving our system's processes of care and service to our patients, physicians, co-workers and community through understanding their needs and striving to exceed their expectations.

GROWTH--We are committed to the implementation of programs that inspire positive development in the organization, our co-workers and our community. We are sensitive to the changes necessary to meet this challenge.

Gaps in Specialty Care at WMHS

Based on a 2007 study sponsored by the Maryland Hospital Association and Med Chi, there is a statewide downward trend in surgical specialty supply from 2007 to 2015. The specific shortages at WMHS coincide fairly well with the Western Region. It is projected in-migration and resident retention will be insufficient to cover departures from retirements in many surgical specialties. Statewide and regional shortages by specialty are summarized as follows.

- General Surgery
 - State Level: Shortage 2007-2015
 - Regional Level: Shortages 2007-2015 in all regions except Central for 2007-2015 and Western for 2007
 - Shortages projected to worsen from 2007-2015
- Neurosurgery
 - State Level: No shortage 2007-2015
 - Regional Level: Shortages in Western 2007, Capital and Southern Regions 2007-2015
- OB/GYN
 - State Level: No shortage 2007-2015
 - Regional Level: Shortages in Southern and Western Regions 2007-2015
- Ophthalmology
 - State Level: No shortage 2007-2015
 - Regional Level: Shortages in Eastern Region 2007-2015, Southern Region 2010 and 2015, and Western Region 2015
- Orthopedic Surgery
 - State Level: No shortage 2007-2015
 - Regional Level: Shortages in Eastern, Southern, and Western Regions 2007-2015
- Otolaryngology
 - State Level: No shortage 2007-2015
 - Regional Level: Shortage in Southern Region 2007-2015
- Plastic Surgery
 - State Level: No Shortage 2007-2015
 - Regional Level: Shortage in Southern Region 2007-2015, WMHS 2008
- Thoracic Surgery
 - State Level: Shortage 2007-2015
 - Regional Level: Shortages in all regions except Capital Region in 2007
 - Impact of Physician Retirements: Significant in 2010 and 2015
- Urology
 - State Level: No Shortage 2007-2015
 - Regional Level: Shortage in Southern Region in 2015, WMHS 2008
 - Significant retirements forecasted from 2007-2015
- Vascular Surgery
 - State Level: Shortage 2007- 2015
 - Regional Level: Western Regions 2007-2015

Based on input from uninsured clients and representatives of community agencies serving the underserved, there is a gap in availability to the following specialty care.

- Orthopedics
- Psychiatry
- Pain Management
- Neurology
- Endocrinology
- Cardiology

Description of the Charity Care Policy

The Western Maryland Health System (Braddock & Memorial Hospitals) grants charity care to those patients who demonstrate a financial need. WMHS has signs posted at all sites where patients are admitted for inpatient care and all sites where patients receive outpatient services, including the emergency room.

Applications for Financial Assistance are made available to patients at the time services are rendered. Applications for Financial Assistance are also made available to any patient or their family members who request the form be mailed to them.

WMHS contracts with an outside agency to interview all inpatients who do not have insurance coverage. When feasible the initial contact is made prior to discharge. The contractor explains to the patient or their family member(s) the benefits that may be available to them through the federal, state and local programs including Medical Assistance, Primary Adult Care and Medicare. The contractor assists the patient or their families in completing applications and accompanies them if needed to any appointments for the purpose of obtaining benefits through the various public programs.

WMHS provides a telephone number for financial assistance on patient statements. WMHS also has staff dedicated to follow-up and assist any patient or their family member(s) who needs support in obtaining financial assistance.

Patients determined to be ineligible for government benefits may be referred to the WMHS Wellness Center and its Community Health Access Program, (CHAP). This unique program, a joint venture of the Western Maryland Health System and Allegany Health Right, links participants to a primary care physician and appropriate health and social services, such as prescription programs, nutritional counseling, and diagnostic care. Through CHAP enrollment individuals are screened for potential eligibility in over 40 area programs.

WMHS	DIVISION: Business Office	POLICY #: 400-04
POLICIES AND PROCEDURES	SUBJECT: Uncompensated Care (Financial Assistance Program)	SUPERSEDES: September 2005
	EFFECTIVE: September 1982	REVISED: August 2007 REVIEWED:

UNCOMPENSATED CARE (FINANCIAL ASSISTANCE PROGRAM)

POLICY

The Western Maryland Health System's policy is to insure availability of a fair and reasonable volume of hospital care for patients who are unable to pay for their services.

PROCEDURE

To determine indigency for our purposes, each case is evaluated on an individual basis. This is done at the time of admission, or after services have been rendered, when our records indicate that a potential charity situation exists. In some cases, the patient cannot be contacted due to isolation, ICU, and other emergency admissions until discharge of the patient.

When determining indigency, the following indications are considered:

1. Aged patients existing on Social Security or Welfare;
2. State, County or Federal Welfare recipients (cash grants);
3. Patients with terminal illnesses who have no future earning capacity;
4. Disabled patients who have limited or no earning ability;
5. Patients whose guarantor is uninsured or underinsured;
6. Patients whose guarantor is unemployed or marginally employed;
7. Patients whose guarantors indicate inability to pay for hospital services;
8. It is recognized that Old Order Amish and Old Order Mennonite patients do not rely on in any manner on any type of government programs or private insurance based upon their religious beliefs. These two Orders rely on their religious community to pull resources together to pay for healthcare bills for members of their community. These patients, who are 100% self-pay, will be granted a 25% discount when bill is paid in full within 30 days of service.

Decisions on probable eligibility will be made within two business days of an initial application. After an evaluation and determination is made that an uncompensated care situation exists (Procedure 400-5), the account is written-off and placed in a special file established for that purpose, and there is no further activity on the account.

By using the Federal poverty income guidelines published annually in the Federal Register, a patient may be found to be responsible for only a percentage of their bill according to their income and number of dependents. The patient's responsibility will be capped based on a percentage of their income. Decisions on probable eligibility will be made within two business days of an initial application. In such cases, a percentage of the bill is charged to the Financial Assistance Program and the patient or his agent is required to pay the remainder not charged to the Financial Assistance Program.

Patients who fail to meet payment requirements will have the amount written off under the Financial Assistance Program debited back to the account before placement to a collection agency.

Approved:

Director, Business Operations

Senior Vice President/Chief Financial Officer

SLIDING SCALE ADJUSTMENTS Based on FPL for 2007

**Community Health Access Program (CHAP)
PATIENT RESPONSIBILITY PERCENTAGES**

Size of family unit	0% (PAC-FAP-unless exception noted)	10%	20%
1	0 (\$10,210) - \$15,213	\$15,214 - \$17,765	\$17,766 - \$20,420
2	0 (\$13,690) - \$20,398	\$20,399 - \$23,821	\$23,822 - \$27,380
3	0 (\$17,170) - \$25,583	\$25,584 - \$29,876	\$29,877 - \$34,340
4	0 (\$20,650) - \$30,769	\$30,770 - \$35,931	\$35,932 - \$41,300
5	0 (\$24,130) - \$35,954	\$35,955 - \$41,986	\$41,987 - \$48,260
6	0 (\$27,610) - \$41,139	\$41,140 - \$48,041	\$48,042 - \$55,220
7	0 (\$31,090) - \$46,324	\$46,325 - \$54,097	\$54,098 - \$62,180
8	0 (\$34,570) - \$51,509	\$51,510 - \$60,152	\$60,153 - \$69,140
FPL range	Thru 149%	150% - 174%	175% - 200%

Each additional person, add \$3,480 to base FPL.

**WMHS Financial Assistance Program (Charity Care)
PATIENT RESPONSIBILITY PERCENTAGES**

Size of family unit	30%	40%	50%
1	\$20,421 - \$22,870	\$22,871 - \$25,423	\$25,424 - \$27,975
2	\$27,381 - \$30,666	\$30,667 - \$34,088	\$34,089 - \$37,511
3	\$34,341 - \$38,461	\$38,462 - \$42,753	\$42,754 - \$47,046
4	\$41,301 - \$46,256	\$46,257 - \$51,419	\$51,420 - \$56,581
5	\$48,261 - \$54,051	\$54,052 - \$60,084	\$60,085 - \$66,116
6	\$55,221 - \$61,846	\$61,847 - \$68,749	\$68,750 - \$75,651
7	\$62,181 - \$69,642	\$69,643 - \$77,414	\$77,415 - \$85,187
8	\$69,141 - \$77,437	\$77,438 - \$86,079	\$86,080 - \$94,722
FPL range	201% - 224%	225% - 249%	250% - 274%

Each additional person, add \$3,480 to base FPL.

SLIDING SCALE ADJUSTMENTS Based on FPL for 2008

**Community Health Access Program (CHAP)
PATIENT RESPONSIBILITY PERCENTAGES**

Size of family unit	0% (PAC-FAP-unless exception noted)	10%	20%
1	0 (\$10,400) - \$15,599	\$15,600 - \$18,199	\$18,200 - \$20,903
2	0 (\$14,000) - \$20,999	\$21,000 - \$24,499	\$24,500 - \$28,139
3	0 (\$17,600) - \$26,399	\$26,400 - \$30,799	\$30,800 - \$35,375
4	0 (\$21,200) - \$31,799	\$31,800 - \$37,099	\$37,100 - \$42,611
5	0 (\$24,800) - \$37,199	\$37,200 - \$43,399	\$43,400 - \$49,847
6	0 (\$28,400) - \$42,599	\$42,600 - \$49,699	\$49,700 - \$57,083
7	0 (\$32,000) - \$47,999	\$48,000 - \$55,999	\$56,000 - \$64,319
8	0 (\$35,600) - \$53,399	\$53,400 - \$62,299	\$62,300 - \$71,555
FPL range	Thru 149%	150% - 174%	175% - 200%

Each additional person, add \$3,600 to base FPL.

**WMHS Financial Assistance Program (Charity Care)
PATIENT RESPONSIBILITY PERCENTAGES**

Size of family unit	30%	40%	50%
1	\$20,904 - \$23,399	\$23,400 - \$25,999	\$26,000 - \$28,496
2	\$28,140 - \$31,499	\$31,500 - \$34,999	\$35,000 - \$38,360
3	\$35,376 - \$39,599	\$39,600 - \$43,999	\$44,000 - \$48,224
4	\$42,612 - \$47,699	\$47,700 - \$52,999	\$53,000 - \$58,088
5	\$49,848 - \$55,799	\$55,800 - \$61,999	\$62,000 - \$67,952
6	\$57,084 - \$63,899	\$63,900 - \$70,999	\$71,000 - \$77,816
7	\$64,320 - \$71,999	\$72,000 - \$79,999	\$80,000 - \$87,680
8	\$71,556 - \$80,099	\$80,100 - \$88,999	\$89,000 - \$97,544
FPL range	201% - 224%	225% - 249%	250% - 274%

Each additional person, add \$3,600 to base FPL.

WMHS	DIVISION: Business Office	POLICY #: 400-05
POLICIES AND PROCEDURES	SUBJECT: Procedure to Determine Indigency	SUPERSEDES: June 2005
	EFFECTIVE: July 23, 1986	REVISED: July 2006 REVIEWED

PROCEDURE TO DETERMINE INDIGENCY FOR POLICY ON UNCOMPENSATED CARE
(FINANCIAL ASSISTANCE PROGRAM)

In accordance with the Western Maryland Health System's Policy on Uncompensated Care (Policy 400-04), an evaluation of a patient's or guarantor's ability to pay for hospital services shall be conducted as follows:

1. Determination should be made that all forms of insurance are not available to pay the patient's bill (Medicare, Medicaid, Blue Cross, or private commercial insurance).
2. Determine Gross Income
 - A. Gross income includes income from all sources: wages, interest, dividends, pensions, social security, checking, savings, CD's, stocks and bonds, child support paid by applicant to be deducted from gross income, etc. The first \$3,000.00 per family of savings is excluded.
 - B. Gross income can be verified from the most recently filed federal income tax return. Pay stubs can also be used to determine gross income. If pay stub is used, be certain that employment is not seasonal. The pay period used must be usual and customary; for an accurate total of annual gross income.
 - C. For the unemployed applicant, the amount of remaining unemployment that the applicant will receive is counted. (26 weeks in a period).
3. Self-Employed
 - A. The previous year's tax return is utilized if current year return is not available.
 - B. Schedule C Profit and Loss are reviewed. Deductions such as depreciation shown on Schedule C are added back to gross income. Other adjustments to Schedule C may be made after review by Department Director.
4. Determine Medical Payments
 - A. Should reflect amounts being paid, not the amount owed. Receipts and/or canceled checks can be used to ascertain amounts being paid. The amount due is needed to determine how long payments will continue. The amount due can be verified by examining a recent statement of account.
 - B. This amount is used to reduce gross income for purposes of finding the proper income level on the Federal Assistance Program allowance scale that is based on Federal Poverty Income Guidelines.
 - C. Formula to be used to ascertain the amount of deduction allowed for medical bills:
 - a. Total all medical bills (including hospital bills and prescriptions)
 - b. Compare total of bills against our extended payment plan
 - c. Allow 12 times the monthly payment we would expect patient to pay on medical bills if they were due Western Maryland Health System

PROCEDURE TO DETERMINE INDIGENCY FOR POLICY ON UNCOMPENSATED CARE
(FINANCIAL ASSISTANCE PROGRAM)

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- d. Reduce yearly income by that amount.
5. Determine the Number of Dependents
 - A. In determining the number of dependents to be counted on an applicant's application, the guidelines used by the IRS will be used and a copy of the income tax return will be required.
 - B. Applicants who have a child and who lives with the child's natural father/mother, the income of the applicant and co-parent will be counted.
 - C. In some situations, the income of the person who lives with the applicant may be counted at the discretion of Administration.
 6. Determine Assets and Resources
 - A. In some situations, an applicant's holdings in real estate may be looked into.
 7. Considerations in Applying For the Financial Assistance Program
 - A. Working, able-bodied patients, over the age of 21, with no disabilities and not pregnant do not usually qualify for Medical Assistance, therefore, at the discretion of the Supervisor and Department Director, the requirement of the patient making application for Medical Assistance May be waived.
 - B. The Financial Assistance Program, when approved, is backdated for services 12 months and valid 24 months forward.
 - C. In certain situations, a 12 month waiting period to re-apply for the Financial Assistance Program may be waived.
 - D. Approved applicants will have their income re-verified each 12 months from the date the original application was approved if new patient debts incur. Income re-verification can be done during any period of time at the discretion of the Department Director.
 - E. Account(s) of the applicant which have been previously placed with a Collection Agency are not included in the application for the Financial Assistance Program. A waiting period of 12 months is required before patient may be eligible to apply for the Financial Assistance Program when account(s) are placed with a Collection Agency.
 8. Application
 - A. The cover letter attached to the Financial Assistance Program application specifies the application to be returned in 10 working days with requested information. If patient does not respond, the patient will be considered not interested. If partial information is returned, the applicant will be given additional time to provide all the requested information.
 - B. Decisions on probable eligibility will be made within two business days of an initial application. The applicant will be notified in writing by someone from the WMHS Business Office of the determination. If additional information is needed for a final determination, the patient/guarantor will be told what additional information is required and the final determination will be communicated to the patient in writing within two business days of receiving the additional information.
 - C. The patient will be made aware that he/she is attesting to the fact that the information he/she has provided is a complete and accurate statement of his/her financial situation by having the Financial Disclosure Statement signed.

PROCEDURE TO DETERMINE INDIGENCY FOR POLICY ON UNCOMPENSATED CARE
(FINANCIAL ASSISTANCE PROGRAM)

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9. Patient Financial Obligation

- A. In situations when the applicant fails to meet previously agreed upon payment arrangements because they did not qualify for a 100% write-off, any amount(s) previously written-off to the Financial Assistance Program will be reversed and the original balance of the account minus any payments made will be placed with a collection agency.
- B. Patients receiving assistance through the Financial Assistance Program must agree to make monthly payments based on the current policy regarding extended payment terms.

Approved:

Director, Business Operations

Vice President, Financial Services

Appendix 4: Description of Mission, Vision & Values WMHS-Braddock & Memorial Hospitals

Mission, Vision & Values

Western Maryland Health System (Braddock & Memorial Hospitals) has a long history of addressing community needs and is often approached by members of the community for support. The mission of the WMHS is to improve the health status and quality of life of the individuals we serve, especially those in need. Commitment to the cause extends from the employees to the Board of Directors, and is reflected in the strategic plan and goals. Through the strategic planning process, adequate resources are identified and community service initiatives are aligned with system-wide objectives. Community service priorities are to promote healthy behaviors, create safe environments, and increase access to services for the vulnerable. Through responsible management of resources and collaboration with partners WMHS is committed to sustain programs that address the community service priorities.

We are a values-driven system that respects and supports life, preserves the dignity of each individual, and promotes a healthy and just society through collaboration with others who share our values. Our actions are guided by our core values: Respect; Integrity; Quality; Community Advocacy; and Resourcefulness.

- **Respect** - Treating those we serve and with whom we work with compassion, demonstrating a high regard for the dignity and worth of each person.
- **Integrity** - Honesty and straightforwardness in all relationships.
- **Quality** - Continuous improvement through creativity and teamwork.
- **Community Advocacy** - Fostering the overall well being of the community, especially those in need, through charitable and community service and responsible action as a corporate citizen.
- **Resourcefulness** - Effective stewardship of the community

WMHS is also the region's largest employer and, as such, one of our strategic initiatives is to be a good corporate neighbor. As a not-for-profit health system, we provide care to all, regardless of their ability to pay. In fiscal year 2008, we provided over \$6.5 million in charity care. There are a number of patient care services that are not self-supporting that we continue to provide since we are the community's only provider. We provide patient and family-centered services through responsible management of our human and fiscal resources.

Making sure that patients have the follow-up resources that they need is also a priority and we work cooperatively with many other community organizations. WMHS took the lead in developing and maintains the software used by many community service agencies, including WMHS, to screen low income, uninsured and underinsured residents for assistance. Residents can visit any one of the various agencies to determine their eligibility for support services from all of the agencies.

WMHS provides both financial support and in-kind support to numerous community organizations that share our mission. In addition to corporate giving, our WMHS Employees Fund contributes more than \$70,000 each year to local nonprofit organizations. WMHS hosts several bloodmobiles for the American Red Cross. It also makes meeting room space available for community organizations at no fee.

WMHS serves as a clinical site for students enrolled in health-related studies at a nearby community college as well as from other colleges and universities. High school students interested in health careers and Kindergarten students from surrounding counties visit the hospital to learn about the services provided. Through these efforts WMHS hopes to secure a quality workforce long into the future.

Western Maryland Health System Mission/Values Alignment Matrix Fiscal Year 2008

<p><u>Mission</u></p> <ul style="list-style-type: none"> • Improve health status and quality of life. • Improve patient and family-centered services. • Respect and support life. • Preserve the dignity of individuals. • Promote a healthy and just society through collaboration. 	<p><u>Vision</u></p> <p>With a commitment to excellence, we envision a premier health care system of quality services that advances the health and well-being of the communities of the Tri-State region. Through partnership with our medical staff and other organizations, we will provide for ease of access to a coordinated network of services that addresses the needs of individuals and families.</p>	<p><u>Core Purpose</u></p> <p>Preserve and improve the health status and quality of life for individuals in the communities we serve.</p>	<p><u>Values</u></p> <p>Respect Integrity Quality Community Advocacy Resourcefulness</p>
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Strategic Goals:

Mission Integration

Demonstrate the organization’s mission and values in practice, emphasizing the direct benefit to the community and the underserved.

Quality/Safety

Support an environment that advances safety and continuous improvement through creativity and partnership with our medical staff and other organizations.

Financial Viability

Ensure long-term financial strength of WMHS by managing finances to maintain a stand-alone health system bond rating of “BBB” or higher.

Leadership / Organizational Effectiveness

Strengthen organizational effectiveness through a commitment to excellence in medical staff, employees, leadership, and governance.

Market Position Enhancement

Strengthen competitive ability and expand critical markets throughout the region, in collaboration with key partners.

Key Strategies:

1. Continue an organized community health program emphasizing lifestyle choices affecting regional health problems, particularly child and adult obesity.
2. Strengthen reporting effectiveness and develop internal and external awareness of WMHS’s community benefit.
3. Participate actively in community organizations, planning, and events to fulfill our mission and obligation to good corporate citizenship.

1. Promote culture of safety by involving physicians, nurses, and clinical staff in education and participation in safety initiatives, including appropriate review and resolution of adverse events.
2. Continue to support major initiatives, including National Patient Safety Goals, Save Five Million Lives Campaign, and Maryland Patient Safety Center Collaboratives.
3. Strive to be a top performer in all reported performance

1. Finalize capital campaign and further develop the framework for a sustained giving campaign.
2. Position WMHS to maximize its placement on the combined HSCRC screens through identifying and implementing cost improvements in inpatient care or outpatient ambulatory surgery.
3. Expand use of Lean and Six Sigma initiatives throughout the organization to achieve process improvement, cost savings, and divestiture of

1. Strengthen responsiveness to physician needs through expanded attention and increased accountability.
2. Become an industry leader in patient and employee satisfaction through stronger focus on the Service Excellence culture and hardwired accountability for outcomes.
3. Guide construction, relocation, and staff planning across the organization to assure effective transition to and occupancy of the new hospital.

1. Continue developing specialty centers and align with physicians in the following areas:
 - a. Initiate Neonatology Associates, Inc. – direction and expansion of the neonatal nursery to accommodate infants requiring intensive care.
 - b. Implement Destination Total Joint Center to enhance reconstructive orthopedics.
 - c. Develop and open Gynecological Oncology Center in Cumberland.

**Western Maryland Health System
Mission/Values Alignment Matrix
Fiscal Year 2008**

Key Strategies: (Continued)	<u>Mission Integration</u>	<u>Quality/Safety</u>	<u>Financial Viability</u>	<u>Leadership / Organizational Effectiveness</u>	<u>Market Position Enhancement</u>
	<p>4. Increase employee involvement in and awareness of mission fulfillment.</p>	<p>measure areas. 4. Utilize existing and evolving technology to enhance patient safety.</p>	<p>unprofitable services, where necessary. 4. Identify Revenue Cycle Metrics and position WMHS to achieve the best practice targets in at least three of the categories.</p>	<p>4. Recruit, select, and retain top talent throughout the organization at all levels (staff, physicians, boards, etc.)</p>	<p>d. Recertify MIEMSS accredited Regional Adult Trauma Center. e. Acquire second IMRT capable linear accelerator in Radiation Therapy. f. Continue to develop WMHS Stroke Center toward a five-year accreditation. 2. Provide continuing direct oversight to all activities related to the 2009 completion of the new WMHS Regional Medical Center, including transition support to medical staff. 3. Enhance access to primary care by recruiting new physicians; also recruit specialists to support critical community needs and WMHS specialty centers.</p>

Calvert Memorial Hospital

FY 2008 Community Benefit Narrative Report

1. What is the licensed bed designation and the number of inpatient admissions for FY2008?
 - The licensed bed designation is 105 beds. The number of inpatient admissions (acute and newborn) for FY 2008 is 9007.

2. Describe your community:
 - Calvert Memorial Hospital is the sole hospital provider in Calvert County, Maryland. Calvert County is located in Southern Maryland and is essentially a peninsula bordered on the east by the Chesapeake Bay and on the west by the Patuxent River. With a long and skinny topography, the county's "spine" is Maryland Routes 2/4 running from Dunkirk in the north to Solomons Island in the south for approximately 45 miles. This topography presents challenges to both transportation and service delivery that are unique to Calvert County. In addition, Calvert Memorial Hospital secondary market area includes the surrounding areas of southern Prince Georges and Anne Arundel Counties, St Mary's County on its southern border and Charles County on its western border.
 - Calvert County is in the outer ring of suburban Washington, D.C. Estimated growth rate for the county was nearly 18% for the period from 2000-2005. Population density increased in the county from 238.7 to 346.5 people per square mile over the period of 1990-2000. Population projections are for Calvert to continue to grow to 95,700 in 2010 and 100,700 people in 2020. The future is projected to bring small growth in population of young people, large increases (on a percentage basis) of the elderly, and modest growth in total number of households and in size of the labor force. Calvert County's estimated median income for 2006 is \$87,400. Despite its relative high income level, Calvert County is home to people who live in poverty. US Census data of 2000 revealed that 635 families in Calvert had income below the federal poverty level. The census revealed a relatively high rate of poverty among children (about 5%) and among the elderly (about 6%). Financial analysis for FY2008 for Calvert Memorial Hospital reveals that 4.9% of gross revenue is from self-pay or uninsured patients and 8.8% of gross revenue is from Medicaid recipients. Maryland Vital Statistics report that Calvert County's mortality rate for all causes of death is 689.2 per 100,000 people which is below the state average of 781.7 deaths per 100,000 people. Heart disease and cancer are the leading causes of death in Calvert and higher than the other surrounding counties. Death from cancers in Calvert County is higher than the Maryland state average.

3. Identification of Community Needs:

- Calvert Memorial Hospital (CMH) uses a variety of resources to identify the health needs of its community.
- Between July 2007 and November 2007, CMH in collaboration with the Calvert County Community Health Improvement Roundtable completed a comprehensive community health assessment. This is done by the Roundtable approximately every five years and takes about one year to complete. The Roundtable membership is representative of the major community partners for health and human services and includes the leadership from the Calvert County Health Department, Calvert County Public Schools, Calvert County Office on Aging, Calvert County of Community Resources, the Calvert County Department of Social Services, Calvert Hospice, Calvert Alliance Against Drug Abuse, the Calvert County Traffic Safety Council and the ARC of Southern MD with CMH as the primary facilitator of the Roundtable. The purpose of the assessment was to determine the current status of community health in the county, to project future needs and to identify areas where their gaps in services. The assessment consisted of two components: the first being the collection of data on the health status of the county as available through local, state and national data sources. It also consisted of personal interviews with key leaders in the community in order to gather information on their perception of the health of this community. These leaders included a county commissioner, the Superintendent of Schools, the County Health Officer, a leading clergy representative from a minority church, the Director of Aging Services at the Office on Aging and the CEO of CMH. The second phase was the development of a public community survey designed to determine resident's views about their health and the local health care system. It utilized face-to face methods, online availability and a paper system. The survey was distributed by community agencies such as the United Way, the local Interagency Council, local churches and employers as well as at a community health forum at the College of Southern Maryland. A total of 1,418 surveys were returned to CMH.
- In October 2007, the Community Health Improvement Roundtable held a community health forum at the College of Southern Maryland, Calvert County campus. It consisted of a panel presentation by the county's health officer, a private physician and the hospital's president with a question and answer period afterwards. Approximately 50 people attended this forum.
- In the fall of 2007, the Community Wellness Department of CMH surveyed its Faith-Based Ministry Council for their concerns and perceptions regarding the health of the community and what recommendations they had for CMH to address in future planning.
- In January 2008, CMH's Medical Staff Development Plan was updated. Applying very specific quantitative analysis along with qualitative medical staff input, the study

showed the need for a significant number of primary care physicians as well as medical and surgical sub-specialties.

- In the Spring of 2008, CMH's Board of Directors initiated a strategic planning process for the years 2009-20012. The purpose of the Plan is to amalgamate and synthesize the key findings and recommendations of key studies and to present a "roll-up" of recommended actions that remain to be implemented.
 - The local health department is integral to the assessment and planning of health care services at CMH. Through active participation on the Community Health Roundtable and other collaborative efforts the hospital and the health department work closely to improve the health of the community. For example, both the county health officer and the hospital's CEO presented the results of the community health assessment to the county commissioner's at their meeting on December 16, 2008.
4. List the major needs identified through the process explained in question #3:
- The recent community health assessment identified seven (7) areas of concern:
 - Children's and adolescent health issues: alcohol and drug use; teen pregnancy; juvenile crime; pediatric dental care and autism
 - Elderly care and end-of-life issues: support services for family caregivers; skilled nursing services; assisted living services and end-of-life care; medical management of diseases related to aging
 - Recruitment and retention of health care providers with emphasis on access to a local physician in a timely manner
 - Motor vehicle crashes
 - Mental health services
 - Increased prevalence of obesity
 - Care for the uninsured
5. Who was involved in the decision making process for determining which needs in the community would be addressed through community benefit activities of the hospital.
- The Community Health Assessment was presented at CMH's Board of Director's Planning and Marketing Committee as well as at their annual board retreat to discuss which areas should be addressed by the organization. The Board of Directors, under the CEO's guidance, were also instrumental in developing the hospital's recent Strategic Plan Update. During the preparation of the Strategic Plan, input was solicited from hospital department directors, and the Executive Team.

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

There are several recent hospital based initiatives that address needs listed in #4.

- Lack of Pediatric Dental Care for the Medicaid Population: CMH has been attempting to address this serious issue for several years by working with the local dental community and other key stakeholders. Just recently, a new plan was developed that utilizes contract dental providers providing services in already existing, under-utilized dental space with the hospital as the billing agent and program coordinator. This initiative has just recently received funding from MD's DHMH Office of Oral Health.
 - Care for the Uninsured: CMH has served on the Board of Director for Calvert HealthCare Solutions. This organization is a grass-roots effort to utilize existing medical resources in the community to provide primary care for the uninsured who meet income qualification guidelines. CMH has written several grant proposals to assist this organization in its mission. One recent grant that CMH is managing is from the Maryland Community Health Resource Commission (MCHRC). Its goal is to reduce inappropriate utilization of Emergency Services by those without health insurance. CMH provides a case manager to work with those who are uninsured to help them establish a medical home. CMH also provides basic lab and Xray diagnostic tests to those enrolled in Calvert HealthCare Solutions at no-cost.
 - Lack of access to primary and specialty medical care: CMH has taken this problem area as a major initiative. This lack of access results in excessive wait times for appointments, inappropriate use of Emergency Services, seeking care out of the area at hardship to the patient and family, disease progression due to not receiving health care as well as other problems. CMH regularly reviews and updates its Physician Recruitment and Retention Dashboard to keep the Board of Directors, medical staff leadership and community stakeholders apprised of its efforts to improve access to care. CMH employs a physician recruiter to assist with this effort as well as works with local area physicians to assist them with recruitment. In recent months, CMH has hesitantly increased the employment of physicians in order to meet this critical community need.
7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major community benefit program initiatives.
- Evaluation of effectiveness is demonstrated by data collected on services provided (volumes, financials, numbers of referrals etc).
 - Patient satisfaction surveys are provided to all recipients of services and are reviewed for recommendations for improvement.

- Emergency Services utilization is reviewed for appropriateness of visit as it applies to patients being managed by the MCHRC grant program. Patient compliance with visits scheduled at medical home is also tracked with follow-up to individual patients as needed.
 - All grant programs have specific outcome criteria that are approved and reported on a quarterly basis.
8. Describe gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured in the hospital.
- The Maryland Physician Workforce Study indicated that in Southern Maryland there are shortages in all specialties with the exception of allergy and neurology. This accounts for 24 specialties or 83% of all specialties reviewed.
 - Calvert Health Care Solutions works with local area physicians to try to arrange primary and specialty care services for patients enrolled in their program. This has had very limited success for specialty care with better success in primary care services.
 - Physicians employed by CMH are expected to provide medical care to the uninsured as appropriate for specialty area. Currently these specialty areas include one gastroenterologist, one general surgeon, one ENT surgeon, one spine surgeon, one OB-GYN surgeon and one pediatric developmental specialist. CMH has continued to support a hospitalist and pediatric hospitalist program so that any patient seeking inpatient care at this facility is ensured quality medical services. In the recent year, CMH has opened one family practice center with two physicians and has continued to support the Twin Beaches Community Health Center which provides primary care to both the insured and uninsured, using a sliding scale process.
 - The 2008 CMH Physician Recruitment and Retention Dashboard indicates the following shortages:
 - Pediatrics – 1 full time pediatrician needed
 - Cardiology – 1 full time cardiologist needed
 - Gastroenterology – 1 full time gastroenterologist needed
 - Hematology/Oncology – 1 full time hematologist/oncologist needed
 - Psychiatry – 1.5 full time psychiatrists needed
 - Physiatrist – 1 full time physiatrist needed
 - Vascular Surgery – 1 part time vascular surgeon needed

- Plastic Surgery – 1 full time plastic surgeon needed
- Otolaryngology – 2 full time ENTs needed
- Orthopedics – 2 full time orthopedic surgeons needed
- Spine Surgeon – 1 full time spine surgeon needed
- OB-GYN – 1 full time OB-GYN needed
- Urologist – 2 full time urologists needed.

Calvert Memorial Hospital

FY 2008 Community Benefit Narrative Report

Appendix 1

Specialist Provider Availability

Describe gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured in the hospital.

- The Maryland Physician Workforce Study, conducted in 2008, indicated that in Southern Maryland there are shortages in all specialties with the exception of allergy and neurology. This accounts for 24 specialties or 83% of all specialties reviewed.
- Calvert HealthCare Solutions works with local area physicians to provide primary and specialty care services for patients enrolled in their program. This program is a grass roots effort to address the health care needs of low income, uninsured residents of Calvert County. Physicians agree to care for a designated number of patients and receive a modest payment for their services. The program has had very limited success for specialty care with better success in primary care services.
- Physicians employed by CMH are expected to provide medical care to the uninsured as appropriate for specialty area. Currently these specialty areas include one gastroenterologist, one general surgeon, one ENT surgeon, one spine surgeon, one OB-GYN surgeon and one pediatric developmental specialist. CMH has continued to support a hospitalist and pediatric hospitalist program so that any patient seeking inpatient care at this facility is ensured quality medical services. In the recent year, CMH has opened one family practice center with two physicians and has continued to support the Twin Beaches Community Health Center which provides primary care to both the insured and uninsured, using a sliding scale process.
- The most recent CMH Physician Recruitment and Retention Dashboard (August 2008) indicates the following shortages:
 - Pediatrics – 1 full time pediatrician needed
 - Cardiology – 1 full time cardiologist needed
 - Gastroenterology – 1 full time gastroenterologist needed
 - Hematology/Oncology – 1 full time hematologist/oncologist needed

- Psychiatry – 1.5 full time psychiatrists needed
- Psychiatrist – 1 full time psychiatrist needed
- Vascular Surgery – 1 part time vascular surgeon needed
- Plastic Surgery – 1 full time plastic surgeon needed
- Otolaryngology – 2 full time ENTs needed
- Orthopedics – 2 full time orthopedic surgeons needed
- Spine Surgeon – 1 full time spine surgeon needed
- OB-GYN – 1 full time OB-GYN needed
- Urologist – 2 full time urologists needed.

Calvert Memorial Hospital

FY 2008 Community Benefit Narrative Report

Appendix 2:

Description of Calvert Memorial Hospital's Charity Care Policy

Calvert Memorial Hospital informs patients about the Hospital's Financial Assistance Program through a variety of methods:

- 1) The Hospital posts a summary of our financial assistance program at all registration points within our hospital.
- 2) All registration areas and waiting rooms have Patient Financial Services brochures that describe the Hospital's Financial Assistance Program and provides a phone number for our Patient Financial Advocate for the patient to call to seek additional information or an application.
- 3) As part of the registration process, all self pay patients receive three items: 1) a "Notice of Financial Assistance", 2) a Patient Financial Services brochure which has a summary of the Hospital's Financial Assistance Program, and 3) the Uniform State of Maryland Application for Financial Assistance.
- 4) The Hospital's website has a section devoted to Patient Financial Services and has an entire page on the Hospital's Financial Assistance Program and allows the user to download the Uniform State of Maryland Application for Financial Assistance from our website.
- 5) At least annually, the Hospital publishes in the local newspapers a Notice of Financial Assistance and also highlights other programs the Hospital offers for patients without insurance or for patients in financial need.
- 6) The Hospital also provides financial counseling to patients and discusses with patients or their families the availability of various government benefits, such as the Medical Assistance program and we also assist patients in understanding how to complete the appropriate forms and what documentation they need in order to prove they qualify for such programs.

**CALVERT MEMORIAL HOSPITAL
PRINCE FREDERICK, MARYLAND 20678**

POLICY AND PROCEDURE: BD 9 EFFECTIVE: 6/27/88

FINANCIAL ASSISTANCE

I. PURPOSE

The purpose of this policy is to determine when financial assistance will be offered to a patient based upon the patient's ability to obtain assistance through state and local agencies and the patient's ability to pay.

II. SCOPE

This policy applies to all patients of Calvert Memorial Hospital for all medically necessary services ordered by a physician.

III. POLICIES

• **Provision of Financial Assistance**

CMH recognizes that the provisions of Federal Anti-Kickback Laws may be violated when an organization forgives financial obligations for reasons other than genuine financial hardship because this could be interpreted as unlawfully inducing the patient to request the provision of medical services. Therefore, financial assistance will be provided to patients solely based upon the patient's ability to obtain assistance through appropriate agencies (i.e. appropriate Department of Social Services), and the patient's ability to pay. CMH also recognizes that as a not-for-profit hospital, part of its mission is to provide appropriate and high quality medical care, within the resources available, to members of its community regardless of the patient's ability to pay.

• **Financial Advocacy**

The Hospital supports financial advocacy for patients through the role of the Financial Advocate. The Financial Advocate's role is to:

- Interview and assess the financial needs of our patients
- Review the patient's financial and medical status against the eligibility criteria for Medical Assistance for a possible referral
- Assist the patient in setting up the initial appointment with a Department of Social Services' caseworker
- Assist the patient in completing the financial assistance application
- Identify for the patient the documentation requirements for Medical Assistance or the Hospital's Financial Assistance Program
- Refer patients to the Pharmacy Assistance Program, Medbank Program, Calvert Healthcare Solutions, and other local agencies as appropriate.

- **Elective Services**

Patients requesting elective medical services may, through consultation with their physician, have their procedure postponed until such time the patient is able to meet the established deposit. Elective procedure patients, who, according to their diagnosis and/or physician, cannot be postponed, will be helped with obtaining assistance from appropriate agencies. If no community assistance is available, and the patient requests consideration for financial assistance, the patient's account will be reviewed against the financial assistance criteria.

Cosmetic surgery is ineligible for financial assistance due to the fact that it is not medically necessary.

- **Obligation to Apply for Assistance through Appropriate Agencies**

If a patient may potentially meet criteria to obtain assistance with their medical bills through appropriate agencies, the patient has the following responsibilities:

- 1) Apply for assistance.
- 2) Keep all necessary appointments.
- 3) Provide the appropriate agency with all required documentation.

A patient who may qualify for Medical Assistance from the State of Maryland may apply simultaneously for Medical Assistance and for Financial Assistance from the Hospital.

- **Hospital Financial Assistance Guidelines**

The Financial Assistance Program is available to assist both self-pay patients and those patients with insurance to assist these patients with co-insurance, deductibles, and co-payments. Financial assistance guidelines for charity care write-offs are based upon Federal Poverty Guidelines (published each February in the Federal Register). In general, patients with annual income up to 175% of the Federal Poverty Level may have 100% of their medical bill written off as charity care if they meet all of the financial assistance guidelines. Patients with annual income from 176% to 230% of the Federal Poverty Level are able to have a portion of their medical bill written off as charity care, based upon a sliding fee schedule, if they meet all of the financial assistance guidelines.

PROCEDURE

- 1) The Financial Advocate or designee shall attempt to interview all identified self-pay inpatients. The Maryland State Uniform Financial Assistance Application must be completed by the patient or the patient's representative. The Financial Advocate shall make an initial assessment of eligibility for public/private assistance, or if it is determined that the patient would not meet the criteria for public assistance and the patient has a financial need, then financial assistance may be considered.

- 2) If a determination is made that the patient is not eligible for financial assistance then normal collection efforts should be pursued. Payment plans are encouraged if the patient is unable to pay the entire medical bill at once.
- 3) Any hospital employee may refer a patient to the Financial Advocate once they become aware that the patient has financial need.
- 4) The Financial Assistance Program is to be promoted to the public through the following methods: 1) information on the financial assistance program is included in the patient handbook, 2) a Patient Notice of Financial Assistance is provided to each patient at the time of registration, 3) patients are provided with a financial communications brochure which educates patients about their financial responsibilities, the potential financial obligation they may incur, their obligations for completing eligibility documentation, and the hospital's bill collection policies , 4) a financial assistance information packet is provided to each active medical staff member of the Hospital, 5) education of hospital staff about the charity care program, 6) signage located in registration areas, 7) notice on all bills that financial assistance is available for patients who meet certain income and asset criteria , 8) an annual notice in a local newspaper, and 9) the enhancement of the Calvert Memorial Hospital's website to communicate to the community the availability for financial assistance if certain income and asset criteria are met.
- 5) In order to be eligible for financial assistance, patients must complete a financial assistance application and provide all required documentation. The Financial Advocate may assist the patient to complete this application. Exhibit A displays the list of documentation to support the determination of need for financial assistance. Patients requesting financial assistance may be required to consent to release of the patient's credit report to validate financial need. The Financial Advocate should review the completed financial assistance application and complete a checklist of required information and forward this documentation request to the patient. The hospital encourages the financial assistance applicant to provide all requested supporting documentation to prove financial need within seven days of completing the Financial Assistance Application; otherwise, normal collection processes will be followed.
- 6) Patients are not eligible for the financial assistance program if: a) they refuse to provide the required documentation or provide incomplete information, b) the patient fails to pay the sliding scale co-payments as required by the financial assistance program, c) the patient refuses to be screened for other assistance programs before screening for the Financial Assistance Program, and d) the patient falsifies the financial assistance application.

7) Upon receipt of the financial assistance application, along with all required documentation, the Financial Advocate will review the completed application against the following financial assistance guidelines:

- A) If the patient is over the income scale, the patient is not eligible for financial assistance and the account should be referred to the Supervisor of Financial Services. A letter will be sent to all patients who fail to meet the financial assistance guidelines explaining why they failed to meet the guidelines along with an invitation to establish a payment plan for the medical bill.
- B) If the patient is under scale but has net assets of \$14,000 or greater, then the request for charity will be reviewed on an individual basis by the Manager of Financial Services to determine if financial assistance will be provided.
- C) Once the patient has provided the required documentation to prove financial need, the Financial Advocate should review and evaluate the financial assistance application against the above guidelines and make a determination whether to request approval or to deny the application. This evaluation of the application should be completed within two business days. If the Financial Advocate or designee believes the application meets the above guidelines, the Financial Advocate should sign the application on the line: "Request for Approval of the Financial Assistance Application" and forward the completed application and all supporting documentation to the following individuals as appropriate:
 - i) Manager of Financial Services (up to \$1,500)
 - ii) Director of Patient Accounting (up to \$3,000)
 - iii) Vice President of Finance (\$3,000 to \$9,000)
 - iv) Vice President of Finance & President & CEO (\$9,000 and over)

Once administrative approval of the charity adjustment is obtained, the approved application and all supporting documentation are forwarded to the Manager of Financial Services who makes the actual adjustment. Patients will receive written notification when the application is approved, denied, or pended for additional documentation.

- D) A special exception for financial assistance may be considered in circumstances where the patient is over the income scale if the patient has a significant medical debt to the hospital and has no net assets. Any special exceptions must have the approval of the President and CEO.

- E) Once a financial assistance application has been approved, all medical services provided three months prior to the approval date may be included in the charity care adjustment upon written request by the patient/guarantor. The initial eligibility period is six (6) months. Each patient will have to reapply at the end of each six-month period in order to continue in the financial assistance program. If there is a change in financial circumstances during the initial or subsequent six-month period such as income or family status, an updated or new application must be completed.
- F) All financial assistance applications along with all supporting documentation should be kept in accordance with the hospital's record retention policy, currently a minimum of 5 years.
- G) The Financial Advocate will keep a database of all financial assistance applications. This database will include the following information:
 - a. Patient Account Number
 - b. Determination of eligibility
 - c. Income
 - d. Family size
 - e. Approved charity care adjustment
 - f. For denied accounts, reason for denial
 - g. Zipcode
 - h. Account Type (Hospital Service)

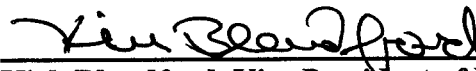
APPROVED:



**Dean Schleicher, Chairman
Board of Directors**



James J. Xinis, President & CEO



Kirk Blandford, Vice President of Finance

**Original: 6/27/88
Reviewed/Revised**

7/93; 6/96, 4/99, 8/02; 8/03; 10/04; 1/08

Exhibit A

Documentation Requirements

Verification of Income:

- Copy of last year's Federal Tax Return
- Copies of last three (3) pay stubs
- Copy of latest W (2) form
- Written verification of wages from employer
- Copy of Social Security award letter
- Copy of Unemployment Compensation payments
- Pension income
- Alimony/Child Support payments
- Dividend, Interest, and Rental Income
- Business income or self employment income
- Written verification from a governmental agency attesting to the patient's income status
- Copy of last year's Federal Tax Return
- Copy of last two bank statements

Size of family unit:

- Copy of last year's Federal Tax Return
- Letter from school

Patient should list on the financial assistance application all assets including:

- Real property (house, land, etc.)
- Personal property (automobile, motorcycle, boat, etc.)
- Financial assets (checking, savings, money market, CDs, etc.)

Patient should list on the financial assistance application all significant liabilities:

- Mortgage
- Car loan
- Credit card debt
- Personal loan

Calvert Memorial Hospital

FY 2008 Community Benefit Narrative Report

Appendix 4

Hospital's Mission, Vision and Value Statement

OUR MISSION is to provide quality inpatient and ambulatory health care to the people of Southern Maryland that is accessible, cost-effective and compassionate. We work in partnership with our community to improve the health status of its members.

OUR VISION is to be recognized as Southern Maryland's premier healthcare provider, bringing innovative services to the people throughout our community and to the healthcare professionals who serve them.

Five "**Pillars of Excellence**" guide our decision-making and shape the culture of our organization.

QUALITY

Calvert Memorial Hospital provides responsible, safe, reliable and effective care and services. We take seriously our responsibility to help our patients feel better. All our team members are committed to continuously improving the quality of the service we offer to our community. We take pride in what we do.

SERVICE

At Calvert Memorial, we understand that health care is not just about medicine, it's about people. Our job is to exceed our customer's expectations at every turn. We want every guest at CMH to have a 5-star experience.

PEOPLE

We recognize that being the healthcare provider and employer of choice means hiring and retaining only the best. Every team member at CMH is selected for their leadership, professionalism, expertise, compassion and commitment to the values that set CMH apart.

INNOVATION

Health care is a dynamic, ever-changing field where new technology and clinical research drive the delivery of top-notch care. Calvert Memorial is committed to the continual pursuit of new and better ways of caring for our patients. We stay abreast of the latest technological advances, provide continuing education and training for all our team members, and serve as a training resource for individuals pursuing health careers.

FINANCE

As a not-for-profit, community hospital, it is our responsibility to provide cost-effective, compassionate care and services. We are leaders in helping improve access to care for all members of our community.

Approved CMH Board of Directors

Approved: 11/28/95

Revisions: 2001, 2002, 2005, 2008



FY 2008 Community Benefit Narrative

■ 1) Carroll Hospital Center (CHC) is a private, non-profit 218-bed acute care facility, governed by a community board of directors. In FY 2008, the hospital had 16,036 inpatient admissions and an annual total of more than 315,000 patient encounters for inpatient and outpatient medical care. With 1,824 employees we are the second largest employer in the county.

■ 2) As the only hospital in the county, CHC's primary service area is the entire county. The hospital does, however, also serve portions of Baltimore and Montgomery counties as well as areas in Northern Pennsylvania.

The general demographics for our primary community (Carroll County) are listed below:

Geography

Land area	449 sq. miles (289,920 acres)
Persons per square mile (2008)	387
Land in farms (2002)	147,252 acres
Agricultural Land Preservation farms (1996-2007)	452
Agricultural Land Preservation acres (1996-2007)	51,296

Sources: Carroll County Department of Planning; US Census Bureau Quickfacts; National Agricultural Statistics Service; MD DHR 2004 FACT PACK; Carroll County Department of Economic Development

Population

Total population estimate (2008)	173,900
Projected population (2010)	179,700

Race (2005):

White	159,684
African American	5,059
Native American	390
Asian/Pacific Islander	2,248
Hispanic	2,600

Age (2005):

0-9	20,946
10-19	26,086
20-34	29, 525
35-54	54,195
55-64	17,670
65+	18,067

Sources: MD State Data Center Carroll County Demographic and Socio-Economic Outlook; MD DHR 2005 Carroll County Snap Shot

Family

Total number of households (2005)	58,500
Average household size (2005)	2.8 persons

Sources: MD State Data Center Carroll County Demographic and Socio-Economic Outlook; 2005 Strengths & Needs Assessment Secondary Family Data Analysis, MD DHMH Vital Statistics

Economics

Per capita personal income (2005)	\$ 36,318
Median household income (2006)	\$ 87,000
State rank	9th
Households below poverty level (2008)	5,565, 8%
Unemployment rate (2008)	4.1%, 5 th lowest in the State
Median cost of homes purchased (2007)	\$335,000
Housing units authorized for construction (2006)	507

Sources: MD DHR 2005 Carroll County Snap Shot; Carroll County Department of Economic Development and Solucient

Business

Private nonfarm establishments with paid employees (2005)	4,537
Private nonfarm employment (2005)	49,414
Federal funds and grants (2004)	\$701,617
Percent of residents that commute 30 min. or more to work (2002)	72%
Percent of residents that commute out of county for work (2002)	62%

Sources: US Census Bureau Quickfacts; National Agricultural Statistics Service; Carroll Commuter Survey (2001)

Other Significant Demographic Characteristics

According to the most recent MD BRFSS (Maryland Behavioral Risk Factor Surveillance Survey) data report (2006), our community has a high rate of insured residents with 92.8% of residents reporting that they have some level of health insurance. In 2008, of the Carroll County residents that were hospitalized (either at CHC or other hospitals), 2,151 or approximately 9% were Medicaid admissions and 365 or 2% were uninsured.

■3) Identification of Community Needs:

Through our community advocacy arm, The Partnership for a Healthier Carroll County, CHC has been involved in numerous health status assessment projects specific to our community. An original Carroll Community Health Assessment in 1997 prioritized eight broad areas where improvement opportunities existed. Later, following successive assessments, that number was expanded to 11. Updates to the original assessment were also completed in 2005 and included two updates, one specific to households without children under the age of 18 and those with children under the age of 18.

Our results were strikingly similar to the leading indicators in the U.S. Government's Healthy People 2010 project. Operating under the guidance of the Surgeon General's Office and the Secretary of the Department of Health and Human Services, Healthy People 2010 is the prevention agenda for the Nation.

In cooperation with our community partners, we seek to make measurable, sustainable, long-term progress...with a couple of quick wins along the way to keep us energized and focused. We gauge our progress related to our effect on the underlying root causes associated with these issues, and again, with and through our many partners, we strive to address root causes.

To track and trend our progress as a community, The Partnership has organized Healthy Carroll Vital Signs - Measures of Community Health. This data is provided by various sources including the Carroll County Health Department and other branches of the Carroll County Government as well as through hospital-based community outreach activities and education. (Data Charts Attached)

Other Assessments used include:

Elder Needs Health Assessment: Completed in February 2008, **(Findings Attached)**

In addition, to keep our finger on the pulse of pertinent issues and continue to be proactive in identifying and creatively meeting the unique needs of our community on an ongoing basis, the hospital has developed and facilitates the following work groups focused on the 11 core health improvement areas identified in our original community health assessment:

Hospital/Partnership Work Groups

Group Name	Purpose
Access to Health Care Work Group	Collaborates with community partners to improve access to health care for the uninsured and underinsured.
American Cancer Society Leadership Council (Cancer Work Group)	Works to reduce cancer incidence and mortality in Carroll County.
Domestic Violence Coordinating Council (Interpersonal Violence Work Group)	Focuses on issues of domestic violence in county. Affiliated with Family and Children's Services of Central Maryland, Carroll County
Elder Health Work Group	Seeks to increase quality and years of healthy life for Carroll Countians over age 65.
Heart Health Improvement Team	Seeks to improve the cardiovascular health and quality of life of adults and children through prevention, detection, and treatment of risk factors.
L.E.A.N. Carroll	Multi-disciplinary hospital/community group working to address childhood obesity in Carroll County through Lifestyle, Education, Activity and Nutrition.
Mental Health Subcommittee of the Behavioral Health and Addictions Advisory Council (Mental Health Work Group)	Supports efforts to improve the mental health of Carroll County residents. A mentally healthy community is indicated by many factors including: low suicide attempt rates, and increased number of county residents whose insurance covers mental health services, an adequate number of out patient services, and a decrease in the stigma associated with mental illness and emotional disturbances.
Prevention & Wellness Partners Work Group	Coordinates projects to improve health outcomes for people in Carroll County as measured by improvement in lifestyle / behavior indicators.
Resource Conservation Coalition	Work group formed to promote health and quality of life for all county residents through a healthier environment and managed growth and development.
School Readiness Team (Positive Youth & Family Development Work Group)	Provides information to parents and community on ways to ensure that children enter school with the skills needed for learning.
Substance Abuse Subcommittee of the Behavioral Health and Addictions Advisory Council (Substance Abuse Wrk Grp)	Focuses on all issues of substance abuse in Carroll County. Produces Substance Abuse Directory (2008 version). Works toward gaps in service that have been identified, including need for a long-term treatment facility for heroin users, lack of space/ capacity for current residential programs, insufficient detox services, inadequate services for adolescents with co-occurring disorders, and a need for more prevention services

Additional Partners Utilized in Community Need Assessment

Group Name	Purpose
Behavioral Health and Addictions Advisory Council	State-appointed local group to evaluate continuum of care in substance abuse and mental health fields in the county. Serves as a quasi-Board of Directors for the Carroll County Core Services Agency. Also coordinates training programs, programs designed to reduce the stigma associated with psychiatric disorders, and public awareness programs.
Caring Carroll, Inc.	Operates Caring Carroll, a Faith in Action volunteer caregiving program. Helps to meet the non-medical needs of isolated elderly, ill, disabled, or frail Carroll County residents striving to remain independent in their own homes.
Carroll County Local Management Board	Works to improve the lives of children and families in Carroll County. Develops and manages community-based family services.
Mid-Western Region Highway Safety Task Force	Carroll County comprehensive highway traffic safety task force. Funds law enforcement, including overtime for DUI enforcement, aggressive driving, motorcycle, and pedestrian enforcement. Education and awareness programs on young/older driver issues, occupant protection, child passenger safety, bicycle, alcohol, aggressive driving, and more.
Minority Health Council	Group dedicated to improving the health and well-being of minorities in Carroll County by addressing cancer and other health disparities.
Risky Business Planning Committee	Plans annual training / awareness-raising conference in <u>June</u> for providers regarding issues of teen risky behaviors, such as pregnancy, drug use, and suicide.
South Carroll Diversity Roundtable	Seeks to inform, stimulate concern, and promote positive South Carroll Community responses to reduce acts of discrimination.
Tobacco Coalition (Carroll Community Health Tobacco Coalition)	Local health coalition that seeks to decrease tobacco use and exposure to secondhand smoke in Carroll County

■ 4. Major needs identified. See “Healthy Carroll Vital Signs II Report” and Data Charts **attached**. This document gives detailed explanation, benchmarks, improvement objectives and key strategies for items identified by the initiatives in #3.

■ 5. Community Benefit program initiatives are decided upon primarily by the input and work of the following:

- The Partnership for a Healthier Carroll County
- The Learning Center
- The Women’s Place
- The Marketing, Business Development and Finance Departments
- This fiscal year, the hospital also has assembled a Community Benefit Review Committee to help further guide the strategic vision of its community benefit initiatives.

■ 6. In addition to the information provided in the “Healthy Carroll Vital Signs II” and the data provided in the Healthy Carroll Vital Signs Data Charts, the hospital’s work in the areas of disease screening and prevention; wellness initiatives; physician supply; and access to health care, has a significant impact on the needs listed in #4. They include:

- \$4,386,621 in charity care provided to more than 2,500 patients by the hospital.
- Access Carroll, a free clinic offering care to the uninsured of the county, with over 5,300 visits last year.
- In-home and inpatient Hospice services offered with 19,486 encounters provided last year regardless of a patient’s ability to pay.

- Significant investment made to ensure an adequate number of physicians to provide primary care and specialty medical care.
- SAFE program for pediatric and adult victims of sexual assault.
- Free or low-cost screenings for blood pressure, cancer, heart disease, osteoporosis nutrition and vascular abnormalities provided to 1,483 people to help prevent and manage disease and wellness.
- More than 2,700 support group encounters to help people manage diseases like prostate and breast cancer, diabetes, Parkinson's disease, fibromyalgia, Crohn's and Colitis, MS and Lupus.

■ 7. In addition to the evaluations listed in the attached reports, the hospital also surveys program participants, tracks participation in programs/screenings/support groups and stays well-connected to industry and health care trends. The hospital plans to continue to monitor the above and also investigate other effective measures to report and track outcomes in FY 09.

■ 8. Gaps in Care: Like most hospitals, Carroll Hospital Center is challenged to provide care to an ever-increasing number of uninsured patients. Last fiscal year, more than 2,500 patients received some form of charity care/financial assistance from the hospital, totaling \$4,386,621. Assistance ranged from emergency, inpatient and outpatient care and testing that was written off, to care provided in our free outpatient clinic, Access Carroll.

While Carroll Hospital Center cares for patients with no means to pay their medical expenses throughout the hospital, it is seen most acutely in the Emergency Department (ED), where many uninsured patients often come for primary and emergent care.

Since all patients presenting to the ED are treated for any medical condition regardless of their ability to pay for care, the uninsured population poses a significant challenge not only to the hospital, but to physicians providing care in the hospital and in the ED. Due in part to a lack of, or minimal reimbursement, it has become increasingly difficult to find specialists to provide on-call services for the ED around-the-clock. The more serious issue is that this trend affects not only our uninsured patients, but all patients seeking treatment in our ED.

The likelihood that patients present more acutely in the uninsured population and the accompanying increased potential for malpractice claims also have contributed to specialists choosing not to cover non-paying patients in the ED. That gap is most significant in surgical specialties including, orthopaedics, otolaryngology (ENT), general surgery and plastic surgery. There has also been increasing reluctance from other specialties with significant ED volumes, including vascular surgery, neurosurgery and neurology.

To help ease the effects of uncompensated care on physicians and address the gap in care for our patients, Carroll Hospital Center has continued two major, costly initiatives to address the gap proactively. First, the hospital contracts with ten medical specialties to ensure 24/7 coverage in the ED. Those specialties include neurosurgery; general, plastic, vascular and oral surgery; orthopaedics; urology; podiatry; ophthalmology and ENT. Implemented in January 2006, in FY08, the expense to pay physicians for ED call has cost the hospital nearly \$656,000.

Additionally, the growing volumes of uninsured patients has caused the hospital to recently institute an additional policy which allows physicians who see patients without a payment source in the ED to be reimbursed for physician services by the hospital at current Medicare rates. While payment for ED call may help with the gaps in coverage for the uninsured, it bears a significant financial toll on the hospital.

Another ongoing significant undertaking in the hospital's mission to continue to provide for the uninsured is our partnership with the Carroll County Health Department to fund Access Carroll, a health care facility that cares for uninsured people in the area. Many Carroll Hospital Center affiliated physicians and specialists donate their time to and accept referrals from Access Carroll. In FY08, Access Carroll had 5,379 patient visits, up 20% from FY 07, with the number of individual patients served up 44%, from 1,427 in FY07 to 2,048 in FY08. Access Carroll also has distributed nearly \$300,000 in free medications to its clients. This clinic will hopefully continue to ease the use of the ED as a source of primary care for the uninsured and ensure they have access to general health care when they need it, so health conditions don't worsen due to their inability to pay for services. In only its third full year, Access Carroll has been very successful in helping its patients manage chronic diseases including diabetes, hypertension, respiratory conditions, chronic pain and mental health issues.

As the population continues to grow, demand for physicians continues to increase in virtually all specialties while the supply of physicians continues to decrease. The trend is leaving hospitals faced with significant challenges in recruiting and retaining the number of physicians required to continue to provide adequate health care access for all patients. In FY 08, nearly \$4 million was spent in recruiting and retaining physicians.

A shortage of primary or specialty providers has perhaps posed the most significant challenges in inpatient care delivery. Substantial physician subsidies have become necessary to ensure that all patients requiring anesthesia and pediatric, critical and general medical care have the access they need once admitted to the hospital.

Equally as important, is access to physicians on an outpatient basis, not just for the uninsured, but for all patients in our growing community. To ensure our community has access to quality physicians, Carroll Hospital Center continually monitors statistically calculated need by developing a comprehensive medical staff development plan based on the health care needs of our medical service area. The report includes both an analysis of the hospital's service area and specific recommendations regarding appropriate staffing levels in a variety of medical specialties. The physician needs assessment methodology used is based on a qualitative standard established by the Internal Revenue Service (IRS). The report guides the hospital's recruiting strategy, helps us to prioritize recruiting efforts and allows the hospital to place contingencies on recruited physicians to ensure they see medically underserved, uninsured, Medicare and Medicaid patients. Approximately \$2 million was spent in various physician subsidies in FY 2008.

APPENDIX 1



FY 2008 Community Benefit CHARITY CARE

Carroll Hospital Center (CHC) has a number of programs to assist patients with their payment obligations. First, we provide a Medicaid enrollment service to patients who qualify for medical assistance. This service assists patients with paperwork and will even provide transportation if needed. This past year, CHC successfully enrolled more than 500 patients in the state's medical assistance program and are currently working on enrollment with an additional 460 patients.

For patients who do not qualify for Medicaid coverage, CHC has an in-house financial assistance program. Our eligibility standards are more lenient than even those proposed by the Maryland Hospital Association guidelines. We write off 100% of the bill for patients whose income is below 300% of the federal poverty guidelines (FPG) and write off a portion of the bill for patients whose income is between 301%-375% of the FPG.

When patients express their inability to pay for services, our staff works to find the best possible option for them by discussing in detail their situation. The family is involved in those conversations to the extent the patient feels comfortable.

The hospital also posts a summary of its policy informing patients of the availability of Financial Assistance, in all registration and intake areas for all patients to see. In addition, it is included in the hospital's patient handbook located in each patient room.

APPENDIX 2

Department: FINANCE
Subject: FINANCIAL ASSISTANCE APPLICATION
Effective Date: January 01, 2005
Revised: December 29, 2008

I. Purpose

This policy describes the options for patients that are uninsured or underinsured. The Financial Assistance policy is designed to assist individuals who qualify for less than full coverage under Federal Medical Assistance and State or local programs, but whose patient balances exceed their own ability to pay. While flexibility in applying guidelines to an individual patient's situation is clearly needed, certain objective criteria are essential to assure consistency in the implementation of the program. Financial information will be documented on the Maryland State Uniform Financial Assistance Application. (Exhibit A)

Policy Statement/Philosophy

It is the policy of the Carroll Hospital Center, Carroll Home Care, and Carroll Hospice, to adhere to its obligation to the communities we serve to provide medically necessary care to individuals who are unable to pay for medical services without discrimination on the grounds of race, color, sex, national origin or creed.

2007 Procedures

The following criteria is used to determine if services are eligible for Financial Assistance:

- A. All services considered medically necessary are covered under the Program for patients living in the primary or secondary service area of the Carroll Hospital Center, and for patients referred by a physician affiliated with the hospital. Medical necessary outpatient services are defined in Exhibit C. Carroll Hospital Center service areas are defined in Exhibit D.
- B. For non-United States citizens, services that can be postponed without harm to the patient or that are not medically necessary are not covered under the program.
- C. Applicants with medical expenses >\$1,500 who meet eligibility criteria for Federal Medicaid must apply and be determined ineligible prior to Financial Assistance consideration. If eligibility criteria according to Hospital Support Services, (age 21 – 64, not disabled and no children), is not met, the Medicaid application process is omitted and the Financial Assistance application is started. The Hospital Support Services representative will submit a letter stating the patient is considered not to be a medical assistance candidate.
- D. Patients with medical expenses <\$1,500 are strongly encouraged to file for Federal Medical Assistance. However, the Medicaid application is omitted if the patient is non-compliant and the Financial Assistance application is started.

E. The following criteria is used to determine financial eligibility for financial assistance:

- i. Eligibility will be based on gross household income plus liquid assets. Gross income is defined as wages and salaries from all sources before deductions. Liquid assets are defined as cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, rental properties etc.
- ii. Household Income – All wages and salaries within the household such as social security, veteran's benefits, pension plans, unemployment and workers compensation, trust payments, child support, alimony, public assistance, strike benefits, union funds, income from rent, interest and dividends or other regular support from any person living in the home.
- iii. Assets – The availability of liquid assets plus annual income will be considered up to 375% of the current poverty guidelines published in the Federal Register.
- iv. Expenses are collected and taken in consideration for analysis purposes.
- v. Proof of Income – For each employed house hold member, submit one of the following with the application:
 - Pay stubs for the previous four weeks
 - Employer certification of income
 - Most recent State and Federal tax returns
- vi. For each household member receiving unearned income, submit the following if applicable:
 - Proof of Social Security Benefits
 - Proof of Disability Benefits
 - Proof of Retirement/Pension Benefits
 - Proof of Unemployment Benefits
 - Proof of Veterans Benefits
 - Proof of Child Support
 - Proof Alimony
 - Rental property income
- vii. Other required documents
 - Applicants claiming zero income must supply proof of how their living expenses are paid
 - The current and previous savings and bank statements
 - Statements of certificates of deposit, stocks, bonds, and money market funds

F. Certain unique cases not meeting the above criteria may on a case-by-case basis be approved by the Director of Patient Financial Services or appointed designee. Consideration will be given to the possible impairment or improvement of the future income potential, as well as

cases considered to be catastrophic, which may or may not change the outcome of the application.

- G. Homeless – Patient’s declaring a homeless status which is later verified by the Manager is consistent with what the patient is stating, may be eligible for charity care without providing the documentation listed in 2E,F, G

- H. Deceased – If an estate does not exist or has been exhausted, financial assistance is offered without providing the documentation listed in 2E,F&G

The following criteria is used to approve or deny the application:

- A. Combined gross income in relation to the number of family members is 300% of the poverty guidelines. Applicant will be eligible for 100% Financial Assistance (Exhibit B)
- B. If combined gross income is more than 300% of the poverty guideline – applicant may be eligible for Financial Assistance with a resource based on a sliding scale.
- C. Financial Assistance eligibility decisions can be made at any time during the revenue cycle as pertinent information becomes available. If the financial information is not available a financial assessment can be completed through other avenues such as credit reports, debt and asset reviews, and referrals from the Medical Assistance Eligibility Company and Collection Agency. If the determination is made that there is a low probability of collections, the account can be approved for Financial Assistance. This write off is account specific, therefore, cannot be applied to other open accounts.
- D. Patients referred to Carroll Home Care or Carroll Hospice from the Carroll Hospital Center will automatically qualify based on the application approved by the hospital. Patients referred from an outside source will follow the same application.
- E. The completed and signed application is forwarded to the Patient Accounting Manager to enter the write off to transaction code 1035. Specific accounts approved through other avenues are written off to transaction code 1094 in an active AR status. Home Care and Hospice accounts are written off to a Charity Care classification..
- F. Applications are stored for 7 years.

2007 All applications are approved by the Manager within seven business days of receipt of the completed application.

- I. Self Pay accounts are handled as follows:
 - i. The Financial Counselor will present all Inpatient self pay patients with the application if unable to pay monthly installments. All accounts must be referred to Medical Assistance Advocacy if the initial financial screening indicates the possibility of eligibility.
 - ii. All outpatient accounts with a combined total of \$1,500 are referred to Medical Assistance Advocacy and are given the Financial Assistance Application if the installment plan payments cannot be met.
 - iii. All accounts are reviewed for grant eligibility (i.e. Maryland treatment fund for cancer diagnosis, children's fund for patients though the age of 18)
 - iv. If assistance is requested with deceased patients, a verification of an existing estate is completed. If no estate can be found, financial assistance is applied.

- v. Assistance with MHIP applications is given for Maryland residents who are unable to get medical insurance coverage and have one of the 60 qualifying health conditions listed in the MHIP manual.
- vi. All applications are pursued to completion; including patients referred to Medical Assistance Advocacy with one follow-up letter and 1 phone call.
- vii. Requests for financial assistance received after services are referred to the Financial Counselor for processing
- viii. Open accounts with dates of service prior to the time of the approved application, and accounts with dates of service up to 6 months after the approved application are eligible for Financial Assistance if there has been no change in status. Bad debt accounts will be returned to active AR prior to write off.
- ix. Applications must be completed and returned to the Financial Counselor within 15 days of receipt. All uncooperative applicants will be transferred to self-pay unless Medical Assistance is pending.
- x. The Financial Counselor will call the patient a minimum of two times, and send 1 reminder letter within the 15 day period to obtain information.
- xi. The Financial Counselor will mail the appropriate letter confirming the approval or non-approval. (Exhibit E)
- xii. Payments received before, during, or after the completion of the Financial Assistance application will not be refunded. The amount of the approved write off will be reduced by the amount of payments received.

Submitted By: Janice Napieralski Date:
 Director, Patient
 Financial Services

Administrative Kevin Kelbly Date:
 Approvals: Senior Vice
 President of Finance

Exhibit A

Maryland State Uniform Financial Assistance Application

Information about You

Name _____
 First Middle Last

Social Security Number _____ - _____ - _____ Marital Status: Single Married
Separated

US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone

 City State Zip code Country

Employer Name _____ Phone

Work Address _____
 City State Zip code

Household members:

_____	_____	_____
Name	Age	Relationship
_____	_____	_____
Name	Age	Relationship
_____	_____	_____
Name	Age	Relationship
_____	_____	_____
Name	Age	Relationship
_____	_____	_____
Name	Age	Relationship
_____	_____	_____
Name	Age	Relationship
_____	_____	_____
Name	Age	Relationship

Have you applied for Medical Assistance Yes No
 If yes, what was the date you applied? _____
 If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

Carroll Hospital Center
 200 Memorial Avenue
 Westminster, MD 21157

2007 Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veteran's benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self-employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
Total	_____

2007 Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____	Approximate value

Automobile	Make _____ Year _____	Approximate value

Additional vehicle	Make _____ Year _____	Approximate value

Additional vehicle	Make _____ Year _____	Approximate value

Other property		Approximate value

Total		_____

IV. Monthly Expenses

Rent or Mortgage

Car payment(s)

Credit card(s)

Car insurance

Health insurance

Other medical expenses

Other expenses

Amount

Total

Do you have any other unpaid medical bills? Yes No
For what service? _____
If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ Applicant signature

_____ Date

_____ Relationship to Patient

EXHIBIT B

**THE 2008 U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES
FEDERAL POVERTY GUIDELINES**

2008 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,400	\$13,000	\$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

SOURCE: *Federal Register*, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972

Carroll Hospital Center

Financial Assistance Work Table

Family Size	FPG	Income Level 300%	75% Reduction	50% Reduction	25% Reduction
1	\$10,400	\$31,200	\$33,800	\$36,400	\$39,000
2	\$14,000	\$42,000	\$45,500	\$49,000	\$52,500
3	\$17,600	\$52,800	\$57,200	\$61,600	\$66,000
4	\$21,200	\$63,600	\$68,900	\$74,200	\$79,500
5	\$24,800	\$74,400	\$80,600	\$86,800	\$93,000
6	\$28,400	\$85,200	\$92,300	\$99,400	\$106,500
7	\$32,000	\$96,000	\$104,000	\$112,000	\$120,000
8	\$35,600	\$106,800	\$115,700	\$124,600	\$133,500

2007 Annual Update of the HHS Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in family or household	Poverty thresholds for 2005 — published Aug. 2006	Column 2 multiplied by 1.032 price inflator	Difference between successive Column 3 entries	Average difference in Column 4	January 2007 poverty guidelines
1	\$9,973	\$10,292			\$10,210
			\$2,871	\$3,480	
2	12,755	13,163			13,690
			2,912	3,480	
3	15,577	16,075			17,170
			4,535	3,480	
4	19,971	20,610			20,650
			3,759	3,480	
5	23,613	24,369			24,130
			3,168	3,480	
6	26,683	27,537			27,610
			3,680	3,480	
7	30,249	31,217			31,090
			3,469	3,480	
8	33,610	34,686			34,570

**CHC Financial Assistance Policy
Scope of Services Matrix
June 2007**

Service	Service Site	Proof of Medical Necessity	Capacity Limitations	Responsible Party for Exceptions
ED and Direct Inpatients	Hospital	N/A		
Scheduled Inpatients	Hospital	Case by case		Simmons
Ambulatory Surgery	Dixon or Hospital	Accept all Access Carroll referrals for cases s/a: Gallbladders Skin Lesions Other diagnoses case by case : Backs Hernias Urology Joints		Simmons
Labs Basic PAP's Hi Cost	Med-Labs	Not needed if on Order Sheet Yes Case by Case		Simmons
Basic Imaging	Dixon Imaging	Not Needed if on Order Sheet		Simmons
High End Imaging MRI's CT's Nuclear Med (non-cardiac)	Dixon Imaging Hospital Hospital	Yes Yes Yes	Monthly Quota Monthly Quota ---	Simmons
Outpatient Clinic Diabetic Counseling Wound Care	Hospital Hospital	--- Case by Case	Access limited to Gestational Diab. Counseling ---	Simmons
Cath/Angio Lab Diagnostic Caths. Angio Procedures Pacemakers/Defibs TEE Cardio-versions	Refer Out Hospital Hospital Hospital	N/A Case by Case Case by Case Case by Case		

**Carroll Hospital Center
Service Area**

Primary

**Finksburg (21048)
Hampstead (21074)
Manchester (21102)
Keymar (21757)
Taneytown (21787)
Mount Airy (21771)
New Windsor (21776)
Union Bridge (21791)
Westminster (21157)
Westminster (21158)
Woodbine (21797)
Upperco (21155)
Sykesville (21784)**

Secondary

**Reisterstown (21136)
Littlestown (17334)
Gettysburg (17325)
Hanover (17331)**

DATE:

PATIENT/GURANTOR NAME
ADDRESS
CITY, STATE

DATE (s) OF SERVICE:

Dear M

Your application for Financial Assistance has been completed and you are 100% approved. If you have any questions, I may be reached at (410) 871-6718.

Thank you.

Sincerely,

Financial Counselor

DATE:

PATIENT/GURANTOR NAME
ADDRESS
CITY, STATE

DATE (s) OF SERVICE:

AMOUNT DUE; \$

Dear M

Your application for Financial Assistance has been denied due to your failure to provide the information requested. Please contact this office at (410 871-6718 within the next 5 working days or your account may be referred for collections.

Thank you.

Sincerely,

Financial Counselor

DATE:

PATIENT/GURANTOR NAME

ADDRESS

CITY, STATE

DATE (s) OF SERVICE:

Dear M

Your application for Financial Assistance has been completed and you are approved for a 75% reduction of your charges. The balance of \$ _____ is due within the next 30 days or this contract may be voided, reinstating the full amount of charges. Please contact this office at (410) 871-6718 to make payment arrangements.

Thank you.

Sincerely,

Financial Counselor

DATE:

PATIENT/GURANTOR NAME
ADDRESS
CITY, STATE

DATE (s) OF SERVICE:

Dear M

Your application for Financial Assistance has been completed and you are approved for a 25% reduction of your charges. The balance of \$ is due within the next 30 days or this contract may be voided, reinstating the full amount of charges. Please contact this office at (410) 871-6718 to make payment arrangements.

Thank you.

Sincerely,

Financial Counselor

DATE:

PATIENT/GURANTOR NAME
ADDRESS
CITY, STATE

DATE (s) OF SERVICE:

Dear M

Your application for Financial Assistance has been completed and you are approved for a 50% reduction of your charges. The balance of \$ is due within the next 30 days or this contract may be voided, reinstating the full amount of charges. Please contact this office at (410) 871-6718 to make payment arrangements.

Thank you.

Sincerely,

Financial Counselor

APPENDIX 3

VISION, MISSION, VALUES - DESCRIPTION

In 2007, as Carroll Hospital Center embarked on our “Journey to Excellence,” a committee was formed to revitalize our mission and vision. The process resulted in two powerful statements that perfectly complemented our existing SPIRIT values (Service, Performance, Innovation, Respect, Integrity and Teamwork) and also fit well into our new business initiatives and six Pillars of Excellence (Service, Quality, Financial, People, Growth and Community). Our goal was to have the new vision and mission statements become as ingrained in our organizational philosophy as our SPIRIT values have been for nearly a decade.

We worked diligently and thoughtfully to craft statements that would recognize our history and form the foundation for all we do into the future. To reflect the tremendous changes in health care over the years, we placed special emphasis on words like quality, community, commitment and good health through all stages of life.

Our vision, mission and values serve as our compass, especially in today’s world where decision-making can be complicated. We hope the statements instill hospital leadership and associates with a sense of responsibility to give the community what it needs and deserves. The spectrum of our services reaches far beyond the Emergency Department. It’s offering advanced inpatient and outpatient services and being a community resource in a variety of ways. The mission and vision are essential help keep the organization focused as we continue to meet the health care needs of the communities we serve.

Our vision, mission and values (as shown in Appendix 4) are proudly displayed throughout the hospital in every department and public area.

APPENDIX 4

VISION, MISSION, VALUES

OUR ACTIONS AND DECISIONS ARE GUIDED BY THESE VALUES.

SERVICE... exceed customer expectations.

PERFORMANCE... deliver efficient, high quality service and achieve excellence in all we do.

INNOVATION... take the initiative to make it better.

RESPECT... honor the dignity and worth of all.

INTEGRITY... uphold the highest standards of ethics and honesty.

TEAMWORK... work together, win together.

MISSION

Our communities expect and deserve superior medical treatment, compassionate care, and expert guidance in maintaining their health and well-being. At Carroll Hospital Center, we offer an uncompromising commitment to the highest quality health care experience for people in all stages of life. We are the heart of health care in our communities.

VISION

Founded by and for our communities, Carroll Hospital Center will help people maintain the highest attainable level of good health throughout their lives. We strive to be the best place to work, practice medicine and receive care. Our commitment is to be the hospital of choice.





APPENDIX 1

GAP ANALYSIS

Based on the most recent formal physician needs assessment conducted by Chester River Hospital Center, the hospital currently has the following gaps in the availability of specialist providers to serve patients in our service area, including but not limited to the uninsured:

Gastroenterology – there are no gastroenterologists practicing in our community. Most basic gastroenterology procedures, specifically endoscopies, are performed by local general surgeons. Patients are referred to gastroenterologists at Shore Health System for non-emergent medical needs and consultation. More complex emergencies are transferred to University of Maryland Medical Center.

Obstetrics – for half of Fiscal Year 2008 there was only obstetrician serving our community; based on our population there is a need for two. A second physician was recruited and established a practice in November 2008. The Hospital paid for locum tenens coverage as necessary to provide time off during the time we had a single provider on our medical staff.

Neurology – there are no neurologists serving our community. While there is not a population to support a full-time neurologist, there is a need for this service on a part-time basis. Emergent neurology patients are currently transported to University of Maryland Medical Center or other specialty centers.

Psychiatry – there are no psychiatrists serving our community and mental health is a significant need. We refer patients requiring inpatient treatment to surrounding facilities in Cambridge, Elkton and Upper Shore Mental Health Center; we refer outpatients to psychiatrists, social workers, counselors in private practice.

Ophthalmology – there is only one ophthalmologist serving the Chestertown area, creating a need for additional access and choice for our community. Ophthalmic emergencies are transferred to Wilmer Eye Center.

Cardiology – although there are two cardiologists on the medical staff at Chester River, which is an appropriate number according to our medical staff development plan, during the six-month period from January through June of 2008 we had cardiology coverage for the emergency

department only 2/3 of the time. We transfer emergency cardiology cases primarily to Washington Hospital Center.

Pulmonology – our lone pulmonologist left our rural community in Fiscal Year 2008 to return to an urban practice. While we recruit to replace this position, emergency patients are transferred, primarily to Shore Health, Christiana or University of Maryland Medical Center.

Orthopedics – although there is an adequate number of orthopedic surgeons on the medical staff based on our medical staff development plan, we do not have continual emergency department coverage in this area; in Fiscal Year 2008 we lacked coverage 13% of the time. Orthopedic trauma cases are generally transported directly to Shock Trauma, bypassing our hospital. Emergency cases may be transferred to Union Hospital in Elkton. Inpatients are visited by our orthopedic surgeons following admission and patients who are discharged from the Emergency Department are directed to follow up with orthopedic physicians in their private practice.



APPENDIX 2

Charity Care Overview

Chester River Hospital Center's registrars provide the hospital's patient financial assistance program packet (a copy of which is attached as Appendix 3) to all self-pay inpatients and outpatients at the time of registration. Emergency department patients who are self-pay also receive this packet if their condition permits. Emergency department patients who are admitted are visited by the hospital's credit and collection officer while in the hospital, and the packet is provided to them at that time. The packet is also available by request. The forms are available in English and Spanish.

Chester River Hospital Center has engaged ROI, a firm which works with patients to help them qualify for medical assistance.

APPENDIX 3

PAGE: 1 of 3

SUBJECT: Patient Financial Assistance

SERVICE: Patient Financial Services - Registration

MANUAL: Patient Financial Services

POLICY:

A patient's inability to obtain financial assistance does not, in any way, preclude the patient's right to receive and have access to medical treatment at Chester River Hospital Center.

PURPOSE:

Chester River Hospital Center is committed to providing excellent medical care to our patients regardless of their ability to pay for those services. This policy has been established to assist patients in obtaining financial aid when it is beyond their financial ability to pay for services received.

GUIDELINES:

The following guidelines will be used to determine eligibility for uncompensated care.

1. Patients shall be eligible for financial assistance provided they meet the necessary criteria for both the services provided and their ability to pay. Income guidelines are based on 200% of the Federal Poverty Income Guidelines.
2. Financial Assistance will be considered for those patients who live in the geographical service area of Chester River Hospital Center. This includes the following counties: Kent and Queen Anne's.
3. Patients who apply for financial assistance, who live outside of our geographic area may be eligible for "one time" assistance.
4. Financial Assistance will be granted without regard to age, race, creed or sex.
5. The application for financial assistance should be made as soon as possible in the admission process; however, an application may be taken at any time on open accounts.
6. The Credit and Collections Officer, Business Office Manager and/or Director of Patient Financial Services will determine if a patient is eligible for financial assistance. In making this determination, 200% of the current Federal Poverty Income Guidelines will be used as a base guide.
7. If it is determined that the patient may be eligible for other third party coverage, including Maryland Medical Assistance, that determination must be made before our internal financial assistance policy can be considered.
8. Approval for financial assistance is granted for six months. After that time limit has expired, a new application must be submitted for continuation of assistance.

9. Patients are NOT ELIGIBLE for financial assistance if they do not comply with their insurance coverage requirements and restrictions. This includes services that should have been performed at another provider location, but the patient chooses to have services rendered at Chester River Hospital Center.
10. Financial Assistance will not cover elective or non-emergent services, such as cosmetic surgery, dental procedures or other services as deemed non-covered by Chester River Hospital Center.
11. Financial Assistance will not cover any account that has been referred to a collection agency or referred for legal action.

PROCEDURE:

1. Patients presenting with no insurance will be given an application at the point of registration, or any time when requested.
2. Patients admitted to Chester River Hospital Center without proof of insurance will be referred to an outside agency to determine eligibility for any federal, state or other assistance program. If they are deemed to be ineligible for outside assistance, internal financial assistance is offered.
3. Patients must complete the application and return it within 30 days and provide any or all of the following information:
 - a. Most recent tax return
 - b. Two most recent pay check stubs, if employed
 - c. If not employed, proof of income
 - d. Two bank statements, if self employed
 - e. Documented household expenses
 - f. Letter documenting circumstances if income is slightly above guidelines or unable to document income
 - g. Letter of denial from Maryland Medical Assistance
4. Applications will be processed no more than 14 days after receipt of completed application and supporting documentation.
5. The application and supporting documentation will be reviewed by the Credit and Collections Officer and the Business Office Manager for approval. The Director of Patient Financial Services will review any application with questionable documentation or for amounts over \$5,000.00.
6. The Credit and Collections Officer will notify the patient by mail of the decision made with regard to financial assistance and will document the reason for approval or denial. If approved, the Credit and Collections Officer will write off all eligible accounts with the appropriate code.
7. The Credit and Collections Officer will continue to review eligible accounts and complete the writeoff for a period of one year.
8. If a patient does not agree with a denial of financial assistance, they may appeal to the Director of Patient Financial Services who will review the documentation and may request additional information to assist in making the determination. If the Director agrees with the initial determination, the patient may request a final review by the Chief Financial Officer of Chester River Hospital Center.

REVIEWED/REVISED BY AND DATE: Director, Patient Financial Services
December, 2008

APPROVED BY AND DATE: Chief Executive Officer
December 2008

ORIGINAL DATE: December 2008

REVIEW CYCLE: Three Years

DISTRIBUTION: Patient Financial Services staffs, Case Management,
Risk Management

COMPREF: S:\Shared\Policies and Procedures\Patient Financial
Services\Financial Assistance policy



APPENDIX 4

Mission Statement

The mission of Chester River Health System is to improve the health of the communities we serve through an integrated network of services and facilities, including:

- Chester River Hospital Center – inpatient, outpatient and emergency health services
- Chester River Home Care & Hospice – home care, hospice and personal care services
- Chester River Manor – long term and sub-acute health care services

Vision Statement

Chester River Health System is a model rural system providing integrated health services to our upper Eastern Shore communities, including:

- High quality, compassionate acute care services
- Home-based clinical, support and personal care services
- Affordable residential and rehabilitative health services

Values Statement

- **Compassion:** We attend to the needs of those we serve with tender care, empathy and equality.
- **Respect:** We recognize the dignity and value of life in every stage and condition.
- **Excellence:** We strive for the highest of personal and organizational standards.
- **Collaboration:** We build relationships based on cooperation, commitment and teamwork.
- **Responsibility:** We operate in an efficient manner to meet our fiscal and social obligations to the communities we serve.
- **Integrity:** We conduct ourselves in an honest, fair and ethical manner.

Appendix 1:

Statement of Access to Specialist Providers for the Uninsured

Civista Medical Center (Civista Health) relies on a combination of pathways to provide access to specialty care for uninsured patients:

- Inpatient specialty care is provided by hospitalists and other professional staff
- OB/GYN services are provided by staff obstetricians and gynecologists at an onsite prenatal clinic
- Physician specialists, as part of their facility privileges, agree to care for all patients who present in our facility regardless of ability to pay or status of health insurance.
- Other specialty services including, but not limited to dental care, mental health, primary care and substance abuse are provided by referral to other community entities such as Health Partners Clinic, Nanjemoy Community Health Center, and Charles County Department of Health.
- Some specialties continue to present challenges due to lack of providers. Maryland Hospital Association 2007 Data reports Charles County with 83% of physician specialties with a shortage.

Much time and resource is devoted to maintaining a network of community providers for referral of uninsured patients through Civista's leadership in organizations such as Partnerships for a Healthier Charles County, Healthy Families, Healthy Start, United Way of Charles County, Health Partners, Red Cross, Hospice, Department of Social Services, and Charles County Department of Health.

Appendix 2:

Charity Care Policy Description

Civista Medical Center posts its charity care policy, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, other areas of the facility in which eligible patients are likely to present. In addition, the policy is available on the Civista website and is posted in the local paper twice each year.

RECEIVING AN APPLICATION:

- Patient can receive an application by calling and requesting one can be mailed to them or coming to the hospital to pick an application up.
- The patients account(s) must be noted that they mailed/received application.

Once we receive the application back you must:

- make sure patient properly filled out all sections of form, if not mail back to patient with the sections highlighted for them to properly fill out. Make sure to note account when you mail this back to them. Also send Pending letter stating what the patient needs to do.
- make sure the application has a signature and is dated.
- must have a copy of the approval or denial letter from Maryland Medical Assistance.
 - patient does not need to apply if:
 - Financial counselor has signed off on application stating the patient will not qualify for MMA.
 - if
 - if
- must have a copy of their most recent federal tax return. We need at least the first 2 pages of the tax return. This does not mean W-2's.
- must have copies of the 2 most recent pay stubs from patient.
 - patient must provide pay stubs for spouse if they are working also.
- If the patient is unemployed(or spouse) they must get a copy of the unemployment wage history from Department of Labor, Licensing, and Regulation
- If the patient is of age/disability to receive Social security, they must provide a copy of their award letter or a copy of their most recent check. If they do not have either but the money is deposited into a checking/savings account, a copy of the most recent bank statement will be valid.
- a copy of the most recent checking and/or savings account from the patient.

If the patient brings this information into the office, please make photocopies of any originals.

Documents:

Application (see example 1)

- must be filled out completely, if not, highlight incomplete sections and mail back to patient with Pending letter.
- must be signed and dated by patient. If they have a spouse, spouse must sign application also.
- if there is a member of the household that should not be included on the application, they must be crossed off the application.
- use patient name for a search and also by their SSN to pull up any accounts that are outstanding.
- Financial counselor must sign on application if patient does not have to apply for MMA, otherwise patient must apply for MMA
- if patient monthly income documents do not match the application, question patient. such as SS check, spouses income, etc.
- make sure checking/savings or other accounts have attachments to the application show the same amount. A single applicant can have no more than \$7500 and applicant plus 1 can have no more than \$15,000.
- for other assets, make sure the patient fills this out. If the patient owns a home, pull up the value of the home on www.dat.state.md.us and click on Real Property to do a search. This will tell you information like when the patient purchased the home and for how much.

Approval or Denial letter from Maryland Medical Assistance (see example 2)

- patient can apply by going to the Department of Social Services or contacting our Financial Counselor.
- if patient is approved for MMA, must check all accounts/dates of service. Add MMA to any account that is now covered. We will only write off accounts that are Self Pay under the financial assistance program.
- review any denial letter from MMA to make sure it was not denied due to patient not providing the proper documentation. They must complete the process with MMA completely.

Tax Return

- must have most recent federal tax return.
- we only need a copy of the first 2 pages of the tax return.
- we do not need copies of the W-2
- make sure that anyone listed on the application is also listed on the tax return. Such as children, if the patient did not claim that child on the tax return, that child can not be included in the application for financial assistance.

Pay Stubs

- must be the two most recent pay stubs
- must also include spouses pay stubs
- if child support is being paid then make sure we are not including that child on the application (this child more than likely is not part of the household).
- if patient is paid "under the table," patient must get the employer to write a letter of how much they get paid and how many hours per week they work.

Unemployment Wage History (see example 3)

- must be obtained if patient and/or spouse is not working.
- this shows the patients income for the last 2 ½ years of work. This will not show any income that was paid as "under the table" income

Social Security Award letter/check

- must have a copy of the award letter or most recent check from patient if they are of age or disabled and receive SS.
- if patient does not have either of the above, their most recent bank statement can be copied for proof of income from SS.

Bank statements

- must have a copy of the most recent checking and/or savings account
- a single applicant can have no more than \$7500 and an applicant plus one can have no more than \$15,000

Support letter

- required if patient is supported financial by someone else or if patient has no income
- letter needs to be written by the person(s) that provides food, shelter, etc.

General Information

Every February you must go to <http://aspe.hhs.gov/poverty/> and click onto the HHS poverty guidelines. You take the figure that is listed on the guidelines and multiply it by 200% to get the guidelines Civista Medical Center uses. These figures are good for the 100% write offs.

To update the table for partial approval you multiply the federal poverty guidelines as follows:

1st column by 225%

2nd column by 250%

3rd column by 275%

4th column by 300%

These figures are good for the % write offs.

Financial Assistance is valid for **6 months** from the date of approval. It retro's back to any existing account whether it is Bad Debt or Final Billed. Do not write off an account that has a valid insurance on the account and is awaiting payment.

Financial Assistance is **ONLY** good for Civista Medical Center bills. Not valid for American Radiology, Laplata Physicians Services or the Doctor(s) that attended to the patient. Patient must call these places to make other arrangements for payment.

Patient **MUST** call Civista Medical Center whenever they get a bill to write off the amount. (You must verify from spreadsheet or notes in the system that patient is valid for those dates of services before writing off account).

Patient can reapply for financial assistance at anytime whether approved or denied. Approval is based off previous year tax return.

We will only accept the most current application for review. Any old or out of date application is not valid.

4 letters

Approved letter- use this letter when the patient has been approved for 100% write off. Use the date that the Collections Supervisor signs/dates the application for the approval. Valid for 6 months(Collections Supervisor signs) (example 1)

Approved % letter- use this letter when the patient has been approved for a partial write off. Partial write off's are also valid for 6 months (Collections Supervisor signs) (example 2)

Pending letter- use this letter when a patient is missing documentation. Patient must get supporting documents back within 30 days, otherwise they must fill out a new application and provide proper documents for review.(Customer Service Representative or Collections Supervisor signs) (example 3)

Denied letter-use this letter when patient has been denied for financial assistance. (Collections Supervisor signs) (example 4)

Mission Statement

7 of 7

Civista Health provides excellent care to each patient in a safe, caring and family-centered environment. Civista fosters a healthier community by providing service, education and access to care in concert with other community organizations.

=====

Vision Statement

Civista will be the preeminent healthcare provider for our community through:

- enhanced facilities, technology, and equipment;
- an excellent record of quality care and patient safety;
- highly responsive emergency services delivery;
- skilled workforce and excellent physician partners;
- financial health to assure funds for re-investment.

Appendix 1

Description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured in the hospital:

Doctors Community Hospital (DCH) is facing increasing challenges relating to specialist on-call coverage for the Emergency Department, with the potential to compromise patient access to needed care. As procedures increasingly shift out of the hospital facility the need for admitting privileges becomes less important for specialists. It is within these agreements that on-call requirements normally reside and many specialists are questioning the necessity of participation. Additionally concerns regarding quality of life, increased liability exposure and a growing indigent population all serve to further discourage call participation by specialists. Through a variety of measures DCH has been able to secure on-call coverage for the hospital to date, but until the more systemic issues of malpractice costs and uninsured patients are addressed it is unlikely that this problem will improve. DCH remains committed to providing access to the highest level of care and will continue to seek all alternatives to reduced specialist coverage.

Appendix 2

Charity care

The hospital has a specified plan for patients unable to pay for their medical care when services are rendered. Patients, families, or staff identifying a need for financial assistance to cover medical expenses will contact the Admitting Office Financial Counselor. The Financial Counselor will assist the patient or their representative in using appropriate resources to cover the expenses. Charity care will be evaluated on a case by case basis as deemed appropriate by Vice President of Finance.

The hospital provides the notice below in the Emergency Department Registration area along with a brochure on how to get financial assistance when needed. The notice is in the Patient Handbook which is given to every patient when they are admitted to a room.

The hospital provides written guidelines during their Orientation to the Registration staff to help them assess if a patient needs to be referred to a Financial Counselor for financial assistance or charity care.

This notice is also placed in the local paper, once a year to notify the community of financial aid services and contact information

NOTICE:

Doctors Community Hospital

NOTICE OF AVAILABLE FINANCIAL ASSISTANCE

Doctors Community Hospital provides medically necessary services to all persons regardless of the person's ability to pay. If you think you cannot pay for a medically necessary service, please contact our Patient Financial Services Department at 301-552-8093 Monday – Friday, 8:30 a.m. – 4:30 p.m., to see if you qualify for financial assistance.

DOCTORS COMMUNITY HOSPITAL
HOSPITAL POLICY/PROCEDURE

SUBJECT: CREDIT AND CHARITY

POLICY NUMBER: 1.5

DATE: November 2008

Administration

Prepared by/Department

SUPERSEDES POLICY

DATED: September 2000

Philip B. Down, President

Approved by/Title

Sajeev Anand, M.D., Chief-of-Staff

Medical Executive Committee

POLICY

- 1.5.1 The Hospital has a specified plan for patients unable to pay for their medical care when services are rendered.

PROCEDURE

- 1.5.2 The Hospital will bill valid insurances on behalf of patients whenever possible.
- 1.5.2 Patients, families, or staff identifying a need for financial assistance to cover medical expenses will contact the Admitting Office Financial Counselor.
- 1.5.3 The Financial Counselor will assist the patient or their representative in using appropriate resources to cover the expenses.
- 1.5.4 Charity care will be evaluated on a case by case basis as deemed appropriate by Vice President of Finance.
- 1.5.5 Refer to Standard Accounting Procedure (located in the Accounting and Business Offices) if additional information is required.

Appendix 4

HOSPITAL MISSION, VISION AND VALUES

The Mission of Doctors Community Hospital is

"Dedicated to Caring for Your Health."

Our Vision is to

"Continuously strive for excellence in service and clinical quality to distinguish us with our patients and other customers."

Our Values are vested in the word SERVICE.

- S - Safety
- E - Excellence
- R - Respect
- V - Vision
- I - Innovation
- C - Compassion
- E - Everyone

**Shore Health System
(Memorial Hospital at Easton and Dorchester General Hospital)**

Community Benefits Report For Fiscal Year 2008

1. Licensed bed designation and number of inpatient admissions for this fiscal year:

Shore Health System, an affiliate of the University of Maryland Medical System, is currently licensed to operate 192 beds combined. Inpatient admissions for fiscal year 2008 was 14,486.

2. Description of the community Shore Health System serves:

The Memorial Hospital at Easton and Dorchester General Hospital in Cambridge are private, not for profit hospitals offering a complete range of inpatient and outpatient services to over 140,000 people throughout the Mid-Shore of Maryland. Situated on Maryland's Eastern Shore, Shore Health System services a four county area, covering Caroline, Dorchester, Queen Anne, and Talbot counties.

Talbot County Statistics from Talbot County Health Plan

Population 36,062

Racial mixture 84% white, 13% black, 2.3% Hispanic (MD Vital Statistics, Annual Report 2006)

Median Household Income, 2005 \$51,637 2006 estimate **\$54,550***

Persons Below Poverty, 2006 8.5%

High School Graduate, 2006 85%

Proportion without health insurance 11%

Mortality Rate 2004 -2006 Ranking (adjusted per 100,000 population) **711.3****

Caroline County Statistics from Caroline County Health Needs Assessment

Population 32,617, population density 93persons per square mile

Racial mixture 84% white, 14% black (MD Vital Statistics, Annual Report 2006)

Median Household Income, 2004 \$41,432 2006 estimate **\$45,050***

Persons Below Poverty, 2004 10.5%

High School Graduate, 2000 75%

Bachelor's Degree or higher, 2000 12.1%

Proportion without health insurance 16%
(less than 65)

Mortality Rate 2004 -2006 Ranking (adjusted per 100,000 population) **889.2****

Leading Causes

1. Heart Disease 200.8

2. Cancer 222.4

3. Stroke 52.4

Dorchester County Statistics from Dorchester County Health Department

Population 31,631

Shore Health System's annual management plan results in activities aligned with the needs of the community it serves. Hospital operations, nursing leadership, finance, and volunteers are involved in developing and participating in activities that reach out to the community.

6. Description of how initiatives address the needs listed in #4:

Access to quality health services

- SHS physicians and clinicians participate in health fairs and lecture series providing information and services to the community.
- SHS aids in obtaining necessary medications or equipment needed for discharge for patients unable to pay.
- Ongoing recruitment efforts over the last year include orthopedic, endocrinology, pediatrics, neurology, pulmonary, ob/gyn, anesthesia and family practice physicians.
- Stipend to Tidewater Anesthesia and Maryland Emergency Medicine paid to provide evening, weekend, and holiday call at Dorchester General Hospital in order to provide emergency Surgical Services 24/7

Cancer

The SHS Breast Center participates in Community Outreach to meet the needs of screening, etc for the underserved population. Oncology Support Social Services offered special education on cancer and resources available for cancer patients.

Stroke Prevention and Awareness

Shore Health System hosted a community forum on stroke prevention and treatment. A panel of healthcare experts discussed stroke and addressed audience questions. Stroke forum attendees received a free blood pressure screening and a voucher redeemable for a discounted cholesterol screening. Information on a variety of health topics, such as diabetes, nutrition, exercise and fitness were made available. Information about the Power to End Stroke Campaign, an initiative to reduce the risk of stroke among African Americans was also on display.

Diabetes

- SHS provides nutrition and diabetic information at health fairs and participates in support groups for adult and juvenile diabetes.
- SHS held a week-long diabetic summer camp for juvenile diabetics.

Maternal, Infant and Child Health

Shore Health System offers a variety of community education programs to meet the needs of the new mother and the family unit. Childbirth classes, infant CPR, Big Brother, Big Sister classes, breastfeeding classes are offered free of charge.

Shore Health System has partnered with the Talbot County Department of Social Services to operate an evidence-based Child Advocacy Center to treat abused children. Shore Health System offers services to sexually assaulted adults and children.

Educational and Community-based Programs

Shore Health System participated in a number of career and health fairs throughout the year. Attendees received educational information on topics including smoking cessation, signs and symptoms of stroke, diabetes, nutrition, medication listing,

7. Description of the efforts taken to evaluate the effectiveness of major Community Benefit program initiative:

Currently SHS uses statistical data gathered by local health departments to assess effectiveness of community benefit initiatives.

SHS is working to incorporate a formal data collection process to improve tracking effectiveness of activities.

8. Description of gaps in the availability of specialist providers, including outpatient specialty care, to service the uninsured cared for by SHS:

- The SHS Medical Staff by-laws require that physicians provide ten day of Emergency Department call. In areas where there is only one or two sub-specialists for a particular specialty, there will be occasions when certain days are not covered. If a patient presents to the Emergency Department and there is no sub-specialty coverage for that day, the patient is stabilized and then transferred to an appropriate facility for treatment.
- Stipend to Tidewater Anesthesia and Maryland Emergency Medicine paid to provide evening, weekend, and holiday call at Dorchester General Hospital in order to provide emergency Surgical Services 24/7

Appendices:

Appendix 1: Describe your charity care policy

- A. Describe how the hospital informs patients and person who would otherwise be billed for services about their eligibility for assistance under federal, state or local government programs or under the hospitals charity care policy.

It is the policy of Shore Health System to work with our patients to identify available resources to pay for their care. All patients presenting as self pay and requesting charity relief from their bill will be screened at all points of entry, for possible coverage through state programs and a probable determination for coverage for either Medical Assistance or Financial Assistance (charity care) from the hospital is **immediately** given to the patient. The process is resource intensive and time consuming for patients and the hospital; however, if patients qualify for one of these programs, then they will have health benefits that they will carry with them beyond their current hospital bills, and allow them to access preventive care services as well. Shore Health System works with a business partner who will work with our patients to assist them with the state assistance programs, which is free to our patients.

If a patient does not qualify for Medicaid or another program, Shore Health System offers our financial assistance program. Shore Health System posts notices of our policy in conspicuous places throughout the hospitals, has information within our hospital billing brochure, educates all new employees thoroughly on the process during orientation, and does a yearly re-education to all existing staff. All staff have copies of the financial assistance application, both in English and Spanish, to supply to patients who we deem, after screening, to have a need for assistance. Shore Health System has a dedicated Financial Assistance Liaison to work with our patients to assist them with this process and expedite the decision process.

Appendix 2: Attach copy of SHS hospital's charity care policy.

- B. Shore Health System Policy LD-34, Patient Financial Services – Financial Assistance Program attached.

Appendix 3: Describe the hospital's mission, vision, and value statements.

Shore Health System has a strategic plan and mission statement, which are tied to community benefits. The 2004-2008 strategic plan is developed involving physicians, board members, Senior Leadership staff, management staff and other SHS employees.

Appendix 4: Attach a copy of the hospital's mission, vision, and value statements.

Mission, Values, and Strategic Principle of Shore Health System

Mission: "To excel in quality care and patient satisfaction"

Values: “Every interaction with another is an opportunity to care”

Strategic Principle: “Exceptional Care, Everyday”

Vision: “Shore Health System is strategically located hospitals and ambulatory care services throughout the five-county mid-shoe area. We manage resources to support the health care needs of the of the region’s residents. We are innovative professionals collaborating to serve our communities and achieve national recognition for exceptional outcomes.”

SHORE HEALTH SYSTEM

Administrative Policy and Procedure

TITLE OF POLICY: PATIENT FINANCIAL SERVICES - FINANCIAL ASSISTANCE PROGRAM

PURPOSE

To establish a standardized policy, in compliance with and to determine the method by which individuals and families will be approved for financial assistance for their medical bills.

1.0 POLICY

- 1.1 Shore Health System will provide uncompensated care to those individuals and families who exhibit the need for uncompensated care, provide adequate evidence on such need and providing that there are no other means of compensation (including the ability to receive care at another facility at which there would be compensation available).
- 1.2 Uncompensated care will be considered for patients that are residents of Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties. Financial Assistance will be offered at 100% for individuals at or below 200% of the Federal Poverty Guidelines. A sliding scale of up to 300% for a reduction in costs will also be offered to residents of these counties.
- 1.3 Individuals who are non-residents of the five counties should seek uncompensated care at the facility that services their locale. Financial Assistance will not be considered until the patient provides Shore Health System with a Medicaid Denial letter and a denial letter from their locale healthcare facility. Financial assistance will only be offered at 100% for those individuals at or below 150% of the Federal Poverty Guidelines. Financial assistance will only be offered on a "one time account" basis for non-residents.
- 1.4 Financial Assistance will not be offered for non-residents of Maryland unless approved by Senior Management. Individuals who are non residents, but are residing with residents of the five counties for an extended period of time, may supply a notarized statement from the individual they are residing with, that details their circumstances. Financial Assistance will only be offered on a "one time account" basis for non-residents.
- 1.5 Uncompensated care will be available regardless of race, disability, religion, age, sex, national origin or creed.
- 1.6 Shore Health System will provide patients seeking services at Dorchester General Hospital coverage under the Hill/Burton Program, as long as patients are not covered by another federal program as their primary insurance (i.e., Medicare.)
- 1.7 Shore Health System will provide patients seeking services at all other locations coverage under the Financial Assistance Program. This program will offer full

discounts and sliding fee scale discounts for all uninsured and underinsured patients within the residential areas defined above.

- 1.8 Shore Health System may require patients to apply for State funded programs, such as Medical Assistance, prior to being considered for Financial Assistance should we believe patient may qualify. Financial Assistance will not be considered unless a Medical Assistance denial is received.
- 1.9 Financial Assistance coverage may be discontinued if the patient is asked to complete a Medical Assistance application by Shore Health System, and the patient refuses to cooperate.
- 1.10 Patients are **NOT ELIGIBLE** for charity care if they do not comply with their insurance coverage requirements and restrictions. This includes services that should have been performed at another provider location, but the patient chooses to have services rendered at Shore Health System. **Patient will be fully liable for services that are not covered due to non-compliance with insurance requirements.**
- 1.11 Services covered under the Veterans Administration but not authorized by them, will not be covered by Financial Assistance. Patients must seek services or authorization of services from the Veterans Administration. Senior Management approval is required to waive this requirement based on specific patient needs.
- 1.12 Financial Assistance will not cover elective or non-emergent services, such as cosmetic surgery, dental procedures, and other services as deemed non-covered by Shore Health System.
- 1.13 Financial Assistance will not cover any accounts that have been referred for legal action.

2.0 PROCEDURE

2.1 Application

- 2.1.1 All patients presenting as self pay and requesting charity relief from their bill will be screened for Medical Assistance coverage prior to being considered for Financial Assistance. If patients do not meet the initial screening for Medical Assistance, but may potentially meet the criteria for Financial Assistance based on a review of the guidelines, patients will be provided an application for Financial Assistance, including a cover letter explaining what the patient must do to be considered for uncompensated care.
- 2.1.2 Application for Financial Assistance (Attachment 1).
- 2.1.3 Cover Letter (Attachment 2).
- 2.1.4 Patients will be instructed to provide the following information with the returned application.

-
- 2.1.4.1 Proof of income may be:
 - 2.1.4.1.1 Most recent two consecutive pay stubs.
 - 2.1.4.1.2 Most recent pay stub (must show year-to-date totals).
 - 2.1.4.1.3 Social Security or Disability award letters.
 - 2.1.4.2 Denial letter from Medical Assistance, which may be required to be completed before Patient Aid can be considered.
 - 2.1.4.3 Previous year's Tax Return statement (not required for Hill Burton), along with copies of W-2.
 - 2.1.4.4 If change in dependency from last filed tax return, or patient not required to file tax return, a list of legal dependents with proof of dependency for the individual.
 - 2.1.4.5 Most recent checking and savings statements.
 - 2.1.4.6 Proof of residency in the defined covered counties.
 - 2.1.4.7 Additional documentation may be requested from individuals who are normally outside the income and residency guidelines, but are requesting consideration based on their individual circumstances at this time.
 - 2.1.5 Incomplete applications or applications missing supporting documentation will be returned to the patient with an explanation of what is needed to complete the application process.
 - 2.1.6 Accounts will remain self pay until a completed application is received and approved.
- 2.2 Eligibility
- 2.2.1 Patient applications will be screened to determine if they meet the income criteria for Financial Assistance. In general, Shore Health System will follow the current guidelines for Hill-Burton uncompensated care program.
 - 2.2.1.1 The maximum allowable income (based on family size) will be twice the Federal Poverty Guidelines pursuant to 42 U.S.C. 9902(2) and as updated and published in the Federal Register. (See Attachment 3 for legal residents of Kent, Queen Anne's, Talbot, Dorchester and Caroline Counties only.)
 - 2.2.1.2 Non-residents of the five counties may be considered for Financial Assistance at 150% of the Federal Poverty Guidelines, along with a denial of eligibility from Medical Assistance.

2.2.1.3 Changes to the income guidelines will become effective 60 days after they have been posted in the Federal Register.

2.2.2 Income Determination

2.2.2.1 Family income will be used to determine eligibility for Patient Aid.

2.2.2.2 Income for all members of the family will be considered. The definition of income will be:

2.2.2.2.1 Money, wages and salaries before any deductions.

2.2.2.2.2 Net receipts from non-farm self employment (receipts from a person's own incorporated business, professional enterprise, or partnership, after deductions for business expenses).

2.2.2.2.3 Net receipts from farm self-employment (receipts from a farm that one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses).

2.2.2.2.4 Regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veteran's payments, public assistance (including Aid to Families with Dependent Children or Temporary Assistance for Needy Families, Supplemental Security Income, and non-Federally funded General Assistance or General Relief money payments), and training stipends.

2.2.2.2.5 Alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household.

2.2.2.2.6 Private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments.

2.2.2.2.7 College or university scholarships, grants, fellowships, and assistantships.

2.2.2.2.8 Dividend, interest, rental income, net royalties, periodic receipts from estates or trusts.

2.2.2.2.9 Net gambling and lottery winnings.

2.2.2.3 Income does not include the following types of money received: **

2.2.2.3.1 Capital gains.

2.2.2.3.2 Any asset drawn down as withdrawals from a bank, the sale of property, a house or a car.

2.2.2.3.3 Tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments or compensation for injury.

2.2.2.3.4 Non-cash benefits such as employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food or fuel produced on farms, the imputed value of rent from owner occupied non-farm or farm housing and such Federal non-cash benefit programs such as Medicare, Medicaid, food stamps, school lunches and housing assistance.

** Please Note: These monies may be considered in reviewing the application for the payment of outstanding medical bills although they are not reported as income.

2.2.2.4 Annual income will be determined by taking the income for the three months prior to the application date and multiplying by four; or by taking the income for the twelve months preceding the date of application.

2.2.3 Family size will be the number of **legally dependent** (by birth or marriage) individuals permanently residing in the household at the time of application. This is more clearly defined as the number of "dependents" documented on the Federal Tax return.

2.3 Denials

2.3.1 Accounts for which applications are completed, with documentation, and are determined to not meet the criteria for uncompensated care will be made self pay.

2.3.2 The patient will be notified in writing of the determination using an *Uncompensated Care Determination Notice* (Attachment 4).

2.3.3 Patient will be informed of the hospital's payment arrangement guidelines.

2.4 Pending

- 2.4.1 If the application is incomplete, the patient will be notified and instructed what information is needed to complete the application using an *Uncompensated Care Determination Notice* (Attachment 4).
 - 2.4.1.1 Highlight the missing information on a copy of the application (always keep the original application).
 - 2.4.1.2 Indicate the missing information on the *Uncompensated Care Determination Notice* (Attachment 4).
- 2.4.2 If supporting documentation is missing, notify the patient using an *Uncompensated Care Determination Notice* (Attachment 4).
- 2.4.3 The account will remain as “Patient Aid Pending” for 30 days. If the patient does not reply within 30 days, the account is made self pay.
- 2.5 Approvals
 - 2.5.1 Accounts for which applications are completed, with documentation, and are deemed to meet the criteria for uncompensated care will be adjusted accordingly.
 - 2.5.2 All accounts for the applicant and their immediate family that are for dates of service on or before the date of application will be written off.
 - 2.5.2.1 Accounts at Memorial Hospital of Easton will be adjusted using the following transaction code: 0317.
 - 2.5.2.2 Account at Dorchester General Hospital will be adjusted as follows:
 - 2.5.2.2.1 Accounts that represent the balance after Medicare and/or Medicaid will be adjusted using the following transaction code: 0317.
 - 2.5.2.2.2 Accounts that are not balances after Medicare and/or Medicaid are eligible to be considered under our Hill-Burton obligation and will be adjusted using the following transaction code: 0318.
 - 2.5.3 Any accounts for dates of service within the six months following the date of application will be written off.
 - 2.5.3.1 Accounts at Memorial Hospital of Easton will be adjusted using the following transaction code: 0317.
 - 2.5.3.2 Accounts at Dorchester General Hospital will be adjusted as follows:
 - 2.5.3.2.1 Accounts that represent the balance after Medicare and/or Medicaid will be adjusted using the following transaction code: 0317.

- 2.5.3.2.2 Accounts that are not balances after Medicare and/or Medicaid are eligible to be considered under our Hill-Burton obligation and will adjusted using the following transaction code: 0318.
- 2.5.4 The patient will be notified, in writing, of the uncompensated care given using a system generated letter based on the write-off being performed.
- 2.5.5 The patient's and all immediate family member's accounts will be updated to show "Patient Aid" as their final insurance plan.
 - 2.5.5.1 The plan code will be changed to "004005" for Patient Aid and to "004006" for Hill Burton.
 - 2.5.5.1.1 It is imperative that the POLICY NUMBER field be completed to show the termination date of the approval - enter: "TERM MM/DD/YY".
 - 2.5.5.2 If a patient has other insurance, Patient Aid should be listed as the last COB.
 - 2.5.5.3 The effective date of Patient Aid should be the application date.
 - 2.5.5.4 The termination date of Patient Aid should be the date **six** months after the effective date, unless patient is only being Patient Aid for one service date.
- 2.5.6 Future visits that occur within the **six** months succeeding an approved application date will be automatically adjusted in accordance with section a) above. However, patients who require inpatient admissions, surgical services, recurring services, and/or high dollar services as determined by the hospital, may be required to apply for Medical Assistance, and failure to comply with this request will result in the application for charity care becoming null and void.
- 2.5.7 Financial Assistance will be good for **6 months unless only one account is approved for coverage**. Patients will be sent a termination notice 30 days prior to the termination date of their coverage, along with a new application. Any visit occurring after the six months succeeding an approved application date will be self pay until such time that a new application for Patient Aid is received and approved.
- 2.5.8 Patients who require inpatient services, or require high dollar, or recurring services, (i.e., radiation oncology) will be asked to comply with a Medical Assistance application. Patients that are deemed potentially eligible, or those that fail to comply with the application process, will have their Financial Assistance application terminated immediately. Notice will be sent to the patient that they are being terminated from Financial Assistance. Patient will have 30 days to reply to the letter and cooperate

with the MA application. Patients that do not reply within the 30 days will immediately be referred to Bad Debt Agency.

2.6 Appeal Process

2.6.1 Patients or physicians who would like to appeal a denial of Hill Burton or Financial Assistance should contact the Director of Patient Financial Services to discuss why Financial Assistance should be extended to an individual or service that is deemed ineligible for the program. All decisions for an overturn will be discussed directly with the CFO.

2.6.2 Second appeal should be referred directly to the Sr. Vice President/CFO directly.

2.6.3 Third and final appeals would be referred directly to the President/CEO.

2.7 File retention

2.7.1 Files of all applications, documentation and correspondence will be maintained in accordance with the *Provider's Guide to the Hill-Burton Uncompensated Services Regulations*.

2.7.2 Separate files will be maintained for each Hospital.


Gerard M. Walsh, Chief Operating Officer

Effective: 10/05

Approved by: *Shore Health System Board of Directors 6/22/05*

Submitted by: *Christine Fontaine, Director, Patient Financial Services*

**Fort Washington Medical Center (FWMC)
11711 Livingston Road
Fort Washington, Maryland 20744**

**Corporate Office:
6196 Oxon Hill Road, Suite 210
Oxon Hill, Maryland 20745
Tele: 301/686-9010**

Beds: 37

Submission Date: December, 2008

Executive Summary

During reporting year 2007-2008, Fort Washington Medical Center (FWMC) provided benefits to the community that included charity care, teaching-preceptor opportunities, health screenings, community health education, community sponsorship opportunities, disaster preparedness and hospital strategic planning activities.

These contributions amounted to \$1,053,262.00 in community benefits, an increase of 62.88% or \$406,605 from FY 2007. The benefits were in four areas: (a) increased participation in nursing and allied health preceptor ship programs; (b) charity care reporting (c) increased health screenings in part with community organizations and (d) increased community awareness.

Since 2004, FWMC has operated under a strategic plan ratified by the Fort Washington Medical Center Board of Trustees in 2005. The goals of the strategic plan are as follows:

- Expand Capacity to Meet Community Needs
- Maintain Clinical Excellence and Improve Community Health;
- Improve Financial Viability and;
- Increase Awareness and Improve Image

During this reporting period, FWMC focused primarily on three goals – “Expand Capacity to Meet Community Needs” and “Maintain Clinical Excellence and Improve Community Health,” under which the community wellness program was initiated for 2006. A third goal that was initiated focused on “Building Community Capacity Through Coalition Building”.

Fort Washington’s newly revised mission statement is as follows: “To advance the health and wellness of individuals in the communities we

serve by delivering the highest quality, most compassionate and responsive health care services.” FWMC’s vision statement is as follows, “To be the health care provider of choice in our community.”

Expand Capacity to Meet Community Needs

In FY 2005-2006, FWMC undertook a feasibility study to determine the community’s viability in supporting a hospital expansion project. In this reporting year, FWMC has continued to work with outside counsel to develop a case for community support for a capital expansion program. Community leadership, including local churches, community and civic associations, businesses and community leaders have been approached about this effort.

During this reporting year, Fort Washington Medical Center continued to see record numbers of people. Through the Emergency Department alone, there have been steady increases, resulting in more than 44,000 patients being seen, accounting for more than 5,000 inpatient admissions. FWMC’s performance still relies upon the outdated infrastructure put in place in 1983, when it was an ambulatory care clinic. In 1991, the infrastructure was expanded to accommodate the hospital. Each week, the Hospital sees nearly 1,200 patients in a facility built to handle 800.

Under the expansion initiative, the hospital will increase the size of its Emergency Room from 14 bays to 30; 51 new single occupancy rooms, a change from 37 double - occupancy beds; expand spaces for other services, including the Radiology Department, the laboratory, and pharmacy; and an increase in the size of the surgery suites.

In addition, the cafeteria will be expanded to allow for on-site food preparation on-site, and areas will be developed for community education. Currently, the only site available for community education is the cafeteria. While planning for the capital expansion is ongoing, the building phase is expected to begin in late 2009-2010.

Building Capacity Through Community Coalition Building

In early 2007, FWMC began meeting with community and civic associations on the capital expansion project; and in June, hosted the first of what has become on-going meetings with Prince George’s County clergy around the issue of expansion. The discussions have also centered on issues surrounding the transformation of the region’s healthcare, sparked by the opening of the National Harbor. The approach utilized was a series of breakfasts targeted to clergy in Prince

George's County, located in the areas of Fort Washington, Oxon Hill, Temple Hills and Accokeek, Maryland.

During the 2007- 2008 reporting year, five breakfasts were held at the Tantallon Country Club and the Lexington Hotel, both of which are located in Fort Washington and Oxon Hill, Maryland respectively. The breakfasts became a way to cultivate relationships with churches in the community, and a way for churches to come together around the focus of health care. These meetings provided a way for the hospital to begin dialogue around the hospital's needs and its challenges.

Likewise, it also presented a way for the community, and specifically the clergy to bring to the hospital the health concerns facing subsets of the population, which included the unemployed and the underemployed; children, and in increasing numbers, the elderly. Of the 200 or so churches invited to attend the breakfast, 15% attended the breakfasts on a regular basis.

In addition to updates on community and hospital development, topics included health presentations by Fort Washington physicians. Topics included heart health, emergency medicine; the key to medical tests; joint replacements, and the new medical technology.

As a result of the breakfasts, a series of town hall meetings were later held by individual ministries in the same churches in the evenings. Churches utilized existing internal church groups to host the meetings. The presentation, "What You Need to Know About Key Medical Tests and Why They Are important," presented by one of the hospital's family medicine practitioners became a much sought after presentation. It provided a way for churches to understand the importance of health maintenance, and the various roles of medicine.

The presentations also provided a way for participants to understand the role of self-care and advocacy. Through the town hall setting, participants also gleaned an understanding of healthcare, including health care policy, health care funding, service lines, and more important the role of the health care provider in the community and the role that health care plays in quality of life.

These sessions provided invaluable information to decision-makers in the hospital and formed the basis of an informal assessment of community need. Recommendations from the community included additional services, such as out-patient rehabilitation and gerontological services. It also confirmed the need for increased bed and emergency room capacity. During this reporting period, a total of four town hall meetings were held with a total of 85 persons attending.

Maintain Clinical Excellence and Improve Community Health

To carry out the goal of “Maintain Clinical Excellence and Improve Community Health,” FWMC has strategic partners. The strategic partners include the American Heart Association, American Lung Association, YMCA-Potomac Overlook, the American Red Cross, Harmony Hall (Maryland Parks and Planning), and the Prince George’s Health Department (PGHD).

The Prince George’s Health Department continues to be a significant partner. It has provided the epidemiological indicators of the health status of residents in Prince George’s County. Data taken from PGHD’s Core Public Health Funding Plan (FY 2006) revealed that Maryland ranks fourth highest in the nation for diabetes prevalence.

Further, the plan states that overweight and obesity are the dual factors that “increase the risk of morbidity and mortality from hypertension, Type 2 diabetes, coronary artery disease, stroke, gallbladder disease, osteoarthritis, and certain cancers.”

The Health Department for the third consecutive year has joined with FWMC to provide a 4-week course entitled, “Take Control of Your Diabetes.” The free four-part series focused on diet and nutrition, exercise, stress management, and how to access needed resources from insurance and health care providers. Launched in August 2006, participants register with the Health Department. The classes are held at FWMC, but are taught by certified instructors through the Health Department. The workshops, promoted by FWMC, are held in February and August.

Since its inception, the four-week sessions, held twice a year, have seen an average of 25 participants per class. Initially participants for the program were recruited from churches, community organizations and civic associations. The participants from the more recent class were also recruited from FWMC. As a new cost containment measure, individuals seen in the Hospital Emergency Room or were hospitalized over the last two years were sent invitations to participate in the program.

It is believed that at least 90% of the emergency room cases are linked to diabetes. According to the Health Department, the program at FWMC has been highly successful. Participants themselves rate the program

highly, noting the expertise of the PGHD instructors, the design of the class and the easy access to the class.

In an effort to help patients better manage diabetes, and to reduce the incidence of recidivism, patients now seen at FWMC or through the Emergency Room, or if hospitalized, will be recruited to participate in the classes.

The Hospital continues to work with its strategic partners, including the American Lung Association (ALA). During this reporting year, Fort Washington co-sponsored a "Breathe Well, Live Well" workshop targeted to adult asthma sufferers. For the second consecutive year, members of FWMC's Respiratory Therapy Department coordinated participation from FWMC for ALA's Annual Asthma Walk, held in May 2008 at the National Mall.

The purpose of the walk is to raise awareness and funds to support programming that will help improve the health of more than 160,000 children in Maryland and the metropolitan area diagnosed with asthma. The walk is one of several activities planned with ALA, including annual workshops on asthma and other respiratory conditions.

For the third consecutive year, Fort Washington Medical Center has worked with the American Red Cross (ARC), Greater Chesapeake and Potomac Region to raise awareness around the need to donate blood. begun working with Fort Washington Medical Center on a regular basis. In FY 2005, one blood drive was held.

In FY 2006 and 2007, a total of six blood drives were held, roughly every 50 to 55 days, thereby increasing blood donations, a tremendous benefit to the community at large. FWMC's partner in the effort was the YMCA Potomac Overlook, which contributed space and manpower to provide further visibility to the drives, and to increase community access. The YMCA also works with FWMC to coordinate health fairs at its facility.

Community Training/Preceptor Opportunities

Fort Washington Medical Center's teaching – preceptor program continues to be a major portion of community benefit. In reporting year 2007-2008, nursing and allied training preceptor opportunities have increased at FWMC. During this reporting period, there were 110 nursing, allied health and EMS students from Prince George's Community College and other teaching institutions in the state.

Under the direction of the FWMC's Performance Improvement Department, which adheres to the standard established by JACHO,

students are required to meet certain hospital standards. The Department works with the nursing and allied health schools to insure that the standards are met and that there is appropriate reporting, as required from all participants.

Gaps In Service

Due to Fort Washington's size, the Hospital has experienced constraints by physicians who provide specialty services. The actual size of the hospital (37 beds) limits the practice of specialists who desire larger caseloads. It has become increasingly difficult to find specialists willing to accommodate smaller case loads. The impact of the limitation is felt by all patients, including the insured and uninsured. During this reporting period, there has been limited availability to specialists, including cardiothoracic surgeons, neurosurgeons and urologists.

Community Benefit Evaluation

During this reporting period, a formal evaluation of FWMC's program was not undertaken. Evaluation of parts of the program, i.e. the Diabetes Awareness Program, and preceptor-ship programs are built in and are done on a continual basis. Funding will be budgeted for 2009 to do an update of the FWMC strategic plan, which includes a formal community needs assessment and an evaluation of the program overall.

Fort Washington Medical Center – Appendix I
Gaps in Services

Gaps In Service

Due to Fort Washington's size, the Hospital has experienced constraints by physicians who provide specialty services. The actual size of the hospital (37 beds) limits the practice of specialists who desire larger caseloads. It has become increasingly difficult to find specialists willing to accommodate smaller case loads. The impact of the limitation is felt by all patients, including the insured and uninsured. During this reporting period, there has been limited availability to specialists, including cardiothoracic surgeons, neurosurgeons and urologists.



Fort Washington Medical Center

Memo

To: All Employees
From: Paul E. Porter, President and CEO
Date: 12/14/07
Re: Financial Assistance Plan

Fort Washington Medical Center (FWMC) follows a specific and compassionate policy for payment practices for financial assistance and uninsured billing. As a not-for-profit organization, one of the ways FWMC demonstrates its commitment to the community is through providing financial assistance to those in need. Our practices are an outgrowth of our mission and values and are evidenced by our providing 9.06% (Maryland Healthcare Cost Commission-MHCC-FY07) of our services as financial assistance (state average 7.49%).

If a patient verbalizes a concern about not being able to make a payment:

- **during business hours (Monday to Friday)**, refer the patient to the Insurance Verification Representative (Financial Counselor) located in Admitting back office.
- **during after hours, holiday or weekend**,
 - provide the patient with a Financial Assistance Program and Practices brochure and a Maryland State Uniform Financial Assistance Application (see attached),
 - tell the patient that he/she can drop off the application with anyone in Admitting and
 - if the patient needs assistance completing the form, ask the patient to leave a message at 301-203-2271 or 2154 and an Insurance Verification Representative (Financial Counselor) will return their call within three business days.

FWMC'S RESPONSIBILITIES:

- Never turn a patient away because of inability to pay.
- Be respectful of the individual's personal dignity and his/her ability to pay.
- Treat all patients equitably, whether insured, underinsured or uninsured.
- Consider the financial resources of patients and their families when establishing a maximum annual patient responsibility.
- Be diligent in our efforts to keep patients notified of their payment options and the opportunities for assistance.
- Ensure that our policies are consistent with the guidelines that have been issued by the American Hospital Association, federal, state and local legislative bodies, and other organizations.
- Provide financial assistance to those in need.

PATIENT'S RESPONSIBILITIES:

- Follow through with the application process.
- Provide all required documents necessary in order to be granted financial assistance.

SEE ATTACHMENTS FOR MORE INFORMATION:

Financial Assistance Plan

Financial Assistance Program and Practices Brochure

Financial Assistance Notice (Registration/triage/Receptionist booths, lobby, ED, Pt Accounts, and Administration)

Maryland State Uniform Financial Assistance Application

TITLE: FINANCIAL ASSISTANCE PLAN

Policy No. RI 240
Page 1 of 5

PURPOSE:

The purpose of this policy is to document the Fort Washington Medical Center (FWMC) process for granting financial assistance where patients are unable to meet their obligations to the organization due to lack of insurance or other financial resources or other conditions of financial hardship.

POLICY:

FWMC provides care to all patients regardless of ability to pay.

It is the policy of Fort Washington Medical Center to provide Financial Assistance based on inability to pay or high medical expenses for patients who meet specified financial criteria and request such assistance.

FWMC will communicate the availability of financial assistance on the hospital website and in hospital publications.

A notice of FWMC's Financial Assistance Plan will be posted in Admitting, Registration, Patient Accounts, in the Emergency Department, and Administration.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing (including any accounts having gone to bad debt within 3 months of application date) and any projected medical expenses.

A determination of Financial Assistance will be re-evaluated every six (6) months as necessary.

The Financial Assistance Plan will be re-evaluated at a minimum every calendar year (Poverty Table will be updated annually.)

PROCEDURE:

1. An evaluation for Financial Assistance can be commenced in a number of ways:
 - a. A patient with a self-pay balance due notifies the self-pay collector that he/she cannot afford to pay the bill and requests assistance.
 - b. A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
 - c. A physician or other clinician refers a patient for financial assistance evaluation for potential admission.
2. The Insurance Verification Representative/Financial Counselor (located in the Admitting office), Admitting and Patient Accounts personnel will be responsible for taking Financial Assistance applications.
3. When a patient requests Financial Assistance, the staff member who receives the request will:
 - a. **AFTERHOURS/WEEKEND:** Give the patient a Financial Assistance Program and Practices brochure and application (attached) and refer the patient to contact the Insurance Verification Representative/Financial Counselor. Patients may drop off applications with anyone in the Admitting area.
 - b. **DURING THE WORKWEEK NORMAL BUSINESS HOURS:** Refer the patient to the Insurance Verification Representative/Financial Counselor.

4. The applicant must bring the following to any personnel in Admitting or Patient Accounts.
 - a. A completed Maryland State Uniform Financial Assistance Application (attached).
 - b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of 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).
 - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
 - d. A Medical Assistance Notice of Determination (if applicable).
 - e. Proof of US citizenship or permanent residence status.
 - f. Proof of disability income (if applicable).
 - g. Reasonable proof of other declared expenses.
5. The Insurance Verification Representative/Financial Counselor will perform an assessment to determine if the patient meets preliminary criteria based on the family size/income as defined by Medicaid regulations (See Attached Poverty Level Guidelines Table).
6. A Letter of Conditional Approval for probable eligibility (see attached) will be sent to the patient within three days of receipt of a completed application.
7. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. If the patient's application for Financial Assistance is determined to be complete and appropriate,
 - a. the Insurance Verification Representative/Financial Counselor will forward all documents and recommended patient's level of eligibility to the Director, Patient Accounts.
 - b. the Director of Patient Accounts has the authority to approve/reject charity amounts less than \$5000.
 - c. the Chief Financial Officer has the authority to approve/reject charity amounts estimated to exceed \$5000.
8. Applications received and preliminary determinations made by the Insurance Verification Representative/Financial Counselor will be sent daily to Patient Accounts for review.

9. The following must be met in order for a review for a final determination for a Financial Assistance adjustment:
 - a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the disability requirement. In cases where the patient has active Medicare Prescription Drug Program or Qualified Medicare Beneficiary (QMB) coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
 - b. Review viability of offering a payment plan agreement.
 - c. The patient must be a United States of America citizen or permanent resident (Must have resided in the U.S.A. for a minimum of one year).
 - d. All insurance benefits have been exhausted.
10. A Letter of Final Determination (see attached) will be sent to the patient within 30 days to inform him/her eligibility for:
 - a. Financial Assistance (Full or partial)
 - b. Payment Plan
11. FWMC has the option to designate certain elective procedures for which no Financial Assistance options will be given.
12. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to Fort Washington Medical Center. If a patient is approved for a percentage allowance due to financial hardship and the patient does not make the required initial payment within 60 days towards their part of the bill, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.
13. Any payment schedule developed through this policy will ordinarily not exceed two years in duration. In extraordinary circumstances, a payment schedule may extend to three years in duration, with the approval of the Chief Financial Officer.
14. The Director of Patient Accounts will advise ineligible patients of other alternatives available to them including Medical Assistance or bank loans.

GLOSSARY

TERM	DEFINITION
Catastrophic circumstances	A situation in which the self-pay portion of the FWMC medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 24 months or less.
Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash/Bank Accounts, Certificates of Deposit, bonds, stocks, Cash Value life insurance policies, pension benefits.
Living Expenses	Per person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Permanent Resident	Holder of a United States Permanent Resident Card, also known as a "green card," which is an identification process card attesting the permanent resident status of alien in the United States of America. The green card serves as proof that its holder, a Lawful Permanent Resident (LPR), has been officially granted immigration benefits, which include permission to conditionally reside and take employment in the USA. The holder must maintain his permanent resident status, and can be removed if certain conditions of such status are not met.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e. drugs, co-pays, deductibles and durable medical equipment.)
Qualified Medicare Beneficiary (QMB)	The QMB program is for persons with limited resources whose incomes are at or below the national poverty level. It covers the cost of the Medicare premiums, coinsurance and deductibles that Medicare beneficiaries normally pay out of their own pockets.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, social security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments; and, credit bureau reports.
Take Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service, after taxes and other deductions.

TRAINING

All staff will be informed of the Financial Assistance Plan and their specific responsibilities related to this plan.

Training will be provided at orientation, annual professional update and periodically as indicated.

ANNUAL EVALUATION:

FWMC Trends of Annual Percent of Financial Benefit
Update Poverty Table
Review of literature for national, state and local legislative review to maintain current compliance.

APPROVAL PROCESS/COMMITTEE FLOW:

Finance Committee
PI Council (for information)
President and CEO

REFERENCE (S):

January 24, 2007 Federal Register (2007 Poverty Level Guidelines)
Maryland legislation § 19-214.1
Maryland State Uniform Financial Assistance Application located at
[\[http://198.173.115.122/data_collection_tools/documents/uniformfinancialassistance.doc\]](http://198.173.115.122/data_collection_tools/documents/uniformfinancialassistance.doc)

ATTACHMENT(S):

Financial Assistance Program and Practices brochure
Letter of Conditional Approval
Letter of Determination
Financial Assistance Notice for lobby
2007 Poverty Level Guidelines (January 24, 2007 Federal Register)
Maryland State Uniform Financial Assistance Application
Maryland legislation § 19-214.1

DATE REVIEWED:	SIGNATURE:	DATE REVIEWED:	SIGNATURE:
APPROVED: Paul E. Porter, President and CEO		DATE ISSUED: 11/1998	DATE REVISED: 12/21/07

Maryland State Uniform Financial Assistance Application



Information About You

Name _____
 First Middle Last

Social Security Number _____ - ____ - ____ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

City State Zip code

Household members:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

Maryland State Uniform Financial Assistance Application



I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____	Approximate value _____
Automobile	Make _____ Year _____	Approximate value _____
Additional vehicle	Make _____ Year _____	Approximate value _____
Additional vehicle	Make _____ Year _____	Approximate value _____
Other property		Approximate value _____
Total		_____

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? Yes No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

 Applicant signature

 Date

 Relationship to Patient

**Please return this form to a Financial Counselor located in the Admitting Office.
 If you have any questions, please call: 301-203-2271 or 2154.**



Fort Washington Medical Center

11711 Livingston Road
Fort Washington, MD 20744

**FINAL LETTER OF DETERMINATION
FOR FINANCIAL ASSISTANCE**

Date:

Dear Sir or Madam:

We have reviewed your MARYLAND STATE UNIFORM FINANCIAL APPLICATION. Based on the information provided, our final decision is that you qualify for:

- Financial Assistance
 - Full
 - Partial
- Payment Plan
- No Financial Assistance

We thank you for your patience during this review process. If we can be of further assistance, please feel free to call the Insurance Verification Representative/Financial Counselor at 301-203-2271 or 2154 or myself at 301-203-5401.

Sincerely,

Betty Edwards
Director, Patient Accounts

**2007 POVERTY GUIDELINES
ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.
INCOME GUIDELINES AS PUBLISHED IN THE FEDERAL REGISTER ON JANUARY 24, 2007**

ANNUAL GUIDELINES	PERCENT OF POVERTY									
	100%	120%	133%	135%	150%	175%	185%	200%	250%	
FAMILY SIZE										
1	10,210.00	12,252.00	13,579.30	13,783.50	15,315.00	17,867.50	18,888.50	20,420.00	25,525.00	
2	13,690.00	16,428.00	18,207.70	18,481.50	20,535.00	23,957.50	25,326.50	27,380.00	34,225.00	
3	17,170.00	20,604.00	22,836.10	23,179.50	25,755.00	30,047.50	31,764.50	34,340.00	42,925.00	
4	20,650.00	24,780.00	27,464.50	27,877.50	30,975.00	36,137.50	38,202.50	41,300.00	51,625.00	
5	24,130.00	28,956.00	32,092.90	32,575.50	36,195.00	42,227.50	44,640.50	48,260.00	60,325.00	
6	27,610.00	33,132.00	36,721.30	37,273.50	41,415.00	48,317.50	51,078.50	55,220.00	69,025.00	
7	31,090.00	37,308.00	41,349.70	41,971.50	46,635.00	54,407.50	57,516.50	62,180.00	77,725.00	
8	34,570.00	41,484.00	45,978.10	46,669.50	51,855.00	60,497.50	63,954.50	69,140.00	86,425.00	

For family units of more than 8 members, add \$3,480 for each additional member.

MONTHLY GUIDELINES	PERCENT OF POVERTY									
	100%	120%	133%	135%	150%	175%	185%	200%	250%	
FAMILY SIZE										
1	850.83	1,021.00	1,131.61	1,148.63	1,276.25	1,488.96	1,574.04	1,701.67	2,127.08	
2	1,140.83	1,369.00	1,517.31	1,540.13	1,711.25	1,996.46	2,110.54	2,281.67	2,852.08	
3	1,430.83	1,717.00	1,903.01	1,931.63	2,146.25	2,503.96	2,647.04	2,861.67	3,577.08	
4	1,720.83	2,065.00	2,288.71	2,323.13	2,581.25	3,011.46	3,183.54	3,441.67	4,302.08	
5	2,010.83	2,413.00	2,674.41	2,714.63	3,016.25	3,518.96	3,720.04	4,021.67	5,027.08	
6	2,300.83	2,761.00	3,060.11	3,106.13	3,451.25	4,026.46	4,256.54	4,601.67	5,752.08	
7	2,590.83	3,109.00	3,445.81	3,497.63	3,886.25	4,533.96	4,793.04	5,181.67	6,477.08	
8	2,880.83	3,457.00	3,831.51	3,889.13	4,321.25	5,041.46	5,329.54	5,761.67	7,202.08	



Financial

Assistance

Program and Practices



FORT WASHINGTON MEDICAL CENTER
11711 LIVINGSTON ROAD
FORT WASHINGTON, MD 20744
Main Number: (301) 292-7000

For Financial Assistance: Visit the Insurance Verification Representative/Financial Counselor located in the Admitting Office or call 301-203-2271 or 2154.

If it is after hours, a holiday or a weekend, you can pick up/drop off an application at a Registration or Information desk. If you need additional assistance, please call and leave a message with a Financial Counselor and someone will return your call within three business days.
<http://www.fortwashington-hospital.com>

FINANCIAL ASSISTANCE PLAN

Fort Washington Medical Center (FWMC) follows a specific and compassionate policy for payment practices for financial assistance and uninsured billing. As a not-for-profit organization, one of the ways FWMC demonstrates its commitment to the community is through providing financial assistance to those in need. Our practices are an outgrowth of our mission and values.

FWMC'S RESPONSIBILITIES:

- FWMC will serve all patients regardless of ability to pay.
- Be respectful of the individual's personal dignity and his/her ability to pay.
- Treat all patients equitably, whether insured, underinsured or uninsured.
- Consider the financial resources of patients and their families when establishing a maximum annual patient responsibility.
- Be diligent in our efforts to keep patients notified of their payment options and the opportunities for assistance.
- Ensure that our policies are consistent with the guidelines that have been issued by the American Hospital Association, federal, state and local legislative bodies, and other organizations.
- Provide financial assistance to those in need.

PATIENT'S RESPONSIBILITIES:

- Follow through with the application process.
- Provide all required documents necessary in order to be granted financial assistance.

FWMC PROCEDURE SUMMARY:

1. An evaluation for financial assistance will be done when a:
 - a. Patient with a self-pay balance due notifies Patient Accounts that he/she cannot afford to pay the bill and requests assistance.
 - b. Patient presents at registration or a clinical area without insurance and states that he/she cannot afford to pay the medical expenses.
 - c. Physician or other clinician refers a patient for a financial assistance evaluation.
2. A Financial Counselor/Insurance Verification Representative will meet with the patient, upon request, to give them instructions on the Financial Assistance Application. If it is after hours, a holiday or a weekend, provide the patient with a copy of the Financial Assistance Program brochure and ask the patient to call 301-203-2271 or 2154 and someone will contact them within three business days.

3. A Letter of Conditional Approval for probable eligibility will be sent to the patient within three days of receipt of a completed application.
4. A Letter of Final Determination will be sent to the patient within 30 days to inform him/her eligibility for:
 - a. Financial Assistance (Full or partial) or
 - b. A Payment Plan (divided payments over two years).
5. During the application process, the patient must provide a copy of the following to the Financial Counselor:
 - a. Most recent Federal Income Tax Return.
 - b. Three most recent pay stubs (if employed).
 - c. Medical Assistance Notice of Determination (if applicable).
 - d. Proof of U.S. citizenship or permanent residence status
 - e. Proof of disability income (if applicable).
 - f. Reasonable proof of other declared expenses.
6. The following are necessary for a final determination:
 - a. The patient must apply for Medical Assistance unless the Financial Counselor can readily determine that the patient would fail to meet the disability requirement.
 - b. Review possibility of a reasonable payment plan agreement.
 - c. The patient must be a United States of America citizen or permanent resident.
 - d. All insurance benefits have been exhausted.
7. The completed Maryland State Uniform Financial Assistance Application and required forms will be forwarded from the Financial Counselor to the Director of Patient Accounts.
8. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses.
9. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to FWMC. If a patient does not make the required payment within 60 days, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.

EXCLUSION: FWMC has the option to designate certain elective procedures for which no financial assistance option will be given.

TERMS OF AGREEMENT TO FINANCIAL ASSISTANCE:

Financial Assistance will remain valid for three months based on the initial date of the determination letter. For recurring patients, patients may qualify for Financial Assistance for up to six months on the basis of a single application.

All determinations of eligibility are solely at the discretion of FWMC

Fort Washington Medical Center

Mission

Advance the health and wellness of individuals in the communities we serve by delivering the highest quality, and most compassionate and responsive health care services.

Vision

Be the health care system of choice in our community.

Core Values

Caring, Compassion, Dignity, Diversity, Excellence, Safety, Teamwork

Franklin Square Hospital Center
Community Benefits
FY08

Franklin Square Hospital Center, a 362-bed community teaching hospital located in the Rosedale section of Eastern Baltimore County, Maryland, is committed to providing the highest quality healthcare and education to our communities based on SPIRIT values: Service, Patient first, Integrity, Respect, Innovation, and Teamwork. FSHC services are provided via six service lines including Medicine, Surgical Services, Women's and Children's Services, Behavioral Health, Oncology, and Community Medicine and Wellness, as well as a wide range of sub-specialty services. Comprehensive oncology services, including CyberKnife, are provided locally at our Harry & Jeannette Weinberg Cancer Institute. Affordable health care is made available through the Primary Care Center and the Family Health Center, both of which work collaboratively with our Residency programs in Family Practice, Internal Medicine and OB/GYN. Clinical sites, faculty, and workforce development support professional education for a wide range of healthcare providers – nursing, technicians, and support services.

The Community Service line coordinates all of the community programs the Hospital provides to the surrounding area including, but not limited to, health education and screenings, child abuse prevention, smoking cessation programs, and wellness activities. The Community Health Education department coordinates community education and involvement including nearly 1,000 health and wellness events for more than 30,000 participants each year. These activities were taken into the community at businesses, schools, faith communities, community centers, after school programs, Senior Centers, shelters, civic organizations, educational centers, malls, retail centers, and health departments.

Demographics

Franklin Square Hospital Center's primary service area includes sixteen zip codes from eastern Baltimore City thru eastern Baltimore County and extending up to southern Harford County, adjacent to the Chesapeake Bay. This area has a large base population of approximately 537,000, and is projected to grow by 3.0% in the next five years, to about 553,000. The service area has become a much more diverse community over the past few decades. The area, particularly eastern Baltimore City and eastern Baltimore County, can be described as blue-collar, high-school educated, and economically depressed, with a diverse population consisting of Caucasians (72%), African-Americans (20%), Asian/Pacific Islanders (2.0%), Hispanics/Latinos (3.0%), and Others (2.0%). Thirty-seven percent of the population is either very young or senior with 24% children under eighteen years old and 13% over 65 years old.

Poverty is a significant problem in Eastern Baltimore County. Statistics show that the median household income in the Essex Middle River area of \$50,244 is much lower than the county average of \$61,976. The number of individuals who are uninsured or under insured in the hospital's catchment area is estimated to be 38% and growing. This is a direct result of the decline in manufacturing industries in the region, which are being reduced or declaring bankruptcy, e.g. General Motors Oldsmobile assembly plant and Bethlehem Steel Corporation, both of whom were previously major employers in the area. Currently, the largest employer in the area is the Hospital. The increasing number of families and individuals with either no health insurance or severely curbed health insurance represents a serious concern for the healthcare community and government agencies.

Franklin Square Hospital Center
Community Benefits
FY08

The vision of the Hospital is to be the trusted leader in caring for people and advancing health. With that vision in mind, the Hospital has taken the lead role in a number of community health initiatives:

East Baltimore Assessment Coalition

Franklin Square has led, and financially supported, the Southeast Area Network of providers in conducting a community needs assessment of the health and well-being in the southeastern portion of Baltimore County. The purpose of this project was threefold: (1) assess current health and well-being in the southeast area; (2) identify discrepancies in service needs and outcomes among area residents; and (3) devise a strategic plan for correcting these discrepancies. In April 2008, Franklin Square published the resulting action plan for developing coordinated and collaborative efforts and investing in economic and social resources in ways that improve the health and well-being for all of southeast Baltimore County's residents now and in the future.

Child Abuse Prevention Services

Franklin Square Hospital evaluates over 300 children who have been suspected of being abused each year. Children in Eastern Baltimore County are almost 50% more likely as children in the rest of the county to be abuse victims.

After reviewing cases of children who were injured and treated in the Emergency Department (ED), it appeared that many were not receiving complete evaluations and cases of child abuse were possibly being missed. Additionally, in a two-year period from 1998-2000, five children who were born at Franklin Square returned severely injured from Abusive Head Trauma (AHT).

In response to the increased incidence of abuse, the Department of Pediatrics developed a comprehensive approach to diagnose and prevent child abuse. The Franklin Square Hospital Child Protection Team (CPT) began to function in November 2000. The leaders of the CPT are a Social Worker Coordinator, the Medical Director, and on-call social work and medical staff. The team provides 24/7 coverage to the Hospital and evaluates any child who is suspected of being physically or sexually abused.

In 2002, a three-pronged prevention program began. The primary focus for the prevention of AHT includes educating all newborn parents about the dangers of shaking infants and giving them strategies to cope with a crying infant. Each parent of a newborn receives a brochure and signs a statement acknowledging the dangers of shaking infants. They are encouraged to watch a video on coping with a crying infant. The other two programs include parent education classes and daycare provider education classes that focus on discipline techniques without the use of violence. These programs are done in collaboration with local non-profit organizations (The Family Tree and Child Care Links).

Impact: The child abuse programs have served thousands of children and parents since its inception in 2000. The CPT has evaluated 2000 children; 35% of the cases were physical abuse evaluations, 32% of the cases sexual abuse, and 30% neglect. Of the cases reported to the Department of Social Services (DSS), 84% of them are accepted for investigation. As a comparison, DSS screens out 40% of countywide referrals. As a measure of the improved evaluative process in the ED, appropriate evaluations of infants with fractures are being done more than twice as often as it was prior to the formation of the CPT.

Franklin Square Hospital Center
Community Benefits
FY08

In the three years prior to the formation of the CPT, 27 infants under 12 months old came to the ED with a fracture, seven (26%) of the infants had a skeletal survey performed. In the four subsequent years with the CPT providing services and education to the ED 17/40 (43%) of the infants with fractures had a skeletal survey performed. More importantly, in infants under 6 months, the rate of skeletal surveys increased from 35% pre-CPT to 75% since formation (p=.02). For the parent classes, 475 parents in post-class surveys have answered favorably to the question "I have learned a new skill I will try at home."

We evaluate the AHT prevention program by monitoring the community for children who have become victims in collaboration with the local children's hospitals and DSS and the overall community rate appears to have fallen to 1 case/year (was 3-5/year prior). A more rigorous case-control study funded by the Centers for Disease Control evaluating the program is ongoing. Additionally, we have monitored the return rate of signed commitment statements. The rate has increased annually from 70% to 95%, showing a statistically significant difference. Our results were recently presented at the North American Conference on Shaken Baby Syndrome.

Community Blood Pressure Screening

Nearly one third of U.S. adults have high blood pressure. There are no symptoms, so many of these people are not aware they are hypertensive. Stroke, heart attack, heart failure or kidney failure may result from uncontrolled high blood pressure, the "silent killer." According to the current East Baltimore County Assessment, heart disease has been identified as a major cause of death for residents of Southeast Baltimore County. Cardiac and vascular problems accounted for over 15% of all principle diagnoses at Franklin Square Hospital in 2008.

For over 15 years, Franklin Square has partnered with various community sites to offer free blood pressure (BP) screenings. The goals of the screenings are to increase the participants' awareness of their individual BP level, the effects of uncontrolled hypertension, and available resources. White Marsh Mall, Eastpoint Mall, Target (Bel Air), and Rosedale American Turner Hall provide space with tables and chairs for Registered Nurses to take participants' BP and advise them of appropriate follow-up activity. Participants are also screened at various health fairs and wellness activities.

Impact: In FY 2008, over 2,000 people were screened at more than 100 events. At each event, an average of half of the participants are identified as hypertensive; a few are advised to take urgent action. For those who do take action, stroke, heart attack and renal failure may be prevented. In addition to avoiding the toll of human suffering, thousands of dollars in emergency and rehabilitative care may be saved.

Tobacco Use Prevention

Adult and youth tobacco use rates are high in Maryland and in the Franklin Square area, contributing to significant morbidity and mortality. In 1997, Franklin Square began offering community tobacco prevention programs. In 2000, Franklin Square began a multifaceted approach to tobacco prevention based on community data. The targeted populations include elementary, middle, and high school children as well as adults. Intervention programs tailored to the audience's educational level occur at health fairs and presentations. The programs utilized include: the Tobacco Truth Tour, Tobacco Choices (brief tobacco intervention for youth), the American Cancer Society's (ACS) Smokefree Teens (tobacco cessation for youth) which transitioned to the American Lung Association's (ALAM) Not On Tobacco program (tobacco

Franklin Square Hospital Center
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cessation for teens), and Stop Smoking Today (adult smoking cessation). Additionally, we provide Hospital staff training in tobacco cessation counseling.

Franklin Square went Tobacco-Free as of July 1, 2008. In preparation, informational and cessation classes were offered to all employees throughout the Spring of 2008.

Impact: Tobacco education programs, sponsored by Franklin Square, directly influenced over 2,200 participants in various stages of use in area businesses, shelters, support centers, churches, senior centers, schools and community organizations. Primary prevention efforts (health fairs, presentations to prevent tobacco usage) include Tobacco Truth Tours that brings small groups of youth into the hospital to view the direct effects of tobacco use (lab, x-ray, and patients). Ninety-five percent of these "Tourists" said they learned new information about tobacco effects. Secondary prevention included interventions at health fairs, events attended by smokers and cessation programs tailored to be population-sensitive.

Franklin Square utilizes visuals and handouts from American Cancer Society (ACS) and American Lung Association of Maryland (ALAM) with our Wellness Wheel that addresses tobacco questions to increase knowledge deficits in youth and adults. Presentations are targeted to the specific age, culture and needs of the participants with audiovisuals from ACS, ALAM and some independent companies.

Fifty-four percent of all youth found smoking on school property who participated in Tobacco Choices, an after-school tobacco intervention program stated that they learned something new about tobacco use. All (100%) the teens in the ALAM Not On Tobacco (NOT) programs found the program helpful in quitting smoking.

The adult cessation program, Stop Smoking Today, is a five session series that combines deep relaxation with guided imagery and traditional behavioral modification. These classes reached 100 adult participants of diverse backgrounds and medical issues including pregnancy at local sites (a long-term homeless men's shelter, Nehemiah House, a large retirement complex, Oakcrest Village, and Chase Elementary School) with a last class quit rate of 49% for 2005-6 year. Ongoing quit rates one-month post classes are 28%. Because of the high quality and comprehensive program approach, the American Lung Association of Maryland, the American Cancer Society and the Baltimore County Department of Health recognize Franklin Square as an expert and leader for tobacco issues in the area.

Partnerships with the Southeast Community Network, the Baltimore County Tobacco Coalition, the American Lung Association of Maryland, the American Cancer Society and the American Heart Association have established a "Best Practice" of working with the community.

Healthcare for the Homeless – Baltimore County

Franklin Square, in partnership with Baltimore County and Healthcare for the Homeless in Baltimore City, established a new access point for primary care for people experiencing homelessness in Baltimore County.

In recent years, Baltimore County has identified 7,000 homeless people; 71 percent of them were women and children and 45 percent reported having no health insurance. Chronic issues that are difficult to treat when homeless include mental and addictive disorders, hypertension, diabetes

**Franklin Square Hospital Center
Community Benefits
FY08**

and HIV/AIDS. In addition, people experiencing homelessness are at an increased risk for cardiovascular problems, leg ulcers, upper respiratory infections and frostbite.

Impact: Over 400 people have benefited from over 1,500 primary care visits at Healthcare for the Homeless – Baltimore County (HCHBC) since its opening in November 2007. Fifty-five percent of those served are temporarily housed in the East Side Family Shelter located in the same building as the clinic. Approximately 18% of HCHBC clients are children. This new partnership establishes a medical home for vulnerable county residents and provides the preventive health care services people need before their health issues escalate into an emergency.

Major HSCRC Category	# Served	Net Benefit
Community Health Improvement Services	294,177	1,498,102
Health Professions Education	1,111	12,382,787
Subsidized Health Services	0	5,480,729
Research	0	21,054
Financial and In-kind Contributions	150	762,208
Community Building Activities	746	179,119
Community Benefit Operations	0	251,473
Traditional Charity Care	0	10,068,600
Total	296,184	30,644,072

Appendix 1

MedStar Health FY 2008 Community Benefit Report Specialist Gaps

The HSCRC has requested that hospitals document gaps/shortages in our communities with regard to specialists. Gaps exist in the availability of both primary care and specialist providers to serve the uninsured in the hospital.

Diminishing the gaps in specialty services for all patients (uninsured and insured) is very important to MedStar. By operating as a system, which includes Franklin Square Hospital Center, Good Samaritan Hospital, Harbor Hospital, Montgomery General Hospital¹, Union Memorial Hospital, Georgetown University Hospital, National Rehabilitation Hospital, and Washington Hospital Center, our goal is to ensure all sites access to MedStar's entire medical staff, including specialty resources when required. Our sites utilize current and planned office space on their campuses to encourage physicians to treat and follow-up with patients in close proximity to the hospital. Our current and planned Emergency Department improvements allow for state of the art treatment of more patients with enhanced care.

Per physician leadership and case management staff, there remain several areas of concern in our communities:

- a) Limited availability of inpatient and outpatient psychiatry services, including substance abuse
- b) Medication assistance for patients
- c) Transportation assistance
- d) Limited durable medical equipment providers
- e) Limited skilled nursing services in the home and/or at rehab facilities
- f) Limited availability of hospice care
- g) Limited health care services for the homeless and undocumented residents

¹ Note: Since joining MedStar in February of 2008, the affiliation has already significantly increased Montgomery General Hospital's specialty resources for neurosurgeons, orthopedic, including rehabilitative services.

Appendix 2

MedStar Health Financial Assistance Policy HSCRC Community Benefit Response

MedStar Health provides financial assistance to the uninsured patients based on income and family size starting at 100% up to 200% of the federal poverty level and a sliding scale for those between 201-400% of the federal poverty levels. Patients must reside in our defined primary and secondary service areas but exceptions can be made for patients treated in one of our specialty services as well as any extenuating circumstances. In addition, patients have the responsibility to comply with our requirements in completing a Medicaid application if deemed eligible through our financial screening and must provide all necessary information for final determination. MedStar Health's facilities will assist uninsured patients who reside within the community to enroll in publicly-funded entitlement programs, publicly funded programs for the uninsured, assist with consideration of funding available from other charitable organizations or offer periodic payment plans to assist patients with financing their healthcare services.

All self pay patients that are either scheduled admissions or ambulatory surgeries receive a thorough financial screening from our on site advocates including Medicaid eligibility or any other federal or state funded program. In addition, they are screened for financial assistance. Emergency admissions are also screened in this manner after the admission occurs. Other outpatients may receive screening afterward their services if they fall into defined criteria for potential MCHIP program. In addition, outpatients may be screened if they identify the inability to pay or the desire to apply for either Medicaid or financial assistance.

Appendix 2

Signs are posted in all registration areas in both English and Spanish. There are patient advocates located on sight during normal business hours to assist patients at the facilities in their application process. In addition, each hospital funds a portion of the State case workers' salary to have that individual available on-sight to work in conjunction with the patient advocate staff and patients to complete the application process. Any patient that completes the application process will be given a list of items that they must provide in order to complete the eligibility process before or at time of discharge. Additional outreach services are provided after discharge and agencies are used for those patients that are less corporative or that need assistance in securing documents or transportation for application completion. These agencies also assist in the appeal process for both Medicaid and Social Security Disability denials.

Each facility provides brochures and or admission packets advising them of the financial assistance policy and where they can inquiry for further information. Applications will be provided at time of registration if the patient makes a request. Our statements provide a number (local and toll free) for patients to contact.

Upon receipt of eligibility determination, the financial services department will either process the claim for billing and reimbursement to the appropriate federal or state program identified and or process the financial assistance application. A final determination letter will be sent to the patient from both the program for which he applied as well as the financial services department at MedStar regarding their financial assistance disposition.

Appendix 2

Lastly, an automated file is run on a weekly basis to validate Medicaid eligibility on any self-pay patients that the patient has been uncooperative and we have been unsuccessful in completing the application for Medicaid on their behalf in the event that they have done so and failed to notify us.

Appendix 3

MedStar Health

Financial Assistance for Uninsured Patients Policy Statement

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

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

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

- Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
- Assist with enrollment in publicly-funded programs for the uninsured (e.g., D.C. Healthcare Alliance).
- Assist with consideration of funding that may be available from other charitable organizations.

¹ This policy does not apply to insured patients who may be "underinsured" (e.g., patients with high-deductibles and/or coinsurance). This policy also does not apply to patients seeking non-medically-necessary services (including cosmetic surgery).

Appendix 3

- Provide charity care and financial assistance according to applicable guidelines.
- Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
- Offer periodic payment plans to assist patients with financing their healthcare services.

Each MedStar Health facility (in cooperation and consultation with the finance division of MedStar Health) will specify the communities it serves based on the geographic areas it has served historically for the purpose of implementing this policy. Each facility will post the policy, including a description of the applicable communities it serves, in each major patient registration area and in any other areas required by applicable regulations, will communicate the information to patients as required by this policy and applicable regulations and will make a copy of the policy available to all patients.

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

- Completing financial disclosure forms necessary to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.
- Working with the facility's financial counselors and other financial services staff to ensure there is a complete understanding of the patient's financial situation and constraints.
- Completing appropriate applications for publicly-funded healthcare programs. This responsibility includes responding in a timely fashion to requests for documentation to support eligibility.

Appendix 3

- Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.
- Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

Charity Care and Sliding-Scale Financial Assistance

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

The determination of eligibility will be made as follows:

1. Based on family income and family size, the percentage of the then-current federal poverty level for the patient will be calculated. If this percentage exceeds 400%, the patient will not be eligible for charity care or sliding-scale financial assistance unless determined eligible in step 3. If the percentage is less than or equal to 400%, the patient is provisionally eligible, subject to the financial resources test in step 2.
2. The patient's financial resources will be evaluated by calculating a pro forma net worth for the patient and her family, excluding (a) funds invested in qualified pension and retirement plans and (b) the first \$100,000 in equity in the patient's principle residence.² The pro forma net worth will include a deduction for the anticipated medical expenses to be incurred during the twelve months commencing on the date of the patient's admission to the facility. If the pro forma net worth is less than \$100,000, the patient is eligible for

² Net worth calculations will incorporate the inclusions and exclusions used for Medicaid. Anticipated recoveries from third parties related to a patient's medical condition (*i.e.* recovery from a motor vehicle accident that caused the injuries) may be taken into account in applying this policy.

Appendix 3

charity care or sliding-scale financial assistance; if the pro forma net worth is \$100,000 or more, the patient will not be eligible for such assistance.

3. For patients whose family income exceeds 400% of the federal poverty level, adjusted family income will be calculated by deducting the amount of medical expenses for the subject episode of care anticipated to be paid during the ensuing twelve month period. This calculation will consider any periodic payment plan to be extended to the patient. Based on this adjusted family income, the adjusted percentage of the then-current federal poverty level for the patient will be calculated. If this percentage exceeds 400%, the patient will not be eligible for charity care or sliding-scale financial assistance. Periodic payment plans may be extended to these patients.

For patients who are determined to be eligible for charity care or sliding-scale financial assistance, the following will be applicable based on the patient’s percentage of the federal poverty level (or adjusted percentage, if applicable):

Adjusted Percentage of Poverty Level	Financial Assistance Level	
	HSCRC-Regulated Services³	Washington Facilities and non-HSCRC Regulated Services
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

³ The assistance levels described above for HSCRC-regulated services do not include any discounts that may be applicable under the HSCRC’s prompt payment regulations.

Appendix 3

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

Appendix 4a

MedStar Health FY 2008 Community Benefit Report Vision, Mission, & Values

MedStar Health has adopted a vision and mission, along with the six values shown below. All MedStar hospitals, including the five hospitals in Maryland (Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, Montgomery General Hospital, and Union Memorial Hospital) share the same MedStar Health Vision and Values. See Appendix 4b for each hospital mission statement.

Mission:

To serve our patients, those who care for them, and our communities

Vision:

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

SPIRIT Values:

S = SERVICE

P = PATIENT FIRST

I = INTEGRITY

R = RESPECT

I = INNOVATION

T = TEAMWORK

Appendix 4b

MedStar Health FY 2008 Community Benefit Report Hospital Mission Statements

Hospital Mission Statements Include:

Franklin Square Hospital:

Franklin Square Hospital Center, a member of MedStar Health, provides the highest quality healthcare and education to our communities.

Good Samaritan Hospital:

We are Good Samaritans, guided by Catholic tradition and trusted to deliver ideal healthcare experiences.

Harbor Hospital:

Harbor Hospital is committed to quality, caring and service for our patients and our communities.

Montgomery General Hospital:

Montgomery General Hospital, a member of MedStar Health, is dedicated to enhancing our community's health & well-being by offering high-quality, compassionate, and personalized care.

Union Memorial Hospital:

Union Memorial Hospital is a comprehensive hospital with regional specialty services of distinction and quality community services, all enhanced by clinical education and research.

**MedStar Health
FY 2008 Community Benefit Report
Subsidy Justification**

The Catholic Health Association guidelines for Community Benefit Reporting allow inclusion of losses for services defined as subsidized care, broadly defined as services that are “needed in the community and other providers are unwilling to provide the services, or the services would otherwise not be available to meet patient demand.” In most cases, these subsidies directly relate services for uninsured or underinsured patients.

The HSCRC has addressed the treatment of these services, requiring that hospitals clearly explain all subsidies included within Category C of their Community Benefit Report.

Category 1 Subsidies:

Hospital-based physicians with whom the hospital has an exclusive contract and/or subsidy IN ORDER TO RETAIN SERVICES THAT REPRESENT A COMMUNITY BENEFIT

- a) Primary Care Subsidies, including Diabetes – These are clinic-based physician practices that provide primary health care services. Most of the patients are from the local community and are low-income families. This service generates a negative margin; however, the practice addresses a community need and supports the hospital’s mission of commitment to patients, communities, physicians and employees. Providing this service allows the local community access to health care services, and therefore more preventive measures and an improvement of the patients’ health status are achieved.
- b) OB and Pediatric Subsidies, including Breast Surgery – These represent physician practices providing health care services for obstetrics, gynecology, and pediatrics where a negative margin is generated. A large number of our patients receiving these services are from minority and low-income families. Prenatal care is provided and OB/GYN and pediatric coverage is provided 24 hours/day. Preventive measures and improvement of the patient’s health status are achieved. The services address a community need for women’s health and children’s services for lower income and minority families.
- c) Radiology Subsidies - For certain sites, payment is made to radiologists to provide services on a 24-hour basis generating a negative margin. These specialists are difficult to recruit due to extreme shortage and nature of the services and the 24-hour availability commitment. The community needs for these services are being met. Our community includes many low- income and minority families.
- d) Surgical House Subsidies - For certain sites with a higher percentage of indigent patients, private physicians often are not willing to provide 24 hour on-call

service. The hospital absorbs these costs and has a negative margin. The community's needs are met.

- e) **Psychiatric/Behavioral Health Subsidies** - The overall cost of 24/7 Psychiatry physician coverage is disproportionate to the total collections from the patients seen by these physicians during off hours. Many of these patients are uninsured. Our hospital absorbs the cost of providing psychiatric supervision for the Emergency Department on a 24/7 basis. If these services were not provided, the patient would be transported to another facility to receive these services. The community needs are being met and commitment to patients is exhibited by providing these services.

Category 2 Subsidies:

Non-Resident house staff and hospitalists

- a) **Hospitalist Subsidies** - Payments are made to an inpatient specialist group to provide 24/7 services in the hospital; resulting in a negative profit margin. The service focuses on preventive health measures and health status improvement for the community.
- b) **ENT Subsidies** - Payments are made for a non- resident ENT fellowship to provide 24/7 services in the hospital; resulting in a negative profit margin. The service focuses on preventive health measures and health status improvement for the community.

Category 3 Subsidies:

Coverage of Emergency Department call

- a) **ER Subsidies** - These include the cost of providing on-call specialists for the Emergency Department for certain surgical specialties. These specialists otherwise would not provide the services because of the low volumes and a large number of indigent patients served. If these services were not provided, the patient would be transported to another facility to receive the specialty services. The community needs are being met and commitment to patients is exhibited by providing these services.

Category 4 Subsidies:

Physician provision of financial assistance to encourage alignment with hospital financial assistance policies

No subsidies reported.

Category 5 Subsidies:

Recruitment of physicians to meet community need as shown by a hospital's medical staff development plan

- a) Anesthesiology Subsidies - This subsidy relates to payments made to anesthesiologists to provide services generating a negative margin. These specialists are difficult to recruit due to extreme shortage and nature of the services and the 24-hour availability commitment. The community needs for health services are being met.

Other Subsidies:

Non-Physician Subsidies

- a) Adult Day Care Subsidies - Adult Day Care services are provided at a negative margin. The community has a need for patient care related to the elderly and disabled. The needs of the participants' family are met. Family members can feel confident that their relatives are being cared for when they cannot be there. Again, a majority of people receiving this service come from low income and minority families.
- b) Cardiac Rehabilitation - One of our sites subsidizes cardiac rehabilitation services to the community.
- c) Community HIV Services Support Subsidies – HIV clinic services are provided at a negative margin. These services include nurse care management, social work, and medical services and help over 200 people who are mostly indigent.
- d) Child Development Center Subsidies - Good Samaritan's Child Development Center opened in 1990 to serve a large number of employee parents by caring for their children ages two to four. The Center also serves parents in the community by providing an environment that is supportive, consistent, and attentive to their needs. Services are provided at a negative margin.
- e) Renal dialysis Program - Good Samaritan Hospital operates the largest not-for-profit dialysis center in the Baltimore area. The Program offers a complete range of renal dialysis services. A social worker is assigned to each patient to address issues such as education, transportation and support. The Program includes a monthly class where, patients and their families can learn more about hemodialysis, peritoneal dialysis and transplantation. These Program services are provided at a negative margin.
- f) Low Income Housing - Sponsored and managed by Good Samaritan Hospital, the facilities of Belvedere Green and Woodbourne Woods provide rent-subsidized apartments and many other features for its residents. Services provided include transportation to doctors' offices, social work consultation, and assistance with healthcare needs, including educational programs, health screenings, and medication schedules. These senior living services operate at a negative margin.

- g) Pharmacy Care Counseling – For patients concerned about their ability to afford their medication, Good Samaritan Hospital provides an advocate who helps them apply for and manage the many programs that provide medication patient assistance.

- h) Subacute Program - Transitional care, sometimes called sub-acute or extended care, is designed for patients who are too sick to go home, but not sick enough to remain in a traditional hospital bed. Patients benefit from the transitional care setting because it provides them with the care and education they need while preparing them to return to their previous living situations. Many times, Rehabilitation services are provided to maximize each patient's level of function and assist patients and their families to cope with the physical limitations secondary to illness or injury. These services are provided at a negative margin.

**Frederick Memorial Hospital
HSCRC – Community Benefit Report
Gaps in the Availability of Specialists to Care for the Uninsured
FY 2008**

Frederick Memorial Hospital is challenged, along with all other Maryland hospitals, to provide care to the uninsured patient. As part of Frederick Memorial's mission to provide services to all patients regardless of their ability to pay, the hospital provided \$4,919,600 in charity care services to patients in fiscal year 2008.

A large number of the patients that fall into this category are seen through the Emergency Department, discharged or admitted to an inpatient floor.

Frederick Memorial Hospital has initiated programs to provide specialists care for both the uninsured and insured patients within our facility. The hospital contracts with over 100 physician specialists to provide ED coverage 24 hours, 7 days a week. Specialists include, cardiologists, orthopedics, GI, neurology, pulmonary, ENT, urology, hematology, vascular and thoracic. The total cost of this program for 2008 was \$1.2 million dollars.

Other programs include an in-house Hospitalist program, where care is provided for inpatients by physicians trained in the care of hospitalized patients. Total costs of this program for 2008 were \$1.8 million dollars. Coverage is also provided by Intensivist and Interventional Cardiology services at a yearly cost of \$900 thousand dollars. Obstetric and Anesthesia coverage is also provided with coverage on a 24 hour, seven day week coverage at a combined cost of \$2.0 million dollars.

Frederick Memorial Hospital has strived to bridge the gap of availability of Specialists care by providing a full range of specialists care coverage for both the inpatient and Emergency Department sector ranging from numerous specialists in the ED, inpatient care coverage, Obstetrical and Anesthesia coverage on a 24 hour, seven day week coverage. The total costs of these programs for 2008 totaled \$5.9 million dollars.

Frederick Memorial Hospital
HSCRC-Community Benefits Report
Charity Care Policy Summary
FY 2008

It is the policy of FMH to publish the availability of the hospital's Financial Assistance on a yearly basis in the local newspaper and will post availability at appropriate intake locations. Notice of availability will also be included as part of the admission packet and be sent to patients on patient bills. Financial Assistance may be extended when a review of patient's individual financial circumstances has been conducted and documented.

TITLE: FINANCIAL ASSISTANCE POLICY

Chapter: FINANCE

Effective Date: 07/01/2008

Responsible Person: Director, Patient Financial Services

Reviewed Date:

Revised Date:

PURPOSE:

It is the policy of Frederick Memorial Hospital to provide Financial Assistance based on indigence or high medical expenses for patients living in the hospital's community who meet specified financial criteria and request such assistance.

POLICY:

FMH will publish the availability of Financial Assistance on a yearly basis in the local newspaper and will post notices of availability at appropriate intake locations. Notice of availability will also be included as part of the admission packet and be sent to patients on patient bills. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing (including any accounts having gone to bad debt within 3 months of application date) and any projected medical expenses.

PROCEDURE:

1.0 PROCEDURES AND RESPONSIBILITIES:

1.1 The following criteria must be met in order for a review for a final determination for a Financial Assistance adjustment:

1.2 The patient must apply for Medical Assistance unless it can be readily determined that the patient would fail to meet the disability requirement. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.

1.3 The viability of a payment plan agreement has been reviewed with the patient.

1.4 All insurance benefits have been exhausted.

2.0 Financial eligibility criteria will be based on gross family income of the patient and/or responsible guarantor. Exception allowance will be deducted for each person living on the gross family income. Annual income criteria used will be 200% of the most current poverty guidelines published yearly in the Federal Register.

3.0 Write offs of accounts meeting the criteria will be noted as financial assistance.

4.0 Some persons may exceed established income levels but still qualify for Financial Assistance when additional factors are considered. These will be reviewed case by case.

5.0 Other financial information such as assets and liabilities will be considered under this policy.

TITLE: FINANCIAL ASSISTANCE POLICY

Chapter: FINANCE

Effective Date: 07/01/2008

Responsible Person: Director, Patient Financial Services

Reviewed Date:

Revised Date:

6.0 Gross incomes refers to money wages and salaries from all sources before deductions. Income also refers to social security payments, veteran's benefits, pension plans, unemployment and worker's compensation, trust payments, alimony, public assistance, union funds, income from rent, interest and dividends or other regular support from any person living the in the home or outside of the home. Also, included as regular income is 100% of all liquid or near liquid assets (i.e. certificates of deposit, stocks, money market funds, etc.).

7.0 Assets refer to real and chattel property. These may be evaluated for inclusion as regular income.

8.0 All other resources will first be applied including Medicaid Medical Assistance, before the Financial Assistance adjustment will be given. The individual must apply for available medical assistance funds as appropriate in each individual case.

9.0 DOCUMENTATION

9.1 Patients requesting Financial Assistance may apply prior to treatment by contacting a Patient Financial Services Representative for a Maryland State Uniform Financial Assistance Application.

9.2 Probable determination for Financial Assistance will be completed within two (2) business days.

9.3 Financial Assistance financial applications will also be considered for accounts final billed and aged in accounts receivable.

9.4 Requests for Financial Assistance will not be considered for patients who are in the bad debt collections process and did not respond to collection activity or statements prior to referral of an account to an outside collection agency.

10.0 QUALITY ASSESSMENT:

10.1 A financial application form will be requested by a Patient Financial Services representative from the patient or responsible party listing all available assets and expenses. All applications and attachments will be forwarded to the Financial Counseling Unit of the Patient Financial Services Department for review

10.2 During the application process, one or more of the following specific documents must be submitted to gain sufficient information to verify income for each employed family member:

a. Copy of payroll stub to include year to date wages.

b. Letter from employer verifying gross income.

c. Letter from federal or state agency indicating the amount of assistance received.

TITLE: FINANCIAL ASSISTANCE POLICY

Chapter: FINANCE

Effective Date: 07/01/2008

Responsible Person: Director, Patient Financial Services

Reviewed Date:

Revised Date:

- d. Copy of most recently filed federal income tax return.
- e. Proof of other income for all persons living in the family.

10.3 An approval or denial letter will be sent directly to the patient or responsible guarantor to inform of the final disposition of the request for Financial Assistance.

10.4 If request is denied, a payment arrangement will be obtained on any balances due by the patient or the guarantor by a Patient Financial Services Representative.

DEFINITIONS:

- 1.1 Financial Assistance is determined by using the U.S. Department of Health and Human Services, U.S. Federal Poverty Measure and adding 200% to the poverty guidelines.
- 1.2 The Poverty Guidelines are issued each year in the Federal Register by the department of Health and Human Services (HHS). The guidelines are a simplification of the Poverty thresholds for use for administrative purposes.
- 1.3 The Poverty Guidelines are available on line at: <http://aspe.hhs.gov/poverty/index.shtml>
- 1.4 Poverty guidelines are updated each year by the Census Bureau whereby thresholds are used mainly for statistical purposes and weighted for the average poverty thresholds determination.
- 1.5 Eligible care covered under this program is all necessary medical care provided.

VISION

SUPERB QUALITY. SUPERB SERVICE.

All the time.

MISSION

The mission of Frederick Memorial Healthcare System is to contribute to the health and well-being of area residents by providing quality healthcare in a caring, cost efficient, safe and convenient manner through a coordinated program of prevention, diagnosis and treatment, rehabilitation, and support.

VALUES

We believe in.

Quality • Responsibility • Stewardship • Respect & Dignity
Empowerment • Honesty & Integrity • Collaboration & Teamwork



FREDERICK MEMORIAL HEALTHCARE SYSTEM

Garrett County Memorial Hospital
Community Benefits Reporting
Fiscal Year 2008
Evaluation Framework

Garrett County Memorial Hospital is a rural facility nestled in the mountains of Western Maryland. We pride ourselves in being a non-profit hospital whose mission is “To promote the health of our regional community and to provide safe, high-quality care and health services to our patients.” The activities stated in our Fiscal Year 2008 Community Benefits Report illustrate our commitment to the general public of Garrett County and the mission of this hospital.

In Fiscal Year 2006, Community Benefits was officially incorporated into the Strategic Plan with the addition of a strategic initiative to develop a Community Benefits Action Plan. The goal of this initiative is to identify the community’s health care needs. The last community needs assessment was completed by the Garrett County Health Department (GCHD) in 1993. Therefore, the hospital, as a member of the Garrett County Health Planning Council, in conjunction with the GCHD, decided to initiate the Mobilizing for Action through Planning and Partnerships (MAPP) program. MAPP is a community-wide strategic planning tool for improving community health. Facilitated by public health leadership, this tool helps communities prioritize public health issues and identify resources for addressing them.

MAPP is a community-driven initiative that brings community members and public health leaders together for the benefit of the community as a whole. Seeing the value of this initiative, the hospital has enlisted several members of our staff to be involved in the MAPP process. They include two wellness coordinators, the director of public relations, the education coordinator, the director of social services, the vice president of clinical services, and the chief executive officer. Broad community participation is essential because a wide range of organizations and individuals contribute to the public’s health. Additional organizations involved in the MAPP process include the Garrett County Board of Education, Community Action, the Federally Qualified Health Center (FQHC), Social Services, Gosnell Construction, Inc., First United Bank & Trust, Wellspring Family Medicine, Cornerstone Family Medicine, Partnership for Children, Youth and Families, and the Emergency Management Services, as well as many other public and private individuals.

The first MAPP meeting was held in August 2006. The goal of the MAPP process was to identify public health issues and solutions for addressing them. Residents of Garrett County were asked to complete a three-page Community Health Survey consisting of ninety-seven items during the winter of 2007. The survey respondents consisted of a “convenience sample” recruited from friends, family, and coworkers known to various MAPP committee members. The 1,324 completed surveys represent about 5% of the adult population of the county. Over ninety percent of respondents stated access to healthcare (family doctor, hospital, etc.) as well as healthy behaviors and lifestyles to be very important factors in a healthy community. However, ten percent of the respondents felt Garrett County was doing very poorly in these areas. The MAPP committee used the survey results to plan their next course of action.

The assessment and strategic planning phases were completed in November 2007 and the completed MAPP process was presented June 2008. Based on their findings, four action-goals were identified:

- Strengthen and support those components of our public health system that are fragile because of funding, workforce capacity, demographic shifts, etc.
- Empower, educate, and motivate Garrett County residents to lead a healthy lifestyle and prevent harmful behaviors such as substance abuse and domestic violence.
- Achieve and maintain optimal health and independence for vulnerable populations.
- Ensure healthy living and working conditions for Garrett County residents by protecting and increasing our natural and built resources as our population grows.

As part of its Community Based Initiatives, Garrett County Memorial Hospital proudly anticipates playing a role in the opening of a Comprehensive Care Center in the community. The possible services to be provided at the center include wound care, infusion therapy and cardiac rehab. Currently, some of these services are not offered in the area and residents of the county need to travel to receive the necessary care based on their medical condition. The expected opening date for the center is February 2009.

Another example of the hospital's community benefit initiatives reflecting evidence-based needs is the Community Blood Screening Program, which is offered once a year, to benefit those individuals who are uninsured or underinsured. The program offers a comprehensive series of blood tests to the participant at a substantially lower cost than a laboratory's rates. In May 2008, participants were asked to answer a survey regarding the program. Of the 479 participants in the program, 89 completed the survey and returned it to the hospital. Of the respondents, forty-seven percent were not covered by health insurance at the time of the screening. Of the respondents with health insurance, forty-seven percent had a deductible of \$100.00 or more. These statistics show the blood screening service is used by individuals that are uninsured or underinsured. Of the participants, fifty-eight percent received at least one abnormal lab result. Thirty-one percent required physician follow-up. Seventeen percent had a new condition or diagnosis identified. Due to the results of the testing, forty-seven percent of the participants reported they made a lifestyle change.

In addition to the Community Blood Screening Program, GCMH continues to bring screening services to the work place. First United National Bank & Trust, Garrett College, Mettiki Coal and Garrett County Board of Education are some of the companies that have contracted with the Wellness department of Garrett County Memorial Hospital to provide blood screening services for all of its employees. This is the purpose of all community benefit activities. We want to improve our community's health one person at a time.

To insure the progress of community benefit initiatives, the bi-monthly Strategic Planning Committee has listed Community Benefits as a standing agenda item. In addition, the management of the hospital is informed on a routine basis of Community Benefit activities. Both the Accounting and Wellness departments will be responsible for monitoring how the hospital's activities fulfill the goals identified in the plan through regular progress reporting. At this time, programs are enhanced, revised, discontinued or repeated based on levels of interest, participation and outcomes. The community is kept informed of activities provided by the hospital through press releases and promotional efforts.

With the MAPP process completed and their strategic plan identified, Garrett County Memorial Hospital and all Garrett County organizations promise to work together to improve the overall health of Garrett County residents. We look forward to many positive results.

Garrett County Memorial Hospital
Fiscal Year 2008
Community Benefit Report
Written Description of Gaps in the Availability of Specialist Providers to Serve the
Uninsured in the Hospital

Garrett County Memorial Hospital (GCMH) is a small acute care hospital located in Garrett County, Maryland. The county has been designated a federal medically underserved area. In addition, the county has a “low income” designation as a Health Professional Shortage Area (HPSA) for primary care as well as a HPSA designation for dental and mental health. Approximately 18% of the population has no form of health care coverage. In the past, most underinsured residents of the area came to the Emergency Room at GCMH for treatment of minor illnesses since we provide care regardless of ability to pay. Recently, GCMH along with the local health department actively pursued the construction and development of a Federally Qualified Health Center (FQHC) in Garrett County. This facility provides primary care to low income individuals in Garrett County regardless of their ability to pay. The facility opened for business in October 2006.


The Independent Dialysis Center which opened November 2006 in the Oakland area continues to provide dialysis services to the residents of Garrett County. In the past, GCMH could not accept patients receiving dialysis treatment. These patients were transferred to another facility. Now, the dialysis center will also provide dialysis to inpatients of GCMH regardless of their ability to pay.

GCMH does not employ any physicians for specialty care. All patients requiring Neurology, Pulmonology, and Cardiology as well as major trauma patients are transferred to another facility. Although we are able to provide basic care, we do not have physicians to provide these specialty services.

Garrett County Memorial Hospital
Fiscal Year 2008
Community Benefit Report
Charity Care Guidelines

Garrett County Memorial Hospital informs patients about the Charity Care policy through several methods. Signs are posted in all registration areas and in the reception area of Patient Financial Services. A Patient Handbook is distributed to patients and the Charity Care program is explained in the book.

The hospital's website and an occasional ad in the local newspaper inform residents of the financial assistance available. In addition to screening self-pay accounts for financial assistance, monthly self-pay statements include a pre-printed notification of the Caring Program.

	Department: Patient Financial Services	Policy Title: Caring Program (Financial Assistance)	
	Original Date: 09/01/01	Policy Number: 8520.000	Page Number: 1 of 6
	Effective Date: 09/01/01; 05/01/06	Reviewed/Revised Dates: 06/03/03; 04/01/06	
Approval Signature & Title: Katherine Rhoden, Director Patient Financial Services Date: 04/03/06	Approval Signature & Title: Gregory J. Was, CFO, VP Finance Date: 04/03/06	Approval Signature & Title: 	

Policy Statement:

The "Caring Program" enables Garrett County Memorial Hospital (GCMH) to offer financial assistance for healthcare services rendered to underprivileged, underemployed, and/or underinsured patients who have difficulty providing themselves with life's necessities, i.e., food, clothing, shelter, and healthcare. In an effort to assist those in need and to further the hospital's charitable mission, GCMH has established a financial assistance program to allow the write-off of unpaid account balances upon determination of the "Caring Program" eligibility. Individuals with a demonstrated inability to pay rather than unwillingness to pay are eligible to apply for the financial assistance program at GCMH.

Objective:

The qualifying criteria are minimal and broad so GCMH can exercise maximum flexibility to offer financial assistance to individuals with special personal circumstances who otherwise would not qualify for the program. GCMH retains the right to use its discretionary judgement in making final decisions regarding eligibility to the "Caring Program." Eligibility to the "Caring Program" represents "free" healthcare and as such, is included as part of the hospital's charitable mission.

Guidelines:

- A. GCMH will grant financial assistance for medically necessary services that are urgent, emergency, or acute in nature along with outpatient laboratory, radiology, and cardiopulmonary services. Elective surgical procedures may be eligible for financial assistance through the "Caring Program" and will require individual consideration by management.
- B. Screening for Medicaid eligibility is required. If Medicaid eligibility is likely, the patient must apply for Medicaid within 60 days of the service date. If the patient applies but does not qualify for Medicaid, he/she may apply for financial assistance through the

"Caring Program" at GCMH. Incomplete applications or failure to apply and/or follow through with the Medicaid application will result in a denial from the "Caring Program."

- C. The "Caring Program" application must be completed and returned via the U.S. Postal Service, delivered in person, or completed over the telephone. All applications require the signature of the individual who is financially responsible for the unpaid bills as well as proof of financial information used to determine program eligibility. If the applicant cannot read/write, PFS will read the policy to the applicant and assist with the form completion, requiring only a witnessed signature of an "X".
- D. In order for an individual to qualify, he/she must have exhausted all other sources of payment, including assets easily liquidated, i.e., bank accounts, money market accounts, Certificate(s) of Deposit, savings bonds, etc. Calculation of the applicant's income excludes net assets of \$10,000 or less.
- E. The following definitions of family size and income will assist in the "Caring Program" eligibility determination:
 - 1. Family: A family is a group of two or more persons related by birth, marriage, or adoption, and/or living together in the same residence, sharing income and expenses. When a household includes more than one family, GCMH will use each separate family's income for eligibility determination.
 - 2. Individual: An individual is a person who is emancipated, married, or 18 years old or older (excluding inmates of an institution) who is not living with any relatives. An individual may be the only person living in a housing unit, or may be living in a housing unit with unrelated persons.
 - 3. Income: Before taxes from all sources, as follows:
 - a. Wages and salaries
 - b. Interest or dividends
 - c. Cash value of stocks, bonds, mutual funds, etc.
 - d. Net self-employment income as calculated by GCMH. Non-cash deductions, such as depreciation, partial use of a home, etc., will be subtracted from the reported business expense deductions, as these items do not represent out-of-pocket expenses
 - e. Regular payments from Social Security, railroad retirement, unemployment compensation, veterans' payments, etc
 - f. Strike benefits from union funds
 - g. Workers' compensation payments for lost wages
 - h. Public assistance including Aid to Families with Dependent Children

- i. Supplemental Security Income
- j. Non-Federally funded General Assistance or General Relief money payments
- k. Alimony, child support, military family allotments or other regular support from an absent family member or someone not living in the household
- l. Private pensions or government employee pensions (including military retirement pay)
- m. Regular insurance or annuity payments
- n. Net rental income, net royalties, and periodic receipts from estates or trusts
- o. Net gambling or lottery winnings
- p. Capital gains
- q. Assets withdrawn from a financial institution one year or less before program application
- r. Proceeds from the sale of property, a house, or a car
- s. Tax refunds
- t. Gifts of cash, loans, lump-sum inheritances
- u. One-time insurance payments or compensation for injury

F. Eligibility for 100% financial assistance at GCMH is available to applicants whose income is up to or equal to 150% of the current Federal Poverty Guidelines when the applicant has less than \$10,000.00 in net assets. Any Individual treated at GCMH, regardless of permanent State residence, may apply for financial assistance through "The Caring Program." Partial assistance is available with incomes up to 200% (after the \$10,000 net asset exclusion) of the Federal Poverty Guidelines, as follows:

1. Eligibility for 95% financial assistance is available for incomes at 151%-155% of the Federal Poverty Guidelines.
2. Eligibility for 85% financial assistance is available for incomes at 156%-160% of the Federal Poverty Guidelines.
3. Eligibility for 75% financial assistance is available for incomes at 161%-165% of the Federal Poverty Guidelines
4. Eligibility for 65% financial assistance is available for incomes at 166%-170% of the Federal Poverty Guidelines.
5. Eligibility for 55% financial assistance is available for incomes at 171%-175% of the Federal Poverty Guidelines.
6. Eligibility for 45% financial assistance is available for incomes at 176%-180% of the Federal Poverty Guidelines.

7. Eligibility for 35% financial assistance is available for incomes at 181%-185% of the Federal Poverty Guidelines.
 8. Eligibility for 25% financial assistance is available for incomes at 186%-190% of the Federal Poverty Guidelines.
 9. Eligibility for 15% financial assistance is available for incomes at 191%-195% of the Federal Poverty Guidelines.
 10. Eligibility for 5% financial assistance is available for incomes at 196%-200% of the Federal Poverty Guidelines.
- G. If ineligibility results from the financial guidelines stated above or the applicant is eligible for partial assistance only and the applicant indicates an inability to pay the outstanding balance, the applicant will be asked to complete a financial statement to determine if his/her available monthly income is consumed by the daily necessities of life. Individual consideration of eligibility for applicants in this situation will apply to assure members of our community who cannot pay for their hospital care are included in our financial assistance program.
1. Mutually agreed upon interest-free monthly payments (based on available income after expenses) will be discussed and offered to those who are otherwise ineligible for the "Caring Program" and have expressed a need for an extended repayment period.
- H. Individuals with a need for financial assistance who are unable to apply or do not have an individual to apply on their behalf are not overlooked for financial assistance through the "Caring Program." The following indicates the available methods for GCMH to obtain information needed for eligibility determination in these situations:
1. Telephone contact, including TTY communication and verbal information about the individual's financial situation
 2. Discuss the situation with the individual's state Medicaid office to obtain a preliminary determination of Medicaid eligibility
 3. Research the applicant's other GCMH accounts
 4. Work with the next of kin or other person able to speak about the individual's financial condition
 5. Have personal knowledge of the individual's living situation
 6. Observe applicant's appearance
- I. Documentation requirements include the application for financial assistance, proof of income and/or any unusual expenses, financial statement, release of information, etc.
- J. GCMH has posted signs publicizing the Program at all registration areas and in the reception area of the Patient Financial Services (PFS) Department. Information about the program is printed in the "Patient Handbook" and on the hospital's web site.

Monthly self-pay statements include a pre-printed notification of the financial assistance program and instructions for applying to the "Caring Program." Automated monthly statement messages also encourage applications for financial assistance. Whenever a patient/guarantor inquires about the availability of a financial assistance program at GCMH, staff members should refer the inquiry to the PFS Department; offer to supply the telephone number of the PFS department, and/or direct patients to the PFS department. All PFS personnel review the financial assistance policy annually, at a minimum, discuss policy changes at departmental meetings, and have access to the current financial assistance policy during all work hours.

- K. GCMH will post, at least on an annual basis, an ad in the local newspaper informing residents of the availability of its financial assistance program, or upon approval of updates to the program guidelines. Printed copies of the application forms are available at the time of registration or at any registration location. Copies of the financial assistance policy and applications are also available in the Patient Financial Services Department upon request and may be picked up in person or mailed to your home.
- L. Self-pay accounts will be screened for financial assistance regardless of the dollar amount of the account; however, self-pay balances resulting from insurance company payment to the individual or from the individual's failure to respond to an insurance or GCMH query will not be considered eligible for the program.
- M. Financial assistance is not available for any account already referred to a collection agency or attorney for formal collection action. All third party collection agencies receive a copy of the financial assistance policy on an annual basis, or when changed, whichever occurs first.
- N. Financial assistance through the "Caring Program" will continue for a period of six months after the eligibility approval date (unless income significantly changes) when based on fixed incomes or the guarantor's past three months of income. Eligibility based on annual tax returns will also continue for a period of six months after the eligibility approval date, but will require additional proof of income.
 - 1. After the six-month period of eligibility, a new application for financial assistance must be completed/signed by the guarantor. Fixed income verification is required annually and applies for one calendar year (January through December) for eligibility determination if the applicant completes the renewal application at the appropriate time.
 - 2. Upon application approval, GCMH will write-off eligible account balances. GCMH may reverse the determination of eligibility if any of the information supplied on the application was incorrect.
 - 3. If an individual's financial status deteriorates and he/she cannot pay the agreed upon monthly payment amount, GCMH will again review (upon request) the individual's eligibility to the program.

4. Once GCMH has determined that an account is eligible for financial assistance or is not collectible, that financial classification is final.
 5. GCMH will post payments received from any source (after the eligible account balance is written-off) to the appropriate hospital account and will adjust the amount of the financial assistance write-off accordingly. GCMH will not refund self-pay payments received before or after the approval of the financial assistance application.
- O. Individuals who have incurred hospital expenses for care and/or treatment ordered through the Garrett County Health Department (GCHD) as part of the Garrett County Cancer Control Program shall be eligible for financial assistance for balances remaining after payment from GCHD. GCHD is responsible for notifying GCMH of all claims that fall into this category.

*GARRETT COUNTY
MEMORIAL HOSPITAL
MISSION STATEMENT*

OUR MISSION

To promote the health of our regional community and provide safe, high-quality care and health services for our patients.

GARRETT COUNTY MEMORIAL
HOSPITAL
VISION STATEMENT

Garrett County Memorial Hospital:

1. *Will be viewed as the provider of choice in the region and be recognized for our progressive personal service encompassing the full continuum of care.*
2. *Will be known for our excellence across the region.*
3. *Will continue as a community partner and resource, striving to proactively respond to the health and wellness needs of our region.*
4. *Will provide a high level of community service and stewardship for the resources with which we have been entrusted.*
5. *Will recruit and retain the most talented and caring employees through continuous efforts to be the employer of choice in the region through employee friendly programs and policies.*
6. *Will collaborate and partner with other providers, as needed, to achieve our strategic direction.*

7. *Will be characterized by cohesive leadership, efficiency, sound management, financial strength and a positive work environment.*
8. *Will maintain a collaborative partnership between the Board of Governors, Medical Staff and Administration.*
9. *Will strive to exceed the expectations of those we serve.*
10. *Will be dedicated to the process of never-ending improvement.*
11. *Will be more obvious in our expression and fulfillment of our charitable mission and community benefit.*
12. *Will be dedicated to providing the best technological tools possible to assist our caregivers in providing the highest level of medical care achievable within our rural location.*



FY 2008 Community Benefit Report Filing
Description of Gaps in Availability of Specialist Providers

Similar to fiscal year 2007, GBMC continues to realize difficulty in providing emergency department coverage for psychiatric, vascular, orthopedic and anesthesia services. As a result, in order to secure coverage, GBMC has agreed to provide a negotiated payment to physicians for uninsured patients.

In addition, several GBMC owned physician practices provide OB/GYN and primary care services specifically designed to meet the needs of underserved patients.



FY 2008 Community Benefit Report Filing
Description of Financial Assistance Policy

GBMC has taken significant measures to ensure that its Financial Assistance Policy is both visible and accessible to patients by enacting the following measures:

1. Availability of Applications & Brochures

- Via website
- All hospital patient registration areas; including admitting, emergency department, laboratory stations, clinics and radiology services
- GBMC owned physician offices
- Billing Office

In addition, to the availability of applications and brochures, signs describing the existence of a Financial Assistance Policy and opportunity for financial assistance are also prominently displayed throughout the hospital.

2. Direct Assistance

Utilizing the admitting and insurance verification process, prior to discharge, the Patient Financial Services department attempts to assist many patients with financial evaluations in order to determine the availability for financial assistance. In addition, during the account resolution process, staff is also trained to evaluate a patient's unique circumstances and attempt to direct patients to financial assistance when appropriate.

GBMC will also assist patients in enrolling for State Medical Assistance coverage.

3. Education

To ensure that employees are qualified to direct patients in accessing financial assistance, new employees and volunteers are specifically educated during new-hire orientation programs on how to obtain financial assistance applications and brochures.

GBMC Healthcare
Financial Assistance Policy

Policy: GBMC recognizes its obligation to the communities it serves to provide medically necessary care to individuals who are unable to pay for medical services regardless of race, color, creed, religion, gender, national origin, age, marital status, family status, handicap, military status, or other discriminatory factors.

The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under Federal Medical Assistance and state or local programs, but whose patient balances exceed their own ability to pay.

While flexibility in applying guidelines to an individual patient's situation is clearly needed, certain objective criteria are essential to assure consistency in the implementation of the Financial Assistance Program.

Eligible / Ineligible Services

- Services considered medically necessary are covered under the program
(Pregnancy related services are eligible for Financial Assistance consideration)
- Services considered elective (i.e. cosmetic) are not covered under the program
- Applicants meeting eligibility criteria for Federal Medicaid must apply and be determined ineligible prior to Financial Assistance consideration
- Financial Assistance will not be generally considered for patients who are in bad debt status and did not respond to collection activity or statements prior to write-off of account(s)

Referral Sources

- Financial Assistance referrals will generally originate in the Insurance Verification, Advocacy and Collection/Insurance departments accompanied with a **Financial Evaluation** (Attachment #1) and **Medical Assistance Eligibility Check List** (Attachment #1a)
- Other referrals such as social services, physician offices, administration, etc. will generally not be accompanied with a **Financial Evaluation**

Financial Eligibility Criteria

- Eligibility is based on gross household income
- Gross household income is defined as wages and salaries from all sources before deductions
- Other financial information such as liquid assets and liabilities are considered
- Annual household income criteria is 300% of the current poverty guidelines published in the Federal Register
- Applicants that exceed established household income levels may still be eligible when additional factors such as disposable net income are considered (See “Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guideline”)

Household Income

- Household Income to be considered
 - All wages and salaries
 - Social Security, veteran’s benefits, pension plans, unemployment and worker’s compensation, trust payments, child support, alimony, public assistance, strike benefits, union funds, income from rent, interest and dividends or other regular support from any person living in the home
- Generally, the availability of liquid assets including cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, etc. exceeding 2 months of living expenses will be considered (referred to in the policy as Liquid Assets)
- Proof of Household Income (Attachment #2)
 - One or more of the following items may be requested from the applicant to verify income for each income producing member of the household. Monthly household income is prorated to determine annual household income level.
 - Two recent pay stubs reflecting year-to-date earnings, for each family member over age eighteen
 - Most recent income tax return(s) with W2s

- Social Security Award Letter(s)
- Most recent unemployment insurance stub
- Two most recent checking and savings account statements
- Two most recent investment statements (money market, CD, stocks, etc.)
- Letter from federal, state or local agency verifying the amount of assistance awarded
- Applicants claiming zero household income must supply proof of how their living expenses are paid with a notarized letter of support. Cancelled checks and/or receipts may also be required if another individual is paying patient's bills.
- Medical Assistance denial or spend-down determination letter
- Other pertinent household income verification documentation as required

Expenses

- Expenses to be considered (also see "Questionable Expenses" under "Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guideline")
 - All reasonable living expenses (mortgage/rent, utilities and loan/credit card payments)
 - Either land-line telephone or cell phone bill will be considered (not both)
 - A monthly car payment of up to \$450 for one car is allowed
The maximum allowance per family (2 adults) is \$900
Any amount over the above allowance will be considered within the miscellaneous allowance
 - Payments for recreational items such as boats, motorcycles, etc. are not allowable expenses Exception: if motorcycle is only source of transportation
 - Expenses for Cable TV, Dish TV and/or Internet are considered within the miscellaneous allowance
 - Expenses for second homes are not allowable expenses (however, income from rental properties will be counted as Household Income)

- \$150 food allowance will be given for patient; and \$75 food allowance for each additional family member
- \$300 miscellaneous allowance will be given for ancillary living expenses (i.e.: gas for automobile, grooming items, automobile maintenance, tuition and tithing)
- Medical expenses
 - Up to \$100 in prescription expenses per person will be considered without receipts
 - Prescription expenses that exceed \$100 per person cannot be considered unless patient provides receipts for the two prior months
 - Medical expenses are considered upon proof from patient of active payment arrangements

Application Process

- Patients may request Financial Assistance prior to treatment or after billing
- A new application must be completed for each new course of treatment with the following exceptions:
 - Inpatient and outpatient Medicare patients are certified for one year (see “Medicare Patients”)
 - Inpatient and outpatient non-Medicare patients are certified for 6 months. However, if it is determined during the course of that period that the patient meets Medical Assistance eligibility criteria they are required to pursue Medicaid prior to receiving additional Financial Assistance
- Finite consideration periods for any of the above patient statuses are at the discretion of the Collection Manager to insure that policy guidelines are met for all levels of service
- At the time of application all open accounts are eligible for consideration with the potential exception of patients who are in bad debt status and did not respond to collection activity or statements prior to write-off of account(s)

- The signed/completed **Financial Evaluation** is referred to the Financial Assistance Department
 - Balance range requirements
 - Combined account balance(s) up to \$2,500
 - Completed **Financial Evaluation**
 - Proof of household income
 - Credit bureau report may be obtained and reviewed if household income and/or household expense discrepancies are found
 - Combined account balance(s) greater than \$2,500
 - Completed **Financial Evaluation**
 - Proof of household income
 - Credit bureau report
 - Obtained and reviewed to verify information, develop additional sources for funds and utilized as a collection tool
 - Accounts are approved or denied based on household income criteria and applicant cooperation

Household Income Criteria for Financial Assistance Approval / Denial

- Combined gross household income less than 300% of the poverty guidelines
 - Applicants are eligible for 100% Financial Assistance
 - However, applicants with liquid assets including cash, checking/savings account balances, certificates of deposit, stocks, bonds, money market funds, etc., not exceeding \$25,000, who meet the income eligibility requirements, will be considered for assistance at the discretion of the Director of Patient Financial Services and/or the Financial Assistance Committee. Inability to replenish the resource and/or current usage of the resource to cover allowed living expenses may qualify the applicant for assistance.
 - Applicants with liquid assets (described above) exceeding \$25,000, may not

qualify for assistance. However, at the discretion of the Chief Financial Officer, inability to replenish the resource and/or current usage of the resource to cover allowed living expenses may qualify the applicant for full or partial assistance

- Combined gross household income greater than 300% of the poverty guidelines and the patient is still unable to make acceptable payment arrangements (minimum - \$25 per month)
 - Applicants are reviewed on a case-by-case basis (see “Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guideline”)

Financial Assistance When Gross Household Income Is Greater Than 300% Poverty Guideline

- Applicants whose gross household income exceeds 300% of the poverty guidelines but state they are still unable to pay all or part of their account balance(s) may be further evaluated for Financial Assistance
- In these cases, consideration is given to expenses, disposable net household income, total liquid assets and account balance(s)
 - Disposable net income is defined as gross household income less deductions and expenses (Program allows \$250 disposable income for one person and \$75 for each additional family member.) Disposable income (exceeding \$250 for one person and \$75 for each additional family member) will be used to determine patient’s ability to pay)
 - The applicant is required to supply proof of “questionable” expenses`
 - “Questionable” expenses are defined as any expense item that appears to be overstated/understated and/or not reasonable or customary
 - A credit bureau report is required to evaluate the application (regardless of account balance)
 - Patients whose disposable income is within the limits stated above and whose liquid assets do not exceed the standard (See Household Income); are eligible for 100% Financial Assistance
 - Patients who exceed the asset standard (See Household Income) are ineligible for Financial Assistance and need to make payment arrangements (See Resource Payment Arrangements)
 - Eligibility for patients who have excess disposable income is determined based on ability to satisfy outstanding balance(s) within timeframe defined

(See Financial Assistance With Resource) All exceptions will be reviewed by the Director of Patient Financial Services

- Applicants approved for 100% Financial Assistance (See “Processing Approved Applications”)

Financial Assistance With Resource

- Resource amounts are determined based on the applicant’s ability to pay a portion of their account balance(s) without causing undue financial hardship using the following guidelines
- Outstanding balance(s) owed to GBMC are divided by excess disposable income to determine the number of months needed to pay the outstanding balance(s) in full
- Excess disposable income determines the amount of the monthly payment (See Resource Payment Arrangements for standards)
- Outstanding balance(s) that cannot be satisfied within 24 months will be reduced by the difference between the total outstanding balance(s) and the total required patient payment amount (excess disposable income multiplied times 24 months)
- All resource amounts are reviewed and approved by the Director and Collection Manager
- Approval process
 - The completed **Financial Evaluation** (including resource recommendation), **Authorization Form** (Attachment #3) and documentation is forwarded to the Collection Manager
 - The Collection Manager will ensure that all required authorization signatures are obtained
 - When authorization is obtained the patient is mailed a **Financial Assistance Reduction Letter** (Attachment #6) and a **Financial Assistance Promissory Note** (Attachment #6A) outlining the terms and conditions of the agreement
 - The **Financial Assistance Promissory Note** must be returned within 14 days. Failure to do so will result in the patient’s ineligibility for Financial Assistance
 - Signed promissory notes are forwarded to the Collection Manager (see “Processing Approved Applications”)

Resource Payment Arrangements

- Resource payment arrangements will not exceed 24 months

- Every effort is made to liquidate the resource amount within the earliest possible time frame
- The minimum monthly payment amount is \$25
 - Patient is set up under a contract in Meditech with an alert on Patient Overview screen (alert is set to remind collector that partial write-off occurred in the event of patient default on resource payments)
 - Patients are automatically sent monthly statements through Meditech indicating their monthly payment amount, due date and account balance(s)
- If a patient qualifies for Financial Assistance with a resource and has multiple account balances, all account balances are allowed leaving only one open account (if possible) for the resource amount
 - A weekly Meditech work list is reviewed to determine if patients are delinquent with their payments
 - Failure to pay as agreed will result in the patient being responsible for both the allowance amount and the unpaid resource balance
 - Forward the delinquent account to the Collection Manager
 - The Collection Manager/ or designee reverses the Financial Assistance allowance
 - Patient is sent a final demand letter

Authorization For Bad Debt

- | | |
|---------------------|--|
| - \$1 - 2,499 | - No Bad Debt Authorization Form required |
| - \$2,500 - 5,000 | - Collection Manager |
| - 5,001 - 10,000 | - Director of Patient Accounting |
| - \$10,001 – 25,000 | - Assistant VP, Financial Operations |
| - GT \$25,000 | - EVP/CFO |

Incomplete / Uncooperative

- Failure to supply required information within 10 days may result in the applicant's ineligibility for Financial Assistance

Processing Approved Applications

- Completed applications are forwarded to the Collection Manager with all appropriate supporting documentation
- The Collection Manager will ensure that each applicant has met household income requirements, supplied appropriate supporting documentation and that proper authorization signatures are obtained
 - The Collection Manager or designee applies the Financial Assistance adjustment and files the **Financial Evaluation, Authorization Form** and related documentation
- The patient is sent a **Financial Assistance Award Letter** (Attachment #4)

Processing Denied Applications

- Applicants that are determined to be ineligible based on household income criteria
- The patient is sent a **Financial Assistance Denial Letter** (Attachment #5)

Medicare Patients

- Medicare patients are required to supply a copy of their Social Security Award Letter on a yearly basis
- Medicare patients are certified for 1 year. However, if it is determined during the course of that year that the patient meets Medical Assistance eligibility criteria they will be required to pursue Medicaid prior to receiving additional Financial Assistance
- The Financial Assistance Department will refer Medicare patients meeting Medicaid eligibility criteria to the Advocacy Department for processing

Medicaid Resources

- Medicaid resources are automatically reviewed for Financial Assistance when a copy of the Department of Social Services (DSS) **0102 Form** (Attachment #7) is supplied to the Financial Assistance Department

- DSS income calculations and Financial Assistance program allowances are used to calculate patient's disposable income (see "Gross Household Income Is Greater Than 300% Poverty Guideline")

Recurring Accounts

- Patients are certified for each course of treatment
- If patients are admitted or start a new course of treatment, they are screened for Medicaid and/or reevaluated for Financial Assistance

Financial Assistance Statistical Reporting

- The Collection Manager or designee is responsible for completing all monthly and year-to-date statistical analysis as required.

Approved By: Eric Melchior,
Executive Vice-President and CFO

Date Distributed: 02/21/2008



FY 2008 Community Benefit Report Filing
Mission, Vision & Values Statement

MISSION

Health. Healing. Hope.

The mission of GBMC is to provide medical care and service of the highest quality to each patient leading to health, healing and hope.

VISION

Medical Sophistication with Personalized Service.

The vision of GBMC is to be the preferred medical center in Maryland for the best physicians, nurses and staff by providing medical sophistication with personalized service, enhanced by clinical education and research with the guiding principle that *“the patient always comes first.”*

GREATER VALUES

The values of GBMC are our GREATER Values of Respect, Excellence, Accountability, Teamwork, Ethical Behavior and Results.

Harbor Hospital

FY 2008 Community Benefit Evaluation

Each year, Harbor Hospital participates in myriad community partnerships and programs that both reflect the clinical strengths of the organization and are consistent with the health priorities identified by our local health departments. This strategic, yet caring, alignment of health care expertise with community need is one of the hallmarks of Harbor's commitment to our communities.

During our century of service, Harbor has developed – and continues to refine – a comprehensive array of programs, seminars and outreach. From our cadre of free health seminars to our attendance at health fairs and other community events, Harbor remains focused on the inherent value of providing a continuum of care.

Community Benefits Planning and Needs Assessment

Planning is an essential element for every business entity, and Harbor Hospital is no different. The hospital engages in regular strategic planning and has an annual process, involving both our executive team and our hospital leadership team, to identify our priorities for each fiscal year and from longer-term perspectives. Through this process, clinical and operational goals are addressed at various levels. As part of this effort, we factor in community needs, both current and projected, into all our planning.

The community planning aspect of our organizational assessment is equally important to its business planning counterpart. Our community relations team has an annual planning process, during which we consider community health needs, interests and trends. Since the AVP for community relations reports to the hospital president and is a member of the executive team, the highest levels of leadership are engaged in the discussion. In addition, we involve peers in physician relations and nursing to help ensure that we are identifying key areas for outreach to meet our community's needs.

We also work closely with our planning team; our clinical specialists who focus on the community; our parish nurses; and with area health departments. In particular, we seek input and feedback from Baltimore City, Anne Arundel County and Baltimore County departments of health. This enables us to continue to assess community health needs, and identify potential roles for Harbor to play in meeting those needs. During FY 2008, our manager of community relations participated in the Community Benefits work group convened by the Baltimore City Health Department. This group discussed numerous efforts tailored to the specific health needs of the city in which local hospitals could participate, and several partnerships have been expanded or enhanced as a result of these meetings. In addition, we attended the Anne Arundel County Forum on Minority Health Issues, as well as numerous other meetings and trainings which help us to better understand the health needs of the communities we serve.

Planning is a dynamic and ongoing process. Through this dialogue, we form the framework of our community outreach. Then, the community relations team, and any appropriate members of our Harbor family, meet regularly to plan and implement our activities. Underpinning all of this is Harbor's mission: we are committed to quality, caring and service for our patients and our communities.

Community Benefits Initiatives

Through our planning process, Harbor Hospital identifies various community benefits initiatives. Harbor Hospital, through our own funding and regional and national grants, is able to work closely with our local health departments and community partners to offer free colon, breast and cervical cancer screenings; yearly prostate cancer screenings; low-cost lung scans; free smoking cessation classes; and a strong Parish Nurse program that provides key outreach to our patient population.

The smoking cessation classes, for example, are a direct result of the higher-than-average rate of lung cancer in this region. Harbor Hospital has worked with Anne Arundel County Department of Health for years to offer both the classes and free nicotine replacement therapy. During FY08, we also had a parish nurse who offered ongoing one-on-one counseling for those who are struggling with the habit.

Our parish nurses also regularly act as health care navigators for residents of the local communities we serve. They hold office hours at local organizations, offer blood pressure screenings and other health care information, and guide their "clients" toward any health care referrals they may need. This is a free service, and our nurses touch many lives each year.

As the average age of Americans increases, Harbor also is ahead of the curve in identifying and developing programs to continue to help seniors navigate the ever-changing world of modern health care. Our Harbor Seniors is a free program for people ages 55 and older that provides free health screenings, educational seminars and opportunities to socialize. Members also get a discount at our Harbor Fitness gym, and many also participate in our free mall-walking program offered at two area malls.

We track and assess all our programs. Some of our outreach is funded by local, regional or national grants. Through those requirements, we track usage rates and outcomes. For example, we can provide exact counts on the number of Baltimore City women who have had free mammograms and Pap smears through our grant with the city, as well as results (number of cancers and pre-cancers identified). We also track the number of participants in all our seminars and free screenings that are funded not by grants but from Harbor's own operating budget.

As another example of assessment, we offer free blood pressure screenings twice a month to our mall-walking programs, and have screened more than 1100 individuals over the course of this fiscal year. We have been offered anecdotal evidence of the value of this program by a cancer patient who, by having her blood pressure checked regularly at one

of the malls, was able to track some dangerous trends in her pressure. She spoke to her physician and showed him her blood pressure card, and he changed some of her medication dosages to ameliorate the problem. Stories like these are shared often with our community relations staff, and underscore the benefits of community outreach initiatives like these.

Community Collaboration

To further our understanding of community needs, a wide representation of hospital clinical staff and administrators serve on committees or participate in community health planning work groups. These activities and partnerships provide us the opportunity to work closely with representatives from the community to better understand the health needs of our constituents and to offer programs and services to meet these needs.

For example, Harbor Hospital has been actively involved with several community organizations, such as the Cherry Hill Trust, a grassroots coalition working for the betterment of the Cherry Hill community. We also are active participants in a number of other community meetings and partnerships, including the Baltimore Police Southern District Community Relations Council, Baltimore City Planning Commission, the Glen Burnie High School Business Advisory Board, Safe Kids Baltimore, the Baltimore Traffic Safety Coalition, Northern Anne Arundel County Chamber of Commerce and the South Baltimore Community Advisory Panel. Our parish nurses regularly visit local senior centers and homeless shelters to provide blood pressure screenings, flu shots and educational programming, and our community relations manager has provided injury prevention and other health-related information at numerous local Head Start centers, health fairs and other community activities.

Other activities included providing health navigation services and blood pressure screenings at the Anne Arundel County Homeless Resource Fair, and assisting a local community coalition with a safe Halloween party for at-risk children. We also maintain ongoing partnerships with other health organizations such as the Juvenile Diabetes Research Foundation, American Cancer Society, March of Dimes and the American Heart Association to provide education and outreach to their constituents. We strive to be engaged members of our communities, where every level of interaction provides stronger ties with, and the creation of more meaningful services for, our neighbors.

Community Benefits Collaboration and Implementation

As articulated above, Harbor Hospital participates in myriad community partnerships and programs that both reflect the clinical strengths of the organization and are consistent with the health priorities identified by our local health departments.

As part of our comprehensive array of programs, seminars and service, Harbor Hospital's *LifeResource* Center serves as the bricks and mortar centerpiece of our community outreach program. Located on the Harbor campus, it is a spacious facility where community members can learn more about health topics and practice healthy lifestyles. Each month, Harbor offers an assortment of free and low-cost education programs and lectures for every member of the family. Presenters include our physicians and other

health care experts, who discuss a variety of diagnoses, diabetes and wound care, personal safety and stress relief – just to name a few. This year we have partnered with several other organizations to provide community training on child safety seat installation, driver safety education for seniors and a free glaucoma screening.

We also continue to offer free health seminars in our Baum and LifeResource Center auditoriums, as well as at convenient locations in Baltimore, Howard and Anne Arundel counties. In addition, we allow our partners in the community to utilize our facilities for meetings. This practice saves them a great deal of money on room rentals, and offers a convenient local meeting space—with free parking—for their constituents.

This past year, we have continued and enhanced our work with The Cherry Hill Learning Zone (CHLZ). This initiative is an advocacy group comprised of representatives of the city school system, Towson University, community groups and other key stakeholders in the business and faith communities. Harbor Hospital is proud to be the health partner for this dynamic and energetic organization. Once again this year, we worked with our CHLZ partners to offer free flu vaccinations to teachers in Cherry Hill public schools, provide a Reading Day for several elementary school classes and assist with its annual Children's Summit.

Harbor Hospital's community outreach includes many layers of service to our diverse communities, focusing not only on their immediate health care needs, but also on risk prevention and becoming a proactive health care consumer. From the GED program that regularly meets, free of charge, in our LifeResource Center and our comprehensive annual flu vaccination clinics that result in nearly 2,000 free and low-cost vaccinations, to our attendance at health fairs and other local events, Harbor remains focused on being a true health care partner to our community members.

Appendix 1

MedStar Health FY 2008 Community Benefit Report Specialist Gaps

The HSCRC has requested that hospitals document gaps/shortages in our communities with regard to specialists. Gaps exist in the availability of both primary care and specialist providers to serve the uninsured in the hospital.

Diminishing the gaps in specialty services for all patients (uninsured and insured) is very important to MedStar. By operating as a system, which includes Franklin Square Hospital Center, Good Samaritan Hospital, Harbor Hospital, Montgomery General Hospital¹, Union Memorial Hospital, Georgetown University Hospital, National Rehabilitation Hospital, and Washington Hospital Center, our goal is to ensure all sites access to MedStar's entire medical staff, including specialty resources when required. Our sites utilize current and planned office space on their campuses to encourage physicians to treat and follow-up with patients in close proximity to the hospital. Our current and planned Emergency Department improvements allow for state of the art treatment of more patients with enhanced care.

Per physician leadership and case management staff, there remain several areas of concern in our communities:

- a) Limited availability of inpatient and outpatient psychiatry services, including substance abuse
- b) Medication assistance for patients
- c) Transportation assistance
- d) Limited durable medical equipment providers
- e) Limited skilled nursing services in the home and/or at rehab facilities
- f) Limited availability of hospice care
- g) Limited health care services for the homeless and undocumented residents

¹ Note: Since joining MedStar in February of 2008, the affiliation has already significantly increased Montgomery General Hospital's specialty resources for neurosurgeons, orthopedic, including rehabilitative services.

Appendix 2

MedStar Health Financial Assistance Policy HSCRC Community Benefit Response

MedStar Health provides financial assistance to the uninsured patients based on income and family size starting at 100% up to 200% of the federal poverty level and a sliding scale for those between 201-400% of the federal poverty levels. Patients must reside in our defined primary and secondary service areas but exceptions can be made for patients treated in one of our specialty services as well as any extenuating circumstances. In addition, patients have the responsibility to comply with our requirements in completing a Medicaid application if deemed eligible through our financial screening and must provide all necessary information for final determination. MedStar Health's facilities will assist uninsured patients who reside within the community to enroll in publicly-funded entitlement programs, publicly funded programs for the uninsured, assist with consideration of funding available from other charitable organizations or offer periodic payment plans to assist patients with financing their healthcare services.

All self pay patients that are either scheduled admissions or ambulatory surgeries receive a thorough financial screening from our on site advocates including Medicaid eligibility or any other federal or state funded program. In addition, they are screened for financial assistance. Emergency admissions are also screened in this manner after the admission occurs. Other outpatients may receive screening afterward their services if they fall into defined criteria for potential MCHIP program. In addition, outpatients may be screened if they identify the inability to pay or the desire to apply for either Medicaid or financial assistance.

Appendix 2

Signs are posted in all registration areas in both English and Spanish. There are patient advocates located on sight during normal business hours to assist patients at the facilities in their application process. In addition, each hospital funds a portion of the State case workers' salary to have that individual available on-sight to work in conjunction with the patient advocate staff and patients to complete the application process. Any patient that completes the application process will be given a list of items that they must provide in order to complete the eligibility process before or at time of discharge. Additional outreach services are provided after discharge and agencies are used for those patients that are less corporative or that need assistance in securing documents or transportation for application completion. These agencies also assist in the appeal process for both Medicaid and Social Security Disability denials.

Each facility provides brochures and or admission packets advising them of the financial assistance policy and where they can inquiry for further information. Applications will be provided at time of registration if the patient makes a request. Our statements provide a number (local and toll free) for patients to contact.

Upon receipt of eligibility determination, the financial services department will either process the claim for billing and reimbursement to the appropriate federal or state program identified and or process the financial assistance application. A final determination letter will be sent to the patient from both the program for which he applied as well as the financial services department at MedStar regarding their financial assistance disposition.

Appendix 2

Lastly, an automated file is run on a weekly basis to validate Medicaid eligibility on any self-pay patients that the patient has been uncooperative and we have been unsuccessful in completing the application for Medicaid on their behalf in the event that they have done so and failed to notify us.

Appendix 3

MedStar Health

Financial Assistance for Uninsured Patients Policy Statement

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

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

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

- Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
- Assist with enrollment in publicly-funded programs for the uninsured (e.g., D.C. Healthcare Alliance).
- Assist with consideration of funding that may be available from other charitable organizations.

¹ This policy does not apply to insured patients who may be "underinsured" (e.g., patients with high-deductibles and/or coinsurance). This policy also does not apply to patients seeking non-medically-necessary services (including cosmetic surgery).

Appendix 3

- Provide charity care and financial assistance according to applicable guidelines.
- Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
- Offer periodic payment plans to assist patients with financing their healthcare services.

Each MedStar Health facility (in cooperation and consultation with the finance division of MedStar Health) will specify the communities it serves based on the geographic areas it has served historically for the purpose of implementing this policy. Each facility will post the policy, including a description of the applicable communities it serves, in each major patient registration area and in any other areas required by applicable regulations, will communicate the information to patients as required by this policy and applicable regulations and will make a copy of the policy available to all patients.

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

- Completing financial disclosure forms necessary to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.
- Working with the facility's financial counselors and other financial services staff to ensure there is a complete understanding of the patient's financial situation and constraints.
- Completing appropriate applications for publicly-funded healthcare programs. This responsibility includes responding in a timely fashion to requests for documentation to support eligibility.

Appendix 3

- Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.
- Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

Charity Care and Sliding-Scale Financial Assistance

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

The determination of eligibility will be made as follows:

1. Based on family income and family size, the percentage of the then-current federal poverty level for the patient will be calculated. If this percentage exceeds 400%, the patient will not be eligible for charity care or sliding-scale financial assistance unless determined eligible in step 3. If the percentage is less than or equal to 400%, the patient is provisionally eligible, subject to the financial resources test in step 2.
2. The patient's financial resources will be evaluated by calculating a pro forma net worth for the patient and her family, excluding (a) funds invested in qualified pension and retirement plans and (b) the first \$100,000 in equity in the patient's principle residence.² The pro forma net worth will include a deduction for the anticipated medical expenses to be incurred during the twelve months commencing on the date of the patient's admission to the facility. If the pro forma net worth is less than \$100,000, the patient is eligible for

² Net worth calculations will incorporate the inclusions and exclusions used for Medicaid. Anticipated recoveries from third parties related to a patient's medical condition (*i.e.* recovery from a motor vehicle accident that caused the injuries) may be taken into account in applying this policy.

Appendix 3

charity care or sliding-scale financial assistance; if the pro forma net worth is \$100,000 or more, the patient will not be eligible for such assistance.

3. For patients whose family income exceeds 400% of the federal poverty level, adjusted family income will be calculated by deducting the amount of medical expenses for the subject episode of care anticipated to be paid during the ensuing twelve month period. This calculation will consider any periodic payment plan to be extended to the patient. Based on this adjusted family income, the adjusted percentage of the then-current federal poverty level for the patient will be calculated. If this percentage exceeds 400%, the patient will not be eligible for charity care or sliding-scale financial assistance. Periodic payment plans may be extended to these patients.

For patients who are determined to be eligible for charity care or sliding-scale financial assistance, the following will be applicable based on the patient’s percentage of the federal poverty level (or adjusted percentage, if applicable):

<i>Adjusted Percentage of Poverty Level</i>	<i>Financial Assistance Level</i>	
	<i>HSCRC-Regulated Services³</i>	<i>Washington Facilities and non-HSCRC Regulated Services</i>
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

³ The assistance levels described above for HSCRC-regulated services do not include any discounts that may be applicable under the HSCRC’s prompt payment regulations.

Appendix 3

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

Appendix 4a

MedStar Health FY 2008 Community Benefit Report Vision, Mission, & Values

MedStar Health has adopted a vision and mission, along with the six values shown below. All MedStar hospitals, including the five hospitals in Maryland (Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, Montgomery General Hospital, and Union Memorial Hospital) share the same MedStar Health Vision and Values. See Appendix 4b for each hospital mission statement.

Mission:

To serve our patients, those who care for them, and our communities

Vision:

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

SPIRIT Values:

S = SERVICE

P = PATIENT FIRST

I = INTEGRITY

R = RESPECT

I = INNOVATION

T = TEAMWORK

Appendix 4b

MedStar Health FY 2008 Community Benefit Report Hospital Mission Statements

Hospital Mission Statements Include:

Franklin Square Hospital:

Franklin Square Hospital Center, a member of MedStar Health, provides the highest quality healthcare and education to our communities.

Good Samaritan Hospital:

We are Good Samaritans, guided by Catholic tradition and trusted to deliver ideal healthcare experiences.

Harbor Hospital:

Harbor Hospital is committed to quality, caring and service for our patients and our communities.

Montgomery General Hospital:

Montgomery General Hospital, a member of MedStar Health, is dedicated to enhancing our community's health & well-being by offering high-quality, compassionate, and personalized care.

Union Memorial Hospital:

Union Memorial Hospital is a comprehensive hospital with regional specialty services of distinction and quality community services, all enhanced by clinical education and research.

**MedStar Health
FY 2008 Community Benefit Report
Subsidy Justification**

The Catholic Health Association guidelines for Community Benefit Reporting allow inclusion of losses for services defined as subsidized care, broadly defined as services that are “needed in the community and other providers are unwilling to provide the services, or the services would otherwise not be available to meet patient demand.” In most cases, these subsidies directly relate services for uninsured or underinsured patients.

The HSCRC has addressed the treatment of these services, requiring that hospitals clearly explain all subsidies included within Category C of their Community Benefit Report.

Category 1 Subsidies:

Hospital-based physicians with whom the hospital has an exclusive contract and/or subsidy IN ORDER TO RETAIN SERVICES THAT REPRESENT A COMMUNITY BENEFIT

- a) Primary Care Subsidies, including Diabetes – These are clinic-based physician practices that provide primary health care services. Most of the patients are from the local community and are low-income families. This service generates a negative margin; however, the practice addresses a community need and supports the hospital’s mission of commitment to patients, communities, physicians and employees. Providing this service allows the local community access to health care services, and therefore more preventive measures and an improvement of the patients’ health status are achieved.
- b) OB and Pediatric Subsidies, including Breast Surgery – These represent physician practices providing health care services for obstetrics, gynecology, and pediatrics where a negative margin is generated. A large number of our patients receiving these services are from minority and low-income families. Prenatal care is provided and OB/GYN and pediatric coverage is provided 24 hours/day. Preventive measures and improvement of the patient’s health status are achieved. The services address a community need for women’s health and children’s services for lower income and minority families.
- c) Radiology Subsidies - For certain sites, payment is made to radiologists to provide services on a 24-hour basis generating a negative margin. These specialists are difficult to recruit due to extreme shortage and nature of the services and the 24-hour availability commitment. The community needs for these services are being met. Our community includes many low- income and minority families.
- d) Surgical House Subsidies - For certain sites with a higher percentage of indigent patients, private physicians often are not willing to provide 24 hour on-call

service. The hospital absorbs these costs and has a negative margin. The community's needs are met.

- e) Psychiatric/Behavioral Health Subsidies - The overall cost of 24/7 Psychiatry physician coverage is disproportionate to the total collections from the patients seen by these physicians during off hours. Many of these patients are uninsured. Our hospital absorbs the cost of providing psychiatric supervision for the Emergency Department on a 24/7 basis. If these services were not provided, the patient would be transported to another facility to receive these services. The community needs are being met and commitment to patients is exhibited by providing these services.

Category 2 Subsidies:

Non-Resident house staff and hospitalists

- a) Hospitalist Subsidies - Payments are made to an inpatient specialist group to provide 24/7 services in the hospital; resulting in a negative profit margin. The service focuses on preventive health measures and health status improvement for the community.
- b) ENT Subsidies - Payments are made for a non- resident ENT fellowship to provide 24/7 services in the hospital; resulting in a negative profit margin. The service focuses on preventive health measures and health status improvement for the community.

Category 3 Subsidies:

Coverage of Emergency Department call

- a) ER Subsidies - These include the cost of providing on-call specialists for the Emergency Department for certain surgical specialties. These specialists otherwise would not provide the services because of the low volumes and a large number of indigent patients served. If these services were not provided, the patient would be transported to another facility to receive the specialty services. The community needs are being met and commitment to patients is exhibited by providing these services.

Category 4 Subsidies:

Physician provision of financial assistance to encourage alignment with hospital financial assistance policies

No subsidies reported.

Category 5 Subsidies:

Recruitment of physicians to meet community need as shown by a hospital's medical staff development plan

- a) Anesthesiology Subsidies - This subsidy relates to payments made to anesthesiologists to provide services generating a negative margin. These specialists are difficult to recruit due to extreme shortage and nature of the services and the 24-hour availability commitment. The community needs for health services are being met.

Other Subsidies:

Non-Physician Subsidies

- a) Adult Day Care Subsidies - Adult Day Care services are provided at a negative margin. The community has a need for patient care related to the elderly and disabled. The needs of the participants' family are met. Family members can feel confident that their relatives are being cared for when they cannot be there. Again, a majority of people receiving this service come from low income and minority families.
- b) Cardiac Rehabilitation - One of our sites subsidizes cardiac rehabilitation services to the community.
- c) Community HIV Services Support Subsidies – HIV clinic services are provided at a negative margin. These services include nurse care management, social work, and medical services and help over 200 people who are mostly indigent.
- d) Child Development Center Subsidies - Good Samaritan's Child Development Center opened in 1990 to serve a large number of employee parents by caring for their children ages two to four. The Center also serves parents in the community by providing an environment that is supportive, consistent, and attentive to their needs. Services are provided at a negative margin.
- e) Renal dialysis Program - Good Samaritan Hospital operates the largest not-for-profit dialysis center in the Baltimore area. The Program offers a complete range of renal dialysis services. A social worker is assigned to each patient to address issues such as education, transportation and support. The Program includes a monthly class where, patients and their families can learn more about hemodialysis, peritoneal dialysis and transplantation. These Program services are provided at a negative margin.
- f) Low Income Housing - Sponsored and managed by Good Samaritan Hospital, the facilities of Belvedere Green and Woodbourne Woods provide rent-subsidized apartments and many other features for its residents. Services provided include transportation to doctors' offices, social work consultation, and assistance with healthcare needs, including educational programs, health screenings, and medication schedules. These senior living services operate at a negative margin.

- g) Pharmacy Care Counseling – For patients concerned about their ability to afford their medication, Good Samaritan Hospital provides an advocate who helps them apply for and manage the many programs that provide medication patient assistance.

- h) Subacute Program - Transitional care, sometimes called sub-acute or extended care, is designed for patients who are too sick to go home, but not sick enough to remain in a traditional hospital bed. Patients benefit from the transitional care setting because it provides them with the care and education they need while preparing them to return to their previous living situations. Many times, Rehabilitation services are provided to maximize each patient's level of function and assist patients and their families to cope with the physical limitations secondary to illness or injury. These services are provided at a negative margin.

FY 2008 UPPER CHESAPEAKE HEALTH NARRATIVE REPORT

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

Harford Memorial Hospital (Provider # 21-0006)

- Licensed Beds – 104
- Inpatient Admissions – 7,352

Upper Chesapeake Medical Center (Provider # 21-0049)

- Licensed Beds – 182
- Inpatient Admissions – 15,803

2. Describe the community your organization serves.

Harford County is a suburban county situated between Baltimore County and the mostly rural Cecil County. Having grown 24% between 1990 and 2007, Harford County is one of the fastest growing counties in the state. The 1990 population was 182,132; the 2007 estimated population is 239,993.

The US Department of Defense recommendations of military base changes across the nation have identified Aberdeen Proving Ground as a primary location for Base Realignment and Closure (BRAC). According to state and local planning experts, Harford County's population is expected to increase as much as an additional 19% over the next 10 years in conjunction with activities related to BRAC alone. The recent past and anticipated growth will provide a serious challenge for residents seeking services in a jurisdiction already experiencing difficult access to care issues. A portion of the resulting population growth will be in hourly wage service sector jobs designed to accommodate the base expansion. Many of these jobs will not include health insurance.

With respect to the demographics of the county, the US Census Bureau in 2005 estimates that 84% of residents are White, 11% are Black, and 2% are Latino, though the actual number of Latino residents is thought to be drastically under-reported. The total number of children receiving MCHP benefits in Harford County is 9,458. Of that total, 5,094 are White; 2,968 are Black, and 450 are Latino; 232 are Asian; and 30 are Native American/Pacific Islander.

Harford County has roughly 87,000 households, of which 31,000 (or 29%) have children under the age of 18. The median household income is \$65,000. Poverty households are those that make less than 30% of the county median income. According to the US Census 2005 American Community Survey, an estimated 5% of family households (approximately 12,000 people) in Harford County live below the poverty level. Approximately 38% of the population has attained only a high school degree or lower.

According to the US Census Bureau Small Area Health Insurance Estimates program, approximately 21,000 residents, or nearly 10% of the County is uninsured, though some estimates put that number as high as 34,000. With potential funding cuts to Medicaid and

rising health care premiums, this group is likely to increase. Additional evidence of the loss of health insurance by many residents is the unprecedented 238% growth in MCHP enrollment in Harford County since the year 2000. In addition, underinsurance is known to exist, but is very difficult to measure.

Who are the Uninsured?

Harford County, as is true across Maryland and the Nation, experiences health disparities in several domains of population demographics including health insurance status, income level, race, and ethnicity. Overall, approximately 12,000 county residents have incomes below 200% of the federal poverty level, and an estimated 21,000-34,000 residents are uninsured.

A 2005 Robert Wood Johnson Foundation study shows that the percent rate of uninsured Blacks in Maryland is 17% and 32% for Latinos, much higher than the 10% rate for Whites. While this data is not broken down at the local level, these figures likely provide a reasonable proxy for the racial and ethnic disparity in access to health care in Harford County.

Data analyzed by the DHMH Office of Minority Health Disparities show that in Harford County from 2001 to 2003, the age adjusted death rate in blacks exceeded that of whites, and that this excess in death rate of Harford County blacks compared to whites is greater than twelve other jurisdictions in Maryland, including Baltimore City. This data can have many implications, ranging from lack of minority access to health care, to the neglect of health concerns, and improper health maintenance. All of these issues can be translated to the less than ideal care received by low-income minority children and adults.

The increase in the rate of minority population growth in Harford County is outstripping that of the white population. According to a US Census report, between 2000 and 2007, Harford County's minority population increased quickly while the rate of growth of its white population slowed. In addition, the availability of medical and mental health care in poor neighborhoods is limited. This requires patients to travel or book months in advance for appointments. Transportation and time off from work is always a difficult obstacle and, in the end, care is often delayed until urgent. With our continued population growth and increasing diversification, access to care will become even more challenging.

While most citizens have health insurance through their employer as a benefit, being employed no longer guarantees that a person will have health coverage. This can be from a variety of reasons. Health benefits may not be offered by the employer or workers may not be eligible to receive benefits. Employee contributions towards health insurance premiums make employer offered health coverage unaffordable for many low wage workers. According to the Kaiser Commission, more than 80% of the uninsured come primarily from working families with low and moderate incomes. Only 19% come from families that have no connection to the workforce.

Local Health Services for the Uninsured

For those individuals who do not have commercial health insurance, there are a number of government or public programs, state and federal, which provide health coverage to the County's residents. Medicaid covers three main groups of non-elderly low-income people:

children, their parents, and persons with disabilities. The Maryland Children's Health Program (MCHP), extends Medicaid benefits to children up to 19 years of age whose families have incomes at or below 200% of the Federal Poverty Level (FPL). Pregnant women are covered up to 250% of the FPL. In addition, under MCHP Premium, health coverage is provided to children under age 19 with family incomes up to 300% of the FPL, if the family pays a small premium. In contrast, the role of Medicaid for adults under the age of 65 is extremely limited. Most low-income adults without dependent children, regardless of how poor they are, do not qualify for Medicaid.

One program which addresses the health care needs of uninsured adults whose incomes are too high to qualify for Medicaid yet too low to enable them to obtain individual and even employer-sponsored health insurance is the Maryland Primary Care (MPC) program. Through this state run program, the Harford County Health Department offers primary care coverage to eligible low income adults between the ages of 19 and 64 but they must have a qualifying chronic medical condition(s). Gross income for a family of four cannot be above \$1,571 per month or \$18,852 per year. Due to funding cuts, there have been times where new patients are not being accepted in the program. In addition, this program does not cover hospitalization or specialty care.

The Upper Chesapeake HealthLink Primary Care Clinic provides free primary care and extensive case management services on a sliding scale fee to eligible uninsured and underinsured Harford County residents ages 19 to 64 and whose income is less than 200% of the federal poverty level. This Clinic is currently able to provide primary care services to approximately 1,000 patients.

The Upper Chesapeake HealthLink Primary Clinic and the Harford County Health Department are Harford County's sources of primary care for the uninsured. The staff of each respective agency works interdependently often sharing resources, clinic space, and expertise as appropriate to provide the best overall health services to their cliental.

Health Consequences of being Uninsured

There is a strong relationship between health insurance and ones ability to access health care services. Uninsured people are less than half as likely as people with health insurance to have a primary care provider; to have received appropriate preventive care, such as recent mammograms or Pap tests; or to have had any recent medical visits. Evidence suggests that lack of insurance over an extended period significantly increases the risk of premature death and that death rates among hospitalized patients without health insurance are significantly higher than among patients with insurance.

According to the Maryland Health Insurance Commission, almost one of every two (49%) uninsured adults with chronic conditions reported forgoing needed medical care or prescription drugs due to cost; one-third reported unmet need for medical care and one of three reported unmet need for prescription drugs. More than 40 percent reported unmet need for dental care. Over six in 10 uninsured black adults who have a chronic condition received no dental care in the past 12 months.

Of special significance is the fact that the uninsured are less likely to have a usual source of care aside from the emergency department. It is estimated that 13% of all Harford County

Emergency Department visits are non urgent self pay patients who are using the ED as their primary care medical home. That is over 11,000 visits that are crowding our emergency rooms every year due to an immediate lack of access to primary care.

3. Identification of community needs. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done.

In December 1993, a group of community leaders, spearheaded by Upper Chesapeake Health, the Harford County Health Department, and Harford County Government, formed Healthy Harford, the Healthy Communities Initiative of Harford County. Incorporated in 1995 as a 501(c)(3), the vision of Healthy Harford - *“to make Harford County the healthiest community in Maryland”* - has consistently motivated the development of this organization’s strategic goals, objectives and programs over the past 15 years. The current President/CEO of Upper Chesapeake Health serves as the President for Healthy Harford; the two primary members are Upper Chesapeake Health and the Harford County Health Department.

Over the years, Healthy Harford has hosted many events and programs designed to promote and improve the general health of adults and children living and working in Harford County. Some of these initial programs included a health carnival, free immunizations for school-aged children, and a Recycle Your Cycle project that encouraged residents to donate their used exercise equipment to benefit the public schools. With a strong commitment to education, Healthy Harford also published yearly health guides, beginning in 1995 with a nutrition “eating out” guide. Since this initial publication, fitness, wellness, healthy heart, substance abuse and cancer prevention guides have been produced and distributed free to the community.

In 1996, Healthy Harford conducted the first Community Health Assessment Project (CHAP), a randomized household phone survey designed to determine the overall health status of community residents based on key health indicators. A 36 member community committee directed this initial process and ultimately identified and prioritized health needs related to preventive health and wellness, heart disease, and cancer. The results of the CHAP assessment also served to align community stakeholders around the common goal of improving the overall health of county residents. Through the creation of Community Action Teams (CATs), Healthy Harford brought together relevant community organizations to develop shared strategies to address each of the top health priorities. Some examples include the “Cancer CAT” that was responsible for implementing a Kids Healthy Lifestyle Program in several Harford County middle schools and the “Heart CAT” that provided education regarding the signs and symptoms of heart attack and stroke to many groups in the community. CHAPs conducted in 2000 and 2005 have enabled Healthy Harford to monitor progress and gather additional information relevant to the community’s overall health. Following CHAP 2000, community report cards were developed with specific goals established for 2005 and 2010 focusing on preventive health and wellness, heart disease, and cancer. Following CHAP 2005, the report cards and 2010 goals were revised based on survey results. The Harford County Master Plan includes and tracks programs, initiatives and education efforts implemented by many organizations in Harford County in support of these goals.

4. Please list the major needs identified through the process explained in question #3.

The following are the report cards and 2010 goals that were developed following the CHAP 2005 survey:

**Healthy Harford, Inc.
Community Health Assessment Project (CHAP)
Report Cards and 2010 Goals**

Healthy Harford Community Report Card – Preventive Health and Wellness				
Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Flu Vaccine	66% of adults 65 years of age and older have had a flu vaccine within the past year.	80% of adults 65 years of age and older have had a flu vaccine within the past year.	77% of adults 65 years of age and older have had a flu vaccine within the past year.	Increase to 90% of adults 65 years of age and older who have had a flu vaccine within the past year.
Pneumonia Shot				75% of adults 65 years of age and older have had the recommended pneumonia shot.
Seatbelt Use While Driving	80% report they always wear their seatbelt while driving.	89% report they always wear their seatbelt while driving.	90% report they always wear their seatbelt while driving.	Increase to 92% of adults who report they always wear their seatbelt while driving.
Seatbelt Use While a Passenger	76% report they always wear their seatbelt while a passenger.	84% report they always wear their seatbelt while a passenger.	87% report they always wear their seatbelt while a passenger.	Increase to 90% of adults who report they always wear their seatbelt while a passenger.
Helmet Use	75% of parents with children under 20 years of age report their children wear a helmet while riding a bicycle or rollerblading.	64% of parents with children under 20 years of age report their children always or often wear a helmet while riding a bicycle or rollerblading.	79% of parents with children under 20 years of age report their children always or often wear a helmet while riding a bicycle, rollerblading or skateboarding.	Increase to 85% of parents with children under 20 that report their children always or often wear a helmet while riding a bicycle, rollerblading or skateboarding.
Sunscreen Use	30% of adults report they regularly wear sunscreen when outdoors.	34% of adults report they regularly wear sunscreen when outdoors.	46% of adults report they regularly wear sunscreen when outdoors.	Increase to 50% of adults who report they regularly wear sunscreen when outdoors.

Healthy Harford Community Report Card – Heart Disease

Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Cholesterol	<p>51% have had their cholesterol screened within the past two years.</p> <p>21% report they have been told by a doctor that they have/had high cholesterol.</p>	<p>95% have had their cholesterol screened within 0-3 years.</p> <p>75% have had their cholesterol screened within the past two years.</p> <p>24% report they have been told by a doctor that they have/had high cholesterol.</p>	<p>92% have had their cholesterol screened within 0-3 years.</p> <p>32% report they have been told by a doctor that they have/had high cholesterol.</p>	<p>90% of adults aged 18 years and older have had their blood cholesterol checked within the preceding 5 years. (2010 goal based on revised recommendations).</p>
Overweight	<p>39% of adults have a BMI >30.</p>	<p>26% of adults have a BMI >30.</p>	<p>32% of adults have a BMI >30.</p>	<p>Reduce to 25% of adults who have a BMI >30.</p>
Smoking	<p>18% of Harford County adults smoke.</p> <p>32% of Harford County youth report smoking. (1998 MYTS)</p>	<p>14% of Harford County adults smoke.</p> <p>21% of Harford County youth report smoking. (2000 MYTS)</p>	<p>9.5% of Harford County adults smoke.</p>	<p>Reduce to 9% the level of smoking among adults.</p> <p>Reduce to 10% the level of smoking among youth.</p>
Blood Pressure	<p>68% have had their blood pressure screened within the past two years.</p> <p>21% of residents report they have or have had high blood pressure.</p>	<p>99% have had their blood pressure screened within 0-3 years.</p> <p>86% have had their blood pressure screened within the past two years.</p> <p>31% of residents report they have or have had high blood pressure.</p>	<p>97% have had their blood pressure screened within 0-3 years.</p> <p>32% of residents report they have or have had high blood pressure.</p>	<p>50% of adults 18 years and older with high blood pressure will have their blood pressure under control. (2010 goal based on revised recommendations)</p>

Healthy Harford Community Report Card – Cancer

Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Cervical Cancer	57% of adult women have had a pap smear within the past two years.	97% of adult women have had a pap smear within 0-3 years. 74% of adult women have had a pap smear within the past two years.	93% of adult women have had a pap smear within 0-3 years.	Maintain 93% of women aged 18 to 70 years who received a pap test within the preceding 3 years.
Breast Cancer	74% of women 50 years of age and older have had a mammogram within the past two years.	51% of women 50 years of age to 69 have had a mammogram within the past year. 76% of women 50 years of age to 69 have had a mammogram within the last two years.	67% of women 50 years of age to 69 have had a mammogram within the past year.	70% of women aged 40 years and older have received a mammogram within the past year. <i>(2010 goal based on revised recommendations)</i>
Prostate Cancer	56% of men 50 years of age and older have had a digital rectal exam within the past year.	62% of men 50 years of age and older have had a digital rectal exam within the past year.	59% of men 50 years of age and older have had a digital rectal exam within the past year.	Increase to 70% of men 50 years of age and older who have had a digital rectal exam within the past year.
Skin Cancer	30% of adults report they regularly wear sunscreen when outdoors.	34% of adults report they regularly wear sunscreen when outdoors. 69% of adults with children <20 report their children regularly wear sunscreen when outdoors.	46% of adults report they regularly wear sunscreen when outdoors. 65% of adults with children <20 report their children regularly wear sunscreen when outdoors.	Increase to 50% of adults who report regularly wearing sunscreen when outdoors. Increase to 70% of adults with children <20 who report that their children regularly wear sunscreen when outdoors.
Colorectal Cancer	13% report they have been tested for colorectal cancer.	33% of respondents >50 have had a fecal occult blood test (FOBT) within the past year. 18% of respondents >50 have had a sigmoid/colonoscopy within the past year.	55% of respondents >50 have had a fecal occult blood test (FOBT) within the past year. 29% of respondents >50 have had a sigmoid/colonoscopy within the past year.	75% of adults 50 years and older report either having a FOBT in the past year or a colonoscopy within the last 10 years. <i>(2010 goal based on revised recommendations)</i>

Healthy Harford Community Report Card – Cancer

Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Oral Cavity and Pharynx	87% of adults report they have been to the dentist in the last two years. 88% of children go to the dentist for regular check-ups.	76% of adults report they have been to the dentist in the last year. 94% of parents report their children go to the dentist for regular check-ups.	79% of adults report they have been to the dentist in the last year. 88% of parents report their children go to the dentist for regular check-ups.	Increase to 90% of adults with dental screenings within the last year.

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefit activities of your hospital?

Decisions to determine which needs in the community would be addressed through community benefits activities of the hospital was a collaborative effort of the following:

- The Director of Community Health Improvement chairs a community “Access to Care” Committee comprised of representatives from Upper Chesapeake Health, the Harford County Health Department, The Office of Mental Health/ - Core Services Agency, and the Department of Social Services. With the Upper Chesapeake HealthLink Primary Care Clinic serving as the sole provider of free primary care and specialty referral services in the County, the Committee works towards collaborative efforts to meet the comprehensive scope of access to care needs for those that are uninsured and underserved in the County. In 2007, the Committee was successful in obtaining an MUA designation for Harford County through a Governor’s Exceptional Designation; they also developed an Access to Care Strategic Plan that identified the strengths, challenges, opportunities and goals for enhanced Access to Care Services in Harford County.
- Through collaboration with the Healthy Harford Board, several community benefit programs were developed based on the CHAP Report Cards and 2010 goals.

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

The following are examples of community benefit programs that resulted from the needs and 2010 goals identified in the CHAP 2005 survey:

- Flu vaccine and pneumonia shots were offered directly in all Senior Centers and nursing homes as well as the majority of Assisted Living Facilities in Harford County.

- Working collaboratively with the State Highway Administration, safety helmets were given to youth and children for a nominal \$3 charge following a proper fitting at several large community events.
- Several community education programs focused on sunscreen use were conducted during May.
- Based on the results of the CHAP Survey with respect to the lack of proper nutrition and daily activity of Harford County residents, a major Healthy Harford Community Action Team has been developed and will begin the task of developing a comprehensive Nutrition and Physical Activity Plan for Harford County in January 2009. Support and direct participation for this project is community-wide and includes Upper Chesapeake Health, the Harford County Health Department, the Harford County Executive's Office, Harford County Council, the Town of Bel Air, Havre de Grace City Council, Aberdeen City Council, Harford County Chamber of Commerce, Harford Community College, the ARC Northern Chesapeake Region, Harford County Public Schools, Harford County Parks 'n Recreation, Harford County Public Libraries, Harford County Sheriff's Office, and the Boys and Girls Club of Harford County. This is a 12 to 18 month project.
- Free blood pressure screenings are offered throughout the County at alternating locations on an on-going basis.
- Through collaboration with Upper Chesapeake Health physicians, free screenings for prostate cancer, skin cancer, colorectal cancer, and oral cavity cancer are provided free of charge once a year at each hospital.

7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major Community Benefit program initiatives.

A primary evaluation strategy is through the Healthy Harford Community Health Assessment Project (CHAP) that is now conducted every 5 years to determine progress on the community report cards and 2010 goals. Planning for CHAP 2010 will commence in early 2009. On an on-going basis, evaluations are given to consumers at the HealthLink Primary Care Clinic and at all community-based events. These evaluations are reviewed on an on-going basis so that improvements and changes can be made based on feedback received.

8. 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.

The Upper Chesapeake HealthLink Primary Care Clinic (UC HealthLink PCC) is a primary care clinic that serves low income (200% of the Federal poverty level) uninsured and underinsured patients ages 19-64. Our patients, due to lack of previous regular health care, mental illness, substance abuse, developmental impairment, etc. often present at our clinic with multiple medical problems that require a variety of specialty care appointments. Since Harford County does not have an FQHC, a Community Health Center, links to a medical resident program, or an abundance of hospital owned physician practices, we are at the mercy of the generosity of local private physicians and medical service providers to donate pro-bono and reduced cost services to our patients. As our patient load increases (we are projecting a 4 fold increase within the next three years), the strain of continuously visiting the

same well of limited specialty care providers is becoming more strained. For the present, our system of case-by-case pro-bono or reduced cost referrals is functional, however, in preparing for the immediate future, the Strategic Plan for the Harford County Access to Care Committee has prioritized the development of a streamlined system that will meet the needs of our target population while maximizing the limited specialty care resources available to us in this county. The Committee will work towards this goal in 2009. The two most critical needs with respect to specialty care include OBGYN and Dental Services.

Appendix 1:

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.

The Upper Chesapeake HealthLink Primary Care Clinic (UC HealthLink PCC) is a primary care clinic that serves low income (200% of the Federal poverty level) uninsured and underinsured patients ages 19-64. Our patients, due to lack of previous regular health care, mental illness, substance abuse, developmental impairment, etc. often present at our clinic with multiple medical problems that require a variety of specialty care appointments. Since Harford County does not have an FQHC, a Community Health Center, links to a medical resident program, or an abundance of hospital owned physician practices, we are at the mercy of the generosity of local private physicians and medical service providers to donate pro-bono and reduced cost services to our patients. As our patient load increases (we are projecting a 4 fold increase within the next three years), the strain of continuously visiting the same well of limited specialty care providers is becoming more strained. For the present, our system of case-by-case pro-bono or reduced cost referrals is functional, however, in preparing for the immediate future, the Strategic Plan for the Harford County Access to Care Committee has prioritized the development of a streamlined system that will meet the needs of our target population while maximizing the limited specialty care resources available to us in this county. The Committee will work towards this goal in 2009. The two most critical needs with respect to specialty care include OBGYN and Dental Services.

Appendix 2:

Describe your Charity Care policy

A summary of Upper Chesapeake Health's Financial Assistance policy is available to every patient who registers for patient care services at Upper Chesapeake Medical Center and Harford Memorial Hospital. There are signs (written in both English and Spanish) located at every patient registration station that notifies a patient that Upper Chesapeake Health provides financial assistance to those patients who are eligible or who have concerns about paying their bill. Along with the Financial Assistance summary, patients who are registered as self-pay as well as any patient who expresses interest or concern receive an application and a cover letter that instructs the patient how to apply for government benefits (MD Medical Assistance) as well as the health system's charity program and who they should contact with questions.

Appendix 3:

Include a copy of your hospital's charity care policy

UPPER CHESAPEAKE HEALTH HOSPITALS
Patient Accounting Department Policy Manual

TITLE: FINANCIAL ASSISTANCE POLICY

Page 1 of 2

APPROVED BY:

Original Date: 02/99

Revised Date: 12/08

Next Scheduled Review Date: 12/09

Related JCAHO Functional Area Chapters: RI

PURPOSE:

The Financial Assistance Policy has been established to provide financial relief to those who are unable to meet their financial obligation to UCH.

POLICY:

Eligibility will be based on 150% of the Federal Poverty Level as published annually by the Federal Government. Percentage determination will be based on income and family size with net liquid assets not exceeding \$10,000.00.

PROCEDURE:

1. All income determinations will be based on Gross income with the exception of Social Security/Pension income which will be determined based on Net income. The patient's/guarantor's eligibility will be determined using the following as proof of income:
 - Employment (most current 3 paystubs)
 - Retirement/Pension Benefits
 - Social Security Benefits
 - Public Assistance Benefits
 - Disability Benefits
 - Unemployment Benefits
 - Veterans Benefits
 - Alimony
 - Rental Property Income
 - Strike Benefits
 - Military Allotment
 - Farm or Self-employment
2. Exclusions from requiring income information:
 - Deceased Patients
 - If it is determined that there is no estate on file, and the patient expired at either Upper Chesapeake Medical Center or Harford Memorial Hospital, the account will be referred for 100% Financial Assistance. If the patient expired anywhere else, a copy of the death certificate will be required before the write off.
 - Out of State Medical Assistance
 - If the patient's account balances total less than \$1000.00, the Medical Assistance Follow Up Representative must contact the out of state Medical Assistance plan to verify the patient's eligibility for that date of service. If the patient was eligible, the account will be referred to the Patient Financial Liaison to prepare the account for Financial Assistance. The account balances

will be eligible for 100% Financial Assistance. If the patient was not eligible with the out of state Medical Assistance plan for that date of service, the account balance will become Self Pay.

➤ **Over 18 Being Supported by Others**

If the patient is not working and has no proof of income, the account will be referred to the appropriate collection agency for verification. A notarized letter is required signed by the person who is providing for the patient.

3. With each application, all prior accounts with a patient liability for this guarantor must be identified and listed on the determination form with the exception of accounts in a Bad Debt status. Once a final determination is made, the Patient Financial Liaison will complete a *Financial Assistance Determination* form that will be submitted to the Patient Accounting Supervisor who will determine approval and forward for additional approval as follows:

Adjustments up to \$ 2,500.00 Patient Accounting Supervisor

Adjustments up to \$ 5,000.00 Patient Accounting Manager

Adjustments up to \$10,000.00 Patient Accounting Director

Adjustments over \$10,000.00 V.P. of Finance

4. After the final determination has been made, the patient will either receive a *Financial Assistance Patient Notification* letter to advise him of the Assistance he will receive or the *Financial Assistance Denial* letter to advise him of the reason that he did not qualify.
5. Any exceptions to the above must be authorized by the Supervisor and/or Director.

Appendix 4/5:

UPPER CHESAPEAKE HEALTH MISSION, VISION, VALUE

Vision: The Vision of Upper Chesapeake Health is to become the preferred, integrated health care system creating the healthiest community in Maryland.

Mission: Upper Chesapeake Health is dedicated to maintaining and improving the health of the people in its communities through an integrated health delivery system that provides high quality care to all. UCH is committed to service excellence as it offers a broad range of health services, technology and facilities. It will work collaboratively with its communities and other health organizations to serve as a resource for health promotion and education.

Excellence: We constantly pursue excellence and quality through teamwork, continuous improvement, customer satisfaction, innovation, education and prudent resource management.

Compassion: People are the source of our strength and the focus of our mission. We will serve all people with compassion and dignity.

Integrity: We will conduct our work with integrity, honesty, and fairness. We will meet the highest ethical and professional standards.

Respect: We will respect the work, quality, diversity, and importance of each person who works with or is served by Upper Chesapeake Health.

Responsibility: We take responsibility for our actions and hold ourselves accountable for the results and outcomes.

Trust: We will strive to be good citizens of the communities we serve and build trust and confidence in our ability to anticipate and respond to community and patient needs.

COMMUNITY BENEFIT NARRATIVE REPORT

FISCAL YEAR 2008

Holy Cross Hospital
1500 Forest Glen Rd
Silver Spring, MD 20910

BACKGROUND

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

The Commission’s response to the legislation was to establish a reporting system for hospitals to report their community benefits activities. The guidelines and inventory spreadsheet rely in large part on the VHA, CHA, and Lyon software community benefits reporting experience, which was then tailored to fit Maryland’s unique regulated environment. The narrative requirement is intended to strengthen and supplement the qualitative and quantitative information that hospitals have reported in the past. The narrative is focused on (1) how hospitals determined the needs of the communities they serve, (2) initiatives undertaken to address those needs, and (3) evaluations undertaken regarding the effectiveness of the initiatives.

Narrative Report:

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

During fiscal year 2008 there were 404 licensed beds and 31,484 inpatient admissions.

2. Describe the community your organization serves. The narrative should address the following topics: (The items below are based on ***IRS Schedule H, Part V, Question 4***).

- Describe the geographic community or communities the organization serves;

Montgomery and Prince George’s Counties are home to an estimated 180,000–200,000 uninsured adults. Target populations have been identified based on critical need looking at the social health determinants of the geographical areas served. The total population of Montgomery and Prince George’s Counties is 1,773,446.

<u>Group</u>	<u>Montgomery County</u>	<u>Prince George’s County</u>
White-Non-Hispanic	576,153 (61.8%)	191,399 (22.7%)
Black Non-Hispanic	152,669 (16.4%)	543,079 (64.6%)
Asian	124,605 (13.4%)	32,177 (3.8%)
Hispanic or Latino (any race)	128,365 (13.8%)	98,579 (11.7%)
All Others	78,704 (8.5%)	74,660 (.04%)

(U.S. Census Bureau, 2006 American Community Survey)

- Describe significant demographic characteristics that are relevant to the needs that the hospital seeks to meet. (e.g., population, average income, percentages of community households with incomes below the federal poverty guidelines, percentage of the hospital's patients who are uninsured or Medicaid recipients, [concentrations of vulnerable populations] and life expectancy or mortality rates);

For many health conditions, non-Hispanic blacks bear a disproportionate burden of disease, injury, death, and disability when compared to their white counterparts (Center for Disease Control and Prevention, 2005).

In Maryland, Asian Americans and Pacific Islanders are more likely to be without health insurance than non-Hispanic whites and are more likely to be unable to afford care when needed (Maryland Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities, 2006).

All minority groups are less likely to have health insurance or to be able to afford to see a physician when compared to their white counterparts (Center for Disease Control and Prevention, 2008).

Although overall breast cancer death rates are falling in Maryland, most Maryland counties do not meet the Healthy People 2010 objectives for breast cancer annual death rates per 100,000. Prince George's County has the sixth-to-eighth highest rate of deaths in the state for breast cancer (Kung H.C., Hoyert D.L., Xu J.Q., Murphy S.L., 2008).

According to the Maryland-National Capital Park and Planning Commission Strategic Plan Fiscal Years 2007-2009 for Montgomery and Prince George's Counties and based on U.S Census Bureau data:

- The Bi-County region is expected to add 20,000 persons and 8,000 households a year over the next 10 years. In both counties, growth has now reached the edge of the development envelope (the area planned and zoned for development). Of necessity, in the near future, a majority of new housing units in both counties will likely be multi-family housing. Population density, or persons per square mile, will increase. This is a major change from the experience of both counties since suburbanization began in the 1920s.
- Fertility (birth) rates among the foreign-born are higher than native-born.
- Foreign-born often have larger households.
- Foreign-born often live in multifamily housing units and/or rental units.
- Foreign-born often utilize public transportation as a main source of transit.
- 21 percent of the foreign-born report that they do not speak English at all.

- 62 percent of foreign-born speak English as a second language.

3. Identification of Community Needs:

- a. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done (*based on IRS Schedule H, Part V, Question 2*).

The following are examples of how community health needs might have been identified:

- Used formal needs assessment developed by the state or local health department. If so, indicate the most recent year;
- Formal needs assessment was done by the hospital. If so, indicate the most recent year and the methods used;
- Did formal collaborative needs assessment involving the hospital. If so, indicate the most recent year, the collaborating organizations, and methods used;
- Analyzed utilization patterns in the hospital to identify unmet needs;
- Surveyed community residents, and if so, indicate the date of the survey;
- Used data or statistics compiled by county, state, or federal government;
- Consulted with leaders, community members, nonprofit organizations, local health officers, or local health care providers (indicate who was consulted, when, and how many meetings occurred, etc.);

During fiscal year 2008, Holy Cross Hospital identified unmet community health needs by participating in community coalitions, partnerships, boards, committees, commissions, advisory groups, and panels. On a quarterly basis, the hospital also analyzes internal patient surveys and publicly available data on the market including demographics and health services utilization. Local needs assessments and reports as they became available; especially the Montgomery County Department of Health and Human Services strategic plan and this past April, the Community Needs Index (CNI) developed by Catholic Healthcare West and the Healthcare business of Thomson Reuters were used to determine the types of community benefit programs that were implemented.

Using the CNI, Holy Cross Hospital gathered vital socio-economic factors to support internal decision-making for resource allocation and location of new programs to meet emerging needs.

Each year the Montgomery County Department of Health and Human Services and members of the community are invited to participate in a review of our community

benefit plan. This provides an opportunity to not only get feedback on our proposed community benefit plan but also to exchange information through dialogue and identify new and emerging needs in the community.

Another source of information used to identify the health needs in our community is from our Ethnic Health Promotion program. This program is comprised of ethnic health promoters that provide culturally competent and linguistically sensitive health education and wellness activities. This program targets racial and ethnic communities who are low-income and medically underserved. The ethnic health promoters' work is based on their shared observation of need and the concerns they hear in the community.

- b. In seeking information about community health needs, did you consult with the local health department?

We work closely with the local health department, the Montgomery County Department of Health and Human Services. We invited the Montgomery County Department of Health and Human Services to participate in a review by an external panel of our community benefit plan. When it came to our attention that the Montgomery County Women's Cancer Control Program (WCCP) that serves medically underserved low-income women was to close to new enrollees in July 2008 due to state and county budget cuts, we immediately partnered with community clinics to provide 288 of their patients with screenings for early breast cancer detection at no cost. These services take place at the hospital and include clinical breast examinations, mammography other diagnostics with links to treatment.

Patients enrolled in the Montgomery Cares clinics which include the Holy Cross Health Center, People's Community Wellness Center and Projecto Salud and our ethnic health promoters make referrals to this breast cancer screening program. The ethnic health promoters provide information on numbers of referrals and other identified needs they observe or have heard about from members of the community.

In our consultation with the Montgomery County Department of Health and Human Services about filling this gap in services, we also discussed the need for a rapid referral system for breast cancer screenings. Holy Cross Hospital has a successful rapid referral model already in place and we are working with a local coalition on a process improvement plan for the County that incorporates our rapid referral system.

We also use the following needs assessments to identify and respond to local needs:

- Blueprint for Latino Health in Montgomery County Maryland, 2008-2012

- Latino Health Initiative Annual Report, Educating, Mobilizing and Empowering our Latino Community, Fiscal Year 2007
- The Children's Agenda 2007 Data Book, Montgomery County Collaboration Council for Children, Youth and Families
- Partnering Toward a Healthier Future 2007 Progress Report, Eliminating Health Disparities in Frederick, Montgomery and Prince George's Counties in Maryland, Center on Health Disparities, Adventist Health Care
- The Maryland Comprehensive Cancer Control Plan, Executive Summary 2004-2008
- Governor's Commission on Hispanic Affairs 2007 Annual Report
- Federal Interagency Forum on Aging-Related Statistics, "Older Americans 2008, Key Indicators of Well-Being"
- Healthy Women, Healthy Babies, An Issue Brief from the Trust for America's Health
- The State of Health Care Quality 2007, National Committee for Quality Assurance, Washington, D.C.

4. Please list the major needs identified through the process explained in question #3.

Based on the above needs assessments, the major community needs identified for fiscal year 2008 were:

- 1.) The need to increase access to quality health care, especially for children, pregnant women, uninsured adults and seniors.
- 2.) The need to obtain medical care for the underserved by enrolling eligible residents in Medicaid, MHIP and other insurance programs, increasing funding for and additional school-based health programs and health centers.
- 3.) The need to eliminate racial and ethnic health disparities by providing culturally and linguistically competent care and targeting diseases that are more prevalent in minority populations.
- 4.) The need to provide health education, disease prevention and chronic disease management (including obesity) to improve the health status of the community.

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

Holy Cross Hospital's interdepartmental leadership and its board of trustees plan, monitor and evaluate the hospital's community benefit efforts. Initiatives are thoughtfully planned to ensure that links exist between the hospital's clinical expertise, strategic and program plans and unmet community needs.

To determine the needs of the community, Holy Cross Hospital has a Chief Executive Officer (CEO) Review Committee on Community Benefit (an internal committee) that utilizes available data (e.g., needs assessments, hospital patient data, CNI) to develop the hospital's "Community Benefit Work Plans." Once a year, an external committee of community leaders (including the Montgomery County Health and Human Services) reviews the goals and objectives. The work plans describe the goals and objectives the hospital expects to meet during the fiscal year. Once approved by the Holy Cross Hospital board of trustees, the CEO Review Committee meets on a quarterly basis to review progress toward the expected outcomes. That progress is reviewed with the Mission and Strategy Committee of the Board of Trustees.

Our activities focus on positively impacting the health of our community with programs tailored to the unique needs of women, infants and seniors, and racial and ethnic and linguistic minorities.

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

- 1.) The need to increase access to quality health care, especially for children, pregnant women, uninsured adults and seniors.
 - Medical Adult Day Center - Provides social and cognitive stimulation, recreational and rehabilitative services for medically disabled and senior adults
 - Discharge assistance program
 - Transportation assistance – Ambulance and taxi vouchers
 - Homecare
 - OB/GYN Clinic – services for the medically underserved and uninsured, including diabetes education
 - Holy Cross Hospital Health Center
 - Outpatient Lactation Services

- 2.) The need to obtain medical care for the underserved by enrolling eligible residents in Medicaid and MHIP and other insurance programs, increasing funding for and additional school-based health programs and health centers.
 - Charity Care – As guided by the hospital's charitable care policy, which includes patients from the HCH OB/GYN Clinic and Holy Cross Health Center
 - Financial counseling that is linguistically sensitive
 - Maryland Health Insurance Program (MHIP) – With enrollment and premium assistance funded by Holy Cross Hospital
 - School-based health center health fairs
 - Expansion of the Holy Cross Health Center

- 3.) The need to eliminate racial and ethnic health disparities by providing culturally and linguistically competent care and targeting diseases that are more prevalent in minority populations.
 - Health fairs and screenings with links to treatment
 - Cancer program research – Increasing racial and ethnic group enrollment
 - Ethnic Health Promotion Program
- 4.) To provide health education, disease prevention and chronic disease management (including obesity) to improve the health status of the community.
 - Faith Community Nursing – Outreach, wellness and chronic disease management, health education
 - Community Health – Outreach, wellness and chronic disease management, health education, and physical fitness
 - Senior Source – Outreach, wellness and chronic disease management, health education and mind/body fitness
 - Perinatal Education – Outreach and education
 - Ethnic Health Promoters – Culturally competent community capacity building around disease prevention, cancer control and tobacco cessation
 - *Kids Fit* – Free children’s multi-component exercise program at Housing Opportunities Commission properties
 - *Senior Fit* – Free multi-component evidence-based exercise program at 19 locations
 - *Diabetes Prevention Program* –Based on a National Institutes of Health evidence-based model
 - *Diabetes Self-Management Program*
 - *Pre-Diabetes Workshops*
 - *Falls Prevention* – Incorporates “A Matter of Balance,” an evidence-based exercise and education program
 - *Heart Failure Workshop* – Congestive heart failure prevention and management
 - *Chronic Disease Self-Management* – Utilizes the Stanford University evidence-based model

7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major Community Benefit program initiatives.

For example: for each major initiative where data is available, provide the following:

- a. Name of initiative:
- b. Year of evaluation:
- c. Nature of the evaluation: (i.e., what output or outcome measures were used);
- d. Result of the evaluation (was the program changed, discontinued, etc.); or

- e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

Program One

- a. Name of initiative: Senior Initiative: *Senior Fit*, a free 45-minute multi-component exercise class for adults age 55 and older that focuses on increasing strength, endurance and flexibility. Offered in partnership with Kaiser Permanente with an enrollment of 2,203 seniors in fiscal year 2008. Fifty-six classes are held each week at 19 sites with 62,253 encounters in fiscal year 2008.
- b. Year of evaluation: 2008 Senior Fit Assessments (Rikli and Jones, 2001)
- c. Nature of the evaluation: The evidence-based Rikli and Jones Senior Fitness assessment Tool (2001) is unique because it measures physiologic parameters using functional movement tasks, such as standing, bending, lifting, reaching and walking. The tool assesses changes in the participants. The biannual Holy Cross Hospital *Senior Fit* assessments include the chair stand (measures lower body strength), arm curl (measures upper body strength), back scratch, (measures flexibility) and the 8-foot up and go test (measures agility and balance).
- d. Result of the evaluation: Fitness Assessment Results

A matched data sample of 263 seniors (205 women and 58 men, ages range from 56-91 years) was gathered in November 2007 and July 2008. The July 2008 tests demonstrated an increase in those that performed “above standard” in following tests: back scratch 40% (91), increased from 38% (86); arm curl 86% (212), increased from 75% (185); and chair stand 69% (170), increased from 67% (163). (The two other parameters – “within and below standard” also showed improved scores in July.)

The valid and reliable Senior Fitness Tests are conducted on a biannual basis. More than 10 years of data have been collected, including samples of matched data for biannual comparison for participant progress and/or health maintenance. This data is also used to evaluate instructor performance and demonstrate effectiveness to support program growth across Montgomery County. The success of the program has resulted in a national rollout of *Senior Fit* programs at seven hospitals within the Trinity Health network. In October of 2008, *Senior Fit* received an Excellence and Innovation Award from Trinity Health for rapid replication of the program.

- e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

Program Two

- a. Name of initiative: Maternal and Child Health Initiative: *Kids Fit*. In partnership with the Housing Opportunities Commission of Montgomery County, Holy Cross Hospital provides *Kids Fit*, a free multi-component exercise class is specially designed for children ages 6 – 12. A one-hour class includes tips on healthy lifestyle, a fun exercise program and a nutritious snack.
- b. Year of evaluation: Kids Fit: December 19, 2007 and June 4, 2008
- c. Nature of the evaluation: The biannual fitness assessments take place every fall and spring and utilize the evidence-based President's Challenge program. The results are scored using norms for age and sex.
- d. Result of the evaluation: Fitness Assessment Results; December 2007 compared with June 2008

The girls' scores improved significantly in the push-up test (upper body strength) and declined in the shuttle run (speed and agility). Scores for the curl-ups (abdominal strength) and sit and reach (flexibility) stayed consistent but remained below the 70th percentile.

Scores for the boys were similar. Upper body strength improved as evidenced by the push-up scores and speed and agility declined per the diminished results in the shuttle run. Scores for the curl-ups improved by 12% and declined by 7% for the sit and reach. Both the shuttle run and sit and reach scores were below the 70th percentile.

Results from the testing showed a need for increased activity in the areas of speed and agility (cardiovascular exercise), abdominal strength (core conditioning) and flexibility (stretching) for the girls. Priorities for the boys include increased cardiovascular training and flexibility work.

- e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

Program Three

- a. Name of initiative: Chronic Disease Management Initiative: Diabetes Prevention and Self-Management Class

The Diabetes Prevention Program is designed to help the person who has pre-diabetes make lifestyle changes that include weight loss and exercise and prevent or delay the onset of diabetes or cardiovascular disease. It is a free twelve-week classroom program, followed by six months of telephone support. A blood test result documenting pre-diabetes or blood pressure or cholesterol elevations that indicate risk for cardiovascular disease are required for inclusion.

- b. Year of evaluation: Outcome measurements: January and July 2008
- c. Nature of the evaluation: Monitoring the following:
 - 1.) Class attendance
 - 2.) Weight control
 - 3.) Exercise regimen
 - 4.) HgbA1c (HgbA1c >6 = pre-diabetic)
 - 5.) Lipid profile
- d. Result of the evaluation: Outcome measurements are as follows
 - 1.) Class attendance
 - 27 individuals began and 23 completed the two classes offered in fiscal year 2008
 - 86% attended at least 80% of classes
 - 47% attended 100% of classes
 - 2.) Weight Control
 - Weight loss was achieved by 93% of attendees
 - 13% met the 7% weight loss goal
 - 13% met the 5% weight loss goal
 - 3.) Exercise regimen
 - 47% (11) increased their exercise level from pre-program levels
 - 34% (8) met the program exercise goal (at least 150 minutes/week)
 - 4.) HgbA1c
 - HgbA1c levels improved in 100% of participants
 - 5.) Lipid profile
 - Lipid levels improved in 80-100% of participants
- e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

Program Four

a. Name of initiative: Chronic Disease Management - Heart Failure

An interactive workshop that offers practical information about the early signs and symptoms of heart failure, a lecture on heart-healthy nutrition, medication review, and a blood pressure screening. A heart-healthy cooking demonstration with lunch is also provided.

b. Year of evaluation: July 2008, completion of four classes for FY08

c. Nature of the evaluation:

A qualitative and quantitative evaluation included the following information: Demographics (age, income and zip code), reason for attendance (not all participants were diagnosed with heart failure), number of times hospitalized, how they heard about the program, and recommendations for change.

A sample class response: 9 participants

- 1.) 87% of the participants learned about body changes that accompany heart failure as compared to 21% who knew this information at the beginning of the class
- 2.) 73% indicated that they would keep follow-up clinic appointments with their cardiologist, as compared to 57% who indicated this at the beginning of the class

d. Result of the evaluation (was the program changed, discontinued, etc.):

- 1.) Expand program to five hours to provide ample time for program and screenings.
- 2.) Hold workshops bi-monthly in the fall
- 3.) Provide participants with practical tools they can use at home such as sample menus for a week, blood pressure and weight monitoring cards.
- 4.) Purchase and use standard video that effectively illustrates the cause of heart failure and depicts individuals living actively with the condition.

e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

A more comprehensive evaluation that reflects the learning is in progress.

Program Five

- a. Name of initiative: Maternal and Child Health Initiative: Managing Gestational Diabetes in Latino Patients

This program was developed due to the prevalence of gestational diabetes in Latinos at a rate of two to three times higher than the general population. Approximately 83% of the obstetrical and gynecological clinic patients at Holy Cross Hospital OB/GYN Clinic are Latina. Many of these patients become at-risk during their pregnancy due to inadequate glycemic control.

- b. Year of evaluation: November 12, 2007 – February 18, 2008

- c. Nature of the evaluation: To monitor dietary intake and glucose levels

Patients recorded diary entry four times per day to document their glucose levels and the number of times they exercised per week.

Nurses entered the glucose levels into a software program that provided graphs of:

- i. The patient's glycemic averages
- ii. Pre- and post-intervention glucose levels
- iii. Individual exercise patterns

Data was summarized on a pre- and post-implementation line graph comparing the average aggregate of weekly glucose levels. Exercise levels were summarized as percentage of patients who exercised one-to-two times per week, three-to-four times per week, or greater than four-times per week.

- d. Results of the evaluation:

During the period of November 12, 2007 through February 18, 2008, the clinic patients showed a three percent decrease in the aggregate average weekly glucose levels as compared to the 14 weeks prior to the data collection period.

During this same period, 59% of the patients reported participating in moderate exercise three or more times a week.

- e. If no evaluation has been done, does the hospital intend to undertake any evaluations in the future and if so, when?

8. 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.

There is reluctance by non-hospital based medical staff to care for the uninsured, especially by "on call" specialty physicians in the emergency center, despite the fact that the "on call" specialists have agreed to care for the uninsured as part of their hospital privileges. Many of the physicians feel the liability and financial burden of caring for these patients is too great.

Inpatient specialty care is provided by hospital employed specialty care physicians, hospitalists, and other professional staff that provide care in the following specialties: Neurology, cardiology, pulmonary, orthopedics, dermatology, infectious disease, oncology, hematology, medical imaging, laboratory, infusion center, wound center, anesthesiology, pre surgical testing, surgery, obstetrics, gynecology, physical therapy, home care, hospice, patient education, pharmacy, sleep lab, electrocardiogram, and pain management. Gaps will occur when the ratio of uninsured patients to insured patients threatens sustainability.

Uninsured outpatients have access to hospital services but are in need of outside resources for most of their specialty care. The Holy Cross Hospital Health Center is fortunate to have experienced, full-time physicians that are able to treat and manage many of the patients requiring specialty care. The Holy Cross Hospital Health Center is able to provide specialty care in neurology, orthopedics, and otorhinolaryngology on-site on a limited basis. These specialists can accommodate the Health Center's immediate needs. Nurses report having a difficult time referring patients for gastroenterology and urology. Nurses are also concerned that the ophthalmology co-pay and travel distance present financial and geographical barriers to access. Physicians are also concerned that there is limited referral access to gastroenterology and hematology.

Holy Cross Hospital financial counselors assist patients in the hospital and at our Health Center with enrollment into the Maryland Health Insurance Program (MHIP), a state health insurance plan for low-income residents of Montgomery County with pre-existing conditions who are unable to obtain health insurance coverage. With funds from Trinity Health, patients that are eligible are also provided with premium assistance.

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Appendix 1

Charity Care Policy Description

All Holy Cross Hospital registration, financial counseling and customer service staff members are trained to be familiar with the availability of financial assistance and the criteria for such assistance.

In addition:

- The financial assistance application and information about the program are prominently displayed in all registration areas, the emergency center and each cashier's office. The information available is offered in both English and Spanish, the predominant languages in our patient population at Holy Cross Hospital.
- Material describing the financial assistance program and an application are to be given or sent to all patients who request this information.
- Staff is responsible for being particularly alert to those who are registered as self-pay patients and provide them with information on how to contact a financial counselor or provide them financial assistance information. All self-pay inpatients are screened for eligibility for federal, state or other local programs before financial assistance is offered.
- The financial assistance application is accessible through the hospital's external website
- Notice of financial assistance availability is indicated on all hospital billing statements

Appendix 2

Charity Care Policy

SUBJECT: FINANCIAL ASSISTANCE TO PATIENTS

PURPOSE: To provide a systematic and equitable way to provide Holy Cross clinical services to those who have medical need for those services and lack adequate resources to pay for those services. To provide that service while recognizing the need to preserve the dignity of individuals in need of this assistance.

POLICY: It is part of the Holy Cross mission to make necessary medical care available to those who are unable to pay for that care. This policy requires patients to cooperate with and avail themselves of all available programs (including Medicaid, workers compensation, and other state and local programs), which would appear to provide coverage for those services. Only services for which it is not possible to obtain any other program coverage will qualify for charitable assistance at Holy Cross.

All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for charitable assistance. Each request for assistance will be reviewed based upon an assessment of the patient's and / or family's needs, income, and financial resources.

By providing services without payment, Holy Cross is trading off the ability (resources) to provide future service to other patients as it provides uncompensated services to patients at present. Since resources are limited, financial assistance must be allocated to the most needy using an equitable method. The method chosen by Holy Cross evaluates both the income and the accumulated resources of the individual requesting financial assistance.

Changes in the formula that is used to set Holy Cross's eligibility scale (income as a percentage of the federal poverty guidelines) as well as the net worth to be exempted will be recommended by the President after consultation with the SVP Finance and the VP Mission Services. The Board of Trustees will approve such changes. Income eligibility schedules will be updated annually by the director of patient accounts when new federal guidelines are published in the federal register.

I. SCOPE:

- A. The financial assistance policy applies to charges for medically necessary patient services that are rendered at facilities operated solely by Holy Cross Hospital; i.e., inpatient, emergency service, clinic, home care, hospice and

other services that are not operated by a “joint venture” or “affiliate” of the hospital. In the event that Holy Cross provides a more cost effective setting for needed services (such as the obstetrics and gynecology clinic or the Holy Cross Hospital Health Center), financial assistance is only applicable to that service when the patient takes advantage of the most cost effective setting.

B. Services not covered by the financial assistance policy:

1. Services not charged and billed by the Hospital are not covered or affected by this policy; i.e., private physician services or charges from facilities in which Holy Cross Hospital has less than full ownership, etc.
2. Cosmetic, convenience, and/or other Hospital services, which are not medically necessary, are excluded from consideration as a free or discounted service. Medical necessity will be determined by the SVP of Medical Affairs after consultation with the patient’s physician and must be determined prior to the provision of any non-emergent service.
3. Patients who qualify for County, State, Federal, or other assistance programs are excluded from the Holy Cross Financial Assistance Program to the extent that needed services would be provided under those programs.
4. Patients who obtain services at Holy Cross outpatient facilities specifically set up to provide services to the indigent will be expected to make the minimum co-payments that are required by those facilities, regardless of the level of charity care for which the patient is eligible. Those minimum obligations are not then eligible to be further reduced via the financial assistance policy.

C. Eligibility:

Holy Cross provides scheduled discounting for patients who make less than 300% of the federal poverty level and whose assets do not exceed \$10,000 as an individual or \$25,000 within a family. In addition any individual who owes \$10,000 or more in Holy Cross balances may request an individualized determination of the need for financial assistance from the credit manager.

Holy Cross believes that health services are of value to individuals and society, and the provision of those services generates a claim for payment that should be honored if the patient has accumulated assets - even in the absence of current income. As a result, if patients meet the income criteria for charitable assistance, a second eligibility requirement also needs to be met before charitable assistance is granted.

Holy Cross also believes that the collection of accounts that would completely wipe out the accumulated assets of an individual is not appropriate. Holy Cross has therefore voluntarily chosen to protect \$10,000 in accumulated net worth of its patients (\$25,000 in accumulated net worth for families) from Holy Cross claims. In addition, Holy Cross Hospital will not pursue a lien against a primary residence or a patient's only vehicle except when the ownership of the property is being transferred as a result of actions other than the hospital lien.

This program provides free care to those most in need – charitable care is provided to patients who have income less than 150% of the federal poverty level. It also provides for a 90% reduction in charges for those between 150% and 199% of the federal poverty level, a 75% reduction in charges for those whose income is between 200 and 232% of the poverty level, 50% assistance from 233% to 265% of the federal poverty level, and 25% assistance from 266% to 300% of the federal poverty level.

II. PROCEDURE:

- A. All registration accounts receivable, and collections staff are to be thoroughly familiar with the availability of charitable assistance and the criteria for such assistance. Material describing the charitable assistance program is to be given or sent to all patients who request this information and public notification regarding the program is to be made annually. Information about the program is to be prominently displayed and staff are to be particularly alert to offer it to those who are registered as self-pay patients. All members of the health care team are encouraged to refer patients needing financial counseling to the Credit Department for evaluation. The Credit Manager will ensure that each self-pay patient whose account is in excess of \$3,000 has been individually contacted and made aware of our charitable assistance program prior to allowing an outside agency to pursue collection of the account.
- B. Whenever a patient is approved for scheduled financial assistance, the credit manager will create and maintain a code within the Holy Cross patient accounting system for that patient. This code will provide an automatic adjustment of up to 100% of covered charges for eligible services for the patient and their dependents for a period of six months. This code is to be entered or deleted only by credit department personnel, and should expire six months from the effective date of a completed and approved application – at which time the patient may re-apply for charitable assistance if their situation continues to merit assistance. Patients whose financial situation improves or who become insured within that six-month period are encouraged to provide

that information to the hospital.

- C. The Credit Manager or designee is responsible for evaluating requests for charitable assistance. Within two business days following receipt of a completed and documented application for charity care services, application for Medical Assistance or both, the facility shall make a determination of probable eligibility. The credit manager can approve requests within scheduled guidelines without further approval and will maintain statistical information on the applications received, those denied and those approved – along with the amount of assistance approved for each applicant.
- D. Individual application processing will be handled as follows:
 - 1. Requests for charitable assistance must be documented with a completed patient and family financial resource and expense statement, along with necessary supporting documents such as, payroll stubs, tax returns, etc. A signature is required on a financial application prior to the evaluation process, and a release to verify financial information is included on that application. Charitable assistance will not be granted if complete and accurate information and supporting documentation is not provided. Any assistance granted will be rescinded if information given on the application is inaccurate or untrue. This form and supporting documentation is to be retained in the patient's file through the period of eligibility for free services and for at least one year thereafter.
 - 2. For receivable balances under \$500.00, a verbal presentation of the required information may be transcribed by hospital staff onto the application form in lieu of a patient filing the form if the information can be verified to the hospital's satisfaction. In that case the charitable assistance will be applied only to the account being processed and no code for future services will be kept in the system.
 - 3. The net asset exclusion (applicable only if the income criteria are met) is to be interpreted as follows:
 - The hospital will not pursue collection of an account from a living individual who meets the income criteria above, if collection of that account would reduce the net assets of the individual below \$10,000 (\$25,000 for a family). These limits do not apply to the execution of a patient's estate. When an estate is being settled, the hospital claim remains valid in full and will not be reduced to protect asset transfers to heirs.

- Conversely if an obligated individual owns a house, a car, or other valuable property with a realizable net value (value after paying off all debt) in excess of \$10,000 (\$25,000 for a family), whether or not they meet the income criteria, a judgment may be sought or a lien may be placed on the property. In these cases the collection may be pursued to the extent that the remaining assets after exercising the lien is at or above the level of protected assets listed. However, in no case is a lien against a primary residence to be pursued except when the ownership of the property is being transferred as a result of actions other than the hospital lien.
4. The credit manager is to take into account the specific situation of each patient in electing to recommend the placement of a lien or obtaining judgments. Holy Cross will not execute a lien that would cause the sale of an occupied primary residence or the only vehicle of a patient, but will maintain that lien until the property is transferred by the patient or their estate. At that time the hospital will expect satisfaction of the lien.
 5. Exception procedure for accounts over \$10,000 or when unusual circumstances merit special consideration. When in the opinion of the Credit manager an individual with a self pay balance in excess of \$10,000 or where unusual circumstances merit an exception, the credit manager will present the case to the SVP support services, the SVP for Corporate Development, and the VP Mission services. This group can collectively approve charitable assistance that does not otherwise meet the program guidelines. In these cases the credit manager should do a complete review of the account and can make recommendations based on the totality of the patient's situation (available resources, current commitments/liabilities, etc.).



HOLY CROSS HOSPITAL Schedule of Financial Assistance

Note that the income levels listed in the table below are the initial qualifier for a two-part test that also involves net assets. Anyone with income in excess of \$80,000 is not eligible for this schedule of financial assistance. Individuals with net assets of \$10,000 and families with net assets of more than \$25,000 are not eligible for scheduled financial assistance.

# of Dependents	Level of Financial Assistance Available				
	100%	90%	75%	50%	25%
1	\$15,600	\$20,800	\$24,232	\$27,664	\$31,200
2	\$21,000	\$28,000	\$32,620	\$37,240	\$42,000
3	\$26,400	\$35,200	\$41,008	\$46,816	\$52,800
4	\$31,800	\$42,400	\$49,396	\$56,392	\$63,600
5	\$37,200	\$49,600	\$57,784	\$65,968	\$74,400
6	\$42,600	\$56,800	\$66,172	\$75,544	\$80,000
7	\$48,000	\$64,000	\$74,560	\$80,000	\$80,000
8	\$53,400	\$71,200	\$80,000	\$80,000	\$80,000
9	\$58,800	\$78,400	\$80,000	\$80,000	\$80,000
10	\$64,200	\$80,000	\$80,000	\$80,000	\$80,000

Table Revised: 02/01/08

Appendix 3

Description of Holy Cross Hospital Mission, Vision and Value Statement

When Holy Cross Hospital opened its doors in 1963, it began a tradition of opening doors to health care for our community.

At our founding, the Congregation of the Sisters of the Holy Cross established a commitment to meeting community need and to improving the health of all those we serve, with particular emphasis on the poor and vulnerable. This commitment is brought to life through our community benefit ministry. Our community benefit efforts include all of the services we provide to community members at no cost or subsidize as part of our mission to be the most trusted provider of health care services in our area.

In meeting this commitment, we focus our efforts on improving health care access. Our proven approach is to systematically identify significant health care needs in our evolving community that are not adequately met because of financial, geographic, racial or cultural barriers. Then we propose and develop innovative solutions to address these needs in ways that can be sustained in the future.

One of our strengths is our ability to collaborate with other organizations to maximize our collective positive impact. We continuously bring together resources toward shared goals by partnering with local, state and federal government agencies; associations; community-based social service organizations; faith communities; charities and others.

Appendix 4

Holy Cross Hospital Mission, Vision and Value Statement

Our Mission

We serve together in Trinity Health, in the spirit of the Gospel, to heal body, mind and spirit, to improve the health of our communities and to steward the resources entrusted to us.

Our Core Values

- Respect
- Social justice
- Compassion
- Care of the poor and underserved
- Excellence

Our Role

Holy Cross Hospital in Silver Spring, Maryland, exists to support the health ministry of Trinity Health and to be the most trusted provider of health care services in our area.

Our health care team will achieve this trust through:

- High-quality, efficient and safe health care services for all in partnership with our physicians and others
- Accessibility of services to our most vulnerable and underserved populations
- Community outreach that improves health status
- Ongoing learning and sharing of new knowledge
- Our friendly, caring spirit

Appendix 5

2008 Holy Cross Hospital Community Report

Improving Access. Improving Care.



HOLY CROSS HOSPITAL

Experts in Medicine, Specialists in Caring.™



December 2008

Access to health care is at the heart of Holy Cross Hospital's mission.

Without it, those who are sick may have to travel far for needed treatment, those who are well may not be able to prevent health issues before they arise and those who are uninsured may not be able to get treatment at all.



We are committed to ensuring that health care is conveniently located for everyone in our community, that the care provided in our facilities is of high quality and that everyone has access to care regardless of their ability to pay.

This report will describe the programs we offer in support of that commitment, including those that are directly related to community benefit – services that we offer at no or subsidized costs – and those that support our ability to offer services directly in the communities we serve.

I am particularly pleased to describe our plans to enhance our current hospital in Silver Spring, build a new hospital in Germantown, open two new health centers for uninsured adults in Gaithersburg and Wheaton, and provide electronic linkages whenever people come for care. These enhancements will enable us to further improve access to care and broaden our commitment to those who are uninsured or underinsured. In addition, our plans will enable us to expand educational opportunities for those interested in health care careers, ensuring that there is an adequate workforce for the health care needs of our community in the years ahead.

Our programs are not developed in isolation, however. All of them are a result of studying unmet current and future needs – such as projected population growth, anticipated labor shortages and increases in underserved groups – and developing specific programs to meet them.

As you will learn in these pages, we take seriously our responsibility as a not-for-profit health care provider to steward the resources entrusted to us and to invest in our community and our community benefit efforts.

I am so proud to continue the tradition of meeting the needs of the community and improving the health of all those we serve, begun by the Congregation of the Sisters of the Holy Cross when the hospital first opened its doors 45 years ago. In the past five years alone, we have provided more than \$100 million in community benefit according to reporting guidelines of the Maryland Health Services Cost Review Commission.

Yesterday, today and tomorrow, we are upholding our mission to be the most trusted provider of health care in our region – through our commitment to access to health care for all.

Kevin J. Sexton
President and CEO
Holy Cross Hospital



“The big problem with access today is the uninsured, but the challenge in the future will be creating sufficient capacity to care for the extraordinary number of seniors,” says Kevin Sexton, president and CEO, Holy Cross Hospital.



Big Plans for a Better Future

Access to Expert Care – Close to Home

Because Holy Cross Hospital is deeply committed to providing high-quality health care services for our community today and in the future, we have put into motion plans to expand our system of health care. We are seeking approval from the state of Maryland for these plans.

A New Full-Service Hospital in Germantown

Nearly 30 percent of Montgomery County residents who visit Holy Cross Hospital for care come from northern and western Montgomery County. Investing in a new five-story, full-service hospital in Germantown will meet the needs of the large and growing population in these areas.

“By providing hospital care close to home for the residents in upper Montgomery County, we will make a major contribution toward meeting the community needs of improved care access and expanded hospital capacity for its growing and aging population,” says Kevin J. Sexton, president and CEO, Holy Cross Hospital. Germantown was selected as the site of the new hospital in large part because of the growing elderly population up county – especially in the Germantown and Gaithersburg areas.

“We looked at places with the greatest needs in Montgomery County,” Sexton says. “The big problem with access today is the uninsured, but the challenge in the future will be creating sufficient capacity to care for the extraordinary number of seniors.”

More Improvements to Holy Cross Hospital

Patients who continue to come to Holy Cross Hospital in Silver Spring will receive the same great care they always have received but with some impressive

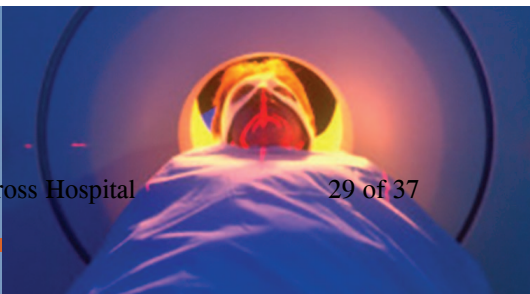
improvements. We plan to build a new seven-story tower at the back of the hospital so that all patients will have private rooms. An all-private-room facility will increase capacity of the hospital by ensuring that all beds are available.

We also plan to further enhance emergency and surgical services, to improve patient and family convenience, and to expand our parking capacity.

Electronic Medical Records System

Making all of these expansion projects work seamlessly will be Holy Cross Hospital’s new, robust information technology system. Holy Cross Hospital is the first in the county to electronically link its entire system of health care. Our enhanced electronic medical records system supports our ability to provide high-quality, safe and efficient care by providing electronic linkages whenever people come to any of our facilities for care.

With Holy Cross Hospital and Montgomery College sharing one location, the possibilities for expanding the number of caregivers to meet future needs are extraordinary.





Proposed Germantown Hospital on Montgomery College's Campus

Expanding Access to Health Care Education

By now, many of us know there is a nursing shortage. But the shortage is not because fewer people want to become nurses.

According to the Maryland Hospital Association, between 2001 and 2005, nursing schools turned away more than 1,850 qualified candidates because of lack of capacity. And, as the population ages, the dramatic increase in seniors will make the need for trained clinicians especially acute.

Clearly something needs to be done.

Expanding the Number of Caregivers

"The key is providing qualified faculty to teach aspiring nurses and other allied health professionals as well as furnishing the physical space to teach students," says Judith Rogers, PhD, MSN, RN, chief nurse executive and vice president, Patient Care Services, Holy Cross Hospital. "We already help educate student nurses from seven schools; what better way to expand that capacity than to locate a full-service hospital right on the grounds of a college campus?"

For Holy Cross Hospital, Montgomery College is an extraordinary partner. The hospital announced in August plans to build a new full-service hospital on the grounds of a future science and technology park on the college's Germantown Campus. With Holy Cross Hospital and Montgomery College sharing one location, the possibilities for expanding the number of caregivers to meet future needs are extraordinary.

Some of the areas already discussed as opportunities open to this partnership include shared clinical and educational space such as laboratories and

classrooms, expanding faculty and mentors, increased support for students and continuing education for mid-career professionals.

Building on a Shared Commitment

What makes a partnership between the Germantown Campus and the hospital even better is that a relationship between Montgomery College and Holy Cross Hospital is already firmly in place. The Holy Cross Hospital Health Center is located in the Health Sciences Center on Montgomery College's Takoma Park/Silver Spring Campus.

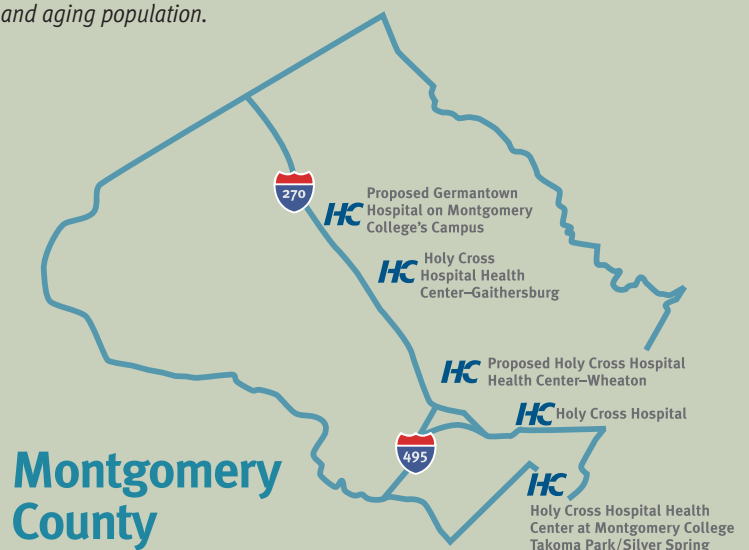
Together, we provide rotations for nursing students as well as students in other health-related fields at this primary care clinic. The new hospital will be an extension of a current and successful partnership and a reflection of both Holy Cross Hospital's and Montgomery College's commitment to the education and well-being of our community.

The Need for Nurses

Consider these statistics from the Maryland Health Association:

- Between 2000 and 2020, Maryland's need for nurses will increase 40 percent, but the number of nurses meeting this demand will increase only 6 percent.
- However, between 2001 and 2005, nursing schools denied acceptance to more than 1,850 candidates because of lack of school capacity.

Holy Cross Hospital's current and proposed locations will provide care close to our patients' homes, making a major contribution toward meeting the community's needs of improved care access and expanded hospital capacity for its growing and aging population.



As the leading safety net provider in Montgomery County, Holy Cross Hospital provides access to prenatal, primary, emergency and hospital care for those unable to pay.



Caring for Those in Need

Primary Care Clinics for the Uninsured

The Holy Cross Hospital Health Center, located in the Health Sciences Center on Montgomery College's Takoma Park/Silver Spring Campus, is a primary care medical home for uninsured adults.

Opened in 2004, the clinic provided 7,371 visits in fiscal 2008. Patients who come to the health center receive care from skilled clinicians who perform follow-up care for emergency room and hospital visits, physical exams, and chronic disease management.

Staff members speak English, French and Spanish, and interpretation in other languages is available.

More Clinics for the Uninsured

As the leading safety net provider in Montgomery County, Holy Cross Hospital provides access to prenatal, primary, emergency and hospital care for those unable to pay. In addition to the existing Holy Cross Hospital Health Center at Montgomery College, Holy Cross Hospital will open two new clinics to provide primary health care to low-income, uninsured adults.

More than 15 percent of the patients using the existing Holy Cross Hospital Health Center at Montgomery College come from Gaithersburg, Germantown, Rockville or Montgomery Village. To serve these communities better, a new health center—capable of handling at least 10,000 patient visits a year—will open in February 2009 in Gaithersburg.

And the following year, Holy Cross Hospital will open a clinic of the same size and scope in Wheaton. Holy Cross Hospital's network of three primary health centers will greatly increase Montgomery County's capacity to serve low-income, uninsured residents

and improve care quality, efficiency, equity and health outcomes, while also freeing up access in emergency centers for the critically ill.





OB/GYN Clinic

Health and Hope From the Start

Nothing is more important than providing the care needed to help ensure a healthy mother and child. For those women who don't have the resources to obtain health insurance, Holy Cross Hospital and the Maternity Partnership Program offer hope for a brighter future.

Holy Cross Hospital participates in the Maternity Partnership Program, a local program that provides every uninsured woman in Montgomery County with the opportunity to receive prenatal care, including routine laboratory tests, prenatal classes and a dental screening by a dental hygienist.

Continuing a Caring Tradition

More babies are born at Holy Cross Hospital than at any other hospital in Maryland or the District of Columbia. Since 1963, we have provided prenatal and obstetric/gynecologic (OB/GYN) services to women regardless of their ability to pay.

In 1999, our commitment to OB/GYN care grew dramatically through the expansion of the Maternity Partnership Program. We remain Montgomery County's leading provider of prenatal, obstetric and gynecologic care for uninsured women, providing care to more than 13,000 women since 2000.

Meeting Women's Needs

Holy Cross Hospital's on-site OB/GYN Clinic provides uninsured women with:

- A single standard of care
- Culturally competent quality care through bilingual staff members

- Comprehensive monitoring of complications during pregnancy and delivery
- An extensive perinatal education program that includes classes in Spanish
- Follow-up care at home

Expanding Service and Support for Pregnant and Uninsured Women

To better serve uninsured women throughout Montgomery County, Holy Cross Hospital plans to build a second OB/GYN clinic in the full-service hospital planned for Germantown (see page 4). This new clinic will complement the existing clinic at Holy Cross Hospital in Silver Spring.

We remain Montgomery County's leading provider of prenatal, obstetric and gynecologic care for uninsured women, providing care to more than 13,000 women since 2000.





Access to Unique Services

Holy Cross Hospital offers a wide range of services that are a direct result of our commitment to our mission. Many of these programs are unique in the community and would not otherwise be available. These programs meet important community needs and are not expected to generate a positive financial return.

- Senior Fit, an innovative 45-minute multicomponent exercise program, is offered free to adults ages 55 and older at 17 locations throughout Montgomery and Prince George's counties and the District of Columbia, through a partnership among Holy Cross Hospital, Kaiser Permanente, Maryland National Capital Parks and Planning Commission, Montgomery County Department of Recreation and local churches. *60,186 encounters**
- The Caregiver Resource Center offers free classes, support groups and a resource library for family members, friends and professionals who are involved in the physical, emotional, spiritual or social care of someone who is medically challenged or facing lifestyle changes as a result of aging or illness. *3,703 encounters**
- The Medical Adult Day Center provides social, recreational and rehabilitative services for medically disabled or older adults who are socially isolated, need supervision or want to participate in group activities. *5,614 encounters**
- The Faith Community Nurse Program supports more than 60 congregational health ministries in educating, empowering and equipping members of their faith communities in the pursuit of health, healing and wholeness. *11,812 encounters**
- The Holy Cross Hospital Health Center at Montgomery College provides affordable primary health care and education to low-income, uninsured adults. *7,371 encounters**
- The Holy Cross Hospital OB/GYN Clinic provides prenatal, obstetric and gynecologic services to uninsured women in partnership with the Montgomery County Department of Health and Human Services. *14,297 encounters**
- Home care nurses provide postnatal home visits to uninsured mothers, creating a bridge from birthing care to pediatric care. *1,129 encounters**
- Pharmacy programs provide prescriptions at discharge to low-income inpatients as well as outpatients of the OB/GYN Clinic. *1,270 encounters**

**Fiscal 2008*

Access to Financial Assistance

An estimated 180,000 to 200,000 adults in Montgomery and Prince George's counties have no health insurance. Many cannot get the care they need for urgent or chronic health problems because they cannot afford it.

Holy Cross Hospital is committed to reducing financial barriers to health care services for people who are vulnerable or underinsured. In fiscal 2008, we provided more than \$9 million in financial assistance through 31,002 encounters with community members.

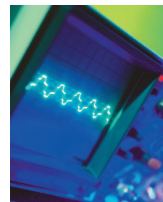
Our financial assistance policy provides a systematic and equitable way to provide necessary services free of charge or at reduced charges to individuals who meet certain financial criteria and are unable to pay.

The policy covers all medically necessary services rendered by the hospital and by hospital-based physicians. Eligibility is based on a patient's household income and accumulated net assets. Once eligibility is established, the patient remains eligible for six months thus eliminating the need for reapplication at each admission.

Helping the Uninsured Get Full Coverage

The Maryland Health Insurance Plan (MHIP) is state-administered health insurance that makes coverage available to residents who are low-income, have pre-existing conditions and do not otherwise have access to health insurance. Holy Cross Hospital embraces this alternative to traditional insurance. Our financial counselors identify patients who may be eligible and work with them toward enrollment.

Holy Cross Hospital is a member of Trinity Health, one of the largest health systems in the country. With support from Trinity Health, Holy Cross Hospital created an innovative premium assistance program that pays half or the full premium for people who are financially eligible.



In the past five years, Holy Cross Hospital has provided more than \$42 million in financial assistance.

Community Benefit Planning and Oversight

Holy Cross Hospital's community benefit plan is driven by identified unmet community needs and focuses on the unique needs of women, infants, seniors, and racial, ethnic and linguistic minorities.

In fiscal 2008, Holy Cross Hospital identified unmet community health needs by participating in community coalitions,

commissions, committees, boards, partnerships and panels, and by working closely with the Montgomery County Department of Health and Human Services. The hospital also analyzed needs assessments and data about the market, demographics, socio-economic factors and health service utilization.

Holy Cross Hospital Community Benefit Summary of Quantifiable Benefits – Fiscal 2008*

Charity Care

Holy Cross Hospital is committed to providing health care services free of charge or at reduced charges to individuals who meet certain financial criteria and are unable to pay. The hospital is the leading provider of prenatal, obstetric and gynecologic services for uninsured women in Montgomery County through the Maternity Partnership Program with the Montgomery County Department of Health and Human Services. Reported charity care is net of client co-pays and Montgomery County support.

Health Professions Education

Holy Cross Hospital is the only non-federal member of the Association of American Medical Colleges' Council of Teaching Hospitals and Health Systems in Montgomery and Prince George's counties. We host physician residency programs affiliated with George Washington University, Children's National Medical Center and Howard University. Holy Cross Hospital trains students from seven area nursing schools, operates its own School of Radiologic Technology, and trains students in other disciplines, including respiratory therapy, laboratory technology, physical therapy, occupational therapy and speech pathology. Holy Cross Hospital helped to develop and launch a collaborative pilot program for licensure of foreign-trained nursing professionals. The Holy Cross Hospital Health Center at Montgomery College also provides training to health care professionals.

Mission-Driven Health Services

Holy Cross Hospital offers a wide range of services that would otherwise not be provided in the community. These services are a direct result of the hospital's commitment to its mission and are not expected to generate a positive financial return. Faith Community Nursing supports the health care ministries of more than 60 congregations in our region. The Medical Adult Day Center provides social, recreational and rehabilitative services for medically disabled or older adults. The Holy Cross Hospital Health Center at Montgomery College provides affordable primary health care and education to low-income, uninsured adults. Pharmacy programs provide prescriptions at discharge to low-income patients. Women's services provide such assistance as postnatal home visits to uninsured mothers.

Community Health Services

Holy Cross Hospital has an expansive Community Health program that provides health screenings, education, physician lectures and exercise programs in multiple locations throughout Montgomery and Prince George's counties. The perinatal community education program offers classes and programs, several in both English and Spanish, to help parents prepare for infants. The Senior Fit program has been recognized as a model program by the National Council on Aging and hospitals around the nation are adopting similar senior exercise programs based on this model developed by Holy Cross Hospital. Our Ethnic Health Promotion Program provides multicultural, multilingual and culturally competent health education, screening and health care navigation.

Research

The hospital participates in studies on health care delivery, incurring unreimbursed costs associated with therapeutic protocols as well as treatment evaluation. The Holy Cross Hospital Cancer Institute is at the forefront of cancer screening research through its participation in the International Early Lung Cancer Action Program (IELCAP) and also participates in clinical trials sponsored by various government agencies, universities and foundations.

Contributions, Community Building and Community Benefit Operations

Holy Cross Hospital supports community organizations by providing in-kind services and hospital space. The hospital also engages in activities to enhance the support systems within the community, including disaster preparedness.



Holy Cross Hospital's interdepartmental leadership and its CEO review committee on community benefit and board of trustees plan, monitor and evaluate the hospital's community benefit efforts. Initiatives are thoughtfully developed to ensure links between areas in which the hospital has a demonstrated clinical

competence and unmet community needs. The hospital also participates with other organizations in the community to leverage community resources toward mutual goals.

			ENCOUNTERS	NET COMMUNITY BENEFIT
			31,472	\$9,466,606
DIRECT COST	INDIRECT COST	OFFSETTING REVENUE		
\$2,236,976	\$1,152,266	\$19,040	1,166	\$3,370,202
\$4,225,809	\$2,173,495	\$1,381,171	35,911	\$5,018,133
\$3,568,086	\$1,837,921	\$602,000	793,085	\$4,804,007
\$281,580	\$145,042	\$0	316	\$426,622
\$723,365	\$339,850	\$0	9,600	\$1,063,215
\$11,035,816	\$5,648,574	\$2,002,211	871,550	\$24,148,785

**Prepared according to guidelines established by the Maryland Health Services Cost Review Commission, which establishes the definition of community benefit and the reporting categories. For more information about Holy Cross Hospital's Community Benefit Ministry, visit www.holycrosshealth.org.*



Our History

Holy Cross Hospital was founded by the Sisters of the Congregation of the Holy Cross in 1963 and is a member of Trinity Health, one of the largest health systems in the United States.

Trinity Health's Mission

We serve together in Trinity Health, in the spirit of the Gospel, to heal body, mind and spirit, to improve the health of our communities and to steward the resources entrusted to us. Our core values are respect, social justice, compassion, care of the poor and underserved, and excellence.

Holy Cross Hospital's Role

Holy Cross Hospital exists to support the health ministry of Trinity Health and to be the most trusted provider of health care services in our area. Our health care team will achieve this trust through:

- High-quality, efficient and safe health care services for all in partnership with our physicians and others
- Accessibility of services to our most vulnerable and underserved populations
- Community outreach that improves health status
- Ongoing learning and sharing of new knowledge
- Our friendly, caring spirit

For additional information about Holy Cross Hospital Community Benefit, contact Kimberley McBride, coordinator, Community Health, at 301.754.7149 or mcbrik@holycrosshealth.org.



1500 Forest Glen Road
Silver Spring, MD 20910
301.754.7000
www.holycrosshealth.org

APPENDIX 1

STATEMENT OF ACCESS TO SPECIALIST PROVIDERS FOR THE UNINSURED


HSCRC Community Benefit Report – The Johns Hopkins Health System Access to Specialist Providers for the Uninsured – FY 2008 Report Submission

This section of the report responds to the new HSCRC requirement for hospitals to include a “written description of gaps in the availability of specialist providers to serve the uninsured in the hospital.”

Johns Hopkins Hospital provides a full range of specialty care by leading physicians in their disciplines, and does so without regard for the health insurance status of the patient. Johns Hopkins Hospital also works in cooperation with Johns Hopkins Bayview Medical Center and Howard County General Hospital to meet the specialty care needs in a timely fashion for all individuals seeking specialty care. These approaches eliminate any gaps in the availability of specialist providers to serve the uninsured in the hospital.

APPENDIX 3

CHARITY CARE POLICY

	Howard County General Hospital, Inc. Policy & Procedure	<i>Policy Number</i>	FIN034H
		<i>Effective Date</i>	3/01/05
	<i>Subject</i> FINANCIAL ASSISTANCE	<i>Page</i>	1 of 15
		<i>Revised</i>	2/5/08

POLICY

This policy applies to Howard County General Hospital, Inc. (HCGH).

Purpose

It is the policy of Howard County General Hospital, Inc. (HCGH) to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing (including any accounts having gone to bad debt within 3 months of application date) and any projected medical expenses.


A determination of Financial Assistance will be re-evaluated every six (6) months as necessary.

PROCEDURES


1. An evaluation for Financial Assistance can be commenced in a number of ways.

For example:

- A patient with a self-pay balance due notifies the self-pay collector that he/she cannot afford to pay the bill and requests assistance.
 - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
 - A physician or other clinician refers a patient for charity care evaluation for potential admission.
2. Each Clinical or Business Unit will refer patients seeking Financial Assistance to the Financial Counselor in the Admitting Department.
 3. When a patient requests Financial Assistance, the Financial Counselor will meet with the patient. An assessment will be done to determine if patient meets preliminary criteria for assistance.
 - a. All hospital applications submitted will be processed within two business days of receipt and a determination will be made as to probable eligibility. In order to determine probable eligibility an applicant must provide family size and family income (as defined by Medicaid regulations). A notice of conditional approval will instruct the applicant of the documentation necessary to complete the application process for a final determination of eligibility.
 4. The following criteria must be met in order for a review for a final determination for a Financial Assistance adjustment:
 - a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the disability requirement. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
 - b. Review viability of offering a payment plan agreement.

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- c. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.
 - d. All insurance benefits have been exhausted.
5. There will be one application process for all of HCGH. The patient is required to provide the following:
 - a. A completed Financial Assistance Worksheet (see example in Appendix 1).
 - b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of 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).
 - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
 - d. A Medical Assistance Notice of Determination (if applicable).
 - e. Proof of disability income (if applicable).
 - f. Reasonable proof of other declared expenses.
 - g. Non-U.S. citizens must complete the Financial Assistance Worksheet. In addition, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO to determine if additional information is necessary.
6. 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, the Financial Counselor taking the application will review and analyze the application and make a recommendation to the Patient Financial Services Department for final determination of eligibility based on HCGH guidelines.
 - a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Counselor will recommend the patient's level of eligibility.
 - b. If the patient's application for Financial Assistance is based on excessive medical expenses or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Director, Revenue Cycle and/or Chief Financial Officer. The Director, Revenue Cycle and/or CFO will have decision-making authority to approve or reject applications for charity care. It is expected that an application for Financial Assistance, which is reviewed by the Director, Revenue Cycle and/or CFO will have a final determination made no later than 30 days from the date it was considered complete. The Director, Revenue Cycle and/or CFO will perform his/her evaluation of financial need based on HCGH guidelines.
7. A department can continue to use a government sponsored application process and associated income scale, as it is required by terms of a program grant or other outside authority governing that

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program. (i.e.: Psychiatry Program). HCGH will provide free care to Maryland Public Health System Emergency Petition patients, Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs. HCGH will accept active enrollees of the Chase Brexton Health Center as eligible without having the enrollee reapply for financial assistance. (See Appendix C)

8. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to HCGH. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.
9. Any payment schedule developed through this policy will ordinarily not exceed two years in duration. In extraordinary circumstances, a payment schedule may extend to three years in duration, with the approval of the CFO.
10. HCGH, through the Public Relations Department, will annually publish the hospital's general charity care policy guidelines in the local newspaper and will post notices of availability in the emergency center and in the Admissions/Business office. Notice of availability will also be sent to patients on patient statements.

REFERENCE¹

HCGH Finance Policies and Procedures Manual

Policy No. FIN017 - Signature Authority: Patient Financial Services

Policy No. FIN033 - Installment Payments


Charity Care and Bad Debts, AICPA Health Care Audit Guide

Federal Poverty Guidelines (Updated annually in February), Federal Register

RESPONSIBILITIES - HCGH

Financial Counselor	<p>Understand current criteria for Assistance qualifications.</p> <p>Identify prospective candidates or follow-up with referred patients; initiate application process.</p> <p>Review preliminary application and make probable eligibility determination. Within two business days of receipt of preliminary application, mail probable eligibility determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments.</p> <p>Review and ensure completion of final application.</p> <p>Deliver completed final application, with recommendation, to Director Revenue Cycle, Patient Financial Services or CFO, as appropriate.</p>
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¹ NOTE: Standardized applications for financial assistance have been developed. For information on ordering, please contact the Patient Financial Services Department. A copy is attached to this policy as Exhibit A.

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Document all transactions in all applicable patient account's comments.

Send letter of final determination to the patient.

Identify retroactive candidates; initiate final application process.

Review and ensure completion of final application.

Deliver completed final application, with recommendation, to Director, Revenue Cycle, Patient Financial Services or CFO, as appropriate.

Document all transactions in all applicable patient account's collection record.

Send letter of final determination to the patient.

Director, Patient Financial Services,
Director, Revenue Cycle or CFO

Review completed final application; determine patient eligibility.

Review and approve Financial Assistance applications in accordance with signature authority established in Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

Request Financial Counselor to send letter of final written determination to patient or to advise ineligible patients of other alternatives available to them including Medical Assistance, installment payments, bank loans, or consideration under the catastrophic program. [Refer to Appendix B - Catastrophic Financial Assistance Guidelines.

SPONSOR

Sr. Director, Patient Financial Services, JHHS


REVIEW CYCLE

Three (3) years

APPROVAL

Sr. VP, Finance, CFO, HCGH

Date

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PROCEDURES - HCGH

1. Financial Counselor

- a. Maintain and understand current guidelines qualifying patients for Financial Assistance.
- b. Maintain supply of Financial Assistance Applications and current Federal Poverty Income guidelines from Federal Register.
- c. Identify prospective candidates and follow-up with referred patients for Financial Assistance. Determine possible eligibility for Financial Assistance as early in the account cycle as possible in cases where identification of Financial Assistance patient was not made before services were provided.
- d. Initiate the Financial Assistance Application process with the patient/guarantor. As necessary, assist patient/guarantor in completing the application.
- e. Review preliminary application and communicate a determination of probable eligibility to patient within two business days.
- f. Review completed application to ensure that all required information is present. Contact appropriate party to obtain any missing documentation.
- g. Compile all supporting documentation (e.g., tax returns, pay stubs, bank statements, etc.); attach to application and place in a file folder marked "Financial Assistance"; deliver file to Supervisor. For non-U.S. citizens contact U.S. Consulate of patient's resident country for background on financial status.
- h. Determine eligibility for charitable Financial Assistance using available information, including application and applicable guidelines (e.g., Table for Determination of Financial Assistance Allowances).
- i. Make recommendation to approve/disapprove applications and forward application, supporting documentation and recommendation to Director, Revenue Cycle, Director, Patient Financial Services or CFO for approval. Disapprove any application, which does not meet the Financial Assistance Guidelines as set forth in Appendix A.

NOTE: Extenuating circumstances not addressed in the policy's guidelines may permit the application to be forwarded to the Vice President, Finance/CFO for further consideration.

- j. Send "Notice of Financial Assistance Determination" to the patient/guarantor. (Decisions for approval/disapproval will be


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made within thirty (30) business days of receiving completed application.)

- k. Document all transactions involving the application process.
 - l. Send all original paperwork to PFS, Alpha Commons. PFS will scan and retain all completed applications for eight (8) years following the end of the fiscal year in which the assistance need was identified.


- 2. Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017 or, those applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Maintain system-generated report of charity amounts written off. Return finalized applications to Financial Counselor for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. Initiate transactions to offset revenue on approved applications.
 - e. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Vice President, Finance/CFO for further action.
 - f. Reconcile monthly Financial Assistance write-offs per the automated report against monthly case files.

- 3. Director, Revenue Cycle, Vice President, Finance/CFO
 - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
 - b. Approve/disapprove applications; return finalized applications to Director for final processing.

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**APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES**

1. ***Notice of the availability of the HCGH Financial Assistance Program will be posted in the Emergency Center and in the Admission/Business office and presented to patients upon request.
2. Each person requesting Financial Assistance must complete an HCGH Financial Assistance application.
3. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.
4. Proof of income must be provided with the final application. Acceptable proofs include:
 - (a) Prior year tax return;
 - (b) Current pay stubs;
 - (c) Letter from employer; and
 - (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
 - (e) For non-U.S. citizens, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO to determine if additional information is necessary.
5. An individual will be eligible for Financial Assistance if the maximum family (husband and wife) income (as defined by Medicaid regulations) level does not exceed HCGH's standard related to the Federal poverty guidelines, and they do not own liquid assets which would be available to satisfy their affiliate bills.
6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify. If it is clear that a non-U.S. citizen will not be eligible for Medical Assistance, a Medical Assistance Notice of Determination will not be necessary.
7. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and non-medically necessary private room accommodations. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is "elective" or "necessary," the patient's admitting physician shall be consulted. Questions as to necessity may be directed to the physician advisor appointed by HCGH.
8. HCGH will determine final eligibility for Financial Assistance within thirty (30) business days (or their specifically established timeline) of satisfactory completion and return of the application. The Financial Counselor will issue the final eligibility determination.
9. Documentation of the final eligibility determination will be made on all (open-balance) patient's account. A determination notice will be sent to the patient.
10. A determination of eligibility for Financial Assistance will remain valid for a period of three (3)

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months for all necessary affiliate services provided based on the initial date of the determination letter. For recurring outpatient therapeutic services (such as chemotherapy or radiation therapy), patients may qualify for Financial Assistance for up to six (6) months on the basis of a single application. Patients will not be required to reapply for Financial Assistance if they are currently receiving Financial Assistance from another affiliate.

- All determinations of eligibility for Financial Assistance shall be solely at the discretion of HCGH.

APPENDIX B CATASTROPHIC FINANCIAL ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a Catastrophic Assistance Application. Under these circumstances, the term "catastrophic" is defined as a situation in which the self-pay portion of the affiliate medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 18 months or less.


General Conditions for Catastrophic Assistance Application:

- Patient has exhausted all insurance coverage.
- Patient is not eligible for any of the following:
 - Medical Assistance
 - The Financial Assistance Program.
 - Other forms of assistance available through affiliates.
- The patient cannot repay the self-responsible portion of the affiliate account in 18 months or less.
- The affiliate has the right to request patient to file updated supporting documentation.
- The maximum time period allowed for paying the non-charitable amount is three (3) years.
- If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the catastrophic assistance program, the patient is still required to file a Catastrophic Assistance Application and non-duplicated supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Catastrophic Assistance Application:

- Current Medical Debt
- Liquid Assets (leaving a residual of \$2,500)
- Living Expenses
- Projected Medical Expenses

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- Annual Income
- Spell of Illness
- Supporting Documentation

Definitions


Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash/Bank Accounts, Certificates of Deposit, bonds, stocks, Cash Value life insurance policies, pension benefits.
Living Expenses	Per person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e. drugs, co-pays, deductibles and durable medical equipment.)
Take Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service, after taxes and other deductions.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, social security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments; and, credit bureau reports.

Exceptions

1. HCGH has the right to refuse treatment for elective procedures, which may result in catastrophic medical debt.
2. The Vice President, Finance/CFO may make exceptions, as circumstances deem necessary.

Evaluation Method and Process

1. The Financial Counselor will review the Catastrophic Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Financial Counselor will then complete a Catastrophic Assistance Worksheet (see below) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

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Note: If the below worksheet is electronically available to preparer, double-click on worksheet and fill in required amounts in **highlighted fields** only. The worksheet will automatically compute rest of the fields.

FINANCIAL ASSISTANCE WORKSHEET

Patient Name: _____
 History #: _____

LINE #	PARTICULAR	AMOUNT
Net Current Medical Debt:		
1	Current Medical Debt	\$ -
2	Total Liquid Assets	\$ -
3	Asset Exclusion (Fixed Amount)	\$ 2,500
4	Net Liquid Assets [If Line 2 > Line 3, then Line 2 - Line 3, otherwise amount is zero "0"]	\$ -
5	Net Current Medical Debt [Line 1 - Line 4]	\$ -

Total Annual Expenses:		
6	Living Expenses	\$ -
7	Projected Medical Expenses	\$ -
8	Total Annual Expenses [Line 6 + Line 7]	\$ -


Annual Income Available:		
9	Income (Net Take Home Pay)	\$ -
10	% Income Available [100% - (Line 8 divided by Line 9 x 100)] [If Line 8 is > Line 9, then % Income Available is zero "0"]	-%
11	Annual Income Available [Line 9 x Line 10]	\$ -

SELECT PATIENT PAYMENT PERIOD PLAN

Patient Payment in 1-Year Period Plan:		
12	Income Available in 1 Year [Line 11]	\$ -
13	Income Available in 1 Year plus Net Liquid Assets [Line 12 + Line 4]	\$ -
14	Monthly Patient Installment Payment within 1 Year [Line 13 / 12 Months]	\$ -
15	Financial Assistance Amount [If Line 1 > Line 13, then Line 1 - Line 13. This is the Financial Assistance Amount] [If Line 1 < Line 13, then the Financial Assistance Amount is zero "0"]	\$ -

Patient Payment in 2-Year Period Plan:		
16	Income Available in 2 Years [Line 11 x 2 Years]	\$ -
17	Income Available in 2 Years plus Net Liquid Assets [Line 16 + Line 4]	\$ -
18	Monthly Patient Installment Payment within 2 Years [Line 17 / 24 Months]	\$ -
19	Financial Assistance Amount [If Line 1 > Line 17, then Line 1 - Line 17. This is the Financial Assistance Amount] [If Line 1 < Line 17, then the Financial Assistance Amount is zero "0"]	\$ -

Patient Payment in 3-Year Period Plan:		
20	Income Available in 3 Years [Line 11 x 3 Years]	\$ -
21	Income Available in 3 Years plus Net Liquid Assets [Line 20 + Line 4]	\$ -
22	Monthly Patient Installment Payment within 3 Years [Line 21 / 36 Months]	\$ -
23	Financial Assistance Amount [If Line 1 > Line 21, then Line 1 - Line 21. This is the Financial Assistance Amount] [If Line 1 < Line 21, then the Financial Assistance Amount is zero "0"]	\$ -

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**APPENDIX C
FINANCIAL ASSISTANCE FOR CHASE BREXTON PATIENTS**

Purpose

Chase Brexton Health Services, Inc. is a non-profit, community based organization that provides a wide range of medical, psychological and social services on a non-discriminatory basis in Baltimore City, Baltimore County, and Howard County. Chase Brexton offers services to everyone regardless of their ability to pay. Chase Brexton cares for those who are un-or under-insured, those with Medicare and Medicaid, and those with commercial insurance. Chase Brexton has Case Managers that work with patients to determine eligibility for care at a low minimum fee, and/or appropriate programs and entitlements available to people with limited resources.

This procedure is for Howard County General Hospital registration sites, verification and scheduling and for Patient Financial Services. It outlines the treatment of patients that have qualified for the Health Alliance program. It is the policy of HCGH to accept patients previously screened by Health Alliance for financial assistance. Patients will not have to apply for assistance but will need to notify us of their participation in this program.


Inpatient/Outpatient cases

All Chase Brexton inpatients are screened by the Howard County General Hospital's Financial Counselor for possible medical assistance. Appointments are made with Howard County General Hospital's in-house medical assistance Case Worker for the application process. If medical assistance is received, the claim is billed to Medical Assistance for payment. If the patient is not eligible for medical assistance, the insurance plan of FAR.PENDIN, FARB20, FARN40, FARN50, FARN70 FARN80, FAR100 is assigned to the case and the claim will be automatically written off to the financial assistance/charity care allowance code when the final bill is released. The insurance code assignment is based on the level of charity care the patient has qualified for.

Insurance listed as:	Charity Care	Patient to pay:
FAR.PENDIN	Pending Verification	
FARB20	20% of charges	80% of charges
FARN40	40% of charges	60% of charges
FARN50	50% of charges	50% of charges
FARN70	70% of charges	30% of charges
FARN80	80% of charges	20% of charges
FAR100	100% of charges	0% of charges

PROCEDURE

1. When a patient presents for services at HCGH and states they are associated with the Chase Brexton health center, the registration staff will enter the insurance code of FAR.PENDIN into Meditech if the patient hasn't been seen within the last 6 months. If the patient is in the system with a service date within the last 6 months and the patient was already identified as a Chase Brexton patient that met a certain level of charity care the registrar can allow the insurance code of (FARB20, FARN40 etc,) to be pulled forward.
2. The Sr. Financial Counselor receives a daily report with all patients registered with a FAR code.
3. The Sr. Financial Counselor will review all patients on the report daily to validate they are active with the Chase Brexton health center and what level of charity care they qualify for.

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4. The Sr. Financial Counselor is responsible for updating the insurance code to reflect the proper level of charity care and collecting the patient balance (if any).
5. The Sr. Financial Counselor is responsible for entering a from and through date into Meditech that the patient is eligible to receive this level of charity care.
6. The Sr. Financial Counselor is responsible for identifying registration errors and forwarding them to the Manager of Admissions for corrective action. These accounts will be changed to self pay and or other insurance as appropriate.


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TABLE FOR DETERMINATION OF FINANCIAL ASSISTANCE ALLOWANCES <div style="text-align: right;">Effective 2/1/08</div>						
# of Persons in Family	Income Level	Upper Limits of Income for Allowance Range				
1	\$ 15,600	\$ 18,720	\$ 20,280	\$ 23,400	\$ 24,960	\$ 28,080
2	\$ 21,000	\$ 25,200	\$ 27,300	\$ 31,500	\$ 33,600	\$ 37,800
3	\$ 26,400	\$ 31,680	\$ 34,320	\$ 39,600	\$ 42,240	\$ 47,520
4	\$ 31,800	\$ 38,160	\$ 41,340	\$ 47,700	\$ 50,880	\$ 57,240
5	\$ 37,200	\$ 44,640	\$ 48,360	\$ 55,800	\$ 59,520	\$ 66,960
6	\$ 42,600	\$ 51,120	\$ 55,380	\$ 63,900	\$ 68,160	\$ 76,680
7	\$ 48,000	\$ 57,600	\$ 62,400	\$ 72,000	\$ 76,800	\$ 86,400
8*	\$ 53,400	\$ 64,080	\$ 69,420	\$ 80,100	\$ 85,440	\$ 96,120
Allowance to Give:	100%	80%	70%	50%	40%	20%

EXAMPLE: Annual Family Income \$48,000
 # of Persons in Family 4
 Applicable Poverty Income Level \$31,800
 Upper Limits of Income for Allowance Range \$57,240 (20% range)
 \$48,000 is less than the upper limit of income; therefore patient is eligible for financial assistance.

*For family units with more than eight (8) members, add \$5,400 for each additional member.

Exhibit A

Howard County General Hospital
5300 Alpha Commons/Suite 300
Baltimore, MD 21224-2724



Maryland State Uniform Financial Assistance Application

Information About You

Name _____
First Middle Last

Social Security Number _____ - _____ - _____ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

_____ City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____ City State Zip code

Household members:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

Exhibit A

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____	Approximate value _____
Automobile	Make _____ Year _____	Approximate value _____
Additional vehicle	Make _____ Year _____	Approximate value _____
Additional vehicle	Make _____ Year _____	Approximate value _____
Other property		Approximate value _____
Total		_____

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? Yes No
 For what service? _____
 If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ Applicant signature

_____ Date

_____ Relationship to Patient

APPENDIX 4

MISSION, VISION, AND VALUE STATEMENTS

HCGH Mission and Vision Statements

I. Howard County General Hospital

A. Mission Statement:

Provide the highest quality care to improve the health of our entire community through innovation, collaboration, service excellence, diversity and a commitment to patient safety.

B. Vision Statement:

To be the premier community hospital in Maryland

APPENDIX 1

STATEMENT OF ACCESS TO SPECIALIST PROVIDERS FOR THE UNINSURED


HSCRC Community Benefit Report – The Johns Hopkins Health System Access to Specialist Providers for the Uninsured – FY 2008 Report Submission

This section of the report responds to the new HSCRC requirement for hospitals to include a “written description of gaps in the availability of specialist providers to serve the uninsured in the hospital.”

Johns Hopkins Hospital provides a full range of specialty care by leading physicians in their disciplines, and does so without regard for the health insurance status of the patient. Johns Hopkins Hospital also works in cooperation with Johns Hopkins Bayview Medical Center and Howard County General Hospital to meet the specialty care needs in a timely fashion for all individuals seeking specialty care. These approaches eliminate any gaps in the availability of specialist providers to serve the uninsured in the hospital.

APPENDIX 3

CHARITY CARE POLICY

	The Johns Hopkins Health System	<i>Policy Number</i>	FIN053
	Policy & Procedure	<i>Effective Date</i>	2/1/05
	<i>Subject</i> Financial Assistance - Pregnancy Care - JHBMC	<i>Page</i>	1 of 1
		<i>Revised</i>	9/10/07

POLICY

This policy applies to the Johns Hopkins Bayview Medical Center (JHBMC).

PURPOSE

JHBMC has witnessed the dramatic growth in pregnancy care for expectant mothers within the East Baltimore Community who are not eligible for any insurance coverage, and have demonstrated significant difficulty in paying for healthcare services. JHBMC recognizes the need to establish a policy pertaining to this population to ensure appropriate care during and immediately following pregnancy. Prenatal services and one postpartum visit are covered by this policy.

Eligibility Criteria:

1. Positive pregnancy test with no other obstetrical healthcare provider;
2. Not eligible for any other insurance benefits or exhausted her insurance benefits;
3. Not eligible for any other sources of funding;
4. Demonstrates inability to pay to Financial Representatives;
5. Resides in the JHBMC primary service area as defined by the 2004 Johns Hopkins Strategic Planning and Market Research definition. The zip codes for the JHBMC primary service area include: (21205, 21206, 21213, 21219, 21220, 21221, 21222, 21224, 21231, 21237).

PROCEDURE

Expectant mothers will be seen in the JHBMC outpatient OB/GYN practice for pregnancy care. Expectant mothers are required to meet with a financial counselor to determine their financial eligibility. Following a review of financial eligibility according to policy, FIN 034A, a determination of need will be made.

SPONSOR

Senior Vice President, Medical Affairs (JHBMC)
Vice President, Finance (JHBMC)

REVIEW CYCLE

Three (3) years

APPROVAL

President, JHHS/JHH

Date

APPENDIX 4

MISSION, VISION, AND VALUE STATEMENTS

JHBMC Mission, Vision, and Value Statements

I. **Johns Hopkins Bayview Medical Center**

A. **Mission Statement:**

1. To deliver quality, patient-centered, service-oriented acute, long-term and preventive health care consistent with the Hopkins' standards of excellence in a cost-effective manner.
2. To function as an integral component of the Johns Hopkins Health System, operating interdependently with the facilities of The Johns Hopkins University in support of education and research in accordance with the Hopkins Mission.
3. To provide an environment that attracts and supports outstanding health care professionals dedicated to patient service.

B. **Vision Statement: Making the Best Even Better**

- ...by providing every patient with an exceptional health care experience
- ...by enhancing access to quality care for a variety of settings
- ...by valuing our staff as our most powerful asset.

C. **Statement of Values**

1. Service Quality - We respect the dignity of individuals - our patients, our co-workers and other external customers. We strive to anticipate and exceed their expectations and to treat them with kindness and understanding.
2. Health Care Excellence - We aspire to be a model in providing patient-centered, quality health care which is enhanced by our commitment to teaching and research.
3. Health Promotion - We promote wellness for our patients, our staff and in our community.
4. Community Partnership - We strive to listen attentively and communicate clearly in our planning and operations and to be responsive to the many constituencies we serve.
5. Resource Utilization - We value and foster the wise and efficacious use of our resources.
6. Innovation - We strive for continuous improvement in carrying out our mission. We are committed to creating a work environment that fosters mutually beneficial relationships among employees, physicians and volunteers.

APPENDIX 1

STATEMENT OF ACCESS TO SPECIALIST PROVIDERS FOR THE UNINSURED


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APPENDIX 3

CHARITY CARE POLICY

	The Johns Hopkins Health System Policy & Procedure	<i>Policy Number</i>	FIN034A
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		<i>Revised</i>	2/5/08

POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: The Johns Hopkins Hospital (JHH), and Johns Hopkins Bayview Medical Center, Inc. (JHBMC)

Purpose

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. JHHS hospitals will publish the availability of charity care on a yearly basis in their local newspaper and will post notices of availability at appropriate intake locations. Notice of availability will also be sent to patients on patient bills.


Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing (including any accounts having gone to bad debt within 3 months of application date;) and any projected medical expenses.

PROCEDURES

1. An evaluation for Financial Assistance can be commenced in a number of ways.

For example:


- A patient with a self-pay balance due notifies the self-pay collector that he/she cannot afford to pay the bill and requests assistance.
 - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
 - A physician or other clinician refers a patient for charity care evaluation for potential admission.
2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, JHOPC first floor administrative staff, Customer Service, etc.
 3. When a patient requests Financial Assistance, the staff member who receives the request will refer the patient to the designated person in their clinical or business unit, who will meet with the patient. An assessment will be done to determine if patient meets preliminary criteria for assistance.
 - a. All hospital applications submitted will be processed within two business days of receipt and a determination will be made as to probable eligibility. In order to determine probable eligibility applicant must provide family size and family income (as defined by Medicaid regulations). A notice of conditional approval will instruct the applicant of the documentation necessary to complete the application process for a final determination of eligibility.
 - b. Applications received will be faxed daily to the JHHS Patient Financial Services Department's dedicated financial assistance application line for review and issuance of a written determination of probable eligibility to the patient.

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4. The following criteria must be met in order for a review for a final determination for a Financial Assistance adjustment:
 - a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the disability requirement. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
 - b. Review viability of offering a payment plan agreement.
 - c. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.
 - d. The patient must be a United States of America citizen or permanent legal resident (Must have resided in the U.S.A. for a minimum of one year).
 - e. All insurance benefits have been exhausted.

5. There will be one application process for all of Johns Hopkins Medicine. The patient is required to provide the following:
 - a. A completed Financial Assistance Application.
 - b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of 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).
 - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
 - d. A Medical Assistance Notice of Determination (if applicable).
 - e. Proof of US citizenship or lawful permanent residence status (green card).
 - f. Proof of disability income (if applicable).
 - g. Reasonable proof of other declared expenses.

6. 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, the Financial Counselor taking the application will review and analyze the application and forward to the Patient Financial Services Department for final determination of eligibility based on JHMI guidelines.
 - a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Counselor will recommend the patient's level of eligibility.
 - b. If the patient's application for Financial Assistance is based on excessive medical expenses or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee. This committee will have decision-making authority to approve or reject applications for charity care. It is expected that an application for Financial Assistance will be approved for charity care.

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Assistance, which is reviewed by the Committee will have a final determination made no later than 30 days from the date it was considered complete. The Financial Assistance Committee will perform its evaluation of financial need based on CPA, JHH and BMC guidelines.

7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
8. A department can continue using an adjustment to total charges (sliding scale) without the completion of Financial Need Assessment paperwork if the sliding scale gives adjustment, which is consistent with the Adjustments and Courtesy for Clinical Services policy. The use of a sliding scale in this manner only applies to the specific service involved. It does not automatically apply to any other services.
9. A department can continue to use a government sponsored application process and associated income scale, as it is required by terms of a program grant or other outside authority governing that program. (e.g. JHBMC Addiction Treatment Services).
10. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to Johns Hopkins. If a patient is approved for a percentage allowance due to financial hardship and the patient does not make the required initial payment within 60 days towards their part of the bill, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.
11. Any payment schedule developed through this policy will ordinarily not exceed two years in duration. In extraordinary circumstances, a payment schedule may extend to three years in duration, with the approval of the designated director.

REFERENCE¹

JHHS Finance Policies and Procedures Manual

Policy No. FIN017 - Signature Authority: Patient Financial Services
Policy No. FIN033 - Installment Payments


Charity Care and Bad Debts, AICPA Health Care Audit Guide

Federal Poverty Guidelines (Updated annually) in Federal Register

RESPONSIBILITIES - JHH, JHBMC

Financial Counselor (Pre-Admission/Admission/In-House/Outpatient) Customer Service	Understand current criteria for Assistance qualifications.
Collector Admissions Coordinator	Identify prospective candidates; initiate application process. (BMC Community Psychiatry completes the "Application for Financial Hardship and Fee Adjustment" form)
Any Finance representative designated to accept applications for Financial Assistance	On the day preliminary application is received, fax to Patient Financial Services Department's dedicated fax line for

¹ NOTE: Standardized applications for financial assistance have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibit A.

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determination of probable eligibility.

Review preliminary application and make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments.

Review and ensure completion of final application.

Deliver completed final application to appropriate management.

Document all transactions in all applicable patient account's comments.

Identify retroactive candidates; initiate final application process.

Review and ensure completion of final application.

Deliver completed final application to Patient Financial Services management.

Document all transactions in all applicable patient account's collection record.

Management Personnel
(Supervisor/Manager/Director)

Review completed final application; determine patient eligibility; communicate final written determination to patient.

Advise ineligible patients of other alternatives available to them including Medical Assistance, installment payments, bank loans, or consideration under the catastrophic program. [Refer to Appendix B - Catastrophic Financial Assistance Guidelines.

Financial Management Personnel
(Senior Director/Assistant Treasurer or affiliate equivalent)
CPP Director and Management Staff

Review and approve Financial Assistance applications in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

SPONSOR

Vice President/Chief Financial Officer and Treasurer, JHHS


REVIEW CYCLE

Three (3) years

APPROVAL

President, JHHS/JHH

Date


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PROCEDURES - JHH


1. Financial Counselor/Patient Financial Services Representative/Counselor
 - a. Maintain and understand current guidelines qualifying patients for Financial Assistance.
 - b. Maintain supply of Financial Assistance Applications and current Federal Poverty Income guidelines from Federal Register.
 - c. Identify prospective candidates for Financial Assistance. Determine possible eligibility for Financial Assistance as early in the account cycle as possible in cases where identification of Financial Assistance patient was not made before services were provided.
 - d. Initiate the Financial Assistance Application process with the patient/guarantor. As necessary, assist patient/guarantor in completing the application.
 - e. Review preliminary application and communicate a determination of probable eligibility to patient within two business days.
 - f. Review completed application to ensure that all required information is present. Contact appropriate party to obtain any missing documentation.
 - g. Compile all supporting documentation (e.g., tax returns, pay stubs, bank statements, etc.); attach to application and place in a file folder marked "Financial Assistance"; deliver file to Supervisor.
 - h. Document all transactions involving the application process.

2. Supervisor
 - a. Review applications for completeness within five (5) business days of receipt. Return incomplete applications to the responsible Financial Representative for completion of documentation, etc.
 - b. Determine eligibility for charitable Financial Assistance using available information, including application and applicable guidelines (e.g., Table for Determination of Financial Assistance Allowances).
 - c. Approve/disapprove applications according to signature authority established in Finance Policy No. FIN017. Disapprove any application, which does not meet the Financial Assistance Guidelines as set forth in Appendix A.

NOTE: Extenuating circumstances not addressed in the policy's guidelines may permit the application to be forwarded to the Director of Patient Financial Services for further consideration.

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- d. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Associate Director, Patient Financial Services.
 - e. Send "Notice of Financial Assistance Determination" to the patient/guarantor. (Decisions for approval/disapproval will be made within thirty (30) business days of receiving completed application.)
 - f. Initiate transactions to offset revenue on approved applications.
 - g. Scan records and ensure their safekeeping. Retain all completed applications for eight (8) years following the end of the fiscal year in which the assistance need was identified.
3. Associate Director, Patient Financial Services
- a. Review applications according to signature authority established in Finance Policy No. FIN017 or, those applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Maintain system-generated report of charity amounts written off. Return finalized applications to Supervisor, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Director, Patient Financial Services for further action.
 - e. Reconcile monthly Financial Assistance write-offs per the automated report against monthly case files.
4. Director, Patient Financial Services
- a. Review applications according to signature authority established in Finance Policy No. FIN017, or those applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Return finalized applications to Associate Director, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Senior Director, Patient Financial Services for further action.


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5. Senior Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017, or applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Return finalized applications to the Director, Reimbursement or designated Manager for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval of applications for amounts equal to or greater than amounts authorized, forward to Vice President, Finance/CFO.

6. Vice President, Finance/CFO and Treasurer or COO
 - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
 - b. Approve/disapprove applications; return finalized applications to Senior Director for final processing.

PROCEDURES – JHBMC


1. Financial Counselor (Inpatient and Outpatient) and Collector CPP Admissions Coordinator and Clinical Staff
 - a. Maintain and understand current guidelines qualifying patients for Financial Assistance.
 - b. Maintain supply of Financial Assistance Applications and current Federal Poverty Income guidelines from Federal Register.
 - c. Identify prospective candidates for Financial Assistance.
 - d. Initiate the Financial Assistance application process with the patient/guarantor. As necessary, assist patient/guarantor in completing the application.
 - e. Review preliminary application and communicate a determination of probable eligibility to patient within two business days.
 - f. Review completed application to ensure that all required information is present. Contact appropriate party to obtain any missing documentation.
 - g. Compile all supporting documentation (e.g., tax returns, pay stubs, bank statements, etc.); attach to the application; place in a file folder marked "Financial Assistance;" deliver file to designated Manager or responsible party.
 - h. Document all transactions in the application process.

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2. Supervisor, Patient Financial Services
CPP Director/Managers
 - a. Review applications for completeness within five (5) business days of receipt. Return incomplete applications to the responsible Financial Representative for completion of documentation, etc.
 - b. Determine eligibility for charitable Financial Assistance using available information, including application and applicable guidelines (e.g., Table for Determination of Financial Assistance Allowances).
 - c. Approve/disapprove applications according to signature authority established in Finance Policy No. FIN017. Disapprove any application, which does not meet the Financial Assistance Guidelines as set forth in Appendix A.

NOTE: Extenuating circumstances not addressed in the policy's guidelines may permit the application to be forwarded to the Director of Patient Financial Services for further consideration.
 - d. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Associate Director, Patient Financial Services.
 - e. Send "Notice of Financial Assistance Determination" to the patient/guarantor. (Decisions for approval/disapproval will be made within thirty (30) business days of receiving completed application.)
 - f. Initiate transactions to offset revenue on approved applications.
 - g. File records and ensure their safekeeping. Retain all completed applications for eight (8) years following the end of the fiscal year in which the assistance need was identified.

3. Associate Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017 or, those applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Maintain system-generated report of charity amounts written off. Return finalized applications to Supervisor, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Director, Patient Financial Services for further action.


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- e. Reconcile monthly Financial Assistance write-offs per the automated report against monthly case files.

- 4. Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017, or applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized.
 - c. Return finalized applications to Associate Director, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval for applications greater than amount authorized, forward to affiliate Senior Director, Patient Financial Services, for further action.


- 5. Senior Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017, or applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Return finalized applications to the Director, Reimbursement or designated Manager for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval of applications for amounts equal to or greater than amounts authorized, forward to Vice President, Finance/CFO.

- 6. Vice President, Finance/CFO or COO
 - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
 - b. Approve/disapprove applications and return finalized applications to Director, Patient Financial Services.

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**APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES**

1. ***Notice of the availability of the JHHS Financial Assistance Program will be posted at patient registration sites, Admissions/Business Office and emergency department within each facility and presented to patients upon request.
2. Each person requesting Financial Assistance must complete a JHM/Financial Assistance application.
3. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.
4. Proof of income must be provided with the final application. Acceptable proofs include:
 - (a) Prior year tax return;
 - (b) Current pay stubs;
 - (c) Letter from employer; and
 - (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
5. An individual will be eligible for Financial Assistance if the maximum family (husband and wife) income (as defined by Medicaid regulations) level does not exceed each affiliates standard related to the Federal poverty guidelines, and they do not own liquid assets which would be available to satisfy their JHHS affiliate bills.
6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify.
7. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and non-medically necessary private room accommodations. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is "elective" or "necessary," the patient's admitting physician shall be consulted. Questions as to necessity may be directed to the physician advisor appointed by the Hospital.
8. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days (or their specifically established timeline) of satisfactory completion and return of the application. The Manager or designated responsible party will issue the final eligibility determination.
9. Documentation of the final eligibility determination will be made on all (open-balance) patient's account. A determination notice will be sent to the patient.
10. A determination of eligibility for Financial Assistance will remain valid for a period of three (3) months for all necessary JHM affiliate services provided based on the initial date of the determination letter. For recurring outpatient therapeutic services (such as chemotherapy or radiation therapy), patients may qualify for Financial Assistance for up to six (6) months on the basis of a single application. Patients will not be required to reapply for Financial Assistance if they are currently receiving Financial Assistance from another affiliate.
11. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.

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APPENDIX B CATASTROPHIC FINANCIAL ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a JHHS Catastrophic Assistance Application. Under these circumstances, the term "catastrophic" is defined as a situation in which the self-pay portion of the JHM affiliate medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 18 months or less.


General Conditions for Catastrophic Assistance Application:

1. Patient has exhausted all insurance coverage.
2. Patient is not eligible for any of the following:
 - Medical Assistance
 - The JHM Financial Assistance Program.
 - Other forms of assistance available through JHM affiliates.
3. The patient cannot repay the self-responsible portion of the JHHS affiliate account in 18 months or less.
4. The affiliate has the right to request patient to file updated supporting documentation.
5. The maximum time period allowed for paying the non-charitable amount is three (3) years.
6. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the catastrophic assistance program, the patient is still required to file a JHHS Catastrophic Assistance Application and non-duplicated supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Catastrophic Assistance Application:

- Current Medical Debt
- Liquid Assets (leaving a residual of \$2,500)
- Living Expenses
- Projected Medical Expenses
- Annual Income
- Spell of Illness
- Supporting Documentation

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Definitions


Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash/Bank Accounts, Certificates of Deposit, bonds, stocks, Cash Value life insurance policies, pension benefits.
Living Expenses	Per person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e. drugs, co-pays, deductibles and durable medical equipment.)
Take Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service, after taxes and other deductions.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, social security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments; and, credit bureau reports.

Exceptions

1. Each affiliate has the right to refuse treatment for elective procedures, which may result in catastrophic medical debt.
2. The Director of Patient Financial Services (or affiliate equivalent) may make exceptions, as circumstances deem necessary.

Evaluation Method and Process

1. The Financial Counselor will review the Catastrophic Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Financial Counselor will then complete a Catastrophic Assistance Worksheet (see below) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

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Note: If the below worksheet is electronically available to preparer, double-click on worksheet and fill in required amounts in **highlighted fields** only. The worksheet will automatically compute rest of the fields.

FINANCIAL ASSISTANCE WORKSHEET

Patient Name: _____
 History #: _____

LINE #	PARTICULAR	AMOUNT
Net Current Medical Debt:		
1	Current Medical Debt	\$ -
2	Total Liquid Assets	\$ -
3	Asset Exclusion (Fixed Amount)	\$ 2,500
4	Net Liquid Assets [If Line 2 > Line 3, then Line 2 - Line 3, otherwise amount is zero "0"]	\$ -
5	Net Current Medical Debt [Line 1 - Line 4]	\$ -

Total Annual Expenses:		
6	Living Expenses	\$ -
7	Projected Medical Expenses	\$ -
8	Total Annual Expenses [Line 6 + Line 7]	\$ -

Annual Income Available:		
9	Income (Net Take Home Pay)	\$ -
10	% Income Available [100% - (Line 8 divided by Line 9 x 100)] [If Line 8 is > Line 9, then % Income Available is zero "0"]	-%
11	Annual Income Available [Line 9 x Line 10]	\$ -

SELECT PATIENT PAYMENT PERIOD PLAN

Patient Payment in 1-Year Period Plan:		
12	Income Available in 1 Year [Line 11]	\$ -
13	Income Available in 1 Year plus Net Liquid Assets [Line 12 + Line 4]	\$ -
14	Monthly Patient Installment Payment within 1 Year [Line 13 / 12 Months]	\$ -
15	Financial Assistance Amount [If Line 1 > Line 13, then Line 1 - Line 13. This is the Financial Assistance Amount] [If Line 1 < Line 13, then the Financial Assistance Amount is zero "0"]	\$ -

Patient Payment in 2-Year Period Plan:		
16	Income Available in 2 Years [Line 11 x 2 Years]	\$ -
17	Income Available in 2 Years plus Net Liquid Assets [Line 16 + Line 4]	\$ -
18	Monthly Patient Installment Payment within 2 Years [Line 17 / 24 Months]	\$ -
19	Financial Assistance Amount [If Line 1 > Line 17, then Line 1 - Line 17. This is the Financial Assistance Amount] [If Line 1 < Line 17, then the Financial Assistance Amount is zero "0"]	\$ -

Patient Payment in 3-Year Period Plan:		
20	Income Available in 3 Years [Line 11 x 3 Years]	\$ -
21	Income Available in 3 Years plus Net Liquid Assets [Line 20 + Line 4]	\$ -
22	Monthly Patient Installment Payment within 3 Years [Line 21 / 36 Months]	\$ -
23	Financial Assistance Amount [If Line 1 > Line 21, then Line 1 - Line 21. This is the Financial Assistance Amount] [If Line 1 < Line 21, then the Financial Assistance Amount is zero "0"]	\$ -



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**TABLE FOR DETERMINATION OF
FINANCIAL ASSISTANCE ALLOWANCES**

Effective 2/1/08

# of Persons in Family	Income Level	Upper Limits of Income for Allowance Range				
		100%	80%	70%	50%	40%
1	\$ 15,600	\$ 18,720	\$ 20,280	\$ 23,400	\$ 24,960	\$ 28,080
2	\$ 21,000	\$ 25,200	\$ 27,300	\$ 31,500	\$ 33,600	\$ 37,800
3	\$ 26,400	\$ 31,680	\$ 34,320	\$ 39,600	\$ 42,240	\$ 47,520
4	\$ 31,800	\$ 38,160	\$ 41,340	\$ 47,700	\$ 50,880	\$ 57,240
5	\$ 37,200	\$ 44,640	\$ 48,360	\$ 55,800	\$ 59,520	\$ 66,960
6	\$ 42,600	\$ 51,120	\$ 55,380	\$ 63,900	\$ 68,160	\$ 76,680
7	\$ 48,000	\$ 57,600	\$ 62,400	\$ 72,000	\$ 76,800	\$ 86,400
8*	\$ 53,400	\$ 64,080	\$ 69,420	\$ 80,100	\$ 85,440	\$ 96,120
Allowance to Give:	100%	80%	70%	50%	40%	20%

EXAMPLE: Annual Family Income \$48,000
 # of Persons in Family 4
 Applicable Poverty Income Level \$31,800
 Upper Limits of Income for Allowance Range \$57,240 (20% range)
 \$48,000 is less than the upper limit of income; therefore patient is eligible for financial assistance.

*For family units with more than eight (8) members, add \$5,400 for each additional member.

APPENDIX 4

MISSION, VISION, AND VALUE STATEMENTS

JHH Mission, Vision, and Value Statements

I. Johns Hopkins Hospital

A. Mission Statement:

The mission of The Johns Hopkins Hospital is to improve the health of the community and the world by setting the standard of excellence in patient care. Diverse and inclusive, The Johns Hopkins Hospital in collaboration with the faculty of The Johns Hopkins University supports medical education and research, and provides innovative patient-centered care to prevent, diagnose and treat human illness.

B. Vision Statement:

The vision of The Johns Hopkins Hospital is to be the world's preeminent health care institution.

C. Statement of Values:

Core Values

- Excellence & Discovery
- Leadership & Integrity
- Diversity & Inclusion
- Respect & Collegiality

James Lawrence Kernan Hospital Community Benefits Evaluation FY 2008

General Statement

The James Lawrence Kernan Hospital is the largest inpatient rehabilitation hospital in the state of Maryland. Known also as Kernan Orthopaedics and Rehabilitation, the hospital is a committed provider of orthopaedic surgery and has been serving patients for over 100 years.

Located on 85 acres on the border of Northwest Baltimore City and Baltimore County, Kernan is dedicated to reaching out to the community and providing personalized care to patients. Kernan continues to be committed to excellence in the areas of patient care and medical education through training programs provided for orthopaedic residents and therapy students. Kernan has kept pace with the changing environment in healthcare by blending a multidisciplinary staff of specialist to meet a variety of patient needs.

The following statistics apply to Kernan Hospital for FY 2008:

Number of licensed beds: 133

ICU beds: 5

Admissions: 3,358

Surgeries: 3,895

Inpatient Rehabilitation Services Provided: 2700

Outpatient Visits: 45,000

As part of the continuum of care for patients whose acute care treatment may begin at The University of Maryland Medical Center, or other acute care hospitals throughout Maryland, Kernan's outreach, community and professional education initiatives, as well as other community involvements are driven by the diagnostic categories that Kernan serves, and the need to invest in the development of future professionals to care for individuals who require the unique blend of services available at Kernan.

Kernan provides specialized rehabilitation services within its four 32-bed units. Each unit is staffed by a multi disciplinary team lead by a rehabilitation physician collaborating in quality care delivery with the disciplines of nursing, physical therapy, occupational therapy, speech therapy, therapeutic recreational, case management and dietary, as well as consulting physician services such as ENT and urology. Kernan has provided inpatient services to over 20,000 patients in the past 10 years.

The Community Health Outreach and Advocacy Strategic Plan developed in FY 2006 is one determinant of Kernan's community outreach initiatives. Other factors that determine these initiatives include an integration of evidence-based research and data obtained through relationships with:

- Brain Injury Association of Maryland
- Maryland Stroke Alliance
- The National Center for Injury Prevention & Control
- USAMS

- Maryland Hospital Association
- National Caregivers Association

and other disability specific organizations that advocate, support and empower our patients and families as they adjust to their disabilities.

Community Benefits Evaluation

The community outreach initiatives involve partnerships with both local education and community groups as well as organizations with specific ties to disabilities treated at Kernan. These groups include Franklinton Community Association; Baltimore City Schools – Dickeyhill Elementary and Middle schools; Baltimore County Schools; Howard County Schools; Greater Catonsville Chamber of Commerce; the Gwynns Falls Trail Council; the Boy Scouts of America-Maryland; Baltimore Municipal Golf Corporation; Baltimore City Department of Parks & Recreation – Therapeutic Division; Howard County Youth Programs; The Brain Injury Association of Maryland; Arthritis Foundation of Maryland; Towson YMCA; Baltimore Adaptive Recreation and Sports; and the Multiple Sclerosis Society of Maryland. Kernan’s leadership consults with community leaders on an ongoing basis to determine how best to meet the needs of their constituents through attendance at monthly meetings and actively participating on board and commissions within these organizations, plus sponsoring of community events.

Community Benefits Implementation

The community outreach initiatives have designated staff members assigned to assist and monitor the community benefits activities. The community groups and hospital leadership are kept abreast of the initiatives and their progress towards goal achievement.

James Lawrence Kernan Hospital

Kernan provides education, serves as an advocate and supports the disability populations within its continuum of care. During FY 2008, Kernan provided and facilitated monthly support groups for brain injury, stroke, spinal cord injury, amputee, and caregivers’ programs.

In addition to support groups, physical space was provided within the hospital for:

- the Brain Injury Association of Maryland
- the MS Day Program funded by US Against MS
- Women Embracing Abilities Now, a mentoring program for women with disabilities
- monthly meeting space for the Franklinton Community Association

Responding to the need to healthcare education and career awareness, opportunities were brought to students within the Kernan community as well. The Boy Scouts of America also benefited from Kernan by the use of physical space and volunteers through sponsorship by Kernan as the hospital’s Health Care Explorer Post. Dental education was provided to Dickeyville Elementary School students. Students at Dickeyville also benefited from the sales of a cookbook that was developed and produced by Kernan employees. High school students in Howard County at Hammond High School and Folly

Quarter Middle School learned about health care careers through activities of Kernan staff at those schools.

Clinical education and mentoring of future health care professionals was provided to numerous college and university students in the fields of occupational therapy, physical therapy, speech language pathology, dental, nursing and medicine.

Community integration and adaptive leisure opportunities were provided through collaborative initiatives with Baltimore Municipal Golf Corporation and Baltimore City Parks and Recreation-Therapeutic Recreation Division.

Community Benefits Evaluations FY 2008

Many of the individual initiatives have tracked outcomes(s) through satisfaction and participation questionnaires. College students who were provided clinical experience for workforce development completed structured evaluations of their experiences. The community fairs and health screenings provided yielded spontaneous input and suggestions from those in attendance. Due to constant feedback from support group attendees Kernan staff are able to develop and implement program content that is the most beneficial to the end-user-the patient.

Gap Coverage

The James Lawrence Kernan Hospital is a Level IV emergency service facility, therefore, the hospital offers reasonable care in determining if an emergency exists, renders life saving first aid and makes appropriate referral to an acute care facility capable of providing continued emergency services.

Visitors and outpatients who suffer cardiopulmonary arrest will have emergent care initiated by the code blue team and then will be transported to an emergency room via 911.

All inpatients requiring treatment by the code blue team will be transported, with monitoring, to the Intensive Care Unit at Kernan at the discretion of the team leader. In consultation, the intensivist and service attending will make the determination regarding patient transport to a tertiary care facility.

Kernan has a rapid response team that will respond to calls regarding visitors/patients who need emergent care or rapid management outside of the critical care setting. The rapid response team consists of a respiratory therapist, registered nurse, intensivist (day shift only) and hospitalist. Patient family members are educated about the services that the rapid response team offers, and how to contact them if family members feel that the patient requires that service.

Appendix 1

Charity Care policy of The James Lawrence Kernan Hospital.

Kernan Orthopaedics and Rehabilitation Hospital, as a part of the University of Maryland Medical System, provides healthcare services to those in need regardless of an individual's ability to pay. Care may be provided without charge, or at a reduced charge, to those who do not have insurance, Medicare/Medical Assistance coverage, and are without the means to pay. An individual's eligibility to receive care without charge, at a reduced charge, or to pay for their care over time is determined on a case by case basis.

Within two days following a patient's request for charity care services, application for medical assistance, or both, the hospital makes a determination of probable eligibility.

Information regarding the charity care policy at Kernan is posted within the hospital in clinic areas and business areas where eligible patients are likely to be present. Patients also receive individualized help in obtaining services and care should they not have the ability to pay. Information regarding Kernan's charity care policy is provided at the time of preadmission or admission to each person who seeks those services. Kernan Hospital makes every effort that information is provided in languages that is understood by the target population of patients utilizing hospital services.

Appendix 2

**UNIVERSITY OF MARYLAND MEDICAL
CENTER
JAMES LAWRENCE KERNAN HOSPITAL
UNIVERSITY SPECIALTY HOSPITAL**

FINANCE POLICY AND PROCEDURE MANUAL

Effective Date: September 2008

Revision: December 2008

**SUBJECT:
FINANCIAL CLEARANCE PROGRAM**

APPROVALS:

- **SVP & Chief Financial Officer**
-

POLICY STATEMENT

This policy outlines the principles of the Financial Clearance Program, also formerly known as the Financial Assistance Program. The Financial Clearance Program is available to all legal residents of the State of Maryland who demonstrate an inability to pay for all or a portion of their prospective or outstanding hospital bill.

SCOPE

The Financial Clearance Program may cover all medically necessary and appropriate hospital-based services provided by the Hospital (which for this policy includes the University of Maryland Medical Center, University Specialty Hospital, and Kernan Hospital) when ordered by a physician on the Hospital's medical staff.

The Financial Clearance Program does not cover the following:

- Services provided by healthcare providers not affiliated with the Hospital (e.g., durable medical equipment, home health services).
- Insurance co-payments for need-based programs such as Medicaid.
- Unpaid balances resulting from cosmetic or other non-medically necessary services.
- Patient convenience items.
- Patient meals and lodging.
- Physician bills.
-

The Patient Financial Services (PFS) staff administers the Financial Clearance Program and evaluates each application in a fair and equitable manner. If PFS staff is unable to review and financially clear a non-emergent/urgent service *before* it has been scheduled to be provided, such service may be subject to rescheduling, after consultation with Hospital Management and the patient's physician. The Hospital 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.

PROCEDURE

1.1 The Financial Clearance Program is available to all legal residents of the State of Maryland who demonstrate an inability to pay for all or a portion of their outstanding hospital bill. In order to be eligible, patients must complete an application and provide all required documentation.

1.2 Individuals are ineligible for the Financial Clearance Program if they:

1.2.1 Refuse to provide requested documentation or provide incomplete information.

1.2.2 Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Hospital due to insurance plan restrictions/limits.

1.2.3 Fail to pay co-payments as required by the Financial Clearance Program.

1.2.4 Fail to keep current on existing payment arrangements with the Hospital or one of its affiliate Hospitals.

1.2.5 Fail to make appropriate arrangements on past payment obligations owed to the Hospital or one of its affiliate Hospitals (including those patients who were referred to an outside collection agency for a previous debt).

1.2.6 Refuse to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.

1.3 Before scheduling hospital based, non-emergent/urgent services for individuals indicating an inability to pay, staff from the faculty practice plans will contact the Hospital's Financial Counseling team to inform them that a patient is being referred for Financial Clearance.

1.3.1 Patients must have a referring/attending physician on staff at the Hospital before they may be evaluated for Financial Clearance eligibility.

1.3.2 Patients can call Financial Counseling staff directly at (410) 821-4140. Hours of operation are Monday – Friday from 8:00 a.m. to 9:00 p.m.

1.3.4 The Financial Counselor will work with the patient to determine if he/she qualifies for Financial Clearance. A determination of probable eligibility will be made within two business days following a patient's initial completed request for Financial Clearance services, application for Medical Assistance, or both.

1.3.5 Notice of the availability of Financial Clearance/Financial Assistance shall be posted in the Admissions Office, Business Office, and Emergency Areas of the Hospital. Such notice will be posted in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing Hospital services.

Individual notice of the availability of Financial Clearance/Financial Assistance, the potential for Medicaid eligibility, and the availability of assistance from other government funded programs shall be provided to each person who seeks services in the Hospital at the time of community outreach efforts, prenatal services, preadmission, or admission. Such notice will be printed in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing Hospital services.

1.3.6 The Hospital will publish notice of the availability of Financial Clearance/Financial Assistance annually in the Baltimore Sun Paper.

1.3.7 If the patient does qualify for Financial Clearance, the Financial Counselor will notify the physician and/or physician office staff who may then schedule the patient for the appropriate Hospital-based service.

1.3.8 If the patient does not qualify for Financial Clearance, the Financial Counselor will notify the physician and/or physician office staff of the determination and the non-emergent/urgent Hospital-based services will not be scheduled.

1.3.9 A decision that the patient may not be scheduled for Hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Physician Leader/Clinical Chair. The Financial Clearance Executive Committee is comprised of the Medical Center Chief Financial Officer and Chief Medical Officer or their designees.

1.4 If there is a change in the patient's financial circumstances, an updated or new application must be completed.

2.0 GUIDELINES

2.1 For emergent/urgent services, applications to the Financial Clearance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving these types of services.

2.2 For scheduled/elective appointments or admissions, all applications to the Financial Clearance Program must be evaluated and approved prior to the patient's date of service.

2.3 The Hospital reserves the right to request and review all pertinent information, including a review of an applicant's credit report history, for purposes of processing the application.

2.4 All applicants will be screened for other programs before screening for the Financial Clearance Program can begin. The other programs are as follows (in order of screening):

2.4.1 Maryland Medicaid—A denial letter may be required, if appropriate.

2.4.2 Other needs based assistance programs.

2.5 Applicants or family members are not eligible for the Financial Clearance Program if they qualify for Medicaid.

2.6 Unemployed applicants who have been unemployed for more than six (6) months and who have no custodial dependents under the age of 12 must provide proof of disability, as evidenced by a physician's certification, prior to qualifying for the Plan. Exceptions to this rule may be considered in accordance with Section 2.19 below.

2.7 Patients who falsify the Financial Clearance Program application or related documentation will be excluded from the Program and will be held responsible for all charges incurred while enrolled in the Program retroactively to the first day that charges were incurred under the Program.

2.8 One hundred percent Financial Clearance may be granted to uninsured patients whose sources of income is less than two times the federal poverty income level and who have less than \$10,000 in total assets. Financial Clearance will be granted on a sliding scale to uninsured patients with incomes more than two times the federal poverty income level.

2.9 Cost of care will be included in the determination of patient's eligibility for Financial Clearance.

2.10 The amount of uninsured medical costs will be considered in determining a patient's eligibility for the Financial Clearance Program, (*e.g.*, a patient whose income is \$40,000 a year but whose child recently incurred \$200,000 in uninsured medical costs).

2.11 The Financial Clearance Program decisions are valid for a six-month period. In order to continue in the Program, each patient must reapply before the end of each six month period. In addition, patients who have been approved for the Program must inform the Hospital of any changes in income, assets, expenses, or family status within 30 days of such change(s).

2.12 The patient must fulfill all co-payment obligations. Co-payments are due at the time of service. If a patient fails to pay the required co-payment at the time of service, he/she will no longer qualify for the Financial Clearance Program.

2.13 The Financial Clearance Program will not cover co-insurance or deductibles for patients who have insurance, including Medicare.

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

2.15 Patients whose insurance program or policy denies coverage for services at the Hospital by their insurance company (*e.g.*, HMO, PPO, Workers Compensation, or Medicaid), are not eligible for the Financial Clearance Program.

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

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

2.18 Where there is a compelling educational and/or humanitarian benefit, School of Medicine faculty or Hospital faculty may request the Financial Clearance Executive Committee to consider exceptions to the Financial Clearance Program guidelines.

2.18.1 Faculty/Physicians requesting Financial Clearance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.

2.18.2 The Chief Medical Officer will notify the attending physician and the Financial Counseling staff of the Financial Clearance Executive Committee determination.

Appendix 3

Mission, Vision and Value Statement for the James Lawrence Kernan Hospital

The staff at Kernan Orthopaedics and Rehabilitation is committed to working with patients and family members to meet their health care needs. Our dedicated staff serves the community with the goal to provide the same care and attention we would want for our families and ourselves.

The hospital's mission is to deliver innovative, high-quality, cost-effective rehabilitation and surgical services to the community and region.

The vision of the hospital is to be widely recognized as an integral component of the University of Maryland Medical System in its role as a regional hospital specializing in rehabilitation and orthopaedic services.

Core values include providing quality and compassionate care, excellent service, and respect for patients, families and employees. Additionally, providing patient safety, quality research and education, as well as cost effective health care are also part of the core values of Kernan Hospital.

**Community Benefits Report FY2008
Laurel Regional Hospital
7300 Van Dusen Road, Laurel, MD 20707**

Appendix 1

Description of gaps in the availability of specialist providers:

Although Laurel Regional Hospital has a large population of uninsured patients, we believe that all patients should receive the highest level of care regardless of economic standing. This goal can only be achieved with experienced specialist physicians caring for all of our patients even when so many of our patients can not afford to pay. To overcome this obvious dilemma, we pay physicians to cover their bad debts so the "gap" exists in the hospital's profits but not in patient care. We get no funds from the regulated system to offset these physician payments but we will always put the patients first.

**Community Benefits Report FY2008
Laurel Regional Hospital
7300 Van Dusen Road, Laurel, MD 20707**

Appendix 2

Description of Financial Assistance Program:

Dimensions Healthcare System provides compassionate care for all, regardless of an individual's ability to pay. We serve as the safety net for the uninsured and underinsured. It is our mission to help save lives and improve the quality of living.

Dimensions Healthcare System through its health care services, provides financial assistance to those who need medical and health care services but do not have the resources to pay for that care...and it does so by preserving the dignity of the individual who needs assistance.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs may be eligible for free or discounted healthcare services based on established criteria.

Eligibility for the Dimensions Healthcare System Financial Assistance Program is based on income and family size. Should you be found eligible for financial assistance, patient will receive a Financial Approval Letter indicating your eligibility amount. Any balance due after the financial assistance allowance has been applied, will become the responsibility of the patient. Physicians bill separately and their charges are not included in the financial assistance program.

**Community Benefits Report FY2008
Laurel Regional Hospital
7300 Van Dusen Road, Laurel, MD 20707**

Appendix 3

See attached Dimensions Financial Assistance Program Corporate Policy #200-41

Appendix 4

See attached Dimensions Mission, Vision, and Values Corporate Policy #200-24

FINANCIAL ASSISTANCE PROGRAM

PURPOSE: To identify circumstances when Dimensions Healthcare System (DHS) may provide care without charge or at a discount commensurate with the ability to pay, for a patient whose financial status makes it impractical or impossible to pay for medically necessary services. This policy applies only to facility charges and not physician or other independent company billings. The provision of free and discounted care through our Financial Assistance Program is consistent, appropriate and essential to the execution of our mission, vision and values, and is consistent with our tax-exempt, charitable status.

Resources are limited and it is necessary to set limits and guidelines. These are not designed to turn away or discourage those in need from seeking treatment. They are intended to assure that the resources the Hospital can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay. Financial assessments and the review of patients' assets and financial information is intended for the purpose of assessing need as well as gaining a holistic view of the patients' circumstances. Dimensions Healthcare System is committed to:

- Communicating this purpose to the patient so they can more fully and freely participate in providing the needed information without fear of losing basic assets and income;
- Assessing the patients' capacity to pay and reach payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency;
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process;
- Avoiding seeking or demanding payment from or seizing exempt income or assets; and
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment.

CANCELLATION: This is a new corporate policy. It supersedes all policies on this subject at the facility level.

POLICY: Dimensions Healthcare System has a long tradition of serving the poor, the needy, and all who require health care services. However, our hospitals alone cannot meet every community need. They can practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, provision for financial assistance will be budgeted annually. Our hospitals will continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon the Federal Poverty guidelines and will be updated annually in conjunction with the published updates by the United States Department of Health and Human Services. All open self-pay balances may be considered for financial assistance. If a determination is made that the patient has the ability to pay all or a portion of the bill, such a determination does not prevent a

reassessment of the person's ability to pay at a later date. The need for financial assistance is to be re-evaluated at the following times:

- Subsequent rendering of services,
- Income change,
- Family size change,
- When an account that is closed is to be reopened, or
- When the last financial evaluation was completed more than six months before.

To be considered for financial assistance, the patient must cooperate with the facility to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as Medicaid. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.

Appropriate signage will be visible in the facility in order to create awareness of the financial assistance program and the assistance available. At a minimum, signage will be posted in all patient intake areas, including, but not limited to, the Emergency Department, the Billing Office, and the Admission/Patient Registration areas. Information such as brochures will be included in patient services/information folders and/or at patient intake areas. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the facility's service area in accordance with the state's Language Assistance Services Act.

The necessity for medical treatment of any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

SPECIAL INSTRUCTIONS/FORMS TO BE USED:

DEFINITIONS:

- A. 1. *Assets:* Assets include immediately available cash and investments such as savings and checking as well as other investments, including retirement or IRA funds, life insurance values, trust accounts, etc. The following are to be considered exempt and shall not be considered in determining whether the uninsured patient qualifies for an uninsured discount:
- a. Homestead property
 - b. \$2,000 for the uninsured patient, or \$3,000 for the uninsured patient and one dependent residing together.
 - c. \$50 for each additional dependent residing in the same household.
 - d. Personal effects and household goods that have a total value of less than \$2,000.
 - e. A wedding and engagement ring and items required due to medical or physical condition.
 - f. One automobile with fair market value of \$4,500 or less.
 - g. Patient must have less than \$10,000 in net assets.

2. *Bad Debt Expense:* Uncollectible accounts receivable that were expected to result in cash inflows (i.e. the patient did not meet the facility's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected uncollectibles resulting from the extension of credit.
3. *Financial Assistance:* Health care services that were never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.
4. *Financial Assistance Committee:* A committee consisting of the Chief Financial Officer, the Corporate Director of Patient Financial Services, the Risk Manager, the Director of Case/Care Management, and the Director of Patient Relations, or a similar mix of individuals.
5. *Contractual Adjustments:* Differences between revenue at established rates and amounts realized from third party payers under contractual agreements.
6. *Disposable Income:* Annual family income divided by 12 months, less monthly expenses as requested on the application in Attachment I.
7. *Family:* The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.
8. *Family Income:* Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, veterans benefits, training stipends, military allotments, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.
9. *Qualified Patient:*
 - a. *Financially Needy:* A person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the medical facility's eligibility criteria set forth in this policy.
 - b. *Medically Needy:* A patient who does not qualify as financially needy, but whose medical or hospital bills, even after payment by third-party payers, exceed 50% of their gross income. The patient who incurs catastrophic medical expenses is classified as medically needy when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.

10. *Medically Necessary Service*: Any inpatient or outpatient hospital service that is covered by and considered to be medically necessary under Title XVIII of the federal Social Security Act. Medically necessary services do not include any of the following:
 - a. Non-medical services such as social, educational, and vocational services.
 - b. Cosmetic surgery.

B. Financial Assistance Guidelines and Eligibility Criteria (see PFS Department for current form)

- a. To be eligible for a 100 percent (100%) reduction from the patient portion of billed charges (i.e. full write-off) the patient's household income must be at or below 150 percent of the current Federal Poverty Guidelines. 150 percent (150%) of the Federal Poverty Guidelines represents an individual earning minimum wage.
- b. Patients with household income that exceeds 150 percent (150%) but is less than 300 percent (300%) of the Federal Poverty Guidelines will be eligible for a sliding scale discount of the patient portion of billed charges.
- c. Medically needy patient accounts will be considered on a case-by-case basis by the Financial Assistance Committee. The discounts to be applied will be based on a determination of what the family could reasonably be expected to pay, based on a review of current disposable income and expenses.
- d. Individuals who are deemed eligible by the State of Maryland to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall be deemed eligible for financial assistance at a level to be determined on a case-by-case basis by the Financial Assistance Committee.
- e. Financial assistance applications will be considered as long as an account is open or when a change in patient financial status is determined.
- f. After the financial assistance adjustment has been computed, the remaining balances will be treated in accordance with Patient Financial Services policies regarding self-pay balances. Payment terms will be established on the basis of a reasonable proportion of disposable income negotiated with the patient. No interest charges will accrue to the account balance while payments are being made. This also applies to payments made through a collection agency.

PROCEDURE:

A. Identification of Potentially Eligible Patients:

- Admitting
1. Where possible, prior to the admission of the patient, the Hospital will conduct a pre-admission interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission interview is not possible, this interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission, the Hospital's evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial interview, the following information should be gathered:
 - a) Routine and comprehensive demographic data.
 - b) Complete information regarding all existing third party coverage.
 2. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process.
 3. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.
- Dir., PFS
4. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Corporate Director of Patient Financial Services to make sure that no application for financial assistance was ever received. Prior to a summons being filed, the CFO's approval is required. Dimensions Healthcare System Facilities will not request body attachments from the court system for payment of an outstanding account; however it is recognized that the court system may take this action independently.

B. Determination of Eligibility:

- PFS
1. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the facility, or in the case of outpatients or emergency patients, a Patient Financial Services representative will mail a financial assistance application to the patient for completion. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the facility should take the required action to have a legal guardian/trustee appointed.
 2. Requests for financial assistance may be received from:
 - a. the patient or guarantor;
 - b. Church-sponsored programs;
 - c. physicians or other caregivers;
 - d. various intake department of the institutions;
 - e. administration;

- f. other approved programs that provide for primary care of indigent patients.

- 3. The patient should receive and complete a written application (Attachment I) and provide all supporting data required to verify eligibility.
- 4. In the evaluation of an application for financial assistance, a patient’s total resources will be taken into account which will include, but not be limited to, analysis of assets (identified as those convertible to cash and unnecessary for the patient’s daily living expense), family income and medical expenses. A credit report may be generated for the patient as well as for the purpose of identifying additional expense, obligations, assets and income to assist in developing a full understanding of the patients’ financial circumstances.
- 5. If a patient qualifies as medically needy, then the application should be referred to the Financial Assistance Committee for review and determination.
- Dir., PFS 6. Approval for financial assistance for amounts up to \$50,000 should be approved by the Director of Patient Financial Services. Those greater than \$50,000 should be approved by the CFO.
- PFS 7. Upon completion of the application and submission of appropriate documentation, the Patient Financial Services representative will complete the Financial Assistance Worksheet (see PFS Department for current form). The information shall be forwarded to the Director of Patient Financial Services or their designee for determination. Financial assistance approval will be made in accordance with the guidelines and documented on the worksheet (see PFS Department for current form).
- 8. Accounts where patients are identified as medically needy or accounts where the collector or Director has identified special circumstances that affect the patient’s eligibility for financial assistance will be referred to the Financial Assistance Committee for consideration and final determination. The Committee’s review of accounts that do not clearly meet the criteria and the decisions and rationale for those decisions will be documented and maintained in the account file (see PFS Department for current form).
- 9. A record, paper or electronic, should be maintained reflecting authorization of financial assistance (see PFS Department for current form). These documents shall be kept for a period of seven (7) years.

C. Notification of Eligibility Determination:

- PFS 1. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides a reason(s) for denial will be provided, generally within thirty (30) days of

receipt of a complete application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.

- FAC 2. If a patient disagrees with the decision, the patient may request an appeal process in writing within seven (7) days of the denial. The Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within two (2) weeks, and reflect the organization’s final and executive review.
- 3. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any other healthcare bracket (i.e., Medicare, Medicaid, etc.). A note will be entered into the patient’s account to suspend collection activity until the financial assistance process is complete. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.
- 4. If the patient complies with a payment plan that has been agreed to by the Hospital, the Hospital shall not otherwise pursue collection action against the patient.
- Patient 5. If the patient has a change in their financial status, the patient should promptly notify Patient Financial Services. The patient may request and apply for financial assistance, or a change in their payment plan terms.

D. Availability of Policy:

- PFS 1. Every hospital, upon request, must provide any member of the public or state governmental entity a copy of its financial assistance policy.

E. Application Forms:

- PFS 1. Every hospital must make available, upon request by a member of the public, a copy of the application used by the Hospital to determine a patient’s eligibility for financial assistance.

F. Monitoring and Reporting:

PFS 1. A financial assistance log from which periodic reports can be developed shall be maintained aside from any other required financial statements. Financial assistance logs will be maintained for a period of seven (7) years. At a minimum, the financial assistance logs are to include:

- a. account number,
- b. date of service,
- c. application mailed (y/n),
- d. application returned and complete (y/n),
- e. total charges,
- f. self-pay balances,
- g. amount of financial assistance approved,
- h. date financial assistance was approved.

- 2. The cost of financial assistance will be reported annually in the community Benefit Report. Financial will be reported as the cost of care provided (not charges) using the most recently audited Medicare cost report and the associated cost to charge ratio.

ORIGINATOR: Administration

APPROVAL:

G. T. Dunlop Ecker
President & Chief Executive Officer

Financial Assistance Program 200-41 (1/23/2008)

ATTACHMENT:

Application for Financial Assistance

MISSION, VISION, VALUES AND SERVICE PRIORITIES

MISSION

Our mission is to provide high quality and efficient healthcare services to preserve, restore and improve health status, in partnership with our community.

VISION

To be recognized as a premier regional healthcare system.

VALUES

Our values consistently show that Dimensions *CARES*. These values include:

- **Compassion** - We demonstrate care, concern and consideration for our patients, their families and each other. We take seriously our role as patient advocates. We strive to bring the “human touch” to all our interactions and help each other.
- **Accountability** - We take responsibility for our actions. We strive to achieve excellent results and accept responsibility for overcoming problems. We avoid blaming others. We never say “It’s not my job”. We are committed to honesty in words and actions.
- **Respect** - We treat all patients, visitors, and staff equally and with dignity. We show our respect by the courtesy we extend to everyone. We greet everyone politely and appropriately. We are forgiving of one another. We recognize the value, diversity and importance of each other, those we serve and the organization.
- **Excellence** - We show excellence in the way we strive to exceed expectations in everything we do. We demand competence and encourage professional and personal growth for every member of our healthcare team. We pursue excellence through teamwork, continuous improvement and prudent resource management.
- **Service** - We strive to do the “right thing” and ensure our actions are in line with our mission, vision and values. We are committed to understanding and meeting the needs and expectations of patients and customers.

SERVICE PRIORITIES

- **Safety** - We work to ensure that all employees, patients and visitors are protected from danger, risk or injury while on the premises of any Dimensions Healthcare System facility

DIMENSIONS HEALTHCARE SYSTEM

POLICY No. 200-24

APRIL 6, 2006

Page 2 of 2

- **Courtesy** - We strive to make each person we encounter feel important and respected. We pleasantly greet fellow employees, physicians, patients and visitors. We identify ourselves whether the encounter is in person or over the telephone.
- **Caring** - We empathize, show compassion and concern to those we encounter each day.
- **Efficiency** - We work collaborative and effectively, taking advantage of economies of scale when possible. We continually evaluate the effectiveness of procedures and processes.

APPROVED:

G. T. Dunlop Ecker
President/CEO

**Maryland General Hospital
Community Benefits Evaluation FY 2008**

1.	Licensed Bed Designation:	242	
	Bassinets	<u>17</u>	259

Inpatient admissions, FY 2008: 12,791

2. Maryland General Hospital is a 238 bed community teaching hospital with a network of services providing care to 110,000 patients each year. In addition, MGH was one of the first hospitals in Baltimore to establish an outreach program offering education, prevention and screening, serving individuals who face significant barriers in obtaining high quality and affordable care. 95% of all admissions to Maryland General Hospital are from Baltimore City, with 70% originating from the primary service area of West Baltimore. MGH serves an urban population and the highest percentage of Medicaid patients of all hospitals in Maryland. Ninety Percent (90%) of MGH's patients are Medicaid, Medicare, or Self pay. Maryland General Hospital has recently celebrated 125 years of service to the Baltimore City community and in 1999, affiliated with the University of Maryland Medical Systems.

As previously mentioned, Maryland General Hospital serves a community with a disproportionate share of federally funded insurance recipients. For Fiscal 2006, Maryland General Hospital had the highest percentage of Inpatients with Medicaid as the primary insurance (45.8%). Maryland General also has the highest combined Medicare, Medicaid, and Self Pay percentage of inpatients at (90.2%) for the same time period. The Hospital serves the second highest percentage of African American patients in the state as a percentage of total patients at 81.1%. Lastly, Maryland General has the fifth (5th) highest percentage of inpatients whose level of severity is either "Major" or "Extreme", according to the APR Severity Index scale and this severity level continues to increase.

Maryland General Hospital is located in an area of Baltimore City which is defined as both a Medically Underserved Area and a Health Professional Shortage Area by the U.S. Department of Health and Human Services.

- A. Maryland General Hospital is assigned a score of 38.6 for Medically Underserved Areas for the area containing the specific census tracts of our catchment zone. Any score of 62.0 or below qualifies for designation as an MUA. The lower the score, the greater the need.
- B. Maryland General Hospital is assigned a score of 22 for Health Professional Shortage Areas for the West/Central Baltimore City zone. Any score below 25 qualifies for designation as a HPSA. The higher the score, the greater the priority.

3. Maryland General Hospital utilizes consultants and internal committees to identify the health needs of our community. A formal survey by the Jackson Group is conducted every 2 to 3

years who conduct personal interviews with randomly selected members of the area. Determinations are made about current health profiles, health statuses, use of health care in the area and level of concern regarding what services are generally needed for themselves and their families. In addition, residents are asked if there are any health services that are not currently available that need to be offered.

Other data used include Baltimore City Health Status reports, The University of Maryland Discharge Abstract database and discussions with local community and religious leaders.

4. The major community health needs identified were access to primary care services and affordable health care. These findings, and others suggest the need for outreach programs for those who cannot afford health care and an evaluation of primary care services in the area.

5. MGH's administration and community outreach staff evaluates and oversees which needs will be addressed through community benefit activities throughout the year.

6. The Community Health Education Center (CHEC) assesses the health education and health screening needs of the community by responding to specific requests by organizations and community leaders. Services offered are in response to the needs assessments performed and evaluated by management. In FY 2008, CHEC attended nearly 100 events in Baltimore City at the request of these leaders. In total, 13,222 people participated in this free program and 18,363 tests were performed. In addition, CHEC has a facility at Maryland General Hospital where access is provided to health information and screening services from 8am to 8pm, Monday through Friday.

7. The effectiveness of the program is measured informally by the number of patients identified as needing additional care. The positive impact the program has had on the community is undeniable. During fiscal year 2008, CHEC identified 1,271 who required follow-up on their blood pressure, 332 who required follow-up with their cholesterol level, 100 who needed to follow-up on their blood sugars, 619 who were reactive on the PPD test for tuberculosis, and 2,324 who had a positive pregnancy test.

We intend to continue and grow our CHEC and other outreach screening programs to meet the needs of our neighbors and the greater community. A formal evaluation process will be implemented in the near future.

8. In January 1999, Maryland General Hospital affiliated with the University of Maryland System to form one of the largest health systems in the Baltimore metropolitan area. This affiliation brought together the world-class research and specialized medical care of the University of Maryland Medical System with the excellent community-based physicians and services of Maryland General Health Systems. Arrangements for specialized care not provided by Maryland General Hospital are available within the University system located 2 miles south of our campus.

APPENDIX 1, Charity Policy Description

1. MGH posts notification of the Financial Assistance policy, and financial assistance contact information at all patient access points.
2. MGH provides a summary of the Financial Assistance policy and financial assistance contact information within the Patient Handbook which is provided to inpatients or their families as part of the intake process;
3. MGH provides a summary of the Financial Assistance Policy, and financial assistance contact information to outpatients within the brochure “Important Information about Your Hospital Bills” see attached.
4. MGH provides a summary of the Financial Assistance Policy, and a Financial Assistance application to outpatients registered with a “Self Pay” insurance plan during registration.
5. MGH contacts / meets with, interviews and completes a Financial Assessment of all “Self Pay” inpatients within 48 hrs of admission to determine / discusses with the patients or their families the availability of various government programs, such as Medicaid and assists patients in qualifying for such programs such as eligibility for Medical Assistance or Financial Assistance where applicable.
6. MGH publishes annually the availability of Financial Assistance at MGH along with a summary of the Financial Assistance Policy, and financial assistance contact information.

APPENDIX 2, Charity Policy

See attached PDF file.



ADMINISTRATIVE POLICY

Number: 2041

Last Review Date: 01/09/08

Title: *Financial Assistance*

Page 1 of 4

POLICY:

It is the policy of Maryland General Hospital to provide quality medically necessary healthcare to our patients and financial assistance for patients who live in our community who are uninsured or underinsured

PURPOSE

- A. To establish the income scale for the means test for financial assistance.
- B. To provide definitions for the five main determinates of eligibility: income, family size, and member of the community, liquid assets, and valid social security card.
- C. To establish the general operational guidelines for the administration of the program.
- D. To establish the patient notification requirements as set forth in the Maryland State Health Plan.

ACTIONS

- A. Income and Family Size Scale: Maryland General Hospital will use a sliding scale based on the Federal Poverty Income Guidelines, which are published in the Federal Register each year. Patients below these guidelines who meet the qualifications set forth in this policy will automatically be eligible for financial assistance. Patients above these guidelines may be eligible for partial financial assistance based on income and family size.
 - 1. The current annual income scale is set forth below:

Number in Family or Household	100%	75%	50%	25%	0% Full Pay
1	0 - 15,600	15,600 - 17,264	17,264 - 18,928	18,928 - 20,800	20,800+
2	0 - 21,000	21,000 - 23,240	23,420 - 25,480	25,480 - 28,000	28,000+
3	0 - 26,400	26,400 - 29,216	29,216 - 32,032	32,032 - 35,200	35,200+
4	0 - 31,800	31,800 - 35,192	35,192 - 38,584	35,584 - 42,400	42,400+
5	0 - 37,200	37,200 - 41,168	41,168 - 45,136	45,136 - 49,600	49,600+
6	0 - 42,600	42,600 - 47,144	47,144 - 51,168	51,168 - 56,800	56,800+
7	0 - 48,000	48,000 - 53,120	53,120 - 58,240	58,240 - 64,000	64,000+
8	0 - 53,400	53,400 - 59,096	59,096 - 64,792	64,792 - 71,200	71,200+

ADMINISTRATIVE POLICY

2. The annual income brackets will be changed yearly when the Federal Poverty Income Guidelines are published.
3. Annually once the Federal Poverty Income Guidelines are published and Maryland General Hospital has revised and approved the new Financial Assistance guidelines, Maryland General Hospital will post a written notice of the availability of Financial Assistance at Maryland General Hospital in a public forum, such as a local newspaper.

B. Means Test Definitions: The determination of eligibility is based on family size and income. For the administration of this policy, the following definitions are utilized:

1. Family. A family is a group of two or more persons related by birth, marriage, or adoption who reside together; all such related persons are considered members of one family.
2. Income. Income refers to total annual cash receipts before taxes for all sources. Income includes regular payments from employment, social security, railroad retirement, unemployment compensation, workers' compensation, veteran benefits, public assistance, alimony, child support, and other regularly received payment from investments or trusts. The income to be utilized for non-farm and farm self-employment is the net receipts from the business.
 - a. To determine eligibility, income data for part of a year may be annualized by multiplying by four the amount of income received during the most recent three months.
 - b. Individuals requesting charity may be required to provide proof of income. Examples of proof of income are prior year income tax submissions, W-2s, recent pay stubs, written eligibility determination from Maryland Medical Assistance, etc.
3. Member of the Community. A patient must reside in Maryland General Hospital's Primary Service Area (PSA) to be eligible for the financial assistance program.
4. Valid Social Security Card. There are three types of cards that are issued by Social Security. Only one of these three types of Social Security cards will be customary to qualify for financial assistance.
 - a. The first type of card shows name and Social Security number and allows work without restriction. This card is issued to U.S. citizens and people lawfully admitted to the United States with permanent DHS work authorization. This type of card is required to apply for financial assistance.
 - b. The second type of card shows name and number with "VALID FOR WORK ONLY WITH DHS AUTHORIZATION" on the card. This type of card is issued to people lawfully admitted to the United States on a temporary basis who have DHS authorization to work. This type of card **cannot** be utilized to apply for financial assistance.
 - c. The third type of card shows name and number with NOT VALID FOR EMPLOYMENT on the card. This card is issued to people from other countries

ADMINISTRATIVE POLICY

admitted to the United States without work authorization from DHS, but with a valid non-work reason for needing a Social Security number and to people who need a number because of a federal law requiring a Social Security to get a benefit or service. This type of card **cannot** be utilized to apply for financial assistance.

C. Guidelines for Program Administration

1. An application for financial assistance must be completed prior to services being rendered to the patient. However, an application may be completed by the patient after services were rendered only if the account is active and not in bad debt. Applications may be taken in person or by telephone interview.
2. Hospital will evaluate all applicant assets. Applicants with liquid assets (cash and cash equivalents, cash, savings, checking accounts, certificates of deposit, stocks, bonds, IRA, trust funds and equity in any real estate that is not the primary residence) in excess of the 100 % of the current year's Federal Poverty Income Guidelines for I will be ineligible for financial assistance. The hospital will not count the house, the car or the applicant's furniture as assets during the financial assistance process.
3. Determination of eligibility will be made within five business days of receipt of the completed Financial Assistance Application. Subsequently a determination letter will be mailed to the patient explaining level of financial assistance they qualified for.
4. If a patient is approved for financial assistance Patient Access will register the patient with one of the following insurance plans:
 - A. CHAR100%: all the charges will be covered:
 - B. CHAR75% 75% of the charges will be covered:
 - C. CHAR50% 50% of the charges will be covered:
 - D. CHAR25% 25% of the charges will be covered.The financial assistance will expire six months from the date of approval and the patient will have to reapply for financial assistance at that time.
5. Financial assistance will cover all hospital care except for the services of a doctor not employed directly by the hospital.
6. The hospital will exhaust all possible sources of payment before the account balance is eligible for financial assistance. Financial assistance should always be the payer of last resort.
7. Copies of the Financial Assistance Application, which indicate the determination, will be filed with the patient's financial record. A separate log of all applications will be maintained in order to provide for reconciliation and documentation of the financial assistance program

ADMINISTRATIVE POLICY

D. Patient Notification Requirements

1. Notices are posted in the Admissions Lobby, Business Office, Emergency Room, ENT and General Clinic's advising patients that financial assistance is available for those unable to pay.
2. Individual notices are available to each person who seeks services in the facility. These notices are available in the Eligibility Services area of the Patient Accounting Department

RESPONSIBILITY

- A. The Assistant Director of Admissions will ensure that the Patient Notification Requirements of this policy are carried out.
- B. The Director of Patient Financial Services or his/her designee will ensure that documentation is maintained of eligibility determine, along with logs of applications acted upon, and patients screened for potential financial assistance.
- C. The Senior Vice president of Finance will ensure that the provisions of this policy are implemented and maintained administratively.

Sylvia Smith Johnson
President and Chief Executive Officer

Original Implementation Date:

Originating Department:

Revision/ Review Dates:



Primary Service Area	Zip Code	Area
PSA	21201	Baltimore West
PSA	21202	Baltimore East Case
PSA	21207	Baltimore/Gwynn Oak
PSA	21213	Clifton
PSA	21215	Baltimore/Arlington
PSA	21216	Baltimore/Walbrook
PSA	21217	Baltimore/Druid Hill
PSA	21218	Baltimore/Waverly
PSA	21223	Baltimore/Franklinton
PSA	21229	Baltimore/Carroll
PSA	21230	Baltimore/Morrell Park

Secondary Service Area	Zip Code	Area
SSA	21205	Baltimore/Clifton East
SSA	21206	Baltimore/Raspeburg
SSA	21211	Baltimore/Hampden
SSA	21212	Baltimore/Govans
SSA	21224	Baltimore/Highlandtown
SSA	21225	Baltimore/Brooklyn Park
SSA	21228	Baltimore/Catonsville
SSA	21239	Baltimore/Northwood

RUN DATE: 04/29/08
RUN TIME: 1712
RUN USER: BAR.SLH

Maryland General B/AR **LIVE**
B/AR LETTER DICTIONARY

PAGE 1

MNEMONIC: CHAR-NEW ACTIVE: Y NAME: NEW CHARITY APPLICATION
PAGE SIZE: 66 LINE LENGTH: 72 LEFT MARGIN:
AUTO SPOOL: AUTO SORT:

MARYLAND GENERAL HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

DATE: [DATE]

[GUARANTOR NAME] PATIENT ACCT #: [NUMBER]
[GUARANTOR ADDRESS LINE]
[GUARANTOR CITY, STATE ZIP] PATIENT SS #: [PATIENT SS #]

DATE OF ADMISSION: [ADM/SER DATE] DATE OF DISCHARGE [DIS DATE]
DATE OF DISCHARGE: [DIS DATE]

ACCOUNT BALANCE: \$ [CUR BALANCE]

Information About You

Name _____
 First Middle Last

Social Security Number _____ - _____ - _____

Marital Status: Single Married Separated

US Citizen: Yes No

Permanent Resident: Yes No

Home Address _____

Phone _____

State _____ City _____ Zip Code _____

Country _____

Employer Name _____

Phone _____

Work Address _____

State _____ City _____ Zip code _____

Household members:

Name	Age	Relationship
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RUN DATE: 04/29/08
RUN TIME: 1712
RUN USER: BAR.SLH

Maryland General B/AR **LIVE**
B/AR LETTER DICTIONARY

PAGE 2

MNEMONIC: CHAR-NEW ACTIVE: Y NAME: NEW CHARITY APPLICATION
PAGE SIZE: 66 LINE LENGTH: 72 LEFT MARGIN:
AUTO SPOOL: AUTO SORT:

Name	Age	Relationship
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Name	Age	Relationship
------	-----	--------------

Name	Age	Relationship
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Name	Age	Relationship
------	-----	--------------

Name	Age	Relationship
------	-----	--------------

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

Monthly Amount

Employment _____
Retirement/pension benefits _____
Social security benefits _____
Public assistance benefits _____
Disability benefits _____
Unemployment benefits _____
Veterans benefits _____
Alimony _____
Rental property income _____
Strike benefits _____
Military allotment _____
Farm or self employment _____
Other income source _____
Total _____

II. Liquid Assets Current Balance

Checking account _____
Savings account _____

RUN DATE: 04/29/08
RUN TIME: 1712
RUN USER: BAR.SLH

Maryland General B/AR **LIVE**
B/AR LETTER DICTIONARY

PAGE 3

MNEMONIC: CHAR-NEW ACTIVE: Y NAME: NEW CHARITY APPLICATION
PAGE SIZE: 66 LINE LENGTH: 72 LEFT MARGIN:
AUTO SPOOL: AUTO SORT:

Stocks, bonds, CD, or money market _____
Other accounts _____
Total _____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance	_____	
Approximate value		_____	
Automobile	Make	_____	Year _____
Approximate value		_____	
Additional vehicle	Make	_____	Year _____
Approximate value		_____	
Additional vehicle	Make	_____	Year _____
Approximate value		_____	
Other property		_____	
Approximate value		_____	
Total		_____	

IV. Monthly Expenses Amount

Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? Yes No

For what service? _____

If you have arranged a payment plan, what is the monthly payment?

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

Please provide proof of income for example pay stub

RUN DATE: 04/29/08
RUN TIME: 1712
RUN USER: BAR.SLH

Maryland General B/AR **LIVE**
B/AR LETTER DICTIONARY

PAGE 4

MNEMONIC: CHAR-NEW ACTIVE: Y NAME: NEW CHARITY APPLICATION
PAGE SIZE: 66 LINE LENGTH: 72 LEFT MARGIN:
AUTO SPOOL: AUTO SORT:

or current income tax return. If this information is not
supplied then your application will be denied.

Applicant signature

Date

Relationship to Patient

Please return to: Terri Peisinger
 Medical Assistance Supervisor
 Maryland General Hospital
 Baltimore, Maryland 21201

Appendix 3



827 Linden Avenue
Baltimore, Maryland 21201

Mission, Vision and Values elaborated:

Our mission is to improve the health care of our community through superior compassionate care and medical education in partnership with our physicians and employees.

We intent to accomplish this by enhancing quality patient care and safety through exceptional customer service;

Secure our financial position to enable investment in key clinical programs and facilities;

Deploy technology to achieve maximum return on investment;

Recruit and maintain a skilled, productive, stable and service focused workforce;

Building a partnership with West Baltimore neighborhoods to provide comprehensive community health and education programs.

Appendix 4



827 Linden Avenue
Baltimore, Maryland 21201

Mission, Vision and Values Statement:

Our Mission: To provide superior, accessible healthcare in Central Maryland, at a reasonable cost.

Our Vision: To be an integrated system of care, positioned as a provider of choice for healthcare consumers and payors in Central Maryland.

Our Values: To provide a comprehensive array of high-quality healthcare services with a commitment to excellence and compassion.

McCready Memorial Hospital Appendix 1

McCready Memorial Hospital is a small, rural community hospital. It is the only hospital in Somerset County. It serves Somerset, southern Wicomico County and Northern Worcester County along the Route 13 corridor of the Eastern Shore. Patients from Smith and Tangier Islands in Chesapeake Bay come to the facility and its emergency room by boat.

Because there are no private physician practices in Crisfield, Marion, Westover, Rumbly, Fairmount and other small towns along Route 413 (the highway from Route 13 to Crisfield on Tangier Sound), McCready Hospital operates an outpatient center which employs two family medicine/internal medicine primary care physicians, a general surgeon and a family medicine physician assistant. McCready also employs its own anesthesiologist and a radiologist. With these physicians and specialty visiting physicians, the hospital is able to provide care for only the basic healthcare needs of local residents.

The nearest private general and specialty practices are about 25 miles away by car so McCready “lends” office space to “visiting” physicians who come one to four times a month to see patients here in Crisfield. They include an orthopedic surgeon, a podiatrist and three cardiologists.

McCready’s emergency room is staffed with emergency physicians via a contract with the Emergency Service Associates group. However, major trauma cases and cases requiring more specialized surgery, diagnostic and medical care must be transported elsewhere.

McCready’s patient population has a tragically high incidence of heart disease, lung disease, diabetes, cancer, obesity and metabolic syndrome – all chronic conditions that would benefit from specialist physician practices. However, the nearest are in Salisbury – 45 minutes away. The service area’s high unemployment rate, a large elderly population and one of the highest poverty levels in the state contribute to the incidence of these potentially serious and often fatal conditions.

**McCready Memorial Hospital
Appendix 2**

McCready Memorial Hospital posts its financial assistance/charity care policy along with necessary contact information in all patient care/registration areas. Upon admission, each patient also receives the same information about the program. Patients whom are uninsured or underinsured receive assistance with determining eligibility for governmental programs or the hospital's financial assistance program through one-on-one financial counseling, including assistance in filling out all necessary paperwork. In addition, self-pay patients whose balances remain unpaid after three consecutive billing cycles receive a financial assistance application with instructions and contact information in their final statement before being sent to collections. Every effort is made to try to identify and assist patients in getting the financial assistance they need.

Appendix 3

McCready Foundation Administrative Policy and Procedure

SUBJECT: Financial Assistance

**FILE: Index Tab
Organizational Ethics**

APPROVED BY: _____
Charles F. Pinkerman, CEO

Page:

**Effective Date: 09/05
Revised: 05/06, 03/07, 03/08**

REFERENCES:

POLICY:

The McCready Health Services Foundation will provide Financial Assistance available on a sliding scale basis for services provided to its patients who meet the eligibility guidelines as noted in this policy.

1. The following annual income scale shall be used for initial qualification. These income brackets will be changed on an annual basis as the Federal Poverty Income Guidelines are published.

Family Size	100%	75%	50%	25%	Full Pay
1	15,600	17,368	19,136	20,800	20,801
2	21,000	23,380	25,760	28,000	28,001
3	26,400	29,392	32,384	35,200	35,201
4	31,800	35,404	39,008	42,400	42,401
5	37,200	41,416	45,632	49,600	49,601
6	42,600	47,428	52,256	56,800	56,801
7	48,000	53,440	58,880	64,000	64,001
8	50,700	56,446	62,192	67,600	67,601

- For family units with more than eight members, add \$5,400 for each additional member for 100% discount

- Family

A family is defined as a group of two or more persons related by birth, marriage, or adoption who reside together; all such related persons are considered members of one family.

- Income

Income refers to total annual cash receipts before taxes for all sources. Income includes regular payments from employment, social security, railroad retirement, unemployment compensation, worker's compensation, veteran benefits, public assistance, alimony, child support, and other regularly received payment from investments or trusts. To determine eligibility, income data for part of a year may be annualized by multiplying by four the amount of income received during the most recent three months.

2. In determining eligibility consideration will be given to the size of the patient's bill relative to the individual's ability to pay.
3. All Maryland Residents who are below 150% of the FPL and have less than \$10,000.00 in assets shall qualify for 100% assistance.
4. All those patients requesting financial assistance who qualify for assistance and fully cooperate with the application process and document eligibility will be provided assistance.
5. Applications are available from either the Business Office or the Financial Services office. All interested parties shall be referred to the Financial Service Counselor who will accept all applications.
6. Applications will be reviewed by the Business Office Manager and approved per guidelines noted with consideration for size of bill.
7. Notice of the availability of Financial Assistance will be provided to all patients and associates.

Our Mission:

"We are working to build a healthy community, one person at a time."

Our Vision:

McCready Foundation is a community organization providing high-quality, coordinated health care services; focusing on prevention, diagnosis, treatment, rehabilitation and long-term care.

Our Values:

We maintain the highest standards in providing effective, efficient and compassionate services either directly or through coordinated efforts with other local and regional healthcare providers.

Appendix 1- Gaps in Specialty Care
WMHS- Braddock & Memorial Hospitals FY08

Gaps in Specialty Care at WMHS

Based on a 2007 study sponsored by the Maryland Hospital Association and Med Chi, there is a statewide downward trend in surgical specialty supply from 2007 to 2015. The specific shortages at WMHS coincide fairly well with the Western Region. It is projected in-migration and resident retention will be insufficient to cover departures from retirements in many surgical specialties. Statewide and regional shortages by specialty are summarized as follows.

- General Surgery
 - State Level: Shortage 2007-2015
 - Regional Level: Shortages 2007-2015 in all regions except Central for 2007-2015 and Western for 2007
 - Shortages projected to worsen from 2007-2015
- Neurosurgery
 - State Level: No shortage 2007-2015
 - Regional Level: Shortages in Western 2007, Capital and Southern Regions 2007-2015
- OB/GYN
 - State Level: No shortage 2007-2015
 - Regional Level: Shortages in Southern and Western Regions 2007-2015
- Ophthalmology
 - State Level: No shortage 2007-2015
 - Regional Level: Shortages in Eastern Region 2007-2015, Southern Region 2010 and 2015, and Western Region 2015
- Orthopedic Surgery
 - State Level: No shortage 2007-2015
 - Regional Level: Shortages in Eastern, Southern, and Western Regions 2007-2015
- Otolaryngology
 - State Level: No shortage 2007-2015
 - Regional Level: Shortage in Southern Region 2007-2015
- Plastic Surgery
 - State Level: No Shortage 2007-2015
 - Regional Level: Shortage in Southern Region 2007-2015, WMHS 2008
- Thoracic Surgery
 - State Level: Shortage 2007-2015
 - Regional Level: Shortages in all regions except Capital Region in 2007
 - Impact of Physician Retirements: Significant in 2010 and 2015
- Urology
 - State Level: No Shortage 2007-2015
 - Regional Level: Shortage in Southern Region in 2015, WMHS 2008
 - Significant retirements forecasted from 2007-2015
- Vascular Surgery
 - State Level: Shortage 2007- 2015
 - Regional Level: Western Regions 2007-2015

Based on input from uninsured clients and representatives of community agencies serving the underserved, there is a gap in availability to the following specialty care.

- Orthopedics
- Psychiatry
- Pain Management
- Neurology
- Endocrinology
- Cardiology

Description of the Charity Care Policy

The Western Maryland Health System (Braddock & Memorial Hospitals) grants charity care to those patients who demonstrate a financial need. WMHS has signs posted at all sites where patients are admitted for inpatient care and all sites where patients receive outpatient services, including the emergency room.

Applications for Financial Assistance are made available to patients at the time services are rendered. Applications for Financial Assistance are also made available to any patient or their family members who request the form be mailed to them.

WMHS contracts with an outside agency to interview all inpatients who do not have insurance coverage. When feasible the initial contact is made prior to discharge. The contractor explains to the patient or their family member(s) the benefits that may be available to them through the federal, state and local programs including Medical Assistance, Primary Adult Care and Medicare. The contractor assists the patient or their families in completing applications and accompanies them if needed to any appointments for the purpose of obtaining benefits through the various public programs.

WMHS provides a telephone number for financial assistance on patient statements. WMHS also has staff dedicated to follow-up and assist any patient or their family member(s) who needs support in obtaining financial assistance.

Patients determined to be ineligible for government benefits may be referred to the WMHS Wellness Center and its Community Health Access Program, (CHAP). This unique program, a joint venture of the Western Maryland Health System and Allegany Health Right, links participants to a primary care physician and appropriate health and social services, such as prescription programs, nutritional counseling, and diagnostic care. Through CHAP enrollment individuals are screened for potential eligibility in over 40 area programs.

WMHS	DIVISION: Business Office	POLICY #: 400-04
POLICIES AND PROCEDURES	SUBJECT: Uncompensated Care (Financial Assistance Program)	SUPERSEDES: September 2005
	EFFECTIVE: September 1982	REVISED: August 2007 REVIEWED:

UNCOMPENSATED CARE (FINANCIAL ASSISTANCE PROGRAM)

POLICY

The Western Maryland Health System's policy is to insure availability of a fair and reasonable volume of hospital care for patients who are unable to pay for their services.

PROCEDURE

To determine indigency for our purposes, each case is evaluated on an individual basis. This is done at the time of admission, or after services have been rendered, when our records indicate that a potential charity situation exists. In some cases, the patient cannot be contacted due to isolation, ICU, and other emergency admissions until discharge of the patient.

When determining indigency, the following indications are considered:

1. Aged patients existing on Social Security or Welfare;
2. State, County or Federal Welfare recipients (cash grants);
3. Patients with terminal illnesses who have no future earning capacity;
4. Disabled patients who have limited or no earning ability;
5. Patients whose guarantor is uninsured or underinsured;
6. Patients whose guarantor is unemployed or marginally employed;
7. Patients whose guarantors indicate inability to pay for hospital services;
8. It is recognized that Old Order Amish and Old Order Mennonite patients do not rely on in any manner on any type of government programs or private insurance based upon their religious beliefs. These two Orders rely on their religious community to pull resources together to pay for healthcare bills for members of their community. These patients, who are 100% self-pay, will be granted a 25% discount when bill is paid in full within 30 days of service.

Decisions on probable eligibility will be made within two business days of an initial application. After an evaluation and determination is made that an uncompensated care situation exists (Procedure 400-5), the account is written-off and placed in a special file established for that purpose, and there is no further activity on the account.

By using the Federal poverty income guidelines published annually in the Federal Register, a patient may be found to be responsible for only a percentage of their bill according to their income and number of dependents. The patient's responsibility will be capped based on a percentage of their income. Decisions on probable eligibility will be made within two business days of an initial application. In such cases, a percentage of the bill is charged to the Financial Assistance Program and the patient or his agent is required to pay the remainder not charged to the Financial Assistance Program.

Patients who fail to meet payment requirements will have the amount written off under the Financial Assistance Program debited back to the account before placement to a collection agency.

Approved:

Director, Business Operations

Senior Vice President/Chief Financial Officer

SLIDING SCALE ADJUSTMENTS Based on FPL for 2007

**Community Health Access Program (CHAP)
PATIENT RESPONSIBILITY PERCENTAGES**

Size of family unit	0% (PAC-FAP-unless exception noted)	10%	20%
1	0 (\$10,210) - \$15,213	\$15,214- \$17,765	\$17,766 - \$20,420
2	0 (\$13,690) - \$20,398	\$20,399- \$23,821	\$23,822 - \$27,380
3	0 (\$17,170) - \$25,583	\$25,584- \$29,876	\$29,877 - \$34,340
4	0 (\$20,650) - \$30,769	\$30,770- \$35,931	\$35,932 - \$41,300
5	0 (\$24,130) - \$35,954	\$35,955- \$41,986	\$41,987 - \$48,260
6	0 (\$27,610) - \$41,139	\$41,140- \$48,041	\$48,042 - \$55,220
7	0 (\$31,090) - \$46,324	\$46,325- \$54,097	\$54,098 - \$62,180
8	0 (\$34,570) - \$51,509	\$51,510- \$60,152	\$60,153 - \$69,140
FPL range	Thru 149%	150% - 174%	175% - 200%

Each additional person, add \$3,480 to base FPL.

**WMHS Financial Assistance Program (Charity Care)
PATIENT RESPONSIBILITY PERCENTAGES**

Size of family unit	30%	40%	50%
1	\$20,421 - \$22,870	\$22,871 - \$25,423	\$25,424 - \$27,975
2	\$27,381 - \$30,666	\$30,667 - \$34,088	\$34,089 - \$37,511
3	\$34,341 - \$38,461	\$38,462 - \$42,753	\$42,754 - \$47,046
4	\$41,301 - \$46,256	\$46,257 - \$51,419	\$51,420 - \$56,581
5	\$48,261 - \$54,051	\$54,052 - \$60,084	\$60,085 - \$66,116
6	\$55,221 - \$61,846	\$61,847 - \$68,749	\$68,750 - \$75,651
7	\$62,181 - \$69,642	\$69,643 - \$77,414	\$77,415 - \$85,187
8	\$69,141 - \$77,437	\$77,438 - \$86,079	\$86,080 - \$94,722
FPL range	201% - 224%	225% - 249%	250% - 274%

Each additional person, add \$3,480 to base FPL.

SLIDING SCALE ADJUSTMENTS Based on FPL for 2008

**Community Health Access Program (CHAP)
PATIENT RESPONSIBILITY PERCENTAGES**

Size of family unit	0% (PAC-FAP-unless exception noted)	10%	20%
1	0 (\$10,400) - \$15,599	\$15,600 - \$18,199	\$18,200 - \$20,903
2	0 (\$14,000) - \$20,999	\$21,000 - \$24,499	\$24,500 - \$28,139
3	0 (\$17,600) - \$26,399	\$26,400 - \$30,799	\$30,800 - \$35,375
4	0 (\$21,200) - \$31,799	\$31,800 - \$37,099	\$37,100 - \$42,611
5	0 (\$24,800) - \$37,199	\$37,200 - \$43,399	\$43,400 - \$49,847
6	0 (\$28,400) - \$42,599	\$42,600 - \$49,699	\$49,700 - \$57,083
7	0 (\$32,000) - \$47,999	\$48,000 - \$55,999	\$56,000 - \$64,319
8	0 (\$35,600) - \$53,399	\$53,400 - \$62,299	\$62,300 - \$71,555
FPL range	Thru 149%	150% - 174%	175% - 200%

Each additional person, add \$3,600 to base FPL.

**WMHS Financial Assistance Program (Charity Care)
PATIENT RESPONSIBILITY PERCENTAGES**

Size of family unit	30%	40%	50%
1	\$20,904 - \$23,399	\$23,400 - \$25,999	\$26,000 - \$28,496
2	\$28,140 - \$31,499	\$31,500 - \$34,999	\$35,000 - \$38,360
3	\$35,376 - \$39,599	\$39,600 - \$43,999	\$44,000 - \$48,224
4	\$42,612 - \$47,699	\$47,700 - \$52,999	\$53,000 - \$58,088
5	\$49,848 - \$55,799	\$55,800 - \$61,999	\$62,000 - \$67,952
6	\$57,084 - \$63,899	\$63,900 - \$70,999	\$71,000 - \$77,816
7	\$64,320 - \$71,999	\$72,000 - \$79,999	\$80,000 - \$87,680
8	\$71,556 - \$80,099	\$80,100 - \$88,999	\$89,000 - \$97,544
FPL range	201% - 224%	225% - 249%	250% - 274%

Each additional person, add \$3,600 to base FPL.

WMHS	DIVISION: Business Office	POLICY #: 400-05
POLICIES AND PROCEDURES	SUBJECT: Procedure to Determine Indigency	SUPERSEDES: June 2005
	EFFECTIVE: July 23, 1986	REVISED: July 2006 REVIEWED

PROCEDURE TO DETERMINE INDIGENCY FOR POLICY ON UNCOMPENSATED CARE
(FINANCIAL ASSISTANCE PROGRAM)

In accordance with the Western Maryland Health System's Policy on Uncompensated Care (Policy 400-04), an evaluation of a patient's or guarantor's ability to pay for hospital services shall be conducted as follows:

1. Determination should be made that all forms of insurance are not available to pay the patient's bill (Medicare, Medicaid, Blue Cross, or private commercial insurance).
2. Determine Gross Income
 - A. Gross income includes income from all sources: wages, interest, dividends, pensions, social security, checking, savings, CD's, stocks and bonds, child support paid by applicant to be deducted from gross income, etc. The first \$3,000.00 per family of savings is excluded.
 - B. Gross income can be verified from the most recently filed federal income tax return. Pay stubs can also be used to determine gross income. If pay stub is used, be certain that employment is not seasonal. The pay period used must be usual and customary; for an accurate total of annual gross income.
 - C. For the unemployed applicant, the amount of remaining unemployment that the applicant will receive is counted. (26 weeks in a period).
3. Self-Employed
 - A. The previous year's tax return is utilized if current year return is not available.
 - B. Schedule C Profit and Loss are reviewed. Deductions such as depreciation shown on Schedule C are added back to gross income. Other adjustments to Schedule C may be made after review by Department Director.
4. Determine Medical Payments
 - A. Should reflect amounts being paid, not the amount owed. Receipts and/or canceled checks can be used to ascertain amounts being paid. The amount due is needed to determine how long payments will continue. The amount due can be verified by examining a recent statement of account.
 - B. This amount is used to reduce gross income for purposes of finding the proper income level on the Federal Assistance Program allowance scale that is based on Federal Poverty Income Guidelines.
 - C. Formula to be used to ascertain the amount of deduction allowed for medical bills:
 - a. Total all medical bills (including hospital bills and prescriptions)
 - b. Compare total of bills against our extended payment plan
 - c. Allow 12 times the monthly payment we would expect patient to pay on medical bills if they were due Western Maryland Health System

PROCEDURE TO DETERMINE INDIGENCY FOR POLICY ON UNCOMPENSATED CARE
(FINANCIAL ASSISTANCE PROGRAM)

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- d. Reduce yearly income by that amount.
5. Determine the Number of Dependents
 - A. In determining the number of dependents to be counted on an applicant's application, the guidelines used by the IRS will be used and a copy of the income tax return will be required.
 - B. Applicants who have a child and who lives with the child's natural father/mother, the income of the applicant and co-parent will be counted.
 - C. In some situations, the income of the person who lives with the applicant may be counted at the discretion of Administration.
6. Determine Assets and Resources
 - A. In some situations, an applicant's holdings in real estate may be looked into.
7. Considerations in Applying For the Financial Assistance Program
 - A. Working, able-bodied patients, over the age of 21, with no disabilities and not pregnant do not usually qualify for Medical Assistance, therefore, at the discretion of the Supervisor and Department Director, the requirement of the patient making application for Medical Assistance May be waived.
 - B. The Financial Assistance Program, when approved, is backdated for services 12 months and valid 24 months forward.
 - C. In certain situations, a 12 month waiting period to re-apply for the Financial Assistance Program may be waived.
 - D. Approved applicants will have their income re-verified each 12 months from the date the original application was approved if new patient debts incur. Income re-verification can be done during any period of time at the discretion of the Department Director.
 - E. Account(s) of the applicant which have been previously placed with a Collection Agency are not included in the application for the Financial Assistance Program. A waiting period of 12 months is required before patient may be eligible to apply for the Financial Assistance Program when account(s) are placed with a Collection Agency.
8. Application
 - A. The cover letter attached to the Financial Assistance Program application specifies the application to be returned in 10 working days with requested information. If patient does not respond, the patient will be considered not interested. If partial information is returned, the applicant will be given additional time to provide all the requested information.
 - B. Decisions on probable eligibility will be made within two business days of an initial application. The applicant will be notified in writing by someone from the WMHS Business Office of the determination. If additional information is needed for a final determination, the patient/guarantor will be told what additional information is required and the final determination will be communicated to the patient in writing within two business days of receiving the additional information.
 - C. The patient will be made aware that he/she is attesting to the fact that the information he/she has provided is a complete and accurate statement of his/her financial situation by having the Financial Disclosure Statement signed.

PROCEDURE TO DETERMINE INDIGENCY FOR POLICY ON UNCOMPENSATED CARE
(FINANCIAL ASSISTANCE PROGRAM)

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9. Patient Financial Obligation

- A. In situations when the applicant fails to meet previously agreed upon payment arrangements because they did not qualify for a 100% write-off, any amount(s) previously written-off to the Financial Assistance Program will be reversed and the original balance of the account minus any payments made will be placed with a collection agency.
- B. Patients receiving assistance through the Financial Assistance Program must agree to make monthly payments based on the current policy regarding extended payment terms.

Approved:

Director, Business Operations

Vice President, Financial Services

Appendix 4: Description of Mission, Vision & Values WMHS-Braddock & Memorial Hospitals

Mission, Vision & Values

Western Maryland Health System (Braddock & Memorial Hospitals) has a long history of addressing community needs and is often approached by members of the community for support. The mission of the WMHS is to improve the health status and quality of life of the individuals we serve, especially those in need. Commitment to the cause extends from the employees to the Board of Directors, and is reflected in the strategic plan and goals. Through the strategic planning process, adequate resources are identified and community service initiatives are aligned with system-wide objectives. Community service priorities are to promote healthy behaviors, create safe environments, and increase access to services for the vulnerable. Through responsible management of resources and collaboration with partners WMHS is committed to sustain programs that address the community service priorities.

We are a values-driven system that respects and supports life, preserves the dignity of each individual, and promotes a healthy and just society through collaboration with others who share our values. Our actions are guided by our core values: Respect; Integrity; Quality; Community Advocacy; and Resourcefulness.

- **Respect** - Treating those we serve and with whom we work with compassion, demonstrating a high regard for the dignity and worth of each person.
- **Integrity** - Honesty and straightforwardness in all relationships.
- **Quality** - Continuous improvement through creativity and teamwork.
- **Community Advocacy** - Fostering the overall well being of the community, especially those in need, through charitable and community service and responsible action as a corporate citizen.
- **Resourcefulness** - Effective stewardship of the community

WMHS is also the region's largest employer and, as such, one of our strategic initiatives is to be a good corporate neighbor. As a not-for-profit health system, we provide care to all, regardless of their ability to pay. In fiscal year 2008, we provided over \$6.5 million in charity care. There are a number of patient care services that are not self-supporting that we continue to provide since we are the community's only provider. We provide patient and family-centered services through responsible management of our human and fiscal resources.

Making sure that patients have the follow-up resources that they need is also a priority and we work cooperatively with many other community organizations. WMHS took the lead in developing and maintains the software used by many community service agencies, including WMHS, to screen low income, uninsured and underinsured residents for assistance. Residents can visit any one of the various agencies to determine their eligibility for support services from all of the agencies.

WMHS provides both financial support and in-kind support to numerous community organizations that share our mission. In addition to corporate giving, our WMHS Employees Fund contributes more than \$70,000 each year to local nonprofit organizations. WMHS hosts several bloodmobiles for the American Red Cross. It also makes meeting room space available for community organizations at no fee.

WMHS serves as a clinical site for students enrolled in health-related studies at a nearby community college as well as from other colleges and universities. High school students interested in health careers and Kindergarten students from surrounding counties visit the hospital to learn about the services provided. Through these efforts WMHS hopes to secure a quality workforce long into the future.

Western Maryland Health System Mission/Values Alignment Matrix Fiscal Year 2008

<p><u>Mission</u></p> <ul style="list-style-type: none"> • Improve health status and quality of life. • Improve patient and family-centered services. • Respect and support life. • Preserve the dignity of individuals. • Promote a healthy and just society through collaboration. 	<p><u>Vision</u></p> <p>With a commitment to excellence, we envision a premier health care system of quality services that advances the health and well-being of the communities of the Tri-State region. Through partnership with our medical staff and other organizations, we will provide for ease of access to a coordinated network of services that addresses the needs of individuals and families.</p>	<p><u>Core Purpose</u></p> <p>Preserve and improve the health status and quality of life for individuals in the communities we serve.</p>	<p><u>Values</u></p> <p>Respect Integrity Quality Community Advocacy Resourcefulness</p>
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Strategic Goals:	<u>Mission Integration</u>	<u>Quality/Safety</u>	<u>Financial Viability</u>	<u>Leadership / Organizational Effectiveness</u>	<u>Market Position Enhancement</u>
	Demonstrate the organization’s mission and values in practice, emphasizing the direct benefit to the community and the underserved.	Support an environment that advances safety and continuous improvement through creativity and partnership with our medical staff and other organizations.	Ensure long-term financial strength of WMHS by managing finances to maintain a stand-alone health system bond rating of “BBB” or higher.	Strengthen organizational effectiveness through a commitment to excellence in medical staff, employees, leadership, and governance.	Strengthen competitive ability and expand critical markets throughout the region, in collaboration with key partners.
Key Strategies:	<ol style="list-style-type: none"> 1. Continue an organized community health program emphasizing lifestyle choices affecting regional health problems, particularly child and adult obesity. 2. Strengthen reporting effectiveness and develop internal and external awareness of WMHS’s community benefit. 3. Participate actively in community organizations, planning, and events to fulfill our mission and obligation to good corporate citizenship. 	<ol style="list-style-type: none"> 1. Promote culture of safety by involving physicians, nurses, and clinical staff in education and participation in safety initiatives, including appropriate review and resolution of adverse events. 2. Continue to support major initiatives, including National Patient Safety Goals, Save Five Million Lives Campaign, and Maryland Patient Safety Center Collaboratives. 3. Strive to be a top performer in all reported performance 	<ol style="list-style-type: none"> 1. Finalize capital campaign and further develop the framework for a sustained giving campaign. 2. Position WMHS to maximize its placement on the combined HSCRC screens through identifying and implementing cost improvements in inpatient care or outpatient ambulatory surgery. 3. Expand use of Lean and Six Sigma initiatives throughout the organization to achieve process improvement, cost savings, and divestiture of 	<ol style="list-style-type: none"> 1. Strengthen responsiveness to physician needs through expanded attention and increased accountability. 2. Become an industry leader in patient and employee satisfaction through stronger focus on the Service Excellence culture and hardwired accountability for outcomes. 3. Guide construction, relocation, and staff planning across the organization to assure effective transition to and occupancy of the new hospital. 	<ol style="list-style-type: none"> 1. Continue developing specialty centers and align with physicians in the following areas: <ol style="list-style-type: none"> a. Initiate Neonatology Associates, Inc. – direction and expansion of the neonatal nursery to accommodate infants requiring intensive care. b. Implement Destination Total Joint Center to enhance reconstructive orthopedics. c. Develop and open Gynecological Oncology Center in Cumberland.

**Western Maryland Health System
Mission/Values Alignment Matrix
Fiscal Year 2008**

Key Strategies: (Continued)	<u>Mission Integration</u>	<u>Quality/Safety</u>	<u>Financial Viability</u>	<u>Leadership / Organizational Effectiveness</u>	<u>Market Position Enhancement</u>
	<p>4. Increase employee involvement in and awareness of mission fulfillment.</p>	<p>measure areas.</p> <p>4. Utilize existing and evolving technology to enhance patient safety.</p>	<p>unprofitable services, where necessary.</p> <p>4. Identify Revenue Cycle Metrics and position WMHS to achieve the best practice targets in at least three of the categories.</p>	<p>4. Recruit, select, and retain top talent throughout the organization at all levels (staff, physicians, boards, etc.)</p>	<p>d. Recertify MIEMSS accredited Regional Adult Trauma Center.</p> <p>e. Acquire second IMRT capable linear accelerator in Radiation Therapy.</p> <p>f. Continue to develop WMHS Stroke Center toward a five-year accreditation.</p> <p>2. Provide continuing direct oversight to all activities related to the 2009 completion of the new WMHS Regional Medical Center, including transition support to medical staff.</p> <p>3. Enhance access to primary care by recruiting new physicians; also recruit specialists to support critical community needs and WMHS specialty centers.</p>

**Shore Health System
(Memorial Hospital at Easton and Dorchester General Hospital)**

Community Benefits Report For Fiscal Year 2008

1. Licensed bed designation and number of inpatient admissions for this fiscal year:

Shore Health System, an affiliate of the University of Maryland Medical System, is currently licensed to operate 192 beds combined. Inpatient admissions for fiscal year 2008 was 14,486.

2. Description of the community Shore Health System serves:

The Memorial Hospital at Easton and Dorchester General Hospital in Cambridge are private, not for profit hospitals offering a complete range of inpatient and outpatient services to over 140,000 people throughout the Mid-Shore of Maryland. Situated on Maryland's Eastern Shore, Shore Health System services a four county area, covering Caroline, Dorchester, Queen Anne, and Talbot counties.

Talbot County Statistics from Talbot County Health Plan

Population 36,062

Racial mixture 84% white, 13% black, 2.3% Hispanic (MD Vital Statistics, Annual Report 2006)

Median Household Income, 2005 \$51,637 2006 estimate **\$54,550***

Persons Below Poverty, 2006 8.5%

High School Graduate, 2006 85%

Proportion without health insurance 11%

Mortality Rate 2004 -2006 Ranking (adjusted per 100,000 population) **711.3****

Caroline County Statistics from Caroline County Health Needs Assessment

Population 32,617, population density 93persons per square mile

Racial mixture 84% white, 14% black (MD Vital Statistics, Annual Report 2006)

Median Household Income, 2004 \$41,432 2006 estimate **\$45,050***

Persons Below Poverty, 2004 10.5%

High School Graduate, 2000 75%

Bachelor's Degree or higher, 2000 12.1%

Proportion without health insurance 16%
(less than 65)

Mortality Rate 2004 -2006 Ranking (adjusted per 100,000 population) **889.2****

Leading Causes

1. Heart Disease 200.8

2. Cancer 222.4

3. Stroke 52.4

Dorchester County Statistics from Dorchester County Health Department

Population 31,631

Shore Health System's annual management plan results in activities aligned with the needs of the community it serves. Hospital operations, nursing leadership, finance, and volunteers are involved in developing and participating in activities that reach out to the community.

6. Description of how initiatives address the needs listed in #4:

Access to quality health services

- SHS physicians and clinicians participate in health fairs and lecture series providing information and services to the community.
- SHS aids in obtaining necessary medications or equipment needed for discharge for patients unable to pay.
- Ongoing recruitment efforts over the last year include orthopedic, endocrinology, pediatrics, neurology, pulmonary, ob/gyn, anesthesia and family practice physicians.
- Stipend to Tidewater Anesthesia and Maryland Emergency Medicine paid to provide evening, weekend, and holiday call at Dorchester General Hospital in order to provide emergency Surgical Services 24/7

Cancer

The SHS Breast Center participates in Community Outreach to meet the needs of screening, etc for the underserved population. Oncology Support Social Services offered special education on cancer and resources available for cancer patients.

Stroke Prevention and Awareness

Shore Health System hosted a community forum on stroke prevention and treatment. A panel of healthcare experts discussed stroke and addressed audience questions. Stroke forum attendees received a free blood pressure screening and a voucher redeemable for a discounted cholesterol screening. Information on a variety of health topics, such as diabetes, nutrition, exercise and fitness were made available. Information about the Power to End Stroke Campaign, an initiative to reduce the risk of stroke among African Americans was also on display.

Diabetes

- SHS provides nutrition and diabetic information at health fairs and participates in support groups for adult and juvenile diabetes.
- SHS held a week-long diabetic summer camp for juvenile diabetics.

Maternal, Infant and Child Health

Shore Health System offers a variety of community education programs to meet the needs of the new mother and the family unit. Childbirth classes, infant CPR, Big Brother, Big Sister classes, breastfeeding classes are offered free of charge.

Shore Health System has partnered with the Talbot County Department of Social Services to operate an evidence-based Child Advocacy Center to treat abused children. Shore Health System offers services to sexually assaulted adults and children.

Educational and Community-based Programs

Shore Health System participated in a number of career and health fairs throughout the year. Attendees received educational information on topics including smoking cessation, signs and symptoms of stroke, diabetes, nutrition, medication listing,

7. Description of the efforts taken to evaluate the effectiveness of major Community Benefit program initiative:

Currently SHS uses statistical data gathered by local health departments to assess effectiveness of community benefit initiatives.

SHS is working to incorporate a formal data collection process to improve tracking effectiveness of activities.

8. Description of gaps in the availability of specialist providers, including outpatient specialty care, to service the uninsured cared for by SHS:

- The SHS Medical Staff by-laws require that physicians provide ten day of Emergency Department call. In areas where there is only one or two sub-specialists for a particular specialty, there will be occasions when certain days are not covered. If a patient presents to the Emergency Department and there is no sub-specialty coverage for that day, the patient is stabilized and then transferred to an appropriate facility for treatment.
- Stipend to Tidewater Anesthesia and Maryland Emergency Medicine paid to provide evening, weekend, and holiday call at Dorchester General Hospital in order to provide emergency Surgical Services 24/7

Appendices:

Appendix 1: Describe your charity care policy

- A. Describe how the hospital informs patients and person who would otherwise be billed for services about their eligibility for assistance under federal, state or local government programs or under the hospitals charity care policy.

It is the policy of Shore Health System to work with our patients to identify available resources to pay for their care. All patients presenting as self pay and requesting charity relief from their bill will be screened at all points of entry, for possible coverage through state programs and a probable determination for coverage for either Medical Assistance or Financial Assistance (charity care) from the hospital is **immediately** given to the patient. The process is resource intensive and time consuming for patients and the hospital; however, if patients qualify for one of these programs, then they will have health benefits that they will carry with them beyond their current hospital bills, and allow them to access preventive care services as well. Shore Health System works with a business partner who will work with our patients to assist them with the state assistance programs, which is free to our patients.

If a patient does not qualify for Medicaid or another program, Shore Health System offers our financial assistance program. Shore Health System posts notices of our policy in conspicuous places throughout the hospitals, has information within our hospital billing brochure, educates all new employees thoroughly on the process during orientation, and does a yearly re-education to all existing staff. All staff have copies of the financial assistance application, both in English and Spanish, to supply to patients who we deem, after screening, to have a need for assistance. Shore Health System has a dedicated Financial Assistance Liaison to work with our patients to assist them with this process and expedite the decision process.

Appendix 2: Attach copy of SHS hospital's charity care policy.

- B. Shore Health System Policy LD-34, Patient Financial Services – Financial Assistance Program attached.

Appendix 3: Describe the hospital's mission, vision, and value statements.

Shore Health System has a strategic plan and mission statement, which are tied to community benefits. The 2004-2008 strategic plan is developed involving physicians, board members, Senior Leadership staff, management staff and other SHS employees.

Appendix 4: Attach a copy of the hospital's mission, vision, and value statements.

Mission, Values, and Strategic Principle of Shore Health System

Mission: "To excel in quality care and patient satisfaction"

Values: “Every interaction with another is an opportunity to care”

Strategic Principle: “Exceptional Care, Everyday”

Vision: “Shore Health System is strategically located hospitals and ambulatory care services throughout the five-county mid-shoe area. We manage resources to support the health care needs of the of the region’s residents. We are innovative professionals collaborating to serve our communities and achieve national recognition for exceptional outcomes.”

SHORE HEALTH SYSTEM

Administrative Policy and Procedure

TITLE OF POLICY: PATIENT FINANCIAL SERVICES - FINANCIAL ASSISTANCE PROGRAM

PURPOSE

To establish a standardized policy, in compliance with and to determine the method by which individuals and families will be approved for financial assistance for their medical bills.

1.0 POLICY

- 1.1 Shore Health System will provide uncompensated care to those individuals and families who exhibit the need for uncompensated care, provide adequate evidence on such need and providing that there are no other means of compensation (including the ability to receive care at another facility at which there would be compensation available).
- 1.2 Uncompensated care will be considered for patients that are residents of Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties. Financial Assistance will be offered at 100% for individuals at or below 200% of the Federal Poverty Guidelines. A sliding scale of up to 300% for a reduction in costs will also be offered to residents of these counties.
- 1.3 Individuals who are non-residents of the five counties should seek uncompensated care at the facility that services their locale. Financial Assistance will not be considered until the patient provides Shore Health System with a Medicaid Denial letter and a denial letter from their locale healthcare facility. Financial assistance will only be offered at 100% for those individuals at or below 150% of the Federal Poverty Guidelines. Financial assistance will only be offered on a "one time account" basis for non-residents.
- 1.4 Financial Assistance will not be offered for non-residents of Maryland unless approved by Senior Management. Individuals who are non residents, but are residing with residents of the five counties for an extended period of time, may supply a notarized statement from the individual they are residing with, that details their circumstances. Financial Assistance will only be offered on a "one time account" basis for non-residents.
- 1.5 Uncompensated care will be available regardless of race, disability, religion, age, sex, national origin or creed.
- 1.6 Shore Health System will provide patients seeking services at Dorchester General Hospital coverage under the Hill/Burton Program, as long as patients are not covered by another federal program as their primary insurance (i.e., Medicare.)
- 1.7 Shore Health System will provide patients seeking services at all other locations coverage under the Financial Assistance Program. This program will offer full

discounts and sliding fee scale discounts for all uninsured and underinsured patients within the residential areas defined above.

- 1.8 Shore Health System may require patients to apply for State funded programs, such as Medical Assistance, prior to being considered for Financial Assistance should we believe patient may qualify. Financial Assistance will not be considered unless a Medical Assistance denial is received.
- 1.9 Financial Assistance coverage may be discontinued if the patient is asked to complete a Medical Assistance application by Shore Health System, and the patient refuses to cooperate.
- 1.10 Patients are **NOT ELIGIBLE** for charity care if they do not comply with their insurance coverage requirements and restrictions. This includes services that should have been performed at another provider location, but the patient chooses to have services rendered at Shore Health System. **Patient will be fully liable for services that are not covered due to non-compliance with insurance requirements.**
- 1.11 Services covered under the Veterans Administration but not authorized by them, will not be covered by Financial Assistance. Patients must seek services or authorization of services from the Veterans Administration. Senior Management approval is required to waive this requirement based on specific patient needs.
- 1.12 Financial Assistance will not cover elective or non-emergent services, such as cosmetic surgery, dental procedures, and other services as deemed non-covered by Shore Health System.
- 1.13 Financial Assistance will not cover any accounts that have been referred for legal action.

2.0 PROCEDURE

2.1 Application

- 2.1.1 All patients presenting as self pay and requesting charity relief from their bill will be screened for Medical Assistance coverage prior to being considered for Financial Assistance. If patients do not meet the initial screening for Medical Assistance, but may potentially meet the criteria for Financial Assistance based on a review of the guidelines, patients will be provided an application for Financial Assistance, including a cover letter explaining what the patient must do to be considered for uncompensated care.
- 2.1.2 Application for Financial Assistance (Attachment 1).
- 2.1.3 Cover Letter (Attachment 2).
- 2.1.4 Patients will be instructed to provide the following information with the returned application.

-
- 2.1.4.1 Proof of income may be:
 - 2.1.4.1.1 Most recent two consecutive pay stubs.
 - 2.1.4.1.2 Most recent pay stub (must show year-to-date totals).
 - 2.1.4.1.3 Social Security or Disability award letters.
 - 2.1.4.2 Denial letter from Medical Assistance, which may be required to be completed before Patient Aid can be considered.
 - 2.1.4.3 Previous year's Tax Return statement (not required for Hill Burton), along with copies of W-2.
 - 2.1.4.4 If change in dependency from last filed tax return, or patient not required to file tax return, a list of legal dependents with proof of dependency for the individual.
 - 2.1.4.5 Most recent checking and savings statements.
 - 2.1.4.6 Proof of residency in the defined covered counties.
 - 2.1.4.7 Additional documentation may be requested from individuals who are normally outside the income and residency guidelines, but are requesting consideration based on their individual circumstances at this time.
 - 2.1.5 Incomplete applications or applications missing supporting documentation will be returned to the patient with an explanation of what is needed to complete the application process.
 - 2.1.6 Accounts will remain self pay until a completed application is received and approved.
 - 2.2 Eligibility
 - 2.2.1 Patient applications will be screened to determine if they meet the income criteria for Financial Assistance. In general, Shore Health System will follow the current guidelines for Hill-Burton uncompensated care program.
 - 2.2.1.1 The maximum allowable income (based on family size) will be twice the Federal Poverty Guidelines pursuant to 42 U.S.C. 9902(2) and as updated and published in the Federal Register. (See Attachment 3 for legal residents of Kent, Queen Anne's, Talbot, Dorchester and Caroline Counties only.)
 - 2.2.1.2 Non-residents of the five counties may be considered for Financial Assistance at 150% of the Federal Poverty Guidelines, along with a denial of eligibility from Medical Assistance.

2.2.1.3 Changes to the income guidelines will become effective 60 days after they have been posted in the Federal Register.

2.2.2 Income Determination

2.2.2.1 Family income will be used to determine eligibility for Patient Aid.

2.2.2.2 Income for all members of the family will be considered. The definition of income will be:

2.2.2.2.1 Money, wages and salaries before any deductions.

2.2.2.2.2 Net receipts from non-farm self employment (receipts from a person's own incorporated business, professional enterprise, or partnership, after deductions for business expenses).

2.2.2.2.3 Net receipts from farm self-employment (receipts from a farm that one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses).

2.2.2.2.4 Regular payments from social security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veteran's payments, public assistance (including Aid to Families with Dependent Children or Temporary Assistance for Needy Families, Supplemental Security Income, and non-Federally funded General Assistance or General Relief money payments), and training stipends.

2.2.2.2.5 Alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household.

2.2.2.2.6 Private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments.

2.2.2.2.7 College or university scholarships, grants, fellowships, and assistantships.

2.2.2.2.8 Dividend, interest, rental income, net royalties, periodic receipts from estates or trusts.

2.2.2.2.9 Net gambling and lottery winnings.

2.2.2.3 Income does not include the following types of money received: **

2.2.2.3.1 Capital gains.

2.2.2.3.2 Any asset drawn down as withdrawals from a bank, the sale of property, a house or a car.

2.2.2.3.3 Tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments or compensation for injury.

2.2.2.3.4 Non-cash benefits such as employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food or fuel produced on farms, the imputed value of rent from owner occupied non-farm or farm housing and such Federal non-cash benefit programs such as Medicare, Medicaid, food stamps, school lunches and housing assistance.

** Please Note: These monies may be considered in reviewing the application for the payment of outstanding medical bills although they are not reported as income.

2.2.2.4 Annual income will be determined by taking the income for the three months prior to the application date and multiplying by four; or by taking the income for the twelve months preceding the date of application.

2.2.3 Family size will be the number of **legally dependent** (by birth or marriage) individuals permanently residing in the household at the time of application. This is more clearly defined as the number of "dependents" documented on the Federal Tax return.

2.3 Denials

2.3.1 Accounts for which applications are completed, with documentation, and are determined to not meet the criteria for uncompensated care will be made self pay.

2.3.2 The patient will be notified in writing of the determination using an *Uncompensated Care Determination Notice* (Attachment 4).

2.3.3 Patient will be informed of the hospital's payment arrangement guidelines.

2.4 Pending

- 2.4.1 If the application is incomplete, the patient will be notified and instructed what information is needed to complete the application using an *Uncompensated Care Determination Notice* (Attachment 4).
 - 2.4.1.1 Highlight the missing information on a copy of the application (always keep the original application).
 - 2.4.1.2 Indicate the missing information on the *Uncompensated Care Determination Notice* (Attachment 4).
 - 2.4.2 If supporting documentation is missing, notify the patient using an *Uncompensated Care Determination Notice* (Attachment 4).
 - 2.4.3 The account will remain as “Patient Aid Pending” for 30 days. If the patient does not reply within 30 days, the account is made self pay.
- 2.5 Approvals
- 2.5.1 Accounts for which applications are completed, with documentation, and are deemed to meet the criteria for uncompensated care will be adjusted accordingly.
 - 2.5.2 All accounts for the applicant and their immediate family that are for dates of service on or before the date of application will be written off.
 - 2.5.2.1 Accounts at Memorial Hospital of Easton will be adjusted using the following transaction code: 0317.
 - 2.5.2.2 Account at Dorchester General Hospital will be adjusted as follows:
 - 2.5.2.2.1 Accounts that represent the balance after Medicare and/or Medicaid will be adjusted using the following transaction code: 0317.
 - 2.5.2.2.2 Accounts that are not balances after Medicare and/or Medicaid are eligible to be considered under our Hill-Burton obligation and will be adjusted using the following transaction code: 0318.
 - 2.5.3 Any accounts for dates of service within the six months following the date of application will be written off.
 - 2.5.3.1 Accounts at Memorial Hospital of Easton will be adjusted using the following transaction code: 0317.
 - 2.5.3.2 Accounts at Dorchester General Hospital will be adjusted as follows:
 - 2.5.3.2.1 Accounts that represent the balance after Medicare and/or Medicaid will be adjusted using the following transaction code: 0317.

- 2.5.3.2.2 Accounts that are not balances after Medicare and/or Medicaid are eligible to be considered under our Hill-Burton obligation and will adjusted using the following transaction code: 0318.
- 2.5.4 The patient will be notified, in writing, of the uncompensated care given using a system generated letter based on the write-off being performed.
- 2.5.5 The patient's and all immediate family member's accounts will be updated to show "Patient Aid" as their final insurance plan.
 - 2.5.5.1 The plan code will be changed to "004005" for Patient Aid and to "004006" for Hill Burton.
 - 2.5.5.1.1 It is imperative that the POLICY NUMBER field be completed to show the termination date of the approval - enter: "TERM MM/DD/YY".
 - 2.5.5.2 If a patient has other insurance, Patient Aid should be listed as the last COB.
 - 2.5.5.3 The effective date of Patient Aid should be the application date.
 - 2.5.5.4 The termination date of Patient Aid should be the date six months after the effective date, unless patient is only being Patient Aid for one service date.
- 2.5.6 Future visits that occur within the six months succeeding an approved application date will be automatically adjusted in accordance with section a) above. However, patients who require inpatient admissions, surgical services, recurring services, and/or high dollar services as determined by the hospital, may be required to apply for Medical Assistance, and failure to comply with this request will result in the application for charity care becoming null and void.
- 2.5.7 Financial Assistance will be good for **6 months unless only one account is approved for coverage**. Patients will be sent a termination notice 30 days prior to the termination date of their coverage, along with a new application. Any visit occurring after the six months succeeding an approved application date will be self pay until such time that a new application for Patient Aid is received and approved.
- 2.5.8 Patients who require inpatient services, or require high dollar, or recurring services, (i.e., radiation oncology) will be asked to comply with a Medical Assistance application. Patients that are deemed potentially eligible, or those that fail to comply with the application process, will have their Financial Assistance application terminated immediately. Notice will be sent to the patient that they are being terminated from Financial Assistance. Patient will have 30 days to reply to the letter and cooperate

with the MA application. Patients that do not reply within the 30 days will immediately be referred to Bad Debt Agency.

2.6 Appeal Process

2.6.1 Patients or physicians who would like to appeal a denial of Hill Burton or Financial Assistance should contact the Director of Patient Financial Services to discuss why Financial Assistance should be extended to an individual or service that is deemed ineligible for the program. All decisions for an overturn will be discussed directly with the CFO.

2.6.2 Second appeal should be referred directly to the Sr. Vice President/CFO directly.

2.6.3 Third and final appeals would be referred directly to the President/CEO.

2.7 File retention

2.7.1 Files of all applications, documentation and correspondence will be maintained in accordance with the *Provider's Guide to the Hill-Burton Uncompensated Services Regulations*.

2.7.2 Separate files will be maintained for each Hospital.


Gerard M. Walsh, Chief Operating Officer

Effective: 10/05

Approved by: *Shore Health System Board of Directors 6/22/05*

Submitted by: *Christine Fontaine, Director, Patient Financial Services*

Mercy Medical Center
Gaps in the Availability of Specialist Providers to Serve the Uninsured

As a major provider of medical services to patients throughout the City of Baltimore (and even regionally), Mercy serves a vital safety net for the medically underserved. This safety net is most severely tested in provision of services to Emergency Department (ED) patients.

- **Emergency Department:** 27% of patients accessing Mercy's ED are uninsured and another 31% are underinsured.
- **Psychiatric Evaluation and Emergency Treatment:** Mercy provides for professional services to evaluate patients presenting to the Emergency Department with psychiatric complaints, 90% of whom are uninsured or underinsured.
- **Orthopedics:** This specialty is especially problematic in terms of Emergency Department coverage. At present Mercy has four orthopedic surgeons who have accepted the responsibility for providing coverage in Mercy's ED, an area where a significant number of uninsured patients seek care.
 - In addition, Mercy supports a weekly Orthopedic Clinic which serves as the site providing follow-up care to patients initially seen in the Emergency Department and other outpatient sites. 99% of the patients are either uninsured or underinsured. Although originally designed to manage the follow-up needs of Mercy's ED, follow up orthopedic services are so limited in the city for patients with inadequate insurance that many patients are referred for free care from other, non-Mercy settings throughout Baltimore City.
 - **Otolaryngology:** This specialty is also problematic in terms of Emergency Department coverage. Mercy currently has two active otolaryngologists on staff. Patients who present with the most urgent problems have higher rates of inadequate insurance coverage (uninsured or underinsured, e.g., Medicaid).
- **Dentistry & Oral Surgery:** Mercy provides as one of the few, if not the only, community hospital based Dentistry & Oral Surgery Program in the City of Baltimore. The Program provides services for adults (which are not covered under the State's Medicaid Program) and pediatric patients seen in the Emergency Department and local community health centers.

Mercy Medical Center
Description of Gaps in the Availability of Specialist Providers to Serve the
Uninsured

- **Substance Abuse and Medical Detoxification:** Mercy is the only inpatient detoxification provider in Baltimore City. Over 90% of patients are under or uninsured. Mercy provides all of the professional reimbursement for these inpatient services. A number of diseases and medical conditions are over-represented in patients with substance abuse (e.g. Otolaryngology, Gastroenterology).
- **General Surgery:** Mercy believes that we provide higher levels of uncompensated care to patients in this discipline than any other community hospital in the City of Baltimore. This is partly attributed to our relationship with Healthcare for the Homeless (where Mercy became one of the founding members).
- **Dermatology:** Mercy supports the only community hospital based Dermatology practice in the central city, which acts as a referral center for dermatologic disease from numerous urban clinics and settings. (Dermatologic disease is often present in advanced HIV disease.)
- **Mammography/Women's Imaging:** Mercy provides the largest hospital-based mammography service to the residents of Baltimore City. In FY 2008, the Center for Women's Imaging provided over 12,000 imaging exams, 25% of which were provided to patients without insurance or to the underinsured. Due in large part to a shortage in mammographers, Mercy is currently experiencing long wait time delays in patients seeking mammography services.
- **Gastroenterology:** Coverage in this specialty remains problematic primarily for inpatients because of Mercy's payor mix. (Emergent gastroenterologic problems involve higher proportions of inadequately insured patients.)

Describe your charity policy. Describe how the hospital informs patients and persons who would otherwise be billed for services about their eligibility for assistance under federal, state, or local government programs or under the hospital's charity care policy.

Mercy attempts to be very proactive in communicating its charity care policy and financial assistance contact information to patients. We post the charity care policy and financial assistance contact information in all admissions areas, including the emergency room. We provide a copy of the policy and financial assistance contact information to patients or their families during the pre-admission, pre-surgery and admissions process.

Mercy utilizes a third party as well as in-house financial counseling staff to contact and support patients in understanding and completing the financial assistance requirements. They also discuss with patients or their families the availability of various government benefits and assist patients with qualifications for such programs.

Even after the patient is discharged, a contact number for financial counseling is included on every billing statement sent. Follow-up phone calls by hospital billing/collection staff made to patients with unpaid balances also stress the availability of financial assistance and charity care availability.

MERCY MEDICAL CENTER
POLICY AND PROCEDURE

FINANCIAL SERVICES

FINANCIAL ASSISTANCE POLICY

POLICY #: 602-176-93

ISSUE/REISSUE DATE: 09/07

Mercy Medical Center provides and promotes health services for the people of Baltimore of every creed, race, economic, and social condition. In the spirit of the Sisters of Mercy who are its sponsors, Mercy continues a special commitment to the underserved and the uninsured.

Consistent with this mission, it has been the policy of Mercy Medical Center to accept, within the limits of its financial resources, all patients who require its services, without regard to their ability to pay for such services. Emergency care will be rendered to all patients without regard to the limitation of financial resources. This policy, however, does not preclude an attempt to review:

- a. The patient's ability to pay;
- b. The availability of insurance benefits;
- c. The eligibility of Medical Assistance for the patient;

FINANCIAL ASSISTANCE

Financial Assistance will be provided at no charge or at a reduced charge to patients who are unable to pay based on a sliding scale that will be applied for incomes up to approximately 400% above the HHS poverty guidelines. The poverty guidelines are issued each year by the DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS).

In order to qualify for financial assistance, one of the following conditions must be met:

1. Patient's income level is at or two times below HHS poverty guidelines and patient has less than \$10,000 in net assets to qualify for full financial assistance.
2. Patient's income level is at or above the parameters of the sliding scale, and their financial profile indicates that expenses related to the necessities of life (food, housing, utilities, etc.) exceed income.
3. Patient is homeless.
4. Patient is deceased, with no person designated as director of financial affairs, or no estate number on file at the applicable Registrars of Wills Department.

5. Patient has a remaining balance after Medical Assistance.

In addition, the following conditions must be met and it will then be determined if the patient qualifies for full or partial assistance:

a. Fixed income such as Social Security, Retirement or Disability with no additional income sources available.

b. Medical expenses which exceed 50% of net monthly income.

In determining eligibility, the size of the patient's bill relative to the patient's ability to pay will be considered. Financial assistance will be granted for necessary hospital services and it will be provided to those who properly document eligibility and cooperate with Mercy Medical Center's financial assistance application process.

Within two business days following a patient's initial request for Financial Assistance services, application for medical assistance, or both, the facility must make a determination of probable eligibility.

Notice of the availability of Financial Assistance shall be posted in the Admissions Office, Business Office, and Emergency Areas of the hospital. Such notice will be posted in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

Individual notice of the availability of Financial Assistance, the potential for Medicaid eligibility, and the availability of assistance from other government funded programs shall be provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission. Such notice will be printed in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

Mercy Medical Center will make an effort to provide the Financial Assistance application, policies, procedures, and information available in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

Developed by: Edna Jacurak
Betty Bopst

APPROVED BY:



John Topper, SVP, CFO



Mary Crandall, Director

Describe the hospital's missions, vision, and values statement.

Rooted in God's love for all people, and sponsored by the Sisters of Mercy, Mercy Health Services is dedicated to carry forward the 134 - year tradition of the Sister's healing ministry in Baltimore. Grounded in a vision of God's healing love for all people, we are committed to providing healthcare for persons of every creed, color and economic and social condition in Baltimore City, Central Maryland and beyond. In the tradition of Catholic healthcare and of the Sisters of Mercy, we continue our special commitment to poor and underserved persons. Mercy Health Services is driven by its mission to serve and will remain steadfast in its commitment to uphold its highest standards for care, its commitment to the poor and its commitment to Baltimore. We are here to provide excellent healthcare, with compassion and respect, to all who come to us for help.



Mercy Health Services Mission Statement

Rooted in God's healing love for all people, and sponsored by the Sisters of Mercy, MERCY HEALTH SERVICES provides healthcare for persons of every creed, color, and economic and social condition in Baltimore City, Central Maryland and beyond. In the tradition of Catholic healthcare and of the Sisters of Mercy, we continue our special commitment to poor and underserved persons.

We strive to provide excellent clinical services across the life span within a community of compassionate care. We create an environment where individuals can take primary responsibility for their own healthcare and where all are served with courtesy and respect. Concern for spiritual and personal well-being is reflected in every aspect of our service.

We commit ourselves to provide safe patient care, and continuously to improve the quality and effectiveness of our work.

Through our university affiliations and relationships with other organizations, we participate in the education of physicians and other healthcare professionals. We support the educational and professional development of all of our employees.

We hold ourselves accountable to the highest standards of clinical and corporate ethics.

We operate in a financially responsible manner, committing all of our human and material resources to further our mission.

We engage in advocacy for public health policies that have as their goal accessible and sustainable healthcare.

Approved by MHS Board of Trustees 2004

MERCY HEALTH SERVICES PHILOSOPHY AND CORE VALUES

We believe that all people are created in the image of a loving God, and thus we strive to reflect that love in our lives. As social beings, people seek interaction with one another and are most fulfilled when others acknowledge them and their actions. Mercy Health Services holds individuals, their families and our community in the highest esteem – offering respect to all and maintaining the dignity of all.

In the healthcare ministry, we come face to face with the mysteries of life, illness, birth, death and resurrection. We believe that every moment in a person's journey to God is sacred.

Guided by both our PHILOSOPHY and MISSION, we in the Mercy Health Services community commit ourselves to the following CORE VALUES:

RESPECT FOR THE DIGNITY OF EACH PERSON

Every human life has worth. We celebrate the inherent value of each person and respond to the needs of the whole person in health, sickness and dying. We honor the God-given gifts of each individual and help to develop them.

HOSPITALITY

From many religious traditions and walks of life, we welcome one another as children of the same God, whose mercy we know through the warmth, courtesy and generosity of others. A climate of hospitality supports healing of body, mind and spirit.

MERCY/JUSTICE

Compassionate love shapes relationships based on integrity, equality and fairness. We advocate strongly on behalf of persons who are poor or vulnerable. We work toward changes necessary to create more just healthcare and other social systems.

EXCELLENCE

Because God's people deserve our best efforts, excellence holds us to the highest professional standards of care, as well as to the courtesy, respect, and compassion with which that care is rendered.

EMPOWERMENT

A healthy community empowers those who serve and those who are served. It enables people to act both on their own behalf and on behalf of others. The ability of persons to shape decisions affecting their own lives is a right, its exercise a responsibility.

STEWARDSHIP

Given to us in trust, our world is sacred and deserves respectful care. Utilizing our human, financial and material resources creatively and wisely responds to that trust. Planning responsibly will permit us to address both present and future needs.

PRAYER

From the beginning to the end of life, we belong to God. Prayer is our response to God's faithful presence in every moment of our lives. Only through God's mercy can we be a people of Mercy.

Approved by the Board of Trustees, November 15, 2000



Montgomery
General Hospital

Close to Our Patients
MedStar Health

Montgomery General Hospital

Community Benefits FY2008 Narrative Report

Serving the greater Baltimore and Washington, D.C. metro areas, Montgomery General Hospital (MGH) is a 149-bed, not-for-profit community hospital. It also is the newest member of the MedStar Health network. Founded in 1920 by Jacob Wheeler Bird, M.D., the original hospital had 28 beds and was the first acute care facility in Montgomery County. Nearly nine decades later, MGH remains committed to improving the health and welfare of the communities it serves and is dedicated to providing high quality care.

While the provision of such care is an imperative, the hospital has devoted itself to prevention, moving beyond its Olney campus and into the various neighborhoods it serves. Throughout the year many MGH faculty and staff take part in projects that not only improve the community but enhance the lives of residents. Staff takes great pride in its outreach efforts and collaboration with community organizations.

Never before has Montgomery General Hospital experienced the level of change and excitement as it has in 2008. From the designation as a tobacco-free hospital to the merger with MedStar Health to beginning the work on our hospital addition, we are making changes that will allow us to better serve the community and its residents.

Promoting a Healthier Community

Improving community health among neighbors and friends is important to Montgomery General Hospital. This year MGH contributed \$855,708 towards community education and outreach, health screenings, support groups, health fairs, counseling, and self-help and wellness programs.

In November MGH joined other hospitals in Montgomery County in establishing a tobacco-free campus. We felt strongly that a tobacco ban was consistent with our mission – to improve the health of the community we serve – and would demonstrate our commitment to healthy living. By going tobacco free, we've eliminated the health and safety risks that the use of the product poses for our patients, employees and visitors. .

Community health lectures, workshops and support groups: Community-based education is provided to local residents through free community health workshops and support groups. These events educate the community on health related illnesses. This year's topics included addressing drug issues, pandemic flu, smoking and cancer, positive parenting, stroke support, children's mental health crisis preparedness, look good and feel better for cancer survivors, headaches, sleep apnea, breast reconstruction, and pulmonary rehabilitation.

Community education programs: Health education and wellness programs are offered to all members of the community, elementary-aged through seniors. Classes are conducted throughout the year. In 2008, these classes included AARP Driver Safety, ACLS for Healthcare Professionals, Babysitting Plus CPR, Big Brother/Sister, Blood Drive, Cardiac Rehab, Caregivers Support Group, Childbirth, First Aid, Heartsaver & AED, Home Alone, I Can Cope, Lamaze Techniques, Mommies with Muscle, Mommy & Me, SIDS, Smoking Cessation, and Yoga.

Health Screenings: Recognizing that prevention is the key to a healthy community, MGH provides a variety of free health screening programs throughout the year.

Dare to C.A.R.E. provided free screenings for cardiovascular disease for those age 60 or over, or those age 50 or over with a history of diabetes or smoking. The screening included a non-invasive ultrasound examination of the carotid arteries in the neck, the aorta in the abdomen, and an evaluation of the circulation in the legs.

Nutritional counseling, BP screenings, and podiatry evaluations were included in the Dare to C.A.R.E. program.

Annual Health EXPO provided free screenings for blood pressure, body fat/waist hip ratio, podiatry, sleep apnea, vision, prostate, breast exam and carotid artery. Up-to-date information on prevention, early detection, treatment, diagnosis and care for various diseases was offered. Attendees enjoyed physician lectures by MGH medical staff, giveaways, and multiple interactive health booths.

Cancer screening and treatment: Educating the community about cancer prevention and treatment is a priority at MGH. An oncology certified registered nurse is available to guide patients' families and physicians through the many facets of tests and treatments that often accompany a cancer diagnosis. This "Cancer Care Navigator" is nurse experienced in the care, treatment and education of cancer patients. The Navigator not only educates patients about cancer and treatments but provides emotional support and encouragement. A culturally competent Community Outreach Specialist with a public health specialty improves our reach directly into the communities where the uninsured undeserved of Montgomery County gather with relevant programs to address their cancer awareness, especially in prostate and breast Cancer.

Montgomery General Hospital continues to make great strides in educating, navigating and providing free screenings to the community.

We currently partner with Komen for the Cure through a "Brains, Breast and Beauty" educational program for uninsured underserved women ages 18-40, living in Montgomery County. This program's aim is to create partnerships with community institutions—including sororities, salons, community colleges/centers and churches to encourage women prior to consider how they can use their brains to protect their breast for a lifetime of beauty through understanding their individual risk so that they may understand risk factors and enter and maintain appropriate screening at the right time. Our second initiative is through a partnership with the American Cancer Society through our "Have Faith in Your Health" program. This programs reach is to men of all ages to educate them regarding their prostate health and the importance of knowing their personal risk and recommended screening.

This past year we provided free clinical exams and screenings at our Annual Health EXPO in March of 2008. More than 300 community members attended educational seminars about a wide variety of health topics and 82 of these attendees received a free clinical breast exam, prostate specific antigen (PSA) prostate screening test or carotid screening.

Addictions and Mental Health Services: An integral component of Montgomery General Hospital for three decades, the Addiction and Mental Health Center (AMHC) has earned a reputation for the efficient and compassionate delivery of a broad range of fully integrated inpatient, outpatient, crisis, and community education and outreach services. Today, the AMHC is the most comprehensive treatment center based at a general hospital in the Baltimore-Washington area.

Through the Addiction and Mental Health Center, MGH maintains a free, 24-hour, mental health help line. This crisis intervention line is staffed around-the-clock, seven days per week by a licensed therapist. On average, the therapists spend six hours a day assisting community members experiencing or affected by a crisis, providing them with information about resources in the community. Staff spent 1,800 hours on the phone during the last fiscal year

Teaching the community

Medical Education: Committed to reducing the shortage of health care professionals in the community, MGH invested \$238,574 in 2008 to provide clinical settings for training students in medicine, nursing and other health fields.

MGH continued its sponsorship of the Medical Careers Program for students in the community who aspire to become nurses or other healthcare professionals in a hospital setting. The program addresses the growing shortage of health care professionals by offering young people an opportunity to experience what it is like to work in the medical field. MGH nurses and clinical support staff worked closely with these students to facilitate a hands-on learning experience. Approximately 1,300 students from several local colleges as well as public and private high schools participate in this program each year. Under the general supervision of the Human Resources Department, students do a full rotation in the hospital with on-site supervision by MGH nurses, radiology technicians, pharmacists, laboratory staff and physical therapists. In addition, the hospital's Nursing Coordinator spends approximately 30 percent of her time supervising the nursing school students.

Each year, the Women's Board of Montgomery General Hospital offers scholarships to qualified students wishing to pursue a nursing or Allied Health career. Scholarships are awarded to students entering college and to those continuing or expanding their careers through advanced degrees.

A total of \$ 63,250 in scholarship funds were awarded to 74 students in 2008. The Women's Board has provided 974 scholarships, worth \$768,050 since it began offering financial assistance to students in the community a dozen years ago.

Protecting our Community

In 2008, Montgomery General Hospital invested \$294,379 and dedicated 8,925 staff hours to improve community building through activities that support systems within the community.

Emergency Preparedness

The Montgomery County Healthcare Collaborative on Emergency Preparedness consists of Montgomery General Hospital, Shady Grove Adventist Hospital, Suburban Hospital, Washington Adventist Hospital, Holy Cross Hospital, Montgomery County Public Health, Montgomery County Fire/Rescue, Montgomery County Dept of Homeland Security, and Kaiser Permanente. It was chartered in November 2001 to help prepare Montgomery County health care providers respond to large-scale emergency events in a coordinated, collaborative manner. To this end, a Memorandum of Understanding was signed by the participating hospitals establishing what is known as EMAS, the Montgomery County Emergency Mutual Aid System.

During the fiscal year, Montgomery General Hospital continued to collaborate with other hospitals and health care providers in the county regarding emergency preparedness. This will allow MGH to provide better urgent care to the community in the event of a local, regional, and/or national disaster. MGH representatives met with other area hospitals and staff to assess the county's overall ability to handle a crisis situation.

Environmental Improvements

Green hospitals are a growing trend but at Montgomery General Hospital environmental consciousness has been a way of life for 15 years. What started as a recycling program has grown to include the more efficient use of energy and a decreasing reliance on toxic chemicals. MGH was the recipient of a 2008 Partner for Change Award from Practice Greenhealth, one of only two Maryland hospitals so honored.

Environmental improvements occupied more than 8,684 hours of staff time during this reporting period. Of that, 624 hours were spent reducing environmental hazards in the air, water and ground, while the reduction of waste production utilized 2,184 staff hours. Additionally, roughly 5,356 staff hours were spent on the hospital's recycling program which has recycled more than 3,000 tons since it started in 1993. Environmental pollution prevention and a sharps disposal program also occupied staff time.

Providing Charity Care to our community

A key element of MGH's clinical services is the charity care provided by the hospital. Charity care is the amount of free or discounted medically necessary care provided to patients unable to pay some or all of their bills. Charity care does not include bad debt from patients failing to pay medical bills.

This year, MGH provided \$5,290,800 in subsidized care to qualifying members of the community. The hospital provides access to urgent or emergent medically necessary health care services at a reduced or waived fee to all patients who meet criteria.

The vision here at MGH is to increase the hospital's value to the community by continuously offering the best of modern medicine in a caring, professional and ethical environment to patients and their families, professional staff, employees and volunteers. The community comes first. And as the community grows, so does the commitment to serving its diverse needs.



Montgomery
General Hospital

MedStar Health

Mission
FY2008

Montgomery General Hospital, a member of MedStar Health, is dedicated to enhancing our community's health & well-being by offering high-quality, compassionate, and personalized care.



Title:

Document Owner: Franzak, Elizabeth (Director, Pt Financial Svcs)

Date Created:
04/23/2008

Department: Patient Financial - Billing

Approver(s): Hogarty, John (Sr VP Fin); Monge, Peter (President); O'Toole, Jeanne (Controller)

Date Approved:
05/14/2008

Affected Departments: All Departments

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Policy: The Hospital will provide access for urgent or emergent medically necessary health care services free or at a reduced fee to all patients who meet the criteria. The determination of urgent or emergent medically necessary health care services is the sole discretion of Montgomery General Hospital. Each applicant for financial assistance or reduced fee arrangements must meet criteria as set by Montgomery General Hospital. Hospital financial aid is not a substitute for employer-sponsored, public or individually purchased insurance. The Hospital will make an effort to provide Financial Assistance application, policies, procedures, and information available in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.

- Procedure:**
1. Notice of the availability of charity care shall be published in local news media on an annual basis. Notice will also be posted in the Admissions Office, Business Office, and Emergency areas within the hospital. Such notice will be posted in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing hospital services.
 2. Individual notice of the availability of charity care, the potential for Medicaid eligibility and the availability of assistance from other government funded programs shall be provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission or admission. Montgomery General Hospital will make an effort to provide Financial Assistance Application, policies, procedures and information in English, Spanish and/or any other language that will be understandable to target populations of patients utilizing hospital services.
 3. Request for charity or reduced fee arrangements can be made prior to or after service is rendered. To request charity or reduced fee arrangements, the patient must complete a Uniform Financial



Title:

- Assistance Application available from a Montgomery General Hospital representative or via the hospital website.
4. A completed "Uniform Financial Assistance Application" must include a completed demographic section as well as a completed income section. To be considered "complete" MGH will require proof of income and verification of number of dependents based upon the previous year's tax return. If this is not available, the last two months' paycheck stubs will be accepted. Dependents must meet IRS definition of dependents to qualify as household members. Photo id and/or proof of residency is required.
 5. MGH staff will then review the application for the following:
 - a. If patient is a Maryland resident and the patient lives in MGH's primary or secondary service area as defined by the following zip codes: 20832, 20833, 20850, 20851, 20853, 20855, 20860, 20861, 20866, 20868, 20872, 20874, 20876, 20877, 20878, 20879, 20882, 20886, 20902, 20904, 20905, 20906, 20910, then the individual is eligible for consideration for charity care. If no, then charity or a reduced fee will not be granted.
 - b. P.O. Box addresses will not be accepted.
 6. Determination of probable eligibility for financial assistance will be reviewed on a weekly basis. A letter will be mailed to patient via certified mail notifying of the review results within 3 business days of the initial decision.
 7. Patients may appeal any denial or partial fee payment arrangements. The appeal process will include the entire completed Uniform Financial Assistance Application along with accompanying documents of proof of Liquid Assets, Other Assets, and Monthly Expenses. Appeals must be received within 30 days of the patient receiving his/her letter of denial or partial fee payment arrangement. Appeals must be submitted in writing to the Senior Vice President/Chief Financial Officer (CFO). The appeal will be reviewed by the CFO that person and the President.
 8. The patient who is appealing will be notified in writing of the appeal decision within 5 business days of MGH receiving appeal. Again, notification will be sent by certified mail.



Title:

9. There is no second level of appeal.
10. If an account was not classified as charity following the steps above it will be classified as charity for financial statement purposes if an outside collection agency determines the account is “uncollectible” and the patient or guarantor is considered destitute. In this scenario, the charity amount will be entered into the accounting system as a journal entry reclassifying from bad debt to charity.
11. As a MedStar facility Montgomery General will follow the MedStar Financial Assistance for Uninsured Policy statement.

Training &

Education: All Patient Financial Services employees (Billing, Registrars and Customer Service) will be oriented to this policy as part of their initial training, annually and throughout the year as necessary.

Auditing &

Monitoring: The Patient Financial Services Director monitors financial assistance applications to ensure that all employees of PFS are offering the application in an appropriate and timely manner. Additional education will be provided as needed.

Related Documents/References:

F:\POLICIES\PPM Links\Medstarhealth Financial Assistance Policy Final 1 1.doc
Maryland State Uniform Financial Assistance Application

Supersedes: ham-pfs-4



Appendix 1

MedStar Health FY 2008 Community Benefit Report Specialist Gaps

The HSCRC has requested that hospitals document gaps/shortages in our communities with regard to specialists. Gaps exist in the availability of both primary care and specialist providers to serve the uninsured in the hospital.

Diminishing the gaps in specialty services for all patients (uninsured and insured) is very important to MedStar. By operating as a system, which includes Franklin Square Hospital Center, Good Samaritan Hospital, Harbor Hospital, Montgomery General Hospital¹, Union Memorial Hospital, Georgetown University Hospital, National Rehabilitation Hospital, and Washington Hospital Center, our goal is to ensure all sites access to MedStar's entire medical staff, including specialty resources when required. Our sites utilize current and planned office space on their campuses to encourage physicians to treat and follow-up with patients in close proximity to the hospital. Our current and planned Emergency Department improvements allow for state of the art treatment of more patients with enhanced care.

Per physician leadership and case management staff, there remain several areas of concern in our communities:

- a) Limited availability of inpatient and outpatient psychiatry services, including substance abuse
- b) Medication assistance for patients
- c) Transportation assistance
- d) Limited durable medical equipment providers
- e) Limited skilled nursing services in the home and/or at rehab facilities
- f) Limited availability of hospice care
- g) Limited health care services for the homeless and undocumented residents

¹ Note: Since joining MedStar in February of 2008, the affiliation has already significantly increased Montgomery General Hospital's specialty resources for neurosurgeons, orthopedic, including rehabilitative services.

Appendix 2

MedStar Health Financial Assistance Policy HSCRC Community Benefit Response

MedStar Health provides financial assistance to the uninsured patients based on income and family size starting at 100% up to 200% of the federal poverty level and a sliding scale for those between 201-400% of the federal poverty levels. Patients must reside in our defined primary and secondary service areas but exceptions can be made for patients treated in one of our specialty services as well as any extenuating circumstances. In addition, patients have the responsibility to comply with our requirements in completing a Medicaid application if deemed eligible through our financial screening and must provide all necessary information for final determination. MedStar Health's facilities will assist uninsured patients who reside within the community to enroll in publicly-funded entitlement programs, publicly funded programs for the uninsured, assist with consideration of funding available from other charitable organizations or offer periodic payment plans to assist patients with financing their healthcare services.

All self pay patients that are either scheduled admissions or ambulatory surgeries receive a thorough financial screening from our on site advocates including Medicaid eligibility or any other federal or state funded program. In addition, they are screened for financial assistance. Emergency admissions are also screened in this manner after the admission occurs. Other outpatients may receive screening afterward their services if they fall into defined criteria for potential MCHIP program. In addition, outpatients may be screened if they identify the inability to pay or the desire to apply for either Medicaid or financial assistance.

Appendix 2

Signs are posted in all registration areas in both English and Spanish. There are patient advocates located on sight during normal business hours to assist patients at the facilities in their application process. In addition, each hospital funds a portion of the State case workers' salary to have that individual available on-sight to work in conjunction with the patient advocate staff and patients to complete the application process. Any patient that completes the application process will be given a list of items that they must provide in order to complete the eligibility process before or at time of discharge. Additional outreach services are provided after discharge and agencies are used for those patients that are less corporative or that need assistance in securing documents or transportation for application completion. These agencies also assist in the appeal process for both Medicaid and Social Security Disability denials.

Each facility provides brochures and or admission packets advising them of the financial assistance policy and where they can inquiry for further information. Applications will be provided at time of registration if the patient makes a request. Our statements provide a number (local and toll free) for patients to contact.

Upon receipt of eligibility determination, the financial services department will either process the claim for billing and reimbursement to the appropriate federal or state program identified and or process the financial assistance application. A final determination letter will be sent to the patient from both the program for which he applied as well as the financial services department at MedStar regarding their financial assistance disposition.

Appendix 2

Lastly, an automated file is run on a weekly basis to validate Medicaid eligibility on any self-pay patients that the patient has been uncooperative and we have been unsuccessful in completing the application for Medicaid on their behalf in the event that they have done so and failed to notify us.

Appendix 3

MedStar Health

Financial Assistance for Uninsured Patients Policy Statement

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

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

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

- Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
- Assist with enrollment in publicly-funded programs for the uninsured (e.g., D.C. Healthcare Alliance).
- Assist with consideration of funding that may be available from other charitable organizations.

¹ This policy does not apply to insured patients who may be "underinsured" (e.g., patients with high-deductibles and/or coinsurance). This policy also does not apply to patients seeking non-medically-necessary services (including cosmetic surgery).

Appendix 3

- Provide charity care and financial assistance according to applicable guidelines.
- Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
- Offer periodic payment plans to assist patients with financing their healthcare services.

Each MedStar Health facility (in cooperation and consultation with the finance division of MedStar Health) will specify the communities it serves based on the geographic areas it has served historically for the purpose of implementing this policy. Each facility will post the policy, including a description of the applicable communities it serves, in each major patient registration area and in any other areas required by applicable regulations, will communicate the information to patients as required by this policy and applicable regulations and will make a copy of the policy available to all patients.

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

- Completing financial disclosure forms necessary to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.
- Working with the facility's financial counselors and other financial services staff to ensure there is a complete understanding of the patient's financial situation and constraints.
- Completing appropriate applications for publicly-funded healthcare programs. This responsibility includes responding in a timely fashion to requests for documentation to support eligibility.

Appendix 3

- Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.
- Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

Charity Care and Sliding-Scale Financial Assistance

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

The determination of eligibility will be made as follows:

1. Based on family income and family size, the percentage of the then-current federal poverty level for the patient will be calculated. If this percentage exceeds 400%, the patient will not be eligible for charity care or sliding-scale financial assistance unless determined eligible in step 3. If the percentage is less than or equal to 400%, the patient is provisionally eligible, subject to the financial resources test in step 2.
2. The patient's financial resources will be evaluated by calculating a pro forma net worth for the patient and her family, excluding (a) funds invested in qualified pension and retirement plans and (b) the first \$100,000 in equity in the patient's principle residence.² The pro forma net worth will include a deduction for the anticipated medical expenses to be incurred during the twelve months commencing on the date of the patient's admission to the facility. If the pro forma net worth is less than \$100,000, the patient is eligible for

² Net worth calculations will incorporate the inclusions and exclusions used for Medicaid. Anticipated recoveries from third parties related to a patient's medical condition (*i.e.* recovery from a motor vehicle accident that caused the injuries) may be taken into account in applying this policy.

Appendix 3

charity care or sliding-scale financial assistance; if the pro forma net worth is \$100,000 or more, the patient will not be eligible for such assistance.

3. For patients whose family income exceeds 400% of the federal poverty level, adjusted family income will be calculated by deducting the amount of medical expenses for the subject episode of care anticipated to be paid during the ensuing twelve month period. This calculation will consider any periodic payment plan to be extended to the patient. Based on this adjusted family income, the adjusted percentage of the then-current federal poverty level for the patient will be calculated. If this percentage exceeds 400%, the patient will not be eligible for charity care or sliding-scale financial assistance. Periodic payment plans may be extended to these patients.

For patients who are determined to be eligible for charity care or sliding-scale financial assistance, the following will be applicable based on the patient’s percentage of the federal poverty level (or adjusted percentage, if applicable):

Adjusted Percentage of Poverty Level	Financial Assistance Level	
	HSCRC-Regulated Services³	Washington Facilities and non-HSCRC Regulated Services
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

³ The assistance levels described above for HSCRC-regulated services do not include any discounts that may be applicable under the HSCRC’s prompt payment regulations.

Appendix 3

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

Appendix 4a

MedStar Health FY 2008 Community Benefit Report Vision, Mission, & Values

MedStar Health has adopted a vision and mission, along with the six values shown below. All MedStar hospitals, including the five hospitals in Maryland (Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, Montgomery General Hospital, and Union Memorial Hospital) share the same MedStar Health Vision and Values. See Appendix 4b for each hospital mission statement.

Mission:

To serve our patients, those who care for them, and our communities

Vision:

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

SPIRIT Values:

S = SERVICE

P = PATIENT FIRST

I = INTEGRITY

R = RESPECT

I = INNOVATION

T = TEAMWORK

Appendix 4b

MedStar Health FY 2008 Community Benefit Report Hospital Mission Statements

Hospital Mission Statements Include:

Franklin Square Hospital:

Franklin Square Hospital Center, a member of MedStar Health, provides the highest quality healthcare and education to our communities.

Good Samaritan Hospital:

We are Good Samaritans, guided by Catholic tradition and trusted to deliver ideal healthcare experiences.

Harbor Hospital:

Harbor Hospital is committed to quality, caring and service for our patients and our communities.

Montgomery General Hospital:

Montgomery General Hospital, a member of MedStar Health, is dedicated to enhancing our community's health & well-being by offering high-quality, compassionate, and personalized care.

Union Memorial Hospital:

Union Memorial Hospital is a comprehensive hospital with regional specialty services of distinction and quality community services, all enhanced by clinical education and research.

**MedStar Health
FY 2008 Community Benefit Report
Subsidy Justification**

The Catholic Health Association guidelines for Community Benefit Reporting allow inclusion of losses for services defined as subsidized care, broadly defined as services that are “needed in the community and other providers are unwilling to provide the services, or the services would otherwise not be available to meet patient demand.” In most cases, these subsidies directly relate services for uninsured or underinsured patients.

The HSCRC has addressed the treatment of these services, requiring that hospitals clearly explain all subsidies included within Category C of their Community Benefit Report.

Category 1 Subsidies:

Hospital-based physicians with whom the hospital has an exclusive contract and/or subsidy IN ORDER TO RETAIN SERVICES THAT REPRESENT A COMMUNITY BENEFIT

- a) Primary Care Subsidies, including Diabetes – These are clinic-based physician practices that provide primary health care services. Most of the patients are from the local community and are low-income families. This service generates a negative margin; however, the practice addresses a community need and supports the hospital’s mission of commitment to patients, communities, physicians and employees. Providing this service allows the local community access to health care services, and therefore more preventive measures and an improvement of the patients’ health status are achieved.
- b) OB and Pediatric Subsidies, including Breast Surgery – These represent physician practices providing health care services for obstetrics, gynecology, and pediatrics where a negative margin is generated. A large number of our patients receiving these services are from minority and low-income families. Prenatal care is provided and OB/GYN and pediatric coverage is provided 24 hours/day. Preventive measures and improvement of the patient’s health status are achieved. The services address a community need for women’s health and children’s services for lower income and minority families.
- c) Radiology Subsidies - For certain sites, payment is made to radiologists to provide services on a 24-hour basis generating a negative margin. These specialists are difficult to recruit due to extreme shortage and nature of the services and the 24-hour availability commitment. The community needs for these services are being met. Our community includes many low- income and minority families.
- d) Surgical House Subsidies - For certain sites with a higher percentage of indigent patients, private physicians often are not willing to provide 24 hour on-call

service. The hospital absorbs these costs and has a negative margin. The community's needs are met.

- e) Psychiatric/Behavioral Health Subsidies - The overall cost of 24/7 Psychiatry physician coverage is disproportionate to the total collections from the patients seen by these physicians during off hours. Many of these patients are uninsured. Our hospital absorbs the cost of providing psychiatric supervision for the Emergency Department on a 24/7 basis. If these services were not provided, the patient would be transported to another facility to receive these services. The community needs are being met and commitment to patients is exhibited by providing these services.

Category 2 Subsidies:

Non-Resident house staff and hospitalists

- a) Hospitalist Subsidies - Payments are made to an inpatient specialist group to provide 24/7 services in the hospital; resulting in a negative profit margin. The service focuses on preventive health measures and health status improvement for the community.
- b) ENT Subsidies - Payments are made for a non- resident ENT fellowship to provide 24/7 services in the hospital; resulting in a negative profit margin. The service focuses on preventive health measures and health status improvement for the community.

Category 3 Subsidies:

Coverage of Emergency Department call

- a) ER Subsidies - These include the cost of providing on-call specialists for the Emergency Department for certain surgical specialties. These specialists otherwise would not provide the services because of the low volumes and a large number of indigent patients served. If these services were not provided, the patient would be transported to another facility to receive the specialty services. The community needs are being met and commitment to patients is exhibited by providing these services.

Category 4 Subsidies:

Physician provision of financial assistance to encourage alignment with hospital financial assistance policies

No subsidies reported.

Category 5 Subsidies:

Recruitment of physicians to meet community need as shown by a hospital's medical staff development plan

- a) Anesthesiology Subsidies - This subsidy relates to payments made to anesthesiologists to provide services generating a negative margin. These specialists are difficult to recruit due to extreme shortage and nature of the services and the 24-hour availability commitment. The community needs for health services are being met.

Other Subsidies:

Non-Physician Subsidies

- a) Adult Day Care Subsidies - Adult Day Care services are provided at a negative margin. The community has a need for patient care related to the elderly and disabled. The needs of the participants' family are met. Family members can feel confident that their relatives are being cared for when they cannot be there. Again, a majority of people receiving this service come from low income and minority families.
- b) Cardiac Rehabilitation - One of our sites subsidizes cardiac rehabilitation services to the community.
- c) Community HIV Services Support Subsidies – HIV clinic services are provided at a negative margin. These services include nurse care management, social work, and medical services and help over 200 people who are mostly indigent.
- d) Child Development Center Subsidies - Good Samaritan's Child Development Center opened in 1990 to serve a large number of employee parents by caring for their children ages two to four. The Center also serves parents in the community by providing an environment that is supportive, consistent, and attentive to their needs. Services are provided at a negative margin.
- e) Renal dialysis Program - Good Samaritan Hospital operates the largest not-for-profit dialysis center in the Baltimore area. The Program offers a complete range of renal dialysis services. A social worker is assigned to each patient to address issues such as education, transportation and support. The Program includes a monthly class where, patients and their families can learn more about hemodialysis, peritoneal dialysis and transplantation. These Program services are provided at a negative margin.
- f) Low Income Housing - Sponsored and managed by Good Samaritan Hospital, the facilities of Belvedere Green and Woodbourne Woods provide rent-subsidized apartments and many other features for its residents. Services provided include transportation to doctors' offices, social work consultation, and assistance with healthcare needs, including educational programs, health screenings, and medication schedules. These senior living services operate at a negative margin.

- g) Pharmacy Care Counseling – For patients concerned about their ability to afford their medication, Good Samaritan Hospital provides an advocate who helps them apply for and manage the many programs that provide medication patient assistance.

- h) Subacute Program - Transitional care, sometimes called sub-acute or extended care, is designed for patients who are too sick to go home, but not sick enough to remain in a traditional hospital bed. Patients benefit from the transitional care setting because it provides them with the care and education they need while preparing them to return to their previous living situations. Many times, Rehabilitation services are provided to maximize each patient's level of function and assist patients and their families to cope with the physical limitations secondary to illness or injury. These services are provided at a negative margin.

Community Benefit Report for Fiscal Year 2008

Northwest Hospital

Description of Gaps in Availability of Specialist Providers for Uninsured

Northwest is a community hospital with an attending staff of approximately 700 physicians, including several specialties. Those specialties include Neurology, Neurosurgery and Infectious Disease. Gaps we have identified for all patients who live in the hospital's community, including the uninsured, include specialists in Endocrinology, Gynecology, Vascular, Colorectal, Orthopedic, and Breast Surgery. Because of these gaps, the hospital is actively recruiting such specialists to fill these service gaps.

When uninsured patients are admitted to the hospital without a primary care physician, their hospital care is managed by hospital-employed hospitalists. The physician fees for these inpatient services is absorbed by the hospital if the uninsured patient does not have resources to cover these costs.

NORTHWEST HOSPITAL OF BALTIMORE

**Hospital Administrative
Policy Manual**

CHARITY CARE

PURPOSE

To assist patients who do not qualify for Financial Assistance from State, County or Federal Agencies but may qualify for uncompensated care under Federal Poverty Guidelines.

POLICY

To provide charity care applications to patients needing financial assistance for their hospital bill. Qualifications are based on gross income and family size according to Federal Poverty Guidelines.

Charity care information is made available to the public through multiple sources including: 1) the admission packet, 2) signage located in Admitting, the Emergency Room, and Patient Accounting, 3) registration and patient accounting staff, and 4) an annual notice in a local newspaper.

Original Date: 7/92
Revised Date: 9/96, 5/98, 9/01, 12/02, 8/04
Review Date: 6/96

Eric Wexler
President

Date

Charles Orlando
Senior Vice President/CFO

Date

SOURCES:

CROSS REFERENCES:

COLLABORATOR(S):

IMPLEMENTATION PROCEDURES

Implementation procedures are different for non-emergent and emergent services.

A. Unplanned, Emergent Services and Continuing Care Admissions

Once financial counseling identifies a patient as potentially qualifying for uncompensated care the account will be referred to the self-pay financial counselor.

The patient will be contacted via phone or interviewed to determine financial ability to pay. If the patient has adequate financial resources, payment arrangements will be made according to Self-Pay Guidelines. GTE will be documented and the appropriate financial class will be coded in the system. If the patient does not have adequate financial resources (MA etc) a charity care application will be completed. The determination will be based upon the following:

- A. # of people in household
- B. Proof of income with one of the following required:
 - ❖ Last 2 paycheck stubs
 - ❖ Copy of prior year's tax statement or W-2 form
 - ❖ Verification of other income, i.e. social security award letter, Retirement/pension etc.

The completed application will be forwarded to the Assistant Director of Billing for review. Patients will be notified within 5 business days. GTE will be documented and the appropriate financial class will be coded in the system.

B. Elective Services (Direct Admits and scheduled Outpatient Surgery excluding Cosmetics

The patient will be contacted via phone or interviewed to determine financial ability to pay. If the patient has adequate financial resources, payment arrangements will be made according to Self-Pay Guidelines. GTE will be documented and the appropriate financial class will be coded in the system. If the patient does not have adequate financial resources (MA etc. the information will be reviewed with the physician's office to determine if the patient could be cancelled or rescheduled).

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_____ Eric Wexler President	_____ Date
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**POLICY MANUAL – SECTION I: LEADERSHIP, GOVERNANCE, MANAGEMENT AND
PLANNING** **1.00**

SUBJECT: MISSION, PHILOSOPHY, VISION

EFFECTIVE DATE: JULY 2, 2004

SUPERSEDES: AUGUST 1998

APPROVALS: Final – President

MISSION

Northwest Hospital Center's mission is to:

- Function as an integral component of LifeBridge Health, acting in close coordination with other LifeBridge Health providers. Deliver a broad array of appropriate inpatient and outpatient hospital and health care services to communities along the northwest corridor, including Baltimore County, southern and eastern Carroll County, Baltimore City and northern Howard County.
- Commit to being a community focused hospital center that meets the continuum of health care needs of the people we serve-either directly through joint programs with other providers and health related agencies or as an advocate for alternate sources of care-regardless of their ability to pay.
- Provide, in partnership with the medical staff, a patient centered environment committed to the continuous improvement of the quality of services provided.
- Maintain an attractive and up-to-date facility equipped with proven state-of-the-art technology that meets the needs of both patients and physicians and is accessible to all.
- Provide an environment in which patients are treated with the utmost safety in mind and all customers are treated with respect and dignity.
- Maintain and foster a caring family atmosphere in which to work, practice medicine, volunteer, visit, and most importantly, receive care.
- Stress education and focus resources on providing quality education to meet the health information needs of the communities we serve, the continuing education needs of our employees and medical staff to facilitate quality care, and clinical experience for students.

- Continue to be a cost-effective organization which manages its resources prudently to ensure its long-term financial viability and, thus, its ability to carry out its mission.

PHILOSOPHY

Northwest Hospital Center, a not-for-profit organization, is committed to creating and maintaining an environment where exceptional quality care and service is achieved and recognized by our patients and their families, members of the medical and allied health staffs, employees, volunteers and the communities we serve. Care and service are provided without regard to age, sex, race, religion, disability or financial status.

VISION

Northwest Hospital Center will be a recognized leader in customer care and clinical quality in the services we choose to offer by exceeding expectations of patients, physicians, employees and the community.

Global/1.00

Peninsula Regional Medical Center Evaluation Framework Proposal

To provide a description of efforts taken to evaluate the effectiveness of a hospital's community benefits, hospitals can use the following questions and performance-based indicators in a way that encourages uniform reporting that identifies core community benefit functions and orients the information to program structure and process. Where possible, hospitals should provide one or two examples to illustrate their efforts.

- **Community Benefits Planning**
 1. Does the hospital have a community benefit plan or explicitly include community benefits as part of its strategic plan?
 - Peninsula Regional completed its last organization-wide strategic plan in 2003. As a part of the 2003 strategic plan under Customer Relationships, the medical center identified the need to “formalize a process within Peninsula Regional Medical Center to develop programs, services, and measures for improving community health.” Additionally, one of the four strategic imperatives is for Peninsula Regional “to continue to be a leader in working collaboratively with other organizations in our region to ensure access to needed healthcare services for improving the health of the communities we serve.”
 - Peninsula Regional utilizes a community Health Council in support of activities to not only “evaluate more effective wellness and preventative service programs” within the community but to also “ensure a process is developed to document the results and outcomes of new community health services and programs.” An internal Health and Wellness committee evaluates current and ongoing community outreach efforts.
 2. Were hospital staff and leadership involved in developing the plan?
 - Hospital leadership including the Board of Trustees, physician leaders, hospital management staff, front-line hospital staff and various community groups were involved in developing the strategic and community outreach plans.
- **Community Needs Assessment**
 3. Does the hospital's plan target specific areas of community need?
 - The overall hospital strategic plan related to Community Benefit does not target specific areas of community need. This is done using a Community Health Assessment survey co-sponsored by Peninsula Regional and the Wicomico, Worcester, and Somerset County Health Departments. The plan reveals areas of need and the participants meet to choose an issue to work on collaboratively. (See response to Question #5)

4. Did the local health department/s provide current needs assessment information that was used by the hospital? Were other information sources used to identify community benefits needs? Please provide a description of these sources.
 - A Community Health Assessment (a self-report phone survey) was conducted by Peninsula Regional in cooperation with the Wicomico County, Worcester County, and Somerset County Health Departments. This needs assessment was completed at the end of October, 2004. Findings from this survey were immediately shared with leaders from Peninsula Regional Medical Center, Atlantic General Hospital, McCready Memorial Hospital, staff from the three local health departments, and area physician and community leaders. The next Community Health Assessment is scheduled for 2008.
 - In addition to the Community Health Assessment, Peninsula Regional uses input from its Health Council (community), local and national community health organizations such as the American Cancer Society, the March of Dimes, and American Diabetes Association, local health departments, and state and national data sources such as the CDC Health People 2010 when determining community health needs.
- Community Benefits Initiatives
 5. Does the hospital identify its Community Based Initiatives?
 - Currently, the medical center collaborates with numerous community organizations. The level of involvement is determined at a department level (i.e. decisions to work with the American Cancer Society on community initiatives are made by Peninsula Cancer Center staff).
 - A Community Health Assessment is conducted every 4-5 years. This survey is used to identify area needs. Recent example:
 - . A tri-county alliance targeting diabetes in Wicomico, Worcester, and Somerset Counties was formed in late January 2005. This alliance received a substantial grant July 1, 2006 using the money to develop a resource guide, establish a web site for both prevention and self-management information, and provide structured education and paper ADA screenings at local events and area employers. This group is currently working on monitoring program effectiveness including scheduled focus groups which will be used to develop more effective interventions for at-risk populations.
 6. Do the hospital's community benefits initiatives reflect evidence-based needs? Please give one or two examples.
 - The Tri-County Incidence of Self Reported Diabetes:
 - Tri-County (14.3%) area has a self-report of diabetes twice Maryland's rate (7.0%) and nearly twice U.S.'s rate (8.7%).

- Local (tri-county area) self report of diabetes has undergone a statistically significant increase from 8.5% in 1995 to 14.3% in 2004.
 - A community cancer cooperative consisting of representatives from Peninsula Regional, the local American Cancer Society, the Wellness Community, and Wicomico, Worcester, and Somerset County Health Departments developed an area Cancer Plan using several cancer data resources. .
7. Were the initiatives performance-based and did they involve process and/or outcome measures?
- Measures for performance and/or outcomes from the Tri-County Diabetes Alliance are currently being developed. As a part of a recent grant local data tracking methods are being analyzed and a recommendation for an improved process in the tri-county area will be provided.
 - Department level initiatives vary depending on the initiative but most include a clinical outcome and/or specific performance measure.
- Community Collaboration
8. Did the hospital involve other community participants in planning and/or implementing its community benefits activities? Was the community involved in identifying the initiatives and setting goal(s) to be achieved?
- The October 2004 Community Health Assessment was conducted for Peninsula Regional's entire five county service area and include input/survey responses from more than 800 community members. The results of the survey were shared with numerous community groups for the purpose of identifying area health needs.
 - Peninsula Regional currently utilizes a community Health Council in support of activities to not only "evaluate more effective wellness and preventative service programs" within the community but to also "ensure a process is developed to document the results and outcomes of new community health services and programs." An internal Health and Wellness committee has been formed to evaluate current and outgoing community outreach initiatives.
 - Members of Peninsula Regional's management team continue to work closely on area projects and are members of the Wicomico County Health Planning Board, the Worcester County Health Planning Board, the Worcester County Department Advisory Council, the Tri-County Health Planning Board, the Tri-County Healthcare Committee, and the Eastern Shore Oral Health Network (ESOHN).
 - Peninsula Regional's service line managers and executive team serve on the boards of many community health and healthy living organizations and well as community workforce enhancement coalitions.
9. Did the hospital participate in any community organizations, partnerships, or efforts to plan and/or implement its community benefits activities?

- Peninsula Regional collaborates and partners with organizations on initiatives ranging from a co-sponsorship of a community Walk at Lunch program and the Tri-County Go Red women's heart check project to the support of community health initiatives such as ESOHN's dental health grant planning for the Lower Eastern Shore.
 - Peninsula Regional staff serves and supports and partners with numerous community health organizations including local chapters of the American Cancer Society, American Diabetes Associates, the March of Dimes, and United Way, Coastal Hospice, The Wellness Community, Healthy U, Lower Shore Enterprises, Women Supporting Women, and the Wicomico County Tobacco Coalition among others.
- Community Benefits Implementation
 10. Does the hospital monitor how its activities fulfill the goals identified in the plan such as through a regular progress reporting process, or by having a staff person assigned to monitor the plan?
 - The progress of individual department collaboration's is monitored through the individual staff members involved in specific projects.
 -
 - An internal Health and Wellness committee evaluates community outreach efforts such as health fairs, free screenings, and free education and outreach sessions. This committee monitors the amount of community contact and the effectiveness of these activities.
 - Peninsula Regional recently conducted a community benefits audit to look at Peninsula Regional programs as well as those reported by other healthcare facilities in the state of Maryland.
 11. Are the community and the hospital leadership kept informed as to the progress and results of the community benefits program?
 - The Executive Team at Peninsula Regional meets regularly in regards to the current strategic plan and therefore regularly reviews and addresses community health needs.
 - Currently, the executive team and the medical center Board of Trustees are provided quarterly updates on the number of community outreach activities in which the medical center participated.
 - Community outreach activities are incorporated in the medical center's annual report provided to the community in January of each year.
 - As the newly assigned person becomes more familiar with activities and begins developing performance measures for community outreach activities, the depth and breadth of the information provided to the Board of Trustees and to the community through quarterly newsletters is expected to increase in the next 12-18 months.

Peninsula Regional Medical Center

Peninsula Regional Medical Center conducted a Medical Staff Development Plan in the spring of 2003 and again in the fall of 2006. The plans (prepared by American Medical Consulting) are used to identify gaps/needs for all physician-types throughout the Medical Center's service area. The methodology employed in the plans include all persons residing within the primary and secondary service area of Peninsula Regional Medical Center. The plan is updated every 3 years by the Medical Center with the next planned update is scheduled to be complete sometime in late 2009. The following are data taken from the fall 2006 report.

With respect to low income and uninsured populations, the plan recognizes the following:

Household income/economic factors can have a significant impact on the general health of a service area. Lower household income may reflect lower primary care utilization and higher critical care utilization. Various studies and articles also suggest greater reliance on hospital emergency rooms for non-emergency diagnosis and treatment in low-income areas. Estimated median household income in Peninsula Regional Medical Center's service area is \$44,507 which is lower than the national median income of \$48,713 and the Maryland median income of \$62,365.

American Medical Consulting feels that the Peninsula Regional Medical Center service area has some household income-related factors that would drive an additional need for physician services within portions of the community. Approximately 9,000 households (13.9%) within the service area earn less than \$15,000 per year. A lack of available resources to the indigent may increase volumes in the emergency room, as patients lacking primary care access often seek routine care through emergency services. Additional physician recruitment may be warranted to serve this population and will be further discussed in this plan.

American Medical Consulting concluded that the Peninsula Regional Medical Center service area would generate more physician visits than other similarly sized average communities nationally. In addition, the area is experiencing steady moderate growth and has an aging patient base. These two factors would suggest that the community should consider a physician population make-up similar to that of U.S. communities of a larger size and similar payor market mix.

The plan identified a need for approximately 100 additional physicians over the next five years. The Medical Center has been aggressively recruiting in those specialties identified as being most needed. Additionally, the Medical Center works closely with T.L.C. (a federally qualified community health center) and the Public Health Departments to ensure all persons needing care are served regardless of their ability to pay.

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ADMINISTRATIVE POLICY MANUAL

Subject: Uncompensated Care

Effective Date: August 1981

Approved by: Alan Newberry, President/CEO

Responsible Parties: Jeff Karns

Revised Date: 12/86, 6/88, 3/90, 3/91, 7/93, 7/94, 8/98, 12/05, 8/08

Reviewed Date: 8/83, 12/85, 2/88, 6/92, 8/95, 7/96, 9/97, 6/00, 6/01, 10/02, 10/04

POLICY

It is the intention of Peninsula Regional Medical Center to make available to all patients the highest quality of medical care possible within the resources available. If a patient is unable to pay due to financial resources, all efforts will be made to help the patient obtain assistance through appropriate agencies, or, if no help is available, to render care at a reduced or zero cost.

Patients requiring elective services may, through consultation with their physician, have their procedure postponed until such a time as the patient is able to make full payment or meet the established deposit. Elective procedure patients, who, according to their diagnosis and/or their physician, cannot be postponed, will be helped with obtaining assistance from agencies. If no assistance is available, and the patient requests, the account will be reviewed for possible financial assistance.

In the event that the patient has applied for and kept all necessary appointments and third party assistance is not available, the patient may be eligible for financial assistance.

ELIBILITY DETERMINATION PROCESS

1. Interview patient and/or family
2. Obtain annual gross income
3. Determine eligibility (preliminary eligibility will be made within 2 business days)
4. Screen for possible referral to external charitable programs
5. If the patient and/or family refuse to disclose financial resources or cooperate, the patient will be subject to standard collection efforts
6. The determination of eligibility (approval or denial) shall be made in a timely manner.

PUBLIC NOTIFICATION

- An annual notice regarding financial assistance will be published in a local, widely circulated newspaper.
- Appropriate notices will be posted in patient registration, financial services, the emergency department, labor and delivery and on the PRMC website.
- Individual notice to patients and other persons regarding our financial assistance policy are available at community outreach events, prenatal services, pre-admission, and admission.

ADMINISTRATION OF POLICY

Procedures are maintained in Patient Accounting related to the administration of the uncompensated care/financial assistance to patients' policy.

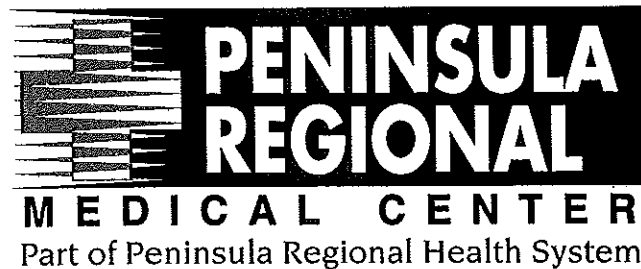
REFERENCE

Board of Trustees

Keywords

**Uncompensated
Patient Accounts
Charity Care**

Alan Newberry
President/CEO



MISSION

Improve the health of the communities we serve.

VALUES

Respect for every individual,
delivery of exceptional service, continuous quality improvement,
safety, effectiveness, trust and compassion.

VISION

We will create a partnership of physicians, hospitals and communities that will take the lead in giving consumers throughout the region easy access to a fully coordinated range of services extending from prevention to the most advanced care available.

VALUE PROPOSITION

We will provide the safest, highest quality health care services in our region. We will provide the most advanced health care services in our region.

PRINCE GEORGE'S HOSPITAL SYSTEM

COMMUNITY BENEFIT REPORT

July 1, 2007 – June 30, 2008

APPENDIX 1

DESCRIPTION OF GAPS IN THE AVAILABILITY OF SPECIALIST PROVIDERS

Although Prince George's Hospital has one of the largest populations of uninsured patients in the State, we believe that all patients should receive the highest level of care regardless of economic standing. This goal can only be achieved with experienced specialist physicians caring for all of our patients even when so many of our patients cannot afford to pay. To overcome this obvious dilemma, we pay physicians to cover their bad debts so the "gap" exists in the hospital's profits but not in patient care. We get no funds from the regulated system to offset these physician payments but we will always put the patients first.

PRINCE GEORGE'S HOSPITAL SYSTEM

COMMUNITY BENEFIT REPORT

July 1, 2007 – June 30, 2008

APPENDIX 2

DESCRIPTION OF FINANCIAL ASSISTANCE PROGRAM

Dimensions Healthcare System provides compassionate care for all, regardless of an individual's ability to pay. We serve as the safety net for the uninsured and underinsured. It is our mission to help save lives and improve the quality of living.

Dimensions Healthcare System through its health care services, provides financial assistance to those who need medical and health care services but do not have the resources to pay for that care, and it does so by preserving the dignity of the individual who needs assistance.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs may be eligible for free or discounted healthcare services based on established criteria.

Eligibility for the Dimensions Healthcare System Financial Assistance Program is based on income and family size. Should a patient be found eligible for financial assistance, the patient will receive a Financial Approval Letter indicating his/her eligibility amount. Any balance due after the financial assistance allowance has been applied, will become the responsibility of the patient. Physicians bill separately and their charges are not included in the financial assistance program.

FINANCIAL ASSISTANCE PROGRAM

PURPOSE: To identify circumstances when Dimensions Healthcare System (DHS) may provide care without charge or at a discount commensurate with the ability to pay, for a patient whose financial status makes it impractical or impossible to pay for medically necessary services. This policy applies only to facility charges and not physician or other independent company billings. The provision of free and discounted care through our Financial Assistance Program is consistent, appropriate and essential to the execution of our mission, vision and values, and is consistent with our tax-exempt, charitable status.

Resources are limited and it is necessary to set limits and guidelines. These are not designed to turn away or discourage those in need from seeking treatment. They are intended to assure that the resources the Hospital can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay. Financial assessments and the review of patients' assets and financial information is intended for the purpose of assessing need as well as gaining a holistic view of the patients' circumstances. Dimensions Healthcare System is committed to:

- Communicating this purpose to the patient so they can more fully and freely participate in providing the needed information without fear of losing basic assets and income;
- Assessing the patients' capacity to pay and reach payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency;
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process;
- Avoiding seeking or demanding payment from or seizing exempt income or assets; and
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment.

CANCELLATION: This is a new corporate policy. It supersedes all policies on this subject at the facility level.

POLICY: Dimensions Healthcare System has a long tradition of serving the poor, the needy, and all who require health care services. However, our hospitals alone cannot meet every community need. They can practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, provision for financial assistance will be budgeted annually. Our hospitals will continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon the Federal Poverty guidelines and will be updated annually in conjunction with the published updates by the United States Department of Health and Human Services. All open self-pay balances may be considered for financial assistance. If a determination is made that the patient has the ability to pay all or a portion of the bill, such a determination does not prevent a

reassessment of the person's ability to pay at a later date. The need for financial assistance is to be re-evaluated at the following times:

- Subsequent rendering of services,
- Income change,
- Family size change,
- When an account that is closed is to be reopened, or
- When the last financial evaluation was completed more than six months before.

To be considered for financial assistance, the patient must cooperate with the facility to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as Medicaid. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.

Appropriate signage will be visible in the facility in order to create awareness of the financial assistance program and the assistance available. At a minimum, signage will be posted in all patient intake areas, including, but not limited to, the Emergency Department, the Billing Office, and the Admission/Patient Registration areas. Information such as brochures will be included in patient services/information folders and/or at patient intake areas. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the facility's service area in accordance with the state's Language Assistance Services Act.

The necessity for medical treatment of any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

SPECIAL INSTRUCTIONS/FORMS TO BE USED:

DEFINITIONS:

- A. 1. *Assets:* Assets include immediately available cash and investments such as savings and checking as well as other investments, including retirement or IRA funds, life insurance values, trust accounts, etc. The following are to be considered exempt and shall not be considered in determining whether the uninsured patient qualifies for an uninsured discount:
- a. Homestead property
 - b. \$2,000 for the uninsured patient, or \$3,000 for the uninsured patient and one dependent residing together.
 - c. \$50 for each additional dependent residing in the same household.
 - d. Personal effects and household goods that have a total value of less than \$2,000.
 - e. A wedding and engagement ring and items required due to medical or physical condition.
 - f. One automobile with fair market value of \$4,500 or less.
 - g. Patient must have less than \$10,000 in net assets.

2. *Bad Debt Expense:* Uncollectible accounts receivable that were expected to result in cash inflows (i.e. the patient did not meet the facility's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected uncollectibles resulting from the extension of credit.
3. *Financial Assistance:* Health care services that were never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.
4. *Financial Assistance Committee:* A committee consisting of the Chief Financial Officer, the Corporate Director of Patient Financial Services, the Risk Manager, the Director of Case/Care Management, and the Director of Patient Relations, or a similar mix of individuals.
5. *Contractual Adjustments:* Differences between revenue at established rates and amounts realized from third party payers under contractual agreements.
6. *Disposable Income:* Annual family income divided by 12 months, less monthly expenses as requested on the application in Attachment I.
7. *Family:* The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.
8. *Family Income:* Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, veterans benefits, training stipends, military allotments, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.
9. *Qualified Patient:*
 - a. *Financially Needy:* A person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the medical facility's eligibility criteria set forth in this policy.
 - b. *Medically Needy:* A patient who does not qualify as financially needy, but whose medical or hospital bills, even after payment by third-party payers, exceed 50% of their gross income. The patient who incurs catastrophic medical expenses is classified as medically needy when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.

10. *Medically Necessary Service:* Any inpatient or outpatient hospital service that is covered by and considered to be medically necessary under Title XVIII of the federal Social Security Act. Medically necessary services do not include any of the following:
 - a. Non-medical services such as social, educational, and vocational services.
 - b. Cosmetic surgery.

B. Financial Assistance Guidelines and Eligibility Criteria (see PFS Department for current form)

- a. To be eligible for a 100 percent (100%) reduction from the patient portion of billed charges (i.e. full write-off) the patient's household income must be at or below 150 percent of the current Federal Poverty Guidelines. 150 percent (150%) of the Federal Poverty Guidelines represents an individual earning minimum wage.
- b. Patients with household income that exceeds 150 percent (150%) but is less than 300 percent (300%) of the Federal Poverty Guidelines will be eligible for a sliding scale discount of the patient portion of billed charges.
- c. Medically needy patient accounts will be considered on a case-by-case basis by the Financial Assistance Committee. The discounts to be applied will be based on a determination of what the family could reasonably be expected to pay, based on a review of current disposable income and expenses.
- d. Individuals who are deemed eligible by the State of Maryland to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall be deemed eligible for financial assistance at a level to be determined on a case-by-case basis by the Financial Assistance Committee.
- e. Financial assistance applications will be considered as long as an account is open or when a change in patient financial status is determined.
- f. After the financial assistance adjustment has been computed, the remaining balances will be treated in accordance with Patient Financial Services policies regarding self-pay balances. Payment terms will be established on the basis of a reasonable proportion of disposable income negotiated with the patient. No interest charges will accrue to the account balance while payments are being made. This also applies to payments made through a collection agency.

PROCEDURE:

A. Identification of Potentially Eligible Patients:

- Admitting
1. Where possible, prior to the admission of the patient, the Hospital will conduct a pre-admission interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission interview is not possible, this interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission, the Hospital's evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial interview, the following information should be gathered:
 - a) Routine and comprehensive demographic data.
 - b) Complete information regarding all existing third party coverage.
 2. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process.
 3. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.
- Dir., PFS
4. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Corporate Director of Patient Financial Services to make sure that no application for financial assistance was ever received. Prior to a summons being filed, the CFO's approval is required. Dimensions Healthcare System Facilities will not request body attachments from the court system for payment of an outstanding account; however it is recognized that the court system may take this action independently.

B. Determination of Eligibility:

- PFS
1. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the facility, or in the case of outpatients or emergency patients, a Patient Financial Services representative will mail a financial assistance application to the patient for completion. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the facility should take the required action to have a legal guardian/trustee appointed.
 2. Requests for financial assistance may be received from:
 - a. the patient or guarantor;
 - b. Church-sponsored programs;
 - c. physicians or other caregivers;
 - d. various intake department of the institutions;
 - e. administration;

- f. other approved programs that provide for primary care of indigent patients.
- 3. The patient should receive and complete a written application (Attachment I) and provide all supporting data required to verify eligibility.
- 4. In the evaluation of an application for financial assistance, a patient's total resources will be taken into account which will include, but not be limited to, analysis of assets (identified as those convertible to cash and unnecessary for the patient's daily living expense), family income and medical expenses. A credit report may be generated for the patient as well as for the purpose of identifying additional expense, obligations, assets and income to assist in developing a full understanding of the patients' financial circumstances.
- 5. If a patient qualifies as medically needy, then the application should be referred to the Financial Assistance Committee for review and determination.
- Dir., PFS 6. Approval for financial assistance for amounts up to \$50,000 should be approved by the Director of Patient Financial Services. Those greater than \$50,000 should be approved by the CFO.
- PFS 7. Upon completion of the application and submission of appropriate documentation, the Patient Financial Services representative will complete the Financial Assistance Worksheet (see PFS Department for current form). The information shall be forwarded to the Director of Patient Financial Services or their designee for determination. Financial assistance approval will be made in accordance with the guidelines and documented on the worksheet (see PFS Department for current form).
- 8. Accounts where patients are identified as medically needy or accounts where the collector or Director has identified special circumstances that affect the patient's eligibility for financial assistance will be referred to the Financial Assistance Committee for consideration and final determination. The Committee's review of accounts that do not clearly meet the criteria and the decisions and rationale for those decisions will be documented and maintained in the account file (see PFS Department for current form).
- 9. A record, paper or electronic, should be maintained reflecting authorization of financial assistance (see PFS Department for current form). These documents shall be kept for a period of seven (7) years.

C. Notification of Eligibility Determination:

- PFS 1. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides a reason(s) for denial will be provided, generally within thirty (30) days of

receipt of a complete application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.

- FAC
2. If a patient disagrees with the decision, the patient may request an appeal process in writing within seven (7) days of the denial. The Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within two (2) weeks, and reflect the organization's final and executive review.
 3. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any other healthcare bracket (i.e., Medicare, Medicaid, etc.). A note will be entered into the patient's account to suspend collection activity until the financial assistance process is complete. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.
 4. If the patient complies with a payment plan that has been agreed to by the Hospital, the Hospital shall not otherwise pursue collection action against the patient.
- Patient
5. If the patient has a change in their financial status, the patient should promptly notify Patient Financial Services. The patient may request and apply for financial assistance, or a change in their payment plan terms.

D. Availability of Policy:

- PFS
1. Every hospital, upon request, must provide any member of the public or state governmental entity a copy of its financial assistance policy.

E. Application Forms:

- PFS
1. Every hospital must make available, upon request by a member of the public, a copy of the application used by the Hospital to determine a patient's eligibility for financial assistance.

F. Monitoring and Reporting:

PFS 1. A financial assistance log from which periodic reports can be developed shall be maintained aside from any other required financial statements. Financial assistance logs will be maintained for a period of seven (7) years. At a minimum, the financial assistance logs are to include:

- a. account number,
- b. date of service,
- c. application mailed (y/n),
- d. application returned and complete (y/n),
- e. total charges,
- f. self-pay balances,
- g. amount of financial assistance approved,
- h. date financial assistance was approved.

2. The cost of financial assistance will be reported annually in the community Benefit Report. Financial will be reported as the cost of care provided (not charges) using the most recently audited Medicare cost report and the associated cost to charge ratio.

ORIGINATOR: Administration

APPROVAL:

G. T. Dunlop Ecker
President & Chief Executive Officer

Financial Assistance Program 200-41 (1/23/2008)

ATTACHMENT:

Application for Financial Assistance

MISSION, VISION, VALUES AND SERVICE PRIORITIES

MISSION

Our mission is to provide high quality and efficient healthcare services to preserve, restore and improve health status, in partnership with our community.

VISION

To be recognized as a premier regional healthcare system.

VALUES

Our values consistently show that Dimensions *CARES*. These values include:

- **Compassion** - We demonstrate care, concern and consideration for our patients, their families and each other. We take seriously our role as patient advocates. We strive to bring the “human touch” to all our interactions and help each other.
- **Accountability** - We take responsibility for our actions. We strive to achieve excellent results and accept responsibility for overcoming problems. We avoid blaming others. We never say “It’s not my job”. We are committed to honesty in words and actions.
- **Respect** - We treat all patients, visitors, and staff equally and with dignity. We show our respect by the courtesy we extend to everyone. We greet everyone politely and appropriately. We are forgiving of one another. We recognize the value, diversity and importance of each other, those we serve and the organization.
- **Excellence** - We show excellence in the way we strive to exceed expectations in everything we do. We demand competence and encourage professional and personal growth for every member of our healthcare team. We pursue excellence through teamwork, continuous improvement and prudent resource management.
- **Service** - We strive to do the “right thing” and ensure our actions are in line with our mission, vision and values. We are committed to understanding and meeting the needs and expectations of patients and customers.

SERVICE PRIORITIES

- **Safety** - We work to ensure that all employees, patients and visitors are protected from danger, risk or injury while on the premises of any Dimensions Healthcare System facility

DIMENSIONS HEALTHCARE SYSTEM

POLICY No. 200-24

APRIL 6, 2006

Page 2 of 2

- **Courtesy** - We strive to make each person we encounter feel important and respected. We pleasantly greet fellow employees, physicians, patients and visitors. We identify ourselves whether the encounter is in person or over the telephone.
- **Caring** - We empathize, show compassion and concern to those we encounter each day.
- **Efficiency** - We work collaborative and effectively, taking advantage of economies of scale when possible. We continually evaluate the effectiveness of procedures and processes.

APPROVED:

G. T. Dunlop Ecker
President/CEO

**Shady Grove Adventist Hospital
Community Benefits Report
For the Year Ended June 30, 2008**

Appendix 1

Gaps in Specialty Services - Community

Shady Grove Adventist Hospital has determined that there are gaps in the availability of coverage in the following specialties for our uninsured and underserved population:

Critical Care
ENT
Neurology
Neurosurgery
Obstetrics & Gynecology
Pediatrics
Urology

**Shady Grove Adventist Hospital
Community Benefits Report
For the Year Ended June 30, 2008**

Appendix 2

Charity Care Policy

Shady Grove Adventist Hospital informs patients of their eligibility for financial assistance under its charity care policy at several intervals. The Hospital's charity policy is clearly posted in the emergency room and inpatient admitting areas so that patients are aware that they can request financial assistance if they do not have the resources necessary for the total payment of their bill. If a patient requests a copy of the Hospital's charity policy at either the time of admission or discharge a copy of the charity policy will be provided to them.

If the Hospital determines at the time a patient is admitted that they do not have the financial means to pay for their services the patient is told that they can apply for financial assistance from the Hospital. If a patient is admitted without resolving how their bill will be paid a financial counselor will visit their room to discuss possible payment arrangements. If the financial counselor determines that the patient may be eligible for Medicaid an outside contractor experienced in qualifying patients for Medicaid will speak to the patient to determine if the patient qualifies for Medicaid or some other governmental program.

As self pay and other accounts are researched by representatives from the billing department after no payments or only partial payments have been received, the billing department will explain to the patients that financial assistance may be available if they do not have the financial means to pay their bill. If patients request financial assistance a copy of the Hospital's charity application will be sent to them.

The Hospital has started an initiative with the outside contractor experienced in qualifying patients for Medicaid to review potential emergency room patients who may qualify for Medicaid.

ADVENTIST HEALTH CARE, INC.
CORPORATE POLICY MANUAL

CHARITY CARE

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SCOPE:

A. The financial assistance policy applies to charges for medically necessary patient services that are rendered at one of the following facilities: Shady Grove Adventist Hospital, Washington Adventist Hospital, Potomac Ridge Behavioral Health, Hackettstown Community Hospital or Adventist Rehab Hospital of Maryland. A patient may apply for Financial Assistance at any time. Services not covered by the financial assistance policy:

1. Services not charged and billed by the hospital are not covered by this policy; i.e., private physician services.
2. Cosmetic, convenience and/or other hospital services, which are not medically necessary, are excluded from consideration as a free or discounted service.
3. Patients who qualify for County, State, Federal or other assistance programs are excluded from the Adventist HealthCare Financial Assistance Program to the extent that services would be provided under those programs.

B. Eligibility

The patient would be required to complete an application for Financial Assistance and be approved using established guidelines, completion of the “Income” and “Family Size” portions of the State Medicaid Application could be considered as “an application for Financial Assistance”. The application should expire six months from the effective date of its approval or denial-at which time the patient may reapply for Financial Assistance if their situation continues to merit assistance or changes so that they might qualify at that time.

This program provides free care to those most in need, based on Income and Family Size, i.e. individuals who have income that is less or equal to 100% of the federal poverty level with 0% patient responsibility. It also provides for a reduction of 90% to 20% for a patient whose income is 125% to 300% of federal poverty level. See attached Sliding Scale Chart.

C. Patient is deceased with no person designated as Executor, or no estate on file with the appropriate jurisdiction, write-off to Charity Care.

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- D.** Patient is from out of state with no means to pay, write-off to Charity Care.

- E.** Patient is residing in Maryland and has no assets or means to pay, write-off to Charity Care.

- F.** Patient is bankrupt and no means to pay the claim, write-off to Charity Care.

- G.** Patient has no address or social security number on file and we have no means of verifying assets, or patient is deemed homeless, write off to Charity Care.

- H.** Patient is denied for Medicaid but is not determined over-scaled, write off to Charity Care.

- I.** Patient is a participant of the Montgomery County Maternity Partnership Program but requiring services not covered under the program. Apply 100% Charity Care write off as patient is already qualified under the Montgomery County Program according to the Federal Poverty Guidelines.

BENEFITS:

Increase in uncompensated care for community residents. Decrease in bad debt placement of account with collection agency. Enhance community services by providing quality medical services regardless of patient's ability to pay.

PURPOSE:

To provide a systematic and equitable way to provide medical services to those who have medical need and lack adequate resources to pay for those services. To provide that service while recognizing the need to preserve the dignity of individuals in need of this assistance.

POLICY:

All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for charitable assistance. Printed public notification regarding the program will be made annually.

Each application for Financial Assistance will be reviewed based upon an assessment of the patient's and/or family's needs, income and financial resources. It is part of Adventist HealthCare's mission to provide necessary medical care to those who are unable to pay for that care. This policy requires patients to cooperate with and avail themselves of all available

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programs (including Medicaid, workers compensation, and other state and local programs) which might provide coverage for those services.

Each hospital's indigent care policy will be governed by their respective state's poverty guidelines and will become part of this policy as attachments.

PROCEDURE:

A. **Financial Counselor, registration and Patient Communication staff** should be thoroughly familiar with the availability of charitable assistance and the criteria for such assistance.

B. All inpatient self-pays are to be referred to vendor by the Admitting Office to complete the Medicaid application.

C. Once the patient/guarantor submits an application to Patient Financial Services, providing, at a minimum, information regarding the patient's income level, the **Customer Service Supervisor or Lead** will take the following actions:

1. Determine probable eligibility within two business days of the initial request.
2. Review application to ensure that all remaining information is complete and, if necessary, contact patient/guarantor specifying what information is still needed.
3. If the patient/guarantor is deemed overscale according to the federal poverty guideline, then a denial letter will be sent to the patient/guarantor specifying that they are overscale per the Federal Poverty Guidelines.
4. If the patient/guarantor qualifies according to their income, the C/Svc. Sup./Lead will review the patient accounting system to identify all of the patient or guarantor's accounts for patient responsibility balances.
5. Accounts still outstanding with the patient/guarantor's insurance carrier for payment will be held until the insurance either makes payment or denies, it will then be processed according to policy for Financial Assistance.

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6. The Sup./Lead will then complete the adjustment form.
Using the charity adjustment code, 23001, or 33001 if the account is in collections, and document the account using the following activity codes:
 - a. CHDN-charity denied-required more info
 - b. CHLT-charity approval sent to patient.
 - c. CHWO-charity write off approved

7. The Sup./Lead will notify any agencies who hold accounts for the patient/guarantor that they have been given Financial Assistance, outlining if there is any patient/guarantor responsibility.

8. The application will then be forwarded to imaging to be scanned into the patient folder.

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**ADVENTIST HEALTHCARE
NOTICE OF AVAILABILITY OF UNCOMPENSATED CARE**

Shady Grove Adventist, Potomac Ridge Behavioral Health System, Washington Adventist Hospital, Hackettstown Community Hospital and Adventist Rehab Hospital of Maryland will make available a reasonable amount of health care without charge to persons eligible under Community Services Administration guidelines. Uncompensated services are available to patients whose family income does not exceed the limits designed by the Income Poverty Guidelines established by the Community Services Administration. The current income requirements are the following. If your income is not more than twice these amounts, you may qualify for uncompensated services.

Each hospital's indigent care policy will be governed by their respective state's poverty guidelines and will become part of this policy as attachments.

2007 Poverty Guidelines

<u>Size of Family Unit</u>	<u>Guideline</u>
1 _____	\$10,210
2 _____	\$13,690
3 _____	\$17,170
4 _____	\$20,650
5 _____	\$24,130
6 _____	\$27,610
7 _____	\$31,090
8 _____	\$34,570

Note: The guidelines increase \$3,480 for each additional family member.

If you feel you may be eligible for uncompensated services and wish to request them, please obtain an application for Community Charity Care from the Admissions Office or by calling (301) 315-3660. A written determination of your eligibility will be made within thirty working days of your request.

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Expenses :

Rent / mortgage _____

Food _____

Transportation _____

Utilities _____

Health Insurance premiums _____

Medical expenses not covered by insurance _____

 Doctor: _____

 Hospital: _____

TOTAL: _____

I hereby certify that to the best of my knowledge and belief, the information listed on this statement is true and represents a complete statement of my family size and income for the time period indicated.

Signed: _____ **Date:** _____

Return Application To:

Adventist HealthCare
Patient Financial Services
Attn: Customer Service Supervisor
1801 Research Blvd, Suite 300
Rockville, Maryland 20850

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	100%	\$10,210	100% ALLOWANCE	0%
2	100%	\$13,690	100% ALLOWANCE	0%
3	100%	\$17,170	100% ALLOWANCE	0%
4	100%	\$20,650	100% ALLOWANCE	0%
5	100%	\$24,130	100% ALLOWANCE	0%
6	100%	\$27,610	100% ALLOWANCE	0%
7	100%	\$31,090	100% ALLOWANCE	0%
8	100%	\$34,570	100% ALLOWANCE	0%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	125%	\$12,762	90% ALLOWANCE	10%
2	125%	\$17,112	90% ALLOWANCE	10%
3	125%	\$21,462	90% ALLOWANCE	10%
4	125%	\$25,812	90% ALLOWANCE	10%
5	125%	\$30,162	90% ALLOWANCE	10%
6	125%	\$34,512	90% ALLOWANCE	10%
7	125%	\$38,862	90% ALLOWANCE	10%
8	125%	\$43,212	90% ALLOWANCE	10%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	150%	\$15,315	80% ALLOWANCE	20%
2	150%	\$20,535	80% ALLOWANCE	20%
3	150%	\$25,755	80% ALLOWANCE	20%
4	150%	\$30,975	80% ALLOWANCE	20%
5	150%	\$36,195	80% ALLOWANCE	20%
6	150%	\$41,415	80% ALLOWANCE	20%
7	150%	\$46,635	80% ALLOWANCE	20%
8	150%	\$51,855	80% ALLOWANCE	20%

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	175%	\$17,867	70% ALLOWANCE	30%
2	175%	\$23,957	70% ALLOWANCE	30%
3	175%	\$30,047	70% ALLOWANCE	30%
4	175%	\$36,137	70% ALLOWANCE	30%
5	175%	\$36,195	70% ALLOWANCE	30%
6	175%	\$48,317	70% ALLOWANCE	30%
7	175%	\$54,407	70% ALLOWANCE	30%
8	175%	\$60,497	70% ALLOWANCE	30%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	200%	\$20,420	60% ALLOWANCE	40%
2	200%	\$27,380	60% ALLOWANCE	40%
3	200%	\$34,340	60% ALLOWANCE	40%
4	200%	\$41,300	60% ALLOWANCE	40%
5	200%	\$48,260	60% ALLOWANCE	40%
6	200%	\$55,220	60% ALLOWANCE	40%
7	200%	\$62,180	60% ALLOWANCE	40%
8	200%	\$69,140	60% ALLOWANCE	40%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	225%	\$22,972	50% ALLOWANCE	50%
2	225%	\$30,802	50% ALLOWANCE	50%
3	225%	\$38,632	50% ALLOWANCE	50%
4	225%	\$46,462	50% ALLOWANCE	50%
5	225%	\$54,292	50% ALLOWANCE	50%
6	225%	\$55,220	50% ALLOWANCE	50%
7	225%	\$69,952	50% ALLOWANCE	50%
8	225%	\$77,782	50% ALLOWANCE	50%

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	250%	\$25,525	40% ALLOWANCE	60%
2	250%	\$34,225	40% ALLOWANCE	60%
3	250%	\$42,925	40% ALLOWANCE	60%
4	250%	\$51,625	40% ALLOWANCE	60%
5	250%	\$60,325	40% ALLOWANCE	60%
6	250%	\$69,025	40% ALLOWANCE	60%
7	250%	\$77,725	40% ALLOWANCE	60%
8	250%	\$86,425	40% ALLOWANCE	60%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	275%	\$28,077	30% ALLOWANCE	70%
2	275%	\$37,647	30% ALLOWANCE	70%
3	275%	\$47,217	30% ALLOWANCE	70%
4	275%	\$56,787	30% ALLOWANCE	70%
5	275%	\$66,357	30% ALLOWANCE	70%
6	275%	\$75,927	30% ALLOWANCE	70%
7	275%	\$85,497	30% ALLOWANCE	70%
8	275%	\$95,067	30% ALLOWANCE	70%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	300%	\$30,630	20% ALLOWANCE	80%
2	300%	\$41,070	20% ALLOWANCE	80%
3	300%	\$51,510	20% ALLOWANCE	80%
4	300%	\$91,950	20% ALLOWANCE	80%
5	300%	\$72,390	20% ALLOWANCE	80%
6	300%	\$82,830	20% ALLOWANCE	80%
7	300%	\$93,270	20% ALLOWANCE	80%
8	300%	\$103,710	20% ALLOWANCE	80%

**Shady Grove Adventist Hospital
Community Benefits Report
For the Year Ended June 30, 2008**

Appendix 4 – Description of Hospital’s Missions, Vision, and Value statement

Shady Grove Adventist Hospital’s Missions, Vision, and Value statement was developed based on the following five concepts:

1. **Respect:** Recognize the infinite worth of each individual and care for each individual as a whole person.
2. **Integrity-** Be above reproach in all that we do.
3. **Service:** Provide compassionate and attentive care in a manner that inspires confidence.
4. **Excellence:** Provide world class clinical outcomes in an environment that is safe for both our patients and our caregivers.
5. **Stewardship:** Take personal responsibility for the efficient and effective accomplishment of our mission.

The overriding goal of our organization is to manage our staff and operations applying these concepts on a daily basis with no exceptions.

Community Benefit Report for Fiscal Year 2008

Sinai Hospital of Baltimore

Description of Gaps in Availability of Specialist Providers for Uninsured

As a teaching hospital with its own accredited, non-university-affiliated residency training programs, Sinai Hospital employs a faculty of 140 physicians in several specialties including Ophthalmology, Cardiac Surgery, Obstetrics and Gynecology, Pediatrics, and so forth. Faculty physicians provide services to patients through a faculty practice plan. When patients request appointments in the faculty practice offices, they are not screened on their ability to pay for services. Physician fees for uninsured patients are determined on a sliding scale based on income. Fees may be waived if a patient has no financial resources nor health insurance.

Additionally, in those specialties in which the hospital does not have a faculty, such as Dentistry, Otolaryngology, Vascular and Neuro-surgery, we employ specialists in order to provide continuous care for patients admitted to the hospital through the Emergency Department. In these cases the hospital covers these specialists' consultation fees and fees for procedures for all indigent patients.

Because of these two arrangements for providing specialty care for uninsured patients, we are not able to document gaps in specialist care for uninsured patients.

SINAI HOSPITAL OF BALTIMORE

Hospital Administrative Policy Manual

CHARITY CARE

PURPOSE

To assist patients who do not qualify for Financial Assistance from State, County or Federal Agencies but may qualify for uncompensated care under Federal Poverty Guidelines.

POLICY

To provide charity care applications to patients needing financial assistance for their hospital bill. Qualifications are based on gross income and family size according to Federal Poverty Guidelines.

Charity care information is made available to the public through multiple sources including: 1) the admission packet, 2) signage located in Admitting, the Emergency Room, and Patient Accounting, 3) registration and patient accounting staff, and 4) an annual notice in a local newspaper.

Original Date: 7/92
Revised Date: 9/96, 5/98, 9/01, 12/02, 8/04
Review Date: 6/96

Neil M. Meltzer
President/Chief Operating Officer

Date

Charles Orlando
Senior Vice President/CFO

Date

SOURCES:

CROSS REFERENCES:

COLLABORATOR(S):

IMPLEMENTATION PROCEDURES

Implementation procedures are different for non-emergent and emergent services.

A. Unplanned, Emergent Services and Continuing Care Admissions

1. Unplanned and Emergent Services are defined as admissions through the emergency room. Continuing care admissions are defined as admissions related to the same diagnosis/treatment as a prior admission for the patient.
2. Patients who believe they will not be able to meet their financial responsibility for services received at Sinai Hospital will be referred to a Patient Financial Advisor or Collection Liaison in Patient Financial Services.
3. For inpatient visits the Patient Financial Advisor or Collection Liaison will work with the Medical Assistance Coordinator to determine if the patient is eligible for Medical Assistance. They will gather information from the patient to make this determination. The Patient Financial Advisor or Medical Assistance Coordinator will determine probable eligibility within 10 business days.
4. If the patient does not qualify for Medical Assistance the Patient Financial Advisor or Collection Liaison will determine if the patient has financial resources to pay for their services based on the Federal Poverty Guidelines.
5. If the patient does have the financial resources according to the guidelines, the Patient Financial Advisor or Collection Liaison will arrange for payment from the patient according to Sinai's payment arrangement guidelines.
6. If the patient does not have the financial resources according to the guidelines, the Patient Financial Advisor or Collection Liaison will assist the patient with the charity application process.
7. The patient will complete the Charity Application and provide the Patient Financial Advisor or the Collection Liaison documented proof of income. At least one of the items below is required.
 - a. Patient's last paycheck stub.
 - b. A copy of the prior year's tax statement or W-2 form.
 - c. Verification of income with employer via telephone.
 - d. Verification of other household income, i.e. Social Security Award Letter, retirement/pension payment, etc.
8. An updated application must be completed every six months.
9. Applications with required attachments must be completed, dated and signed by the applicant.

10. Charity care is based upon the Federal Poverty Guidelines published in the Federal Register. The poverty levels are revised annually. Patients with an annual income up to 200% of the Federal Poverty Level may have 100% of their medical bill covered by charity.
11. Patients slightly above 200% annual income are able to have a portion of their medical bill covered by charity based on a sliding scale. The charity amount is determined by a calculation:
 - ❖ Identify the annual income based on the income tax form or W-2 (A)
 - ❖ Identify 200% of the Federal Poverty Level for the patient based on household size (B).
 - ❖ Subtract B from A. This is the maximum amount for which the patient would be responsible (C).
 - ❖ Subtract C from the patient liability on the bill. This is the charity amount.
- 12 The Director of Patient Financial Services or his/her designee approves or denies the application.
- 13 Patients will receive charity eligibility or denial in writing within two business days from receipt of completed form.

B. Planned, Non-Emergent Services

1. Prior to an admission, the physician's office or hospital scheduler will determine if a patient has medical insurance. If the patient does not have medical insurance, the physician's office or hospital scheduler will call a Patient Financial Advisor (PFA) in Admitting. The PFA will work with the Medical Assistance Coordinator to determine if the patient is eligible for Medical Assistance. The PFA will determine probable eligibility within 10 business days.
2. The Patient Financial Advisor will obtain information from the patient to determine Medical Assistance eligibility. If the patient qualifies, the appointment will be confirmed and the patient will receive service as scheduled.
3. If the patient is scheduled for service before Medical Assistance eligibility can be determined, the Patient Financial Advisor will contact the physician's office to postpone the service. If the physician does not want to postpone the service, the PFA will inform the physician that the Vice President of Finance will determine whether the case will be postponed, provided, or denied. The Vice President of Finance will contact the physician regarding the case. The Vice President of Finance will review the case, including clinical and financial information, business impact, and location of the patient's residence in determining whether charity should be provided. Final determination will be made on a case-by-case basis.
4. If the patient does not qualify for Medical Assistance, the Patient Financial Advisor will determine a charge estimate for the services. The PFA will contact the patient for payment.
5. For planned, non-emergent services, self pay patients who are United States citizens must pay at least 50% of estimated charges prior to service, with an agreement to pay the remaining 50% within two years. For patients who are not United States citizens, 100% of the estimated charges must be paid prior to service.

6. If an agreement is made, the patient must bring payment three (3) business days prior to service, and sign the Sinai Hospital Self Pay Agreement form. If the patient has the financial resources according to the Federal Poverty Guidelines, but does not pay the money prior to service or sign the agreement form, the Patient Financial Advisor will contact the doctor's office to request that the planned visit is cancelled due to insufficient payment.
7. If there are extenuating circumstances regarding the patient, the patient's clinical condition, or the patient's financial condition, the patient or the physician may seek an exception from the Vice President of Finance. If an exception is requested, the Patient Financial Advisor will gather documented proof of income as stated in the emergent section of this procedure. The Vice President of Finance will review the case, including clinical and financial information, business impact, and location of the patient's residence in determining whether charity should be provided. Final determination will be made on a case-by-case basis.

Sinai Hospital of Baltimore
Mission Statement

Sinai Hospital of Baltimore provides a broad array of high quality, cost effective health and health related services to the people of Greater Baltimore. Central to its role is the provision of undergraduate and graduate medical education and educational programs to other health professionals, employees, and the community at large.

As an organization founded and supported by the Jewish community, it carries out its mission with sensitivity to the needs of Jewish patients and staff, and asserts traditional Jewish values of excellence, compassion and community concern for all.

October, 1992



SOUTHERN MARYLAND HOSPITAL CENTER
7503 SURRETT'S ROAD • CLINTON, MARYLAND 20735 • (301) 868-8000

December 31, 2008

Mr. Robert Murray, Executive Director
Health Systems Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Community Benefit Report

Dear Mr.  Murray:

Attached is the community benefit report for Southern Maryland Hospital. While the hospital is the only taxable hospital in the state, we choose to file the report in order to show the community benefits provided in addition to the taxes paid.

Southern Maryland Hospital for the fiscal year 2007-8, is licensed for 257 beds under the Maryland regulatory system and the total physical capacity is 340 beds. For the Fiscal Year ending 6-30-08 there have been 19,468 admissions to the facility and well over 100,000 outpatient visits such as emergency room visits, outpatient surgeries, and other types of one-day services.

Southern Maryland Hospital Center is located in Clinton, Maryland. A detailed set of maps and charts in **Appendix A** graphically depict characteristics of the population served by the Hospital accompanied by projected growth estimates by the year 2011 within the Hospital's primary service area based on zip code assessment, and summarized as follows:

- Based on 2006 resource data, the estimated population within the Hospital's service area is 351,638 and is expected to increase 6% by 2011. As reported by the Prince George's County government, in the estimated overall census for 2005, there were 846,123 people, 286,610 households, and 198,047 families residing in the county.
- Among the highest growing segments within this population, it is estimated females aged 35+ will represent 11% growth, adults age 65+ will grow 32%, and those in the age category 45 – 65 (a.k.a. the so called "baby boomer" generation) will grow 14%.
- With respect to the demographic make-up of the Hospital's service area, 97% is non-Hispanic and 3% Hispanic. Segments within the non-Hispanic population are African-American 73%, Caucasian 21%, Asian 3%, other 3%.

- Prince George's County statistics reveal the median income for a household in the county was \$55,256, and the median income for a family was \$62,467. Males had a median income of \$38,904 versus \$35,718 for females. The per capita income for the county was \$23,360. About 5.30% of families and 7.70% of the population were below the poverty line including 9.20% of those under age 18 and 6.90% of those age 65 or over. Southern Maryland Hospital Center has rendered services to **5.7% of our patient population that are self pay and have no insurance and 14.6% with Medicaid or Medicaid-MCO.**

Responsive to the HSCRC request for a written description of gaps in availability of specialist providers to serve the uninsured in the community, the following perspective is provided:

Over a period of several years, various medical specialty practitioners as well as primary care physicians on the active medical staff within our service areas, gradually began to notify the hospital that they would no longer be able to participate in emergency room call coverage for their specialty or continue to directly admit patients to the hospital. Researching the dynamics of this experience with other hospitals in our region, we found our situation was clearly not unique with respect to gaps in coverage from the available pool of providers that could potentially be drawn upon to serve the uninsured and underinsured in the community.

It also became apparent that the solution other facilities gravitated to out of necessity, was to essentially "underwrite" the cost for these provider services, that would in effect subsidize the medical specialist for attending to "no pay," or "limited pay," patients. The medical specialists we are reporting are also those in which, by virtue of their area of specialization, there tends to be a higher incidence of "no pay," or "limited pay" patient encounters.

For the specialties of Obstetrics and Gynecology, Pediatrics and Neonatology, Orthopedics, Neurosurgery, and Primary Care, the hospital found that these independent medical groups encountered the most consistent trend in which their patient encounters had the potential of leading to no reimbursement or minimal reimbursement for services provided. The hospital quickly came to the realization that these specialty services were critical to the continued operation of this facility as an acute care hospital offering immediate access to the full range of acute care services responsive to the needs of all segments of the patient population we serve. Measured steps have been undertaken by the hospital to mitigate gaps in provider coverage:

1. Hospitalist physicians: the hospital was proactive years ago in responding to a recognized need for attending to unassigned Emergency Room admissions many of whom were among the uninsured within the community. Staff physician's employed by the hospital within this group are available on a 24/7 basis fulfilling a pivotal role in filling gaps in coverage for primary care.
2. Anesthesia: Likewise, an internal staffing model was created for anesthesia to assure optimal 24/7 obstetrical coverage.

3. Emergency Medicine: The hospital established an Emergency Medical three years ago and is employed and managed by the hospital.
4. Obstetrics and perinatology: The hospital employs and managed obstetrical practitioners and neonatologists.
5. The hospital underwrites specialty coverage for *Orthopedics* and *Neurosurgery* from local providers 24/7.

Also attached are Appendix B, a description of our charity care policy, Appendix C, a copy of the charity care policy, and Appendix D, the hospital's mission statement.

If you need additional information, please contact me at (301) 877-5527.

Sincerely,

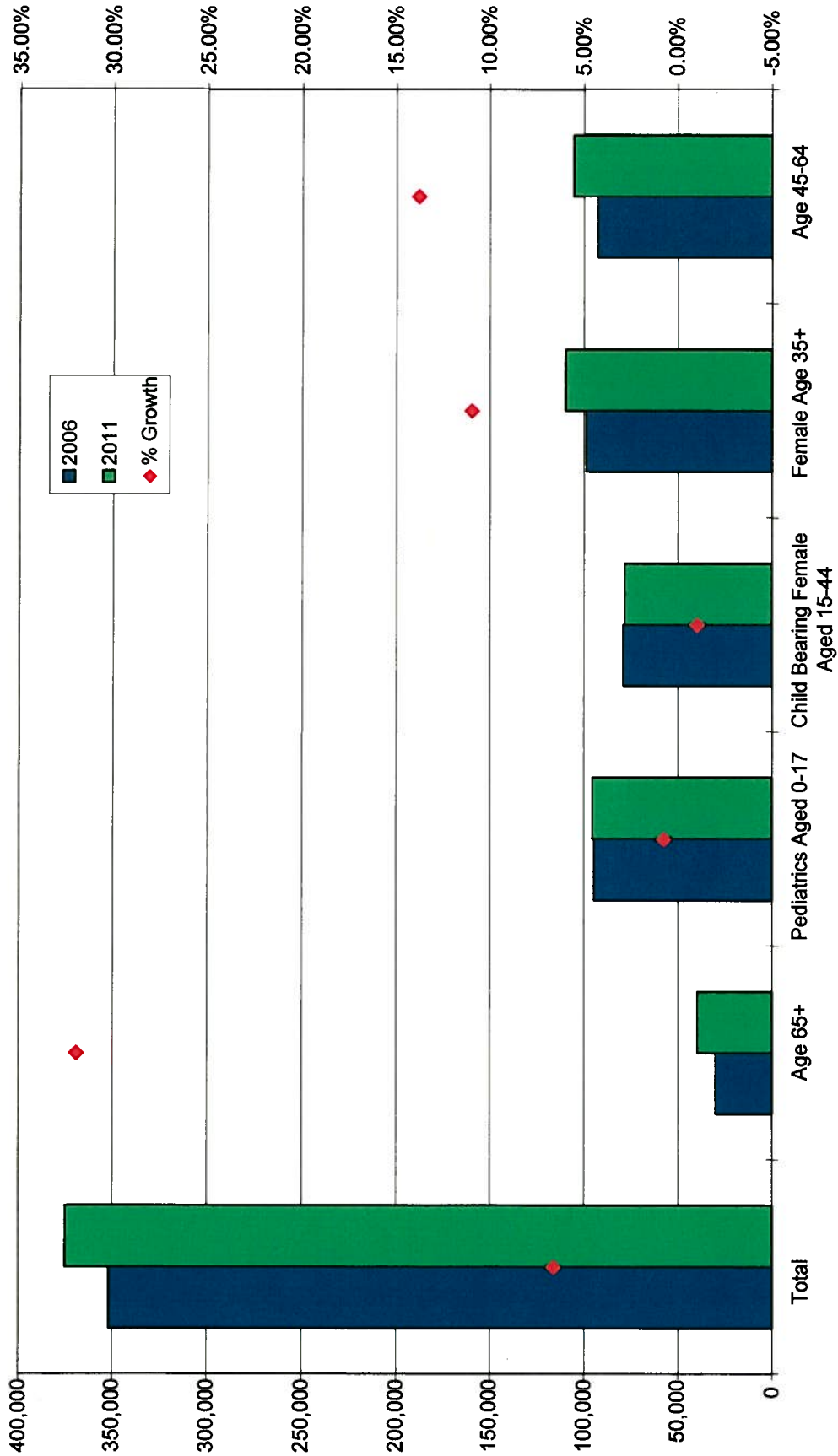


Charles R. Stewart
Vice President of Business, Finance, and Corporate Compliance

Attachments

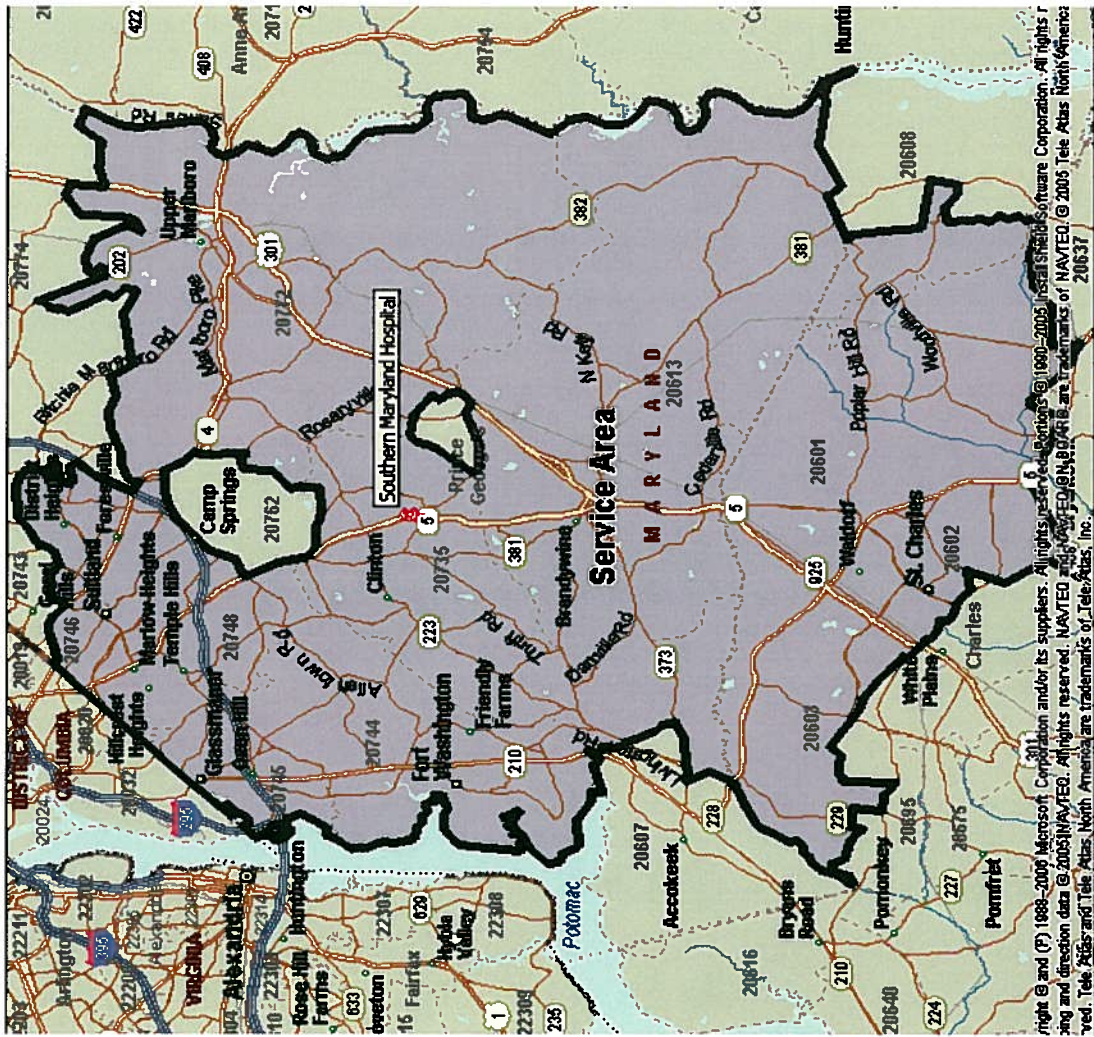
APPENDIX A

Southern Maryland Hospital Center Service Area Demographics—Population



Southern Maryland Hospital Center Primary Service Area by Zip Code

ZIP CODE	CITY	COUNTY	STATE
20601	Waldorf	Charles	MD
20602	Waldorf	Charles	MD
20603	Waldorf	Charles	MD
20613	Brandywine	Prince George's	MD
20735	Clinton	Prince George's	MD
20744	Fort Washington	Prince George's	MD
20745	Oxon Hill	Prince George's	MD
20746	Suitland	Prince George's	MD
20747	District Heights	Prince George's	MD
20748	Temple Hills	Prince George's	MD
20772	Upper Marlboro	Prince George's	MD



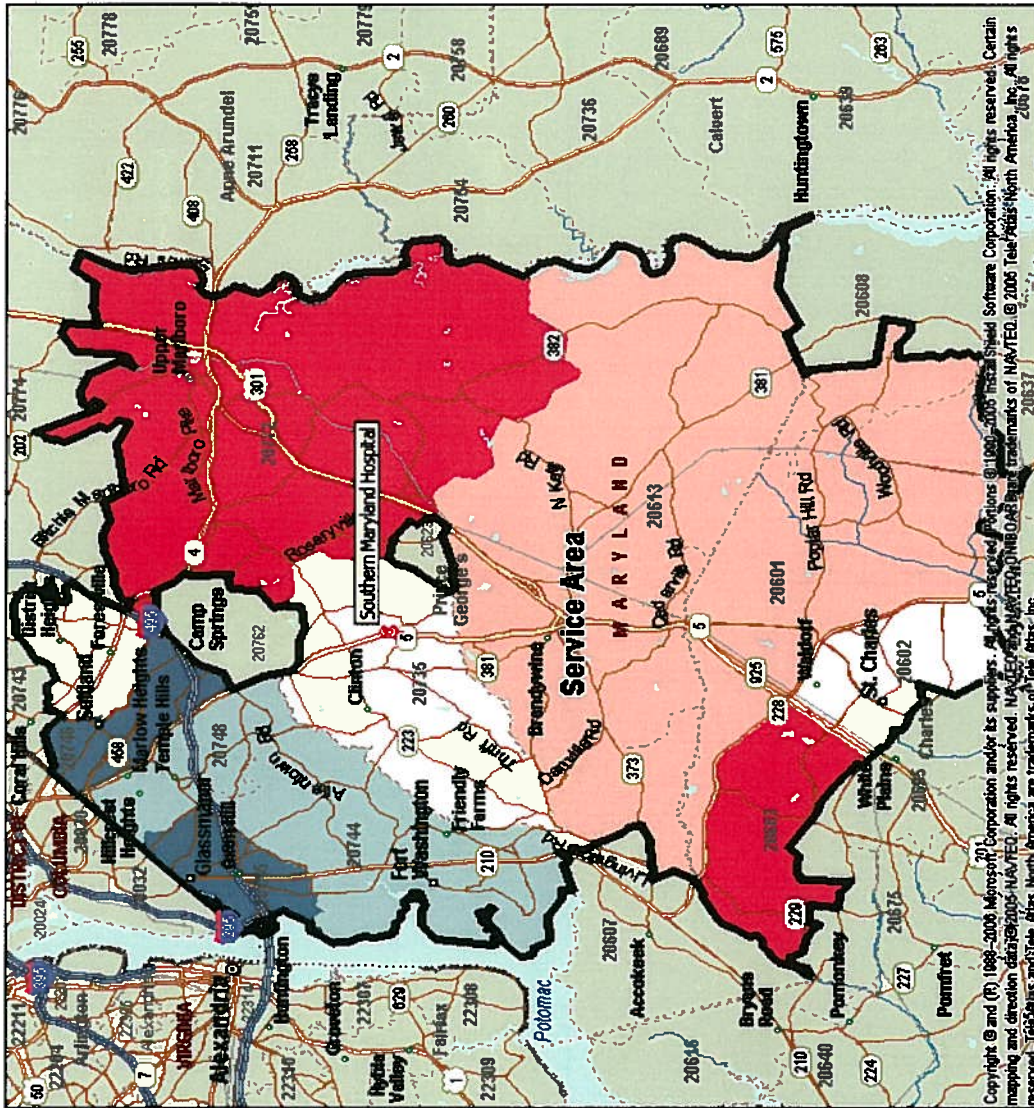
APPENDIX A

Southern Maryland Hospital Center Primary Service Area by Demographics

Population	2006	2011	% Growth
Total	351,638	374,943	6.63%
Age 65+	29,928	39,475	31.90%
Pediatrics Aged 0-17	94,848	95,558	0.75%
Female Aged 15-44	79,053	78,238	-1.03%
Female Pop 35+	98,768	109,607	10.97%
Male/Female Aged 45-64	92,604	105,379	13.80%

APPENDIX A

Southern Maryland Hospital Center Demographics (Zip Code Detail)



ZIP CODE	2006	2011	5-Yr % Growth
20603	26,166	30,582	16.9%
20772	41,587	47,048	13.1%
20601	25,159	27,680	10.0%
20613	9,423	10,206	8.3%
20735	35,819	38,136	6.5%
20747	41,543	43,563	4.9%
20602	22,538	23,618	4.8%
20744	50,793	53,047	4.4%
20748	41,458	42,773	3.2%
20746	29,138	29,875	2.5%
20745	28,014	28,415	1.4%
Totals	351,638	374,943	6.6%

APPENDIX A

Southern Maryland Hospital Center Population by Zip Code – Chart A

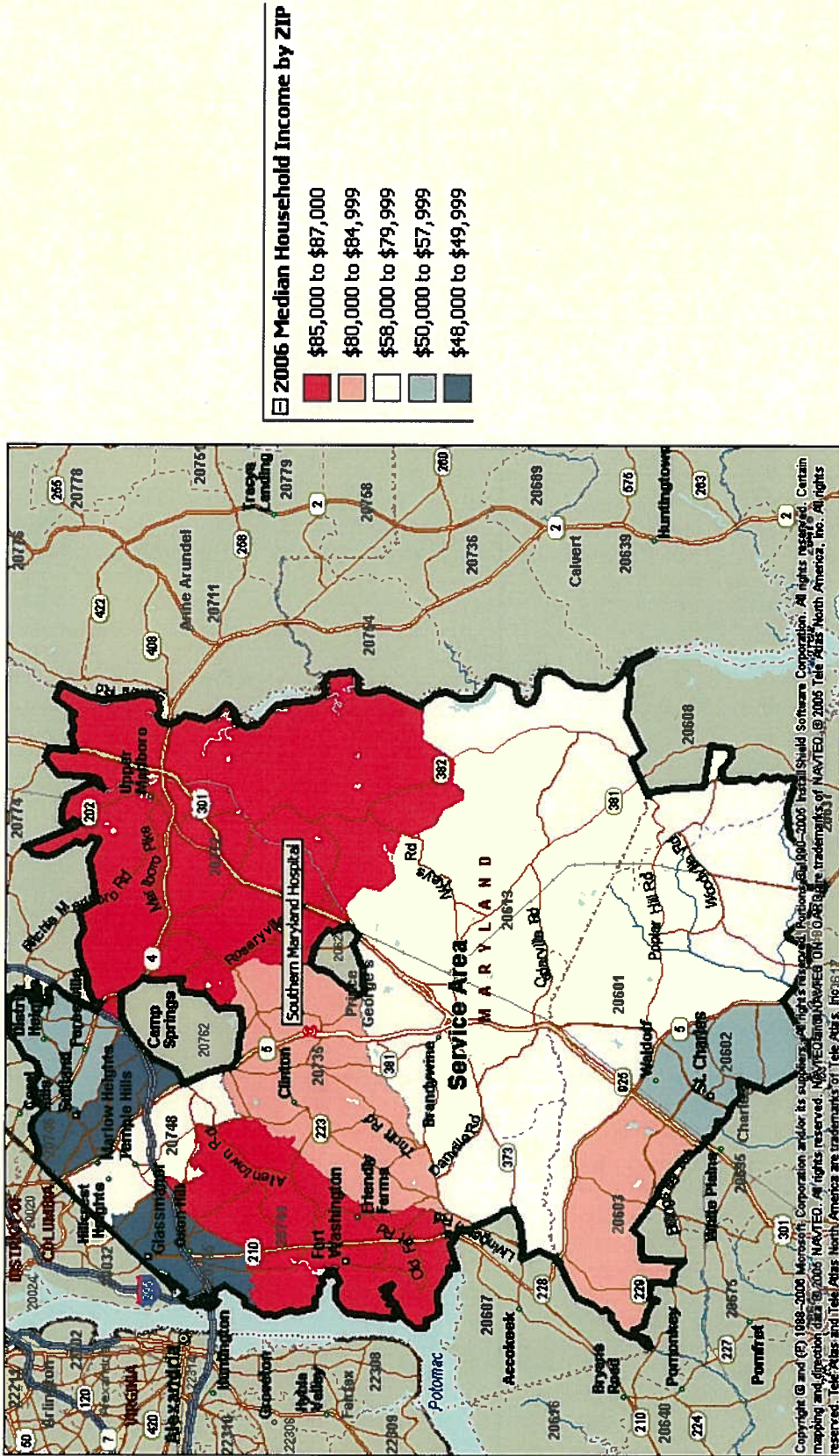
Service Area	Total			Age 65+			Age 0-17		
	2006	2011	5-Yr. Growth	2006	2011	5-Yr. Growth	2006	2011	5-Yr. Growth
20601	25,159	27,680	10.02%	1,620	2,375	46.60%	6,863	6,921	0.85%
20602	22,538	23,618	4.79%	1,561	2,012	28.89%	6,415	6,264	-2.35%
20603	26,166	30,582	16.88%	1,215	1,893	55.80%	7,928	8,594	8.40%
20613	9,423	10,206	8.31%	1,152	1,438	24.83%	2,413	2,477	2.65%
20735	35,819	38,136	6.47%	3,616	4,788	32.41%	9,211	9,120	-0.99%
20744	50,793	53,047	4.44%	5,266	6,926	31.52%	12,126	11,810	-2.61%
20745	28,014	28,415	1.43%	2,276	2,877	26.41%	8,006	7,805	-2.51%
20746	29,138	29,875	2.53%	2,270	2,823	24.36%	8,556	8,443	-1.32%
20747	41,543	43,563	4.86%	3,119	4,094	31.26%	11,980	11,860	-1.00%
20748	41,458	42,773	3.17%	4,495	5,413	20.42%	10,538	10,442	-0.91%
20772	41,587	47,048	13.13%	3,338	4,836	44.88%	10,812	11,822	9.34%
Totals	351,638	374,943	6.63%	29,928	39,475	31.90%	94,848	95,558	0.75%

APPENDIX A

Southern Maryland Hospital Center Population by Zip Code – Chart B

Service Area	Age 15-44 Female				Age 35+ Female				Age 45-64					
	Child Bearing Years								Baby Boomers"					
	2006	2011	5-Yr. Growth	2006	2011	5-Yr. Growth	2006	2011	5-Yr. Growth	2006	2011	5-Yr. Growth	2006	2011
20601	6,034	6,174	2.32%	6,418	7,505	16.94%	6,258	7,661	22.42%					
20602	5,458	5,338	-2.20%	5,674	6,304	11.10%	5,144	6,055	17.71%					
20603	6,446	6,958	7.94%	6,441	8,005	24.28%	6,015	8,283	37.71%					
20613	1,730	1,735	0.29%	2,791	3,030	8.56%	2,777	3,181	14.55%					
20735	7,442	7,311	-1.76%	10,894	11,778	8.11%	10,487	11,699	11.56%					
20744	10,205	9,975	-2.25%	15,485	16,544	6.84%	16,161	17,050	5.50%					
20745	6,503	6,166	-5.18%	7,551	8,083	7.05%	6,885	7,300	6.03%					
20746	7,043	6,719	-4.60%	7,910	8,646	9.30%	6,669	7,345	10.14%					
20747	10,064	9,721	-3.41%	11,520	12,677	10.04%	10,012	11,433	14.19%					
20748	9,035	8,717	-3.52%	12,478	13,421	7.56%	11,020	11,818	7.24%					
20772	9,093	9,424	3.64%	11,606	13,614	17.30%	11,176	13,554	21.28%					
Totals	79,053	78,238	-1.03%	98,768	109,607	10.97%	92,604	105,379	13.80%					

Southern Maryland Hospital Center Service Area Median Household Income



The Financial Assistance Policy for Southern Maryland Hospital Center is attached as Appendix C. This policy is posted in all the admission areas of the hospital as well as in of the emergency room. While a copy the policy is not routinely provided to the patient at registration, at any point in the patient process, from registration to final payment of the bill, a patient may indicate a need for financial assistance. At that point in the process the patient or guarantor is given a copy of our financial assistance policy and the application for financial assistance. Upon completion of the application and submission of the requested information, a determination of the amount of assistance is made according to the attached policy. During the registration process, depending on the type of services to be provided, a hospital representative may speak with the patient or guarantor about other state or federal programs to assist with payment.

Southern Maryland Hospital, Inc. Policy and Procedure Manual Department of Collections		Subject: Financial Assistance Number: 12	
Original Date: 5/93	Review Date(s): 12/98	Revision Date(s): 6/02, 12/04, 3/08	Page: 1 of 4
Departments Involved: Collections, Out-Patient Services, Emergency Room and Admitting			
<p><u>Purpose:</u> To help facilitate medical care to persons regardless of their age, sex, race, color, national origin, creed, religion, sexual orientation, physical handicap or financial ability to pay for services.</p> <p><u>Procedure:</u> If a patient/guarantor expresses the inability to pay for services based on lack of income or resources, the patient/guarantor may be offered consideration for a financial adjustment.</p> <p>An application for financial assistance must be completed and the appropriate documentation (as defined on the application) attached to be considered for a financial adjustment. The director of Collections must approve any exception to this requirement.</p> <p>One of the following conditions must be met or exist to be eligible to apply for financial assistance:</p> <ul style="list-style-type: none"> ➤ Patient/Guarantor whose income level is at or below the current Federal Poverty Guidelines as published in the Federal Register; ➤ Patient/Guarantor whose income level is above the current Federal Poverty Guidelines as published in the Federal Register, but whose financial profile indicates that expense related to the necessities of life (food, housing, utilities and medications) consume most or all of their income; ➤ No ownerships of real estate, other than primary residence; no ownership of stocks, bonds, and other assets that affects the net worth of patient/guarantor; ➤ Fixed income such as Social Security, retirement, or disability with no other sources of income; ➤ Medical expenses which exceed 50% of monthly income; ➤ Patient is homeless, whereby a Medical Assistance application cannot be completed; ➤ Patient is deceased with no estate on file. 			

Southern Maryland Hospital, Inc. Policy and Procedure Manual Department of Collections		Subject: Financial Assistance Number: 12	
Original Date: 5/93	Review Date(s): 12/98	Revision Date(s): 6/02, 12/04, 3/08	Page: 2 of 4
Departments Involved: Collections, Out-Patient Services, Emergency Room and Admitting			

A. Patient Registering In Admitting Office

1. Admitting Office representatives will refer any self-pay patient or responsible party, who demonstrates need, or has requested financial assistance, to the Medicaid facilitator. The Medicaid facilitator will then complete a medical assistance profile application and determine if the patient or responsible party may qualify for Medicaid.
2. Should the patient or responsible party be determined ineligible for Medicaid, the Medicaid facilitator will notify the Admitting Office and Collection Department.
3. Should the patient or responsible party demonstrate financial inability, a Financial Assistance Application can be completed and returned along with supporting documentation to apply for Financial Assistance through Southern Maryland Hospital Center.

B. Patients Registering In Out-Patient Services

1. Out-Patient Services representatives will refer any self-pay patients or responsible parties, who demonstrate need or have requested financial assistance to the Collections Department. The Collections Department representative will perform financial counseling to include providing a Financial Assistance Application. The patients will be informed that the application must be returned within thirty (30) days along with all required documents.

Southern Maryland Hospital, Inc. Policy and Procedure Manual Department of Collections		Subject: Financial Assistance Number: 12	
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Original Date: 5/93	Review Date(s): 12/98	Revision Date(s): 6/02, 12/04, 3/08	Page: 3 of 4
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Departments Involved: Collections, Out-Patient Services, Emergency Room and Admitting

C. Patients Registering In the Emergency Room

1. Emergency Room representatives must ensure that the patient or responsible party receives a copy of the Financial Assistance brochure and/or read the displayed signs. If the patient or responsible party does not have: Medicare, Medical Assistance benefits, commercial insurance, Workman's Comp, or any other insurance information at the time of registration, the Emergency Room representative will provide a Financial Assistance Application. If patient/responsible party requests it.

-
1. All Financial Assistance Applications and supporting documentation are then forwarded to the Collections Department Administrative Assistant or Supervisor to determine eligibility, after which they are directed to the Department Head for signature of approval or denial.
 2. The applicant is advised via letter or telephone call of approval or denial within two business days of review and any patient responsible portion of the bill.

The following formula is to be used to calculate the patient's responsibility:

Less Monthly HHS Poverty Guidelines (most current)	< _____ >
Gross Monthly Income Available	_____
Multiply by 0.92935	_____
Less Patient Monthly Expenses	< _____ >
**Patient Responsibility per Month	_____

Southern Maryland Hospital, Inc. Policy and Procedure Manual Department of Collections		Subject: Financial Assistance Number: 12	
Original Date: 5/93	Review Date(s): 12/98	Revision Date(s): 6/02, 12/04, 3/08	Page: 4 of 4
Departments Involved: Collections, Out-Patient Services, Emergency Room and Admitting			
<p>Total Amount of Patient's Bill _____</p> <p>Divide by a maximum of 18 monthly payments, if needed _____</p> <p>**If the patient responsibility is equal to or less than zero, then 100% of the balance is adjusted. If the patient's responsibility is less than the medical bill, the patient is only responsible for "Patient Responsibility" amount. The remaining balance of the bill should be adjusted. **</p> <p>The Department of Health and Human Services poverty guidelines represents the minimal income for the number of person's dependant on the income per Exhibit A, attached.</p> <p>3. All Financial Assistance write-offs under this policy shall be adjusted using the adjustment code "991-1001".</p> <p>4. Any patient responsibility will be due to Southern Maryland Hospital Center and paid no later than 18 months from the date of Financial Assistance approval. All eligible Financial Assistance applicants must have a signed contract on file with Southern Maryland Hospital Center for any balance due.</p> <p>NOTE: Non-U.S. citizens who travel to the U.S. primarily for the purpose of receiving medical services are not eligible for Financial Assistance.</p>			

Southern Maryland Hospital Center

Mission

Southern Maryland Hospital Center is a full-service, regional health care facility founded in 1977 to provide a complete range of inpatient, outpatient and community services for the residents of Southern Maryland. At SMHC, highly skilled health professionals efficiently deliver respectful and compassionate care using the most advanced medical technology.

Southern Maryland Hospital Center is a resource center seeking to prevent illness and promote health through education and screening. Our goal is to assist the residents of Southern Maryland in achieving the highest possible level of physical and mental health, and thereby improve the quality of life in our community.

Southern Maryland Hospital Center continuously evaluates all services and seeks to improve the delivery of care. Each SMHC employee, medical staff member and volunteer is motivated by an uncompromising commitment to quality as measured by the satisfaction of our patients and their families.

Values

The employees, medical staff and volunteers of Southern Maryland Hospital Center hold in common these values with respect to our patients and our professional relationships.

Quality - We perform each task to the best of our abilities and never cease to try to do better.

Respect - We acknowledge the dignity of every individual and appreciate the differences and uniqueness of each.

Integrity - We are forthright with our patients and each other and fulfill our tasks promptly, accurately, and completely.

Safety - We are committed to improving patient safety and reducing risks in the care environment for patients and others, including health care providers.

Flexibility - We continually adjust our methods to better serve our patients and we readily embrace change and new technology.

Efficiency - We manage our work so as to conserve resources and hold down the costs of health care without compromising patient care.

Confidentiality - We protect the rights of our patients and their families and safeguard their privacy.

Accountability - We accept responsibility for the results of our work and set aside personal interests for the good of our patients.

Physician ED Indigent Care Subsidy Summary – St. Agnes Hospital FY 2008

St. Agnes Hospital currently has the 4th-busiest Emergency Department (ED) in the state. Like many urban-based hospitals with significant ED volumes, a large proportion of the indigent and charity care provided by the hospital overall is generated through the ED. The increasing community need for indigent care coverage through the ED, coupled with declining physician reimbursement and greater malpractice exposure, has created greater “gaps” in the availability of specialist physicians to treat these patients. Consequently, mission-based hospitals like St. Agnes, with an imperative to care for the poor and underserved, feel a duty to respond to fill in these gaps.

Specifically, various surgical sub-specialty physicians who are not being compensated for their services to this at-risk community have sought assistance from the hospital, which receives at least a portion of their uncompensated care in rates. For FY08, this subsidy paid by the hospital for this coverage amounted to almost \$1.4 million, which was spread out over multiple physicians and specialties, including:

Specialty	Daily/Annual Stipend	Fee For Service Comp.
Hand Surgery	X	
Orthopedic Surgery	X	X
Thoracic Surgery	X	X
Vascular Surgery	X	X
Oral Surgery		X
ENT	X	
Plastic Surgery	X	
Urology	X	
Neurosurgery	X	
General Surgery	X	
Pediatric Surgery	X	

All of the above costs have been included in line “C5 – Physician ED Indigent Care Subsidies”.

In addition, St. Agnes further compensates specialist physicians for serving poor and vulnerable populations in our FQHC-based Community Clinic. These specialists include OB/GYN, G.I., and Oncology physicians, as well as Family Practice physicians. These portions have been included in line “C4 – Community Care Center”.

Communication of Saint Agnes Charity Care Policy – FY 2008

Information regarding Saint Agnes' charity care policy is displayed at all registration areas throughout Saint Agnes Hospital. In addition, brochures and flyers are displayed and available to the public that describe the policy. As part of the Corporate Responsibility Program (CRP) annual training for registration and billing personnel is conducted that includes knowledge of the organization's charity care policy. Finally, a public notice regarding the charity care policy is published annually in the *Baltimore Sun*.

<p align="center">St. Agnes HealthCare System Policy and Procedure Manual</p>	<p>Page: <u> 1 </u> of <u> 2 </u></p>	<p align="center">SYS FI 05</p>
<p>Subject: Charity Care (Financial Assistance Non-Elective)</p>	<p>Effective Date: 2/05</p>	
	<p>Reviewed: Revised:</p>	
<p>Approvals: Final - President/CEO: _____ Date: _____ Concurrence: _____ Date _____ <i>(Policies become operational 30 days after CEO signs.)</i></p>		

POLICY STATEMENT

It is the mission of St. Agnes HealthCare to provide healthcare services to the poor within the availability resources of St. Agnes HealthCare. This policy establishes criteria for evaluating the eligibility of patients for reductions in their bills based upon lack of financial resources and other criteria that may be established.

This policy applies to all non-elective services and procedures provided by St. Agnes HealthCare.

SCOPE

This policy applies to all entities of the St. Agnes HealthCare system.

PROCEDURE/RESPONSIBILITIES

Patients seeking financial assistance will be interviewed at the time of their request for financial assistance. Based on the information provided at the time of the interview, patients will be provided with a determination of probable eligibility within two business days of their request.

Eligibility Criteria

- Patients wishing to be considered for financial assistance must complete an application and provide, as necessary, supporting documentation required to verify financial resources. If an application or documentation is incomplete, an attempt may be made to confirm the patient's financial status and assistance eligibility through a credit bureau report. In such cases, any decision must be approved by the divisional patient accounts manager and corporate director of patient accounting, or the Seton Medical Group director of finance. Some patients initially qualify for financial assistance through the BMS clinic. The Hospital will accept the approved BMS financial assistance application for most outpatient services. However, patients who receive hospital, inpatient surgery, oncology, MRI or pet scan services will be required to complete the Hospital application process.
- Before St. Agnes financial assistance will be considered, all other possible external sources of payment must be exhausted. These include health insurance, Medicare, Medical Assistance, workers compensation, automobile insurance and other state, federal and private programs which may be available for this purpose.
- Patients who are currently eligible for Medical Assistance will qualify for financial assistance for balances after Medicaid payment.
- When an individual is determined to be eligible, all dependents of that individual

whose income and assets were considered in the original application are deemed to be eligible.

- Patients who have been approved for State Pharmacy Assistance will receive 100% charity care.
- A charity allowance is valid for six months or until there is a change in the financial resources of the applicant, whichever comes first.
- Individuals with liquid assets in excess of \$10,000 or families with liquid assets of more than \$25,000 are not eligible for financial assistance. Liquid Assets are defined as cash, checking accounts, savings accounts, stocks and bonds.
- Any self pay balance, regardless of the amount, is eligible for charity care determination.
- Any patient with an account balance of more than \$10,000 may request an individualized review of their financial situation. It is recognized that some patients may experience an unusual medical, financial, or humanitarian burden, but, based upon the criteria set forth in this policy, fail to qualify for charity care. In such cases, it is within the discretionary authority of St. Agnes HealthCare to waive the charity eligibility requirements and apply charity care, as it deems appropriate.
- Patients or families may appeal decisions regarding eligibility for financial assistance by contacting the Corporate Director of Patient Financial Services.

Sliding Scale

- Patients with income less than or equal to 200% of the Federal Poverty Level (FPL) will be eligible for 100% charity care write off of the charges for services.
- Patients with income above 200% of the FPL but not currently exceeding 300% of the FPL will receive a charity care write off based on a sliding scale. The sliding scale will be updated annually to reflect the current FPL as published in the Federal Register. Upper FPL limits may change at the discretion of hospital senior management.

Authorization Levels

Charity allowances in accordance with the policy require the following approvals:

Account Balance	Approval Authority
Up to \$499.99	Collection Representative or Financial Interviewer/Collection Supervisor
\$500.00 - \$4,999.99	Patient Accounts Director
\$5,000.00 - \$9,999.99	Patient Accounts Director Corporate Director of Patient Financial Services
\$10,000.00 and greater	Patient Accounts Director Corporate Director of Patient Financial Services Senior Vice President / CFO

CROSS REFERENCES:

Ascension Health System Policy 16: Billing and Collection for the Uninsured

<p align="center">St. Agnes HealthCare System Policy and Procedure Manual</p>	<p>Page: <u>1</u> of <u>1</u></p>	<p align="center">SYS FI 39</p>
<p>Subject: Charity Care (Financial Assistance- Elective Services)</p>	<p>Effective Date: 2/05</p>	
	<p>Reviewed: Revised: 7/07</p>	
<p>Approvals: Final - President/CEO: _____ Date: _____ Concurrence: _____ Date _____ <i>(Policies become operational 30 days after CEO signs.)</i></p>		

POLICY STATEMENT

It is the mission of St. Agnes HealthCare to provide healthcare services to the poor within the availability resources of St. Agnes HealthCare. This policy establishes criteria for evaluating the eligibility of patients for reductions in their bills based upon lack of financial resources and other criteria that may be established.

This policy applies to all elective services and procedures provided by St. Agnes HealthCare exclusive of cosmetic services which are not eligible for charity care.

SCOPE

This policy applies to all entities of the St. Agnes HealthCare system.

PROCEDURE/RESPONSIBILITIES

Financial assistance for elective services will be provided to qualified patients that live within our service area. Please refer to policy SYS FI 05 for eligibility criteria.

If a patient has prior bad debt history and does not qualify for financial assistance, up front cash payment will be required for elective services.

Financial assistance for patients that live outside of our service area and patients that are non-US citizens nor permanent residents will be limited to non-elective care and related follow up care. Up front cash payment will be required for elective services.

Patients, families, or physicians may appeal decision regarding eligibility for financial assistance by contacting the Corporate Director of Patient Financial Services. It is recognized that some patients may experience an unusual medical, financial, or humanitarian burden, but, based upon the criteria set forth in this policy, fail to qualify for charity care. In such cases it is within the discretionary authority of St. Agnes HealthCare to waive the charity eligibility requirements and apply charity care, as it deems appropriate.

CROSS REFERENCES:

SYS FI 05 Charity Care

St. Agnes HealthCare Mission Statement

Our Mission

We, St. Agnes Hospital, commit ourselves to spiritually centered health care, which is rooted in the healing ministry of Jesus. In the spirit of St. Elizabeth Ann Seton, and in collaboration with others, we continually reach out to all persons in our community with a special concern for those who are poor and vulnerable. As a Catholic health care ministry and member of Ascension Health, we are dedicated to the art of healing to sustain and improve the lives of the individuals, families, and communities we serve.

We advocate for a just society. Through our words and deeds, we minister in an atmosphere of deep respect, love, and compassion.

Our Vision

Patients are our passion. Our physicians and associates are our pride. Healing is our joy.

Together, we promise to deliver:
Health care that works,
Health care that is safe, and
Health care that leaves no one behind.

Our Core Values

We are called to:
Service to the Poor
Reverence
Integrity
Wisdom
Dedication
Creativity

FY '08 COMMUNITY BENEFIT REPORT NARRATIVE

Special Programs to Benefit the Community

St. Clare Medical Outreach

St. Joseph Medical Center in Towson, Maryland, supports St. Clare Medical Outreach, a primary care operation that provides free, primary care to uninsured adults at two locations in Baltimore City with \$580,000 for operational costs. This fiscal year, after almost ten years of traveling and providing care in a 38-foot recreational vehicle outfitted with two exam rooms, a medication room and a central area for laboratory draws and patient education, the bilingual staff of physicians, nurse practitioners, registered nurses, and other ancillary staff moved their care delivery at the Hispanic Apostolate (rededicated the Esperanza Center) inside in a newly created health clinic space. This renovation was the culmination of three years of planning among Catholic Charities, St. Joseph Medical Center, University of Maryland Dental School and Johns Hopkins Medicine to create a shared space in which to deliver care to immigrants, most of whom are Hispanic. The coach continues to travel to the Franciscan Center on the third clinic day. In FY08 2,063 persons were provided 2,533 primary care visits which included diagnostic testing and starter supplies of medications, where appropriate. Additional needed inpatient and outpatient services totaled \$435,458 and were provided as part of the medical center's charity care program. Additionally, thirty-eight specialists agreed to provide, on a pro-bono basis, consultation for 117 patients and surgery or invasive treatment to forty-seven.

African American Men's Health Conference:

St. Joseph Medical Center in Towson, MD partnered as a presenting sponsor with the American Cancer Society, St. Agnes Hospital, and Bon Secours Health System to develop and bring, for the first time, to the African American men in the greater Baltimore metropolitan area a day long program devoted to health education, discussion of relevant health issues, health screenings, and exhibits. This first time event served 515 men from all socio-economic strata. The screening program, developed by St. Joseph Medical Center and provided by 12 additional community partnering organizations, screened 264 men for prostate cancer, HIV, STD, Hepatitis, cholesterol, blood glucose, diabetes risk, hypertension, heart disease and stroke, and obesity. The screening participants also received counseling on risk factor reduction, nutrition, and health care resources, as well as follow-up on positive screening results. Of the 264 men screened, 110 were uninsured and 126 had no primary care physician.

St. Joseph Medical Center Village Wellness Program – Tanzania, East Africa

Established in 2002 by St. Joseph Medical Center, the Village Wellness Program (VWP) serves 70,000 villagers in 21 villages of the Karatu District of Tanzania, East Africa. The VWP is a comprehensive initiative and includes a variety of sustainable projects designed to work in tandem to improve the overall health and well-being of the villagers. St. Joseph partners with Karatu Lutheran Hospital and identifies candidates for medical and clinical scholarships to assist at the hospital and in the villages.

Addressing the root cause of illness is a key component of the VWP and to that end St. Joseph sponsors capacity building projects (mama stoves, pit latrines), animal projects and micro loan recipients. Additional VWP projects include water collection and filtration, scholarships and trainings for medical officers, famine relief and HIV/AIDS prevention and counseling. In November 2008 the VWP launched a malaria prevention initiative with the delivery of 62,000 insecticide treated bed nets. With support from friends and donors, St. Joseph Medical Center is able to extend our hearts and hands around the globe to our brothers and sisters in Tanzania. To learn more about the Village Wellness Program, please visit

www.sjmcmd.org > Foundation > Tanzania Mission

ST. JOSEPH MEDICAL CENTER
ADMINISTRATIVE POLICY

TITLE: Financial Assistance (Charity Care)

POLICY NUMBER: AD 9
RESPONSIBLE PARTY: Director of Revenue Cycle
POLICY EXECUTIVE: CFO
POLICY OWNER: Director of Revenue Cycle

ORIGINAL DATE: 6/99
LAST REVISION DATE: 3/05
PAGE: 1 of 20

POLICY APPROVAL STATUS:

Executive Council :
_____ (President & CEO) Date _____

Medical Executive Committee:
_____ (President of Medical Staff) Date _____

Board of Directors:
_____ (Chairman of the Board) Date _____

VALUE STATEMENT:

This policy reflects all of CHI and SJMC values. We treat our patients, families, staff and community with reverence and compassion in all our work. We work with integrity while striving for excellence in all that we do. SJMC treats all patients regardless of the ability to pay.

PURPOSE:

To outline the process for enabling qualified patients to apply for Financial Assistance who do not have the resources to pay for medical care and are not qualified for financial assistance from state, county or federal agencies.

POLICY:

I. Background – Purpose and Overview

As a Catholic health care provider and tax-exempt organization, St. Joseph Medical Center is called to meet the needs of the people who seek our care, regardless of their ability to pay for services provided. Charity care is defined as care provided to patients without expectation of payment for those services. Charity care may be provided to those who are uninsured, underinsured, or determined to be medically indigent. All patients requiring medically necessary services will have the option to apply for charity care.

II. Identifying Patients Unable to Pay for Needed Services

A. Hospitals, Outpatient Surgical Services and Clinics

1. Consistent with the principles of Catholic faith-based healthcare ministry, any patient seeking urgent or emergent care at SJMC will be treated without regard to a patient's ability to pay for care. SJMC will operate in accordance with all federal and state requirements for the provision of healthcare services, including screening and transfer requirements under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA).

The following definitions of urgent and emergent care are provided for in this Standard.

- a) The definition of urgent care is that provided to a patient with a medical condition that is not life/limb threatening or not likely to cause permanent harm, but requires prompt care and treatment, as defined by the Centers for Medicare and Medicaid Services (CMS) to occur within 12 hours, to avoid:
 - i. Placing the health of the patients in serious jeopardy or to avoid serious impairment or dysfunction; or
 - ii. Likely onset of an illness or injury requiring emergent services, as defined in this document.
 - b) The definition of emergent care is that provided to a patient with an emergent medical condition, further defined as:
 - i. A medical condition manifesting itself by acute symptoms of sufficient severity (e.g., severe pain, psychiatric disturbances and/or symptoms of substance abuse, etc.) such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
 - Placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
 - Serious impairment to bodily functions, or
 - Serious dysfunction of any bodily organ or part.
 - ii. With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or her unborn child.
 - iii. Health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, in the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses average knowledge of health and medicine, to result in:
 - 1) placing the patient health in serious jeopardy;
 - 2) serious impairment of bodily functions; or
 - 3) serious dysfunction of any bodily organ or part.
2. Patients who qualify for charity care discounts shall be identified as soon as possible, either before services are provided or after an individual has received services to stabilize a medical condition. If it is difficult to determine a patient's eligibility for a charity care discount prior to the provision of services, such determination shall be

made as soon as possible but shall not exceed a period of 18 months after the provision of such services.

3. The Financial Assistance policy will apply to the variety of medically necessary services provided by SJMC. This includes all hospital services, ranging from inpatient and outpatient elective surgery, diagnostic testing, home health services, TCU services and educational programs.
4. SJMC will maintain documentation that includes an attestation from the patient's physician indicating appropriate medical necessity for all patients who apply for charity care discounts:
 - a) Medical necessity is defined as any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, resulting in illness or infirmity, threatening to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.
 - b) SJMC will utilize SJMC medical necessity software to assure that all medical necessity determinations are administered in a consistent manner.
5. SJMC will clearly post signage in English to advise patients of the availability of financial assistance. Staff members will communicate the contents of signs to people who do not appear able to read.
6. Sharing information about charity care is differentiated into two scenarios – one for an emergency patient and another for a non-emergency patient scheduling an admission or other procedure.
 - a) Scenario – emergency patient:
 - i. Patients receiving emergency services shall be treated in accordance with SJMC's emergency services policy, developed in accordance with EMTALA and other requirements.
 - ii. SJMC will engage in reasonable registration processes for individuals requiring examination or treatment:
 - 1) Reasonable registration processes shall include asking whether an Individual is insured and, if so, the name of the insurance program utilized, if such inquiry does **not** delay screening or treatment.
 - 2) Reasonable registration process shall **not** unduly discourage patients from remaining for further evaluation. Therefore, discussions regarding financial issues shall be deferred until after the patient has been screened and necessary stabilizing treatment has been initiated.
 - 3) Once EMTALA requirements are met, patients identified through the registration process as being without Medicare/Medicaid, other local health care financial assistance or adequate health insurance shall be mailed a Financial Assistance Application within ten days of the date of service. This will ensure that all self-pay patients are informed of Financial Assistance availability in a timely manner. Compliance will be monitored through a Meditech NPR Report.

- b) Scenario – non emergency patient scheduling an admission or other procedure:
 - i. Patients without Medicare/Medicaid, other local health care financial assistance or adequate health insurance shall be mailed a Financial Assistance Application within ten days of the date of service. This will ensure that all self-pay patients are informed of Financial Assistance availability in a timely manner. Compliance will be monitored through Meditech NPR report.
- c) Under either scenario, the Financial Assistance Application and accompanying instructions will clearly indicate that SJMC provides care, without regard to ability to pay, to individuals with limited financial resources, and will explain how patients can apply for financial assistance . In addition, SJMC Billing and Payment Guidelines brochure will address patient financial assistance.
 - i. For instances in which there are significant number of patients not proficient in reading, writing or speaking English, additional information shall be provided (or assistance shall be made available) to complete necessary forms.
 - ii. In the event that SJMC service area consists of 10% or more of a population who does not speak English, SJMC will prepare informational notices in each of the languages that account for 10% or more of the total population.
 - iii. To allow SJMC to properly determine charity care eligibility, documents provided by patients to the MBO shall be written in English.
 - iv. Records maintained by SJMC to substantiate eligibility for charity care shall be completed in English.
 - v. SJMC will identify the availability of financial assistance in information booklets provided to patients and in general information provided on SJMC’s website.
 - vi. SJMC will begin the process of assessing financial ability as soon as patients contact the hospital to schedule a procedure or when they register as an emergency patient (subject to the EMTALA requirements discussed above).

B. Other Services

Physician practices owned by SJMC or clinics that are an integral part of SJMC or its non-profit subsidiaries shall adopt the SJMC charity care policy. These organizations shall comply with the same charity care policy and procedures adopted by the SJMC Board of Directors.

C. Joint Operating and Joint Venture Agreements

1. SJMC under a joint operating agreement (JOA) shall adopt the CHI-SJMC charity care standard unless adoption is not permitted by language contained in the applicable JOA.
2. The CHI-SJMC charity care standard shall apply to both minority and majority owned joint venture agreements in accordance with the respective governing documents.
3. SJMC shall consider charity care obligations in agreeing upon the terms and conditions in JOA’s and joint ventures.

Providing Assistance to Patients

SJMC will use the guidelines below to determine whether a patient is eligible for a charity care discount and the amount eligible for write-off or discount. SJMC will access all applications using a consistent methodology. The methodology will consider income, family size, and available resources.

The authorization of charity care discounts will be restricted to Director of Revenue Cycle up to \$10,000, the Controller \$20,000, and CFO \$20,000 and above.

A.. Authorization and Methodology

1. SJMC will utilize the *CHI Standardized Patient Charity Care Discount Application Form*.
 - **See attached Exhibit 1: Catholic Health Initiatives SJMC Financial Assistance Application** (4 pages).
2. SJMC will utilize the *CHI Standardized Charity Care Determination Checklist*.
 - **See attached Exhibit 2: Catholic Health Initiatives SJMC Financial Assistance Checklist** (1 page).
3. All available financial resources shall be evaluated before determining financial assistance eligibility. SJMC will consider financial resources not only of the patient, but also of other persons having legal responsibility to provide for the patient (e.g., the parent of a minor child or a patient’s spouse). The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance (i.e., individual and/or group coverage), Medicare, Medicaid, workers’ compensation, third-party liability (e.g., automobile accidents or personal injuries) and other programs. Patients with health spending accounts (HSAs), formerly known as medical spending accounts (MSAs), are considered to have insurance; the amount that the patient has on deposit in the HSA is to be considered insurance and not eligible for any discount.
 - **Note** The term “patient/guarantor” sometimes is used subsequently in this document to refer collectively to the patient as well as any such other person(s) having legal responsibility for the patient.
4. Eligibility for charity care discounts shall be determined based on 130% of the annually updated *HUD Geographic Very-Low Income Guidelines*, referenced later in this document, available assets and any extenuating circumstances such as an liability settlement and/or an inheritance. Thus, the standards of eligibility for the application of charity discounts must consider assets over \$2,500 as well as income.
 - d) Determinations of eligibility for charity care discounts are made for a 90-day period and applications must be submitted within 18 months of the date of service. Confirmations of continued eligibility shall be updated every 90 days for patients who require ongoing health care services. Individual claims within 90 days that are greater than \$10,000 will need signatures by appropriate person.
 - b) An individual’s occupation may be indicative of eligibility for a charity care discount. Examples of low-paying jobs might include:
 - Day labor
 - Farm worker
 - Migrant worker
 - Fast food service worker
5. Information provided in the financial assistance application may indicate that a patient is eligible for financial assistance or insurance coverage not only for health care

services but also other benefits. Financial counseling staff shall assist patients in applying for available coverage.

- a) All information obtained from patients and family members shall be treated as confidential. Assurances about confidentiality of patient information shall be provided to patients in both written and verbal communications. Assessment forms shall provide documentation of all income sources on a monthly and annual basis (taking into consideration seasonal employment and temporary increases and/or decreases in income) for the patient/guarantor, including the following evidence of:
 - Income from wages
 - Income from self-employment
 - Alimony
 - Child support
 - Military family-allotments
 - Public assistance
 - Pension
 - Social Security
 - Strike benefits
 - Unemployment compensation
 - Workers' compensation
 - Veterans' benefits
 - Other sources, such as income and dividends, interest or rental property
 - b) Copies of documents to substantiate income levels shall be obtained (e.g., pay check stubs, alimony and child-support documents).
6. For situations in which patients have other assets, liquid assets shall be defined as investments that could be converted into cash within one year, these assets shall be evaluated as cash available to meet living expenses. Assets that shall not be considered as available to meet living expenses include; a patient's primary place of residence; adequate transportation; adequate life insurance; and sufficient financial reserves to provide normal living expenses if the wage earners are unemployed or disabled. Listings of other assets shall be provided, including copies of the following documents.
- Savings, certificates of deposit, money-market or credit union accounts
 - Descriptions of owned property
7. The patient/guarantor shall provide demographic information for the patient/guarantor. The patient/guarantor shall provide information about family members and/or dependents residing with the patient/guarantor, including the following information for all:
- Name, address, phone number (both work and home)
 - Age
 - Relationship
8. In evaluating the financial ability of a patient/guarantor to pay for health care services, questions may arise as to the patient/guarantor's legal responsibility for purported dependents. While legal responsibility for another person is a question of state law (and may be subject to Medicaid restrictions), the patient/guarantor's most recent-filed federal income tax form shall be relied upon to determine whether an individual should be considered a dependent. The patient/guarantor, shall provide employment information for the patient/guarantor as well as any others for whom the guarantor is legally obligated in regard to the well-being of the patient. Such information shall

identify the length of service with the current employer, contact information to verify employment and the individual's job title.

9. Assessment forms shall provide for a recap of average monthly expenses including:
 - Rental or mortgage payments
 - Utilities
 - Car payments
 - Food
 - Medical bills
10. Copies of rent receipts, utility receipts or monthly bank statements shall be requested. Determination of eligibility for charity care discounts shall occur as closely as possible to the time of the provision of service and not to exceed 18 months after the date of service to enable SJMC to properly record the related revenues, net of charity care.
11. SJMC will utilize a sliding scale to provide up to a full discount of charges for patients with no third-party insurance and up to a full waiver of co-payments after the third-party insurance proceeds, based on indigence. (See attachment) The following points shall be taken into consideration.
 - a) The standards of eligibility for the application of charity discounts must consider assets, as well as income. Eligibility shall be based on 130% of the annually updated *HUD Very-Low Income Guidelines*. These HUD guidelines take into consideration family incomes that do not exceed 50% of the median family income for a geographic area and shall utilize a sliding scale approach based on income and family size.
 - b) When circumstances indicate the presence of severe financial hardship or personal loss, those patients with few resources and a high number of dependents shall receive higher levels of financial assistance. This shall be determined by the use of a sliding scale based on income and family size. The maximum income level eligibility as defined on the sliding scale represents 150% of the new base, effectively 195% of the *HUD Very-Low Income Guidelines*.
12. Patients/guarantors shall be notified when SJMC determines the amount of charity care eligibility related to services provided by SJMC. Patients/guarantors shall be advised that such eligibility does not include services provided by non-SJMC employees or other independent contractors (e.g., private, physicians, physician practices, anesthesiologists, radiologists, pathologists, etc., depending on the circumstances). The patient/guarantor shall be informed that the charity care eligibility will apply to service rendered for 90 days after approval. Patient financial records shall be flagged to indicate future services shall be written off in accordance with the financial assistance determination. Patients/guarantors shall be informed in writing if financial assistance is denied and a brief explanation shall be given for the determination provided. A copy of the letter shall be retained in the confidential central file, along with the patient/guarantor's application.
13. Completed financial assistance applications will be evaluated by the Patient Financial Eligibility Coordinator and reviewed by the Director of Revenue Cycle. On a quarterly basis, SJMC will report each account with a charity care discount threshold of \$100,000 or more to the finance committee of the SJMC Board.
14. Determining eligibility for charity care discounts shall be a continuing process. A retroactive review of accounts referred to outside collection agencies shall be conducted either annually or semi-annually to determine if any accounts would have been more properly recorded as charity care discounts and, if so, SJMC will recall such accounts

from the outside collection agency and reclassify them to charity, in accordance with generally accepted accounting principles.

15. If a fee or tuition amount is charged for an SJMC-sponsored community health educational program, SJMC will include a reference that financial assistance is available. The name, address and phone number of the Patient Financial Eligibility Coordinator shall be provided in promotional materials.
16. SJMC will retain a central file by each patient/guarantor containing financial assistance applications. To assure confidentiality, applications for financial assistance shall not be retained with the patient account registration or detailed billing information. A listing of all charity care discounts shall be maintained by the Patient Financial Eligibility office, documenting patients names, patient account numbers, date of service, brief descriptions of services provided, total charges, amount written-off to charity, dates of write-offs and the names of the authorizing individuals. Written denials of charity care discounts, including denial reasons, shall be retained in a confidential central file.

B. Medical Indigency

The decision about a patient's medical indigency is fundamentally determined by SJMC without giving exclusive consideration to a patient's income level when a patient has significant and/or catastrophic medical bills. Medically indigent patients do not have appropriate insurance coverage that applies to services related to neonatal care, open-heart surgery, cancer, long and/or intensive care, etc., within the context of medical necessity. Such patients may have a reasonable level of income but a low level of liquid assets and the payment of their medical bills would be seriously detrimental to their basic financial well-being and survival.

SJMC Charity Care Committee will make a subjective decision about a patient/guarantor's medically indigent status by reviewing formal documentation for any circumstance in which a patient is considered eligible for a charity care discount on the basis of medical indigency.

1. The patient shall apply for a charity care discount in accordance with the policy in effect.
2. SJMC will obtain and/or develop documentation to support the medical indigency of the patient.
The following are examples of documentation that shall be reviewed:
 - Copies of all patient/guarantor medical bills.
 - Information related to patient/guarantor drug costs.
 - Multiple instances of high dollar patient/guarantor co-pays, deductibles, etc.
 - Other evidence of high-dollar amounts related to the healthcare costs.
3. SJMC will grant a charity care discount either through the use of the sliding scale approach or up to 100% if the patient has the following or does not qualify for MD Medicaid:
 - No material applicable insurance.
 - No material usable liquid assets.
 - Significant and/or catastrophic medical bills.
4. In most cases, the patient shall be expected to pay some amount of the medical bill, but SJMC Charity Care Committee will not determine the amount for which the patient shall be responsible based solely on the income level of the patient.

C. **Presumptive Charity Care Eligibility**

Some patients are presumed to be eligible for charity care discounts on the basis of individual life circumstances (e.g., homelessness, patients who have no income, patients who have qualified for other financial assistance programs, etc.). SJMC will grant 100% charity care discounts to patients determined to have presumptive charity care eligibility. SJMC will internally document any and all recommendations to provide presumptive charity care discounts from patients and other sources such as physicians, community or religious groups, internal or external social services or financial counseling personnel.

1. To determine whether a qualifying event under presumptive eligibility applies, the patient/guarantor shall provide a copy of the applicable documentation that is dated within 30 days from the date of service.
2. For instances in which a patient is not able to complete an application for financial assistance, SJMC will grant a 100% charity care discount without a formal request, based on presumptive circumstances, approved by Director of Revenue Cycle or the CFO.
3. SJMC will utilize the *CHI Standardized Patient Charity Care Discount Application Form – Presumptive Eligibility*.
 - **See attached Exhibit 3: Catholic Health Initiatives/SJMC Uninsured /Underinsured Patient Discounts Application Form – Presumptive Eligibility** (1 page)
4. The determination of presumptive eligibility for a 100% charity care discount shall be made by SJMC on the basis of patient/guarantor income, not solely based on the income of the affected patient.
5. Individuals shall not be required to complete additional forms or provide additional information if they already have qualified for programs that, by their nature, are operated to benefit individuals without sufficient resources to pay for treatment. Rather, services provided to such individuals shall be considered charity care and shall be considered as qualifying such patients on the basis of presumptive eligibility. The following are examples of patient situations that reasonably assist in the determination of presumptive eligibility:
 - Patient has received care from and/or has participated in Women’s, Infants and Children’s (WIC) programs.
 - Patient is homeless and/or has received care from a homeless clinic.
 - Patient family is eligible for and is receiving food stamps.
 - Patient’s family is eligible for and is participating in subsidized school lunch programs.
 - Patient qualifies for other state or local assistance programs that are unfounded or the patient’s eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down).
 - Family or friends of a patient have provided information establishing the patient’s inability to pay.
 - The patient’s street address is in an affordable or subsidized housing development. In this case:
 - SJMC will contact the individual state agency that oversees HUD Section 8 subsidized housing programs for low-income individuals.
 - SJMC will maintain a listing of eligible addresses in its market.
 - Patient/guarantor’s wages are insufficient for garnishment, as defined by state law.
 - Patient is deceased, with no known estate.

D. Charity Care Review Committee

SJMC will establish a Charity Care Review Committee to assist in the evaluation of subjective information related to patient accounts that do not clearly qualify under basic charity care discount eligibility criteria.

1. The types of patient accounts to be reviewed by the Committee shall include, but not limited to, the following:
 - Patients with extenuating circumstances (e.g., patients who may be medically indigent , patient who may have presumptive eligibility for a charity care discount, etc.).
 - Patient who have significant non-liquid assets.
 - Patient whose eligibility exceeds 195% of the HUD Very Low Income Guidelines and thus are not eligible for charity care discounts on the sliding scale, but whose medical bills are so large that they are unable to pay.
2. The Committee will be chaired by the Director of Revenue Cycle. At a minimum membership will include social worker, staff from mission/ministry, general accounting and patient financial services. Other members may be appointed to the Committee as deemed appropriate by SJMC.
3. The Committee shall meet monthly or on a ad hoc basis as needed.
4. The agenda for each meeting shall be comprised of patient cases requiring additional review and input by the Committee prior to the determination of charity care discount eligibility. For each patient case, the agenda will include a summary of the case, the financial situation of the patient and the other pertinent information as necessary.
5. Documentation of the Committee’s meeting shall be recorded. Actions related to specific patients shall be included in the central file.

III. Recording Charity Care

SJMC will properly distinguish write-offs of patient accounts between charity care discounts and bad debt expenses. Such amounts shall be recorded in accordance with generally accepted accounting principles and properly disclosed in financial statements and other reports.

A. Generally Accepted Accounting Principles

1. Section 7.2 of the AICPA *Accounting Guide* states the following, with regard to distinguishing bad debt expense from charity care: Distinguishing bad-debt expense from charity care requires judgment. Charity care results from an entity’s policies to provide health care services free of charge to individuals who meet certain financial criteria. The establishment of a policy clearly defining charity care should clearly result in a reasonable determination. Although it is not necessary for the entity to make this determination upon admission of the individual, at some point the entity must determine that the individual meets its pre-established criteria for charity care. Charity care represents health care services that were provided but never expected to result in cash flows. As a result, charity care does not qualify for recognition as receivables or revenue in the financial statements.
2. SJMC will write off patient accounts in one of the following two categories.
 - Charity care discounts – consisting of;
 - Patients with no third-party payment source and for whom there is no expectation of payment
 -**Or**.....
 - Medicare and Medicaid patients who are determined to be financially unable to pay

applicable co-payment obligations, in which case the unpaid co-payment qualifies as a charity care discount for the MBO and can be claimed on any filing for reimbursement as a Medicare (Medicaid) bad debt.

- Bad debts – consisting of patients who have the ability to pay for health care services (including those with private insurance), where the patient or insurer does not pay the applicable obligation.

B. Financial Statement Disclosures

1. Section 2.4 of the American Institute of Certified Public Accountants (AICPA) *Audit and Accounting Guide for Audits of Providers of Health Care Services* includes the following guidance:

The level of charity care provided should be disclosed in the financial statements. Such disclosure is made in the notes to the financial statements and measured based on the provider's rates, costs, units of service, or other statistics.

2. SJMC will include information about charity care discounts in the consolidated year-end CHI community benefit disclosure.

C. IRS Reporting

SJMC will include the information noted in the preceding Section IV-B of this document in the IRS Form 990 federal reporting and required state reporting.

D. Charity Care Discounts

A line item for charity care discounts does not appear in SJMC statements of operations because the amount is netted against gross revenues. The amounts written-off should be tracked for comparison with both the amounts budgeted for charity care discounts and prior-period charity care discounts. The cost of providing charity care discounts to all patients is recorded in the appropriate natural expense classifications in the statement of operations when expenses are incurred through payroll records or accounts payable. Where scholarships are provided for community health education programs, the waived tuition or fee amounts should be tracked and reported as part of the community benefit reporting process.

E. Reserves for Charity Discounts

There is a lag between the times when services are provided and the determination is made about the eligibility for a charity care discount or financial assistance. As a result, effective July 1, 2005, SJMC will establish a reserve methodology for recording charity care discounts.

V. Recording Community Benefit

SJMC will utilize the CHI Community Benefit Handbook for determining and reporting Community Benefit.

Authors/Reviewers: Adapted from CHI Standards & Guidelines for Uninsured/Underinsured Patient Discounts.

Approved by: _____
President and CEO

St. Joseph Medical Center

7601 Osler Drive Towson, MD 21204-7582

Financial Assistance Application

Patient Name	Social Security #	Date of Birth	Account #
Guarantor's Name	Relationship to Patient	Date of Birth	Social Security #
Guarantor's Address	City, State, Zip	Home Phone #	Length of Residence
Previous Address (if less than 2 years at above)	City, State, Zip	Marital Status	# of Dependents in Household
List Names and Ages of Dependents in Household:			
Employer (Guarantor/Patient)	Previous Employer	Spouse Employer	
Address			
Job Title/Length of Employment			
Business Telephone #			
Hourly Rate			
Monthly Income Gross			
Monthly Income Net			
Other Income Source/Amount	Total Family Monthly Income	Total Family Income last 12 months	
Have you applied for Medicaid or any other State/County Assistance? (check one)	Yes	No	

Application Date		Caseworker Name/Telephone Number			
Have you filed Bankruptcy?		Chapter 7	Chapter 13	Date Filed	Date of Discharge
Yes	No				
Are you a Homeowner?		Approximate \$ Value	Approximate Balance on Loan	Years left on Loan	
Yes	No				
Bank Name	Checking Account #	Avg. Checking Balance	Savings Account #	Avg. Savings Balance	
AUTOMOBILE(S)					
1. Make:	Model:	Year:	Pymt Amount:	Balance Due:	
2. Make:	Model:	Year:	Pymt Amount:	Balance Due:	
Other Assets (Stocks Bonds, Property, Boat, Business, etc.)					
Description	Monthly Payment	Payment To	Account #	Balance Due	Limit
Rent/Mortgage	\$			\$	\$
Charge Cards	\$			\$	\$
	\$			\$	\$
	\$			\$	\$
Bank Loans	\$			\$	\$
	\$			\$	\$
School Loans	\$			\$	\$
List Other Expenses Below:					
	Monthly Payment		Monthly Payment		Monthly Payment
FOOD	\$	MEDICATION	\$	AUTO INS	\$
UTILITIES	\$	LIFE INSURANCE	\$	OTHER	\$
GAS (CAR)	\$	MEDICAL BILLS	\$	OTHER	\$
TOTAL MONTHLY EXPENSE	\$				

Note: Attach additional sheet if necessary. **Important:** income verification must be attached – W2, Pay Stub, Tax Return, etc.

CERTIFICATION

1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of St. Joseph Medical Center information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize St. Joseph Medical Center to perform a credit check for both guarantor/patient and spouse.

Signature (Guarantor/Patient)	Date	Witness	Date
Signature (Spouse)	Date	Witness	Date

DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

1: Complete the patient name, patient’s social security number, patient’s date of birth, and the hospital account number(s) if known.

2: Complete the guarantor name, relationship to patient, guarantor’s date of birth, and guarantor’s social security number. If the guarantor is the same as the patient, note “Same” in this field.

3: Complete the guarantor’s address, home telephone number and length of residence at this address.

4: Complete the guarantor’s previous address (if current residence is less than two years), guarantor’s marital status, and number of dependents living in household. If there are no dependents, please mark “-0-“ in the dependent field.

5: List the names and ages of dependents.

6: Complete the employer information for the guarantor or patient, depending upon who has responsibility for the balance. Please complete the name of the employer, the employer’s address, the guarantor/patient’s job title and length of employment. Please also include the guarantor/patient’s business telephone number, hourly (or salary) rate, and the monthly income (both gross and net). If there is no employment, please note how expenses are being met.

7: Complete the previous employer information for the guarantor/patient. This includes the employer’s name and address, the guarantor/patient’s job title and length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If there is no prior employment, mark “N/A”.

8: Complete the income information for the guarantor/patient’s spouse. Include the name of the employer, the employer’s address, job title/length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If the spouse is unemployed, or there is no spouse, mark “N/A”.

9: Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This also includes rental income, alimony, pension income, welfare and VA benefits. Complete the total family income (add the guarantor/patient net income), then complete the total family income from the last 12 months. If there has been no income, please note how expenses are being met.

10: Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance (and on what date). Please provide the assigned Caseworker's name and telephone number. You may attach a separate sheet if needed. Please mark N/A if this field does not apply to you.

11: Please indicate if you have ever filed bankruptcy. If you have not filed bankruptcy, please mark "No". Please verify that all questions have been completed. Attach additional paper if needed for any explanations.

12: Please complete the homeowner information. If you are a homeowner, please note the approximate dollar value, the approximate balance on the loan, and the number of years left on the loan. If you are not a homeowner, please mark "No".

13: Please complete the banking information as requested and list the bank name. Complete the checking account number and provide the average checking account balance. Please do the same for the savings account field. If there is no savings account, please place "N/A" in the savings field.

14: For automobile information, please list the make, model and year of your vehicle. Please list the monthly payment amount and the current balance.

15: Please complete the section listing other assets you may have. This includes stocks, bonds, property, boats and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark "N/A".

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION:

RENT/MORTGAGE: Please verify the amount you are paying in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others. Use additional paper if needed.

CHARGE CARDS: Please indicate any charge card payments you are currently making. Please indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Please indicate the credit limit for each card. Use additional paper if you needed to complete this field. If you have no charge cards please note "N/A".

BANK LOANS: Please indicate any bank loans you may be paying. Indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due. Use additional paper if needed to completely explain this field. If you have no bank loans, please mark "N/A".

SCHOOL LOANS: Please list any educational loans you may be paying. This can include, but not be limited to, college loans, private school loans (or tuition), day-care expenses or any other

loans that apply to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this does not apply to you, please mark "N/A".

LIST OTHER MONTHLY EXPENSES:

FOOD: Please list the amount paid for food on a monthly basis.

UTILITIES: Please list the amount paid on a monthly basis for electricity, gas, water, trash and any other utility you may pay. Please add these and place the total (for all of them) in the utilities section. If there are no monthly utilities paid, please mark "N/A" in this section and explain. Use a separate sheet of paper if needed.

GAS (CAR): Please list the amount paid on a monthly basis for transportation needs related to your vehicle. If there is no payment made on a monthly basis for gas, please mark the field "N/A".

MEDICATION: Please add the amounts you pay on a monthly basis for medication needs. If there are several prescriptions or medications you take, please add them together and place the total amount in this section. If there are no monthly medication payments, please place "NA" in this section.

LIFE INSURANCE: If you have a life insurance policy, please indicate the monthly amount you pay. If there is no payment, please place "N/A" in this section.

MEDICAL BILLS: Please add any medical bills you may be paying on a monthly basis. This may include, but not be limited to, physician bills, insurance co-pays, insurance deductibles, other hospital bills, radiology bills, ambulance bills, etc. Please use a separate sheet of paper to list these amounts. Add them together and place the total amount paid on a monthly basis for these accounts in this section. If there are no monthly medical payments being made, please place "N/A" in this section.

AUTO INSURANCE: Please place the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide the quarterly payment by three and place the amount in this section. If you pay every six months, please divide the total amount you pay by six and place the amount in this section. If there is no monthly payment being made, please mark N/A in this section.

OTHER: This includes any monthly payments you currently are making that are not listed in the previous sections. Please provide details of what you are paying, to whom, and the balances due. Please use a separate sheet of paper if needed. If this section does not apply to you, mark "N/A".

TOTAL MONTHLY PAYMENTS: Please total all the above payments and place this amount in this section.

DOCUMENTATION: Please notice that your signature indicates you have agreed to attach all income verification. In addition to the items requested by this application, you may attach bank statements, copies of social security checks (or letters). If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

WHAT YOU ARE AGREEING TO:

1. Stating that the guarantor/patient has completed this form accurately.
2. Stating that the guarantor/patient will apply for any assistance to pay this bill. This may include acquiring a bank loan or putting the balance on your credit card.

3. Authorizing St. Joseph Medical Center to obtain credit information and perform a credit check.

PLEASE RETURN THE FOLLOWING INFORMATION:

- _____ Completed and signed application form
- _____ Proof of income for all household members
- _____ Bank statements showing interest
- _____ Award or denial letters from Social Services or Social Security
- _____ W-2 form from most recent tax year
- _____ Tax return from most recent tax year
- _____ Denial letter from Maryland Medical Assistance Program

EXHIBIT 2

**Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 3: Uninsured/Underinsured Patient Discounts (Charity Care)**

Charity Care/Extended Monthly Payment Checklist (Page 1 of 2)

INITIAL IF YES	INFORMATION REQUIRED FOR COMPLETE APPLICATION
	1—The demographic information is completed for patient <u>and</u> guarantor (i.e., address, telephone number, etc.).
	2—The dependent information is completed (i.e., number in household, names, ages, etc.).
	3—The employment and income information is completed for patient/guarantor and spouse.
	4—A copy of most recent year’s IRS Tax Return is attached.
	5—A copy of most current pay stub is attached.
	6—A copy of medical savings account balance (if any) is attached.
	7—If no income is documented, attach an explanation for how expenses are being met.
	8—If the patient/guarantor has filed bankruptcy, all questions are answered.
	9—If the patient/guarantor is a homeowner, all questions are answered.
	10—Information is completed for banking information (i.e., checking and savings accounts).
	11—Information is completed for automobile.
	12—Information is completed for other assets.
	13—The expense/monthly payment information is completed.
	14—Does all information look reasonable?
	15—Are there any luxury items listed that might prevent patient/guarantor from paying the bill (e.g., country club dues, maid or lawn service, boat, high cable bills, etc.)?
	16—Has the patient/guarantor and spouse signed and dated the form?
	17—Has the witness signed and dated the form?
	18—Compare the <i>Total Family Monthly Income</i> to the <i>Total Monthly Expenses</i> . Can the patient/guarantor afford to make monthly payments? If so, contact the patient/guarantor to establish payment arrangements. STOP.
	19—If the patient/guarantor <u>cannot</u> afford monthly payments, use the Poverty Guidelines Matrix to determine if the patient/guarantor qualifies for Charity Care.
	20—If the patient qualifies for Charity Care and the total discount is less than \$2000, log on Charity Log, process discount and send acceptance for Charity Care letter to patient.
	21—If the patient qualifies for Charity Care and the total discount is over \$2000, log on Charity Log and forward all information to Director of Revenue Cycle to review and approve.
	22—If the patient does not qualify for Charity Care, send denial for Charity Care letter to patient/guarantor.
	23—If the application is incomplete, return application and all supporting documentation to patient with a letter indicating what is required and that it needs to be returned.
	24—The Director of Revenue Cycle (see policy for approval levels) needs to approve for Charity Care discounts.

INITIAL IF YES	INFORMATION REQUIRED FOR COMPLETE APPLICATION	
	25—The Director of Revenue Cycle will return the Charity Log and all supporting documentation to the Patient Financial Eligibility Representative to send acceptance for a Charity Care letter to the patient.	
	26—The Patient Financial Eligibility Representative will send an acceptance for the Charity Care letter to the patient and return all information to the Central File for Charity Care.	
	27—The Director of Revenue selects this chart for Quality Review.	
Signature – Patient Financial Eligibility Representative		Date
Signature – Director of Revenue Cycle		Date

**Catholic Health Initiatives
Financial Standards and Guidelines Manual
Section 3: Uninsured/Underinsured Patient Discounts (Charity Care)**

My name is (please print): _____
LAST
FIRST
MI

I am: _____ The Patient _____ The Patient's Guarantor
 _____ Neither (Please state your relationship to the Patient: _____)

Instructions:

1. Please indicate that the Patient is eligible for charity care discount because the Patient is in one or more of the following categories.
2. More than one copy of this form may be required if it is to be completed by more than one individual (e.g., Patient, Guarantor, etc.).

Please initial if category is applicable	#	Is relevant document attached?		Category
		Yes	No	
	1			Patient has received care from and/or has participated in Women's, Infants and Children's (WIC) programs.
	2			Patient is homeless and/or has received care from a homeless clinic.
	3			Patient is eligible for and is receiving food stamps.
	4			Patient's family is eligible for and is participating in subsidized school lunch programs.
	5			Patient qualifies for other state or local assistance programs that are unfunded or the patient's eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down).
	6			Family or friends of a patient have provided information establishing the patient's inability to pay.
	7			The patient's street address is in an affordable or subsidized housing development.
	8			Patient/guarantor's wages are insufficient for garnishment, as defined by state law.
	9			Patient is deceased, with no known estate.
	10			Other – <u>Provide explanation:</u>

Signature _____ Date _____

Authorized by: _____ Date _____

Title: _____

2010 Vision Statement

St. Joseph **sets a standard for excellence** in Christ's healing ministry, offering a **blend of community-based hospital services and regional centers of excellence** preferred by patients, payers, employees and physicians.

St. Joseph Medical Center **will be recognized as the leading regional destination hospital** by providing superior clinical expertise and quality combined with the most compassionate health care. **Patient safety and operational excellence will be hallmarks** of St. Joseph's reputation and culture. We will advance healthier and more productive lives in the community by **building collaborative and mutually beneficial relationships** with physicians, employees and other local resources.

By living our core values we will be a **voice and advocate for the poor, underserved and most vulnerable**. The leadership of St. Joseph will be recognized for creating a **high performance organization with a culture of trust, exceeding the expectations of all stakeholders** and fostering growth through, people, information, quality and performance.

ST. JOSEPH MEDICAL CENTER MISSION

MISSION

The mission of St. Joseph Medical Center and Catholic Health Initiatives is to nurture the healing ministry of the Church by bringing it new life, energy and viability in the 21st century.

Fidelity to the Gospel urges us to emphasize human dignity and social justice as we move toward the creation of healthier communities.



FY 2008 COMMUNITY BENEFIT ASSUMPTIONS WORKSHEET

GENERAL INFORMATION

Hospital Name:

St. Joseph Medical Center

HSCRC Hospital ID #:

15-0007

of Employees:

2,464

Contact Person:

Beth Kelly

Contact Number:

(410) 337-1507

Contact Email:

bethkelly@chi-east.org

ASSUMPTIONS

H CHARITY CARE

Charity Care calculation consists of the following:

HSCRC Uncompensated Care Fund		\$2,629,696
Charity Care - Hospital		\$3,924,111
Charity Care - TCU		\$2,537
Charity Care - Part B		\$280,187
TOTAL		\$6,836,531

I1 INDIRECT COST RATIO

St. Clare Outreach	A2	\$230,156
Women's Health	A2	\$256,565
As Pediatric Service	A2	\$68,003
Screenings	A2	\$33,255
Oncology Research	D1	\$123,508
Center for Health Enhancements	A4	\$58,772
TOTAL		\$770,259

I6 NET REVENUE

The formula change equates to the excess of revenue over expenses per audited Financial Statements.

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

AAA (ABDOMINAL AORTIC ANEURYSM) SCREENING

Description: Ultrasound of Abdominal aorta to detect aneurysm which could leak or rupture.
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Gloria Webster (410-337-1012)
Objective: To detect critical aneurysm size in abdominal aorta so treatment may prevent rupture.
Persons: 38
Expenses: 2,354
Revenues: 0
Benefit: 2,354

ADMINISTRATIVE TIME SPENT ON BOARDS

Description: Administrative time spent on outside boards (i.e., American Heart Association, Upper Chesapeake Hospice, Hispanic Apostolate/Catholic Charities Coalition, etc.).
Gender: Both Males and Females
Department: 8610 (Administration)
Department Contact: Sharon Connolly (410-337-1923)
Objective: Provide administrative support to various community agencies while serving on their Board.

Attend meetings to improve healthcare throughout the committee by serving on coalitions.
Baseline/Goal: Improved healthcare in the community.
Network with other organizations to strengthen relationships.
Persons: 15
Expenses: 2,298
Revenues: 0
Benefit: 2,298

AFRICAN AMERICAN MEN'S HEALTH FORUM

Description: A forum offering educational presentations on various health topics and screenings provided by partners and community resources.
Gender: Males
Department: 8761 (Community Outreach)
Department Contact: Bernie White (410-337-1254)
Objective: Reduce the risk of cancer.
Detect cancer as early as possible.
Partners: The American Cancer Society, Bon Secours Health System, St. Agnes HealthCare and American Diabetes Associate are planning and implementing the forum.
Baseline/Goal: Heighten health awareness among African American males.
Persons: 300
Expenses: 7,370
Revenues: 0
Benefit: 7,370

AS PEDIATRIC SERVICE

Gender: Both Males and Females

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Department: 7470 (AS Pediatric Service)
Department Contact: ()
Persons: Unknown
Expenses: 141,419
Revenues: 0
Benefit: 141,419

BALTIMORE COUNTY CANCER COALITION

Description: SPONSORED BY BALTIMORE COUNTY HEALTH DEPT., THE COALITION CONSISTS OF HEALTH CARE, FAITH-BASED, AND COMMUNITY PARTNERS WHO MEET BIMONTHLY TO PROMOTE CANCER PREVENTION, SCREENINGS, AND DETECTION.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: BERNIE WHITE (4103371254)

Objective:

1. INCREASE COMMUNITY AWARENESS OF CANCER PREVENTION AND IMPORTANCE OF SCREENING FOR EARLY DETECTION.
2. PROVIDE SCREENING OPPORTUNITIES.
3. PROMOTE COMMUNITY PARTICIPATION IN SCREENINGS.
4. ESTABLISH EFFECTIVE COMMUNITY NETWORKS FOR CANCER EDUCATION, SCREENING AND EDUCATION.

Partners: BALTO CO HEALTH DEPT, FRANKLIN SQUARE HOSP CENTER, GBMC, SINAI-WELLBRIDGE, AMERICAN CANCER SOCIETY, PHILIPINO AMERICAN SOCIETY, BMS, AND VARIOUS CHURCH GROUPS.

Baseline/Goal:

1. COMMUNITY MEMBERS WILL PARTICIPATE IN SCREENINGS.
2. COMMUNITY MEMBERS WILL RECEIVE INFORMATION ON CANCER PREVENTION, SCREENING AND EARLY DETECTION.

Persons: 20
Expenses: 256
Revenues: 0
Benefit: 256

BEAUTIFUL SKIN WORKSHOP

Description: A 6 hour workshop for girls age 13-15 to focus on healthy skin, safe sun practice to avoid skin cancer and premature aging, acne, avoid/discontinue smoking to promote healthy skin, nutrition, exercise and yoga to promote good health. The girls are also treated to facials, makeovers and consults with hair and manicure specialists. Beauty consults are donated by vendors.

Gender: Females

Department: 8761 (Community Outreach)

Department Contact: Gloria Webster/Andrea Praskiev (410-37-1012)

Objective: To promote good skin care practices to prevent skin cancer, premature aging.

To provide nutritional information to promote a healthy complexion

To explore exercise and yoga as strategies for maintaining general wellness

To promote prevention of tobacco to monitor health and appearance

Partners: Proctor & Gamble, Mary Kay Cosmetics, Sodexo Dietary and Nutritional Services, Professional Esthetics, CVFitness

Baseline/Goal: To promote good skin care practices to aid in a more positive self-image of oneself

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Persons: 41
Expenses: 3,353
Revenues: 950
Benefit: 2,403

BLOOD PRESSURE SCREENING

Description: free Blood pressure screening in the community at various sites (currently: health fairs; formerly: St. Mary's Govans, Towson United Methodist, etc.)

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Gloria Webster (410-337-1012)

Objective: Extend healing mission of SJMC to community through parish nursing.
Provide health care information designed to meet the health care needs of the poor and underserved within the Govans Community.

Baseline/Goal: Improve health care status in Govans Community.
Assist GFHC in planning new programs.
Heightened community awareness of SJMC's Outreach Programs.

Persons: 17
Expenses: 196
Revenues: 0
Benefit: 196

BONE DENSITY SCREENINGS

Description: Participants are screened using ultrasound heel measurement with Halogioic somometer. Printed results are provided so that information can be shared with the participant's physician. Educational information is provided by a RN. Written material is provided.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Karen Zink Brown/Gloria Webste (410-337-1012)

Objective: To provide baseline BMD information

To provide educational information about Osteoporosis management and life style practices to facilitate bone health.

Baseline/Goal: Participants are provided with baseline information regarding bone density that they are encouraged to share with their physician. Referrals are made as necessary. Information and resources are provided.

Persons: 429
Expenses: 5,375
Revenues: 0
Benefit: 5,375

BREAST CANCER SCREENINGS

Description: Aimed at those women without insurance, living on a low income. Free self breast exam and screening mammogram

Gender: Females

Department: 8761 (Community Outreach)

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Department Contact: Karen Zink Brown/Gloria Webste (410-337-1012)
Objective: Identify new cases of breast cancer as early as possible to provide referral information to those with positive screening results.
Baseline/Goal: To help identify breast cancer in the early stages.
Persons: 92
Expenses: 3,646
Revenues: 0
Benefit: 3,646

BREAST SELF EXAM EDUCATION

Description: Classroom program or information display at health fair to teach the proper techniques for performance breast self-examinations.
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Christine Duke (410-337-1555)
Objective: 1. Teach proper technique for performing BSE.
2. Teach participants proper timing and expectations for a good breast health program including mammography, clinical breast exam, sonography, and BSE
Partners: ACS
Baseline/Goal: 1. Participants will demonstrate proper technique for performing BSE.
2. Participants will know three components of a proper breast health program.
Persons: 34
Expenses: 334
Revenues: 0
Benefit: 334

CAB SERVICES TO AND FROM MENTAL HEALTH TREATMENT

Description: Provision of transportation for patients who cannot afford transportation or who do not have social support to provide transportation to and from for mental health services.
Gender: Both Males and Females
Department: 6220 (Acute Psych)
Department Contact: Grace Serafini (410-337-1584)
Objective: To facilitate treatment for mental health patients
Baseline/Goal: Permit after care in partial hospitalization at St. Joseph Medical Center
Persons: 107
Expenses: 4,870
Revenues: 0
Benefit: 4,870

CANCER INSTITUTE ART EXHIBIT 2008

Description: Expenses incurred to offer art exhibit for The Cancer Institute to the community.
Gender: Females
Department: 8613 (Foundation)
Department Contact: Sharon Connolly (410-337-1923)

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Persons: Unknown
Expenses: 13,911
Revenues: 0
Benefit: 13,911

CARDIOVASCULAR FITNESS PHASE III

Description: Provides preventive maintenance exercise regime, support,
Gender: Both Males and Females
Department: 7113 (CV Fitness)
Department Contact: Anna Melick (1369)
Persons: 13
Expenses: 39
Revenues: 0
Benefit: 39

CATHOLIC HIGH SCHOOL LECTURES

Description: Lectures by healthcare professionals to students to taking a required health course on a variety of topics relevant to adolescence.
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Christine Duke (410-337-1555)
Objective: 1. To provide students with accurate information about health topics relevant to their life.
Partners: The Catholic High School of Baltimore
Baseline/Goal: Students will have factual information to help them make decisions.
Students will recognize risky situations they or their friends may encounter.
Persons: 559
Expenses: 944
Revenues: 0
Benefit: 944

CENTER FOR HEALTH ENHANCEMENTS - 1091

Description: Health Enhancement Provider fo rmassages for open heart, bi-lateral hip and knee surgery patients. Also included are NICU baby massages and expectant mother massages.
Gender: Both Males and Females
Department: 7752 (Center for Health Enhancements)
Department Contact: Claudia Simpson (410-337-5557)
Persons: 1,546
Expenses: 252,359
Revenues: 0
Benefit: 252,359

CHILDBIRTH CLASSES AT SJMC (INCLUDES WEEKENDER PROGRAM)

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Description: Education for expectant mothers and her labor partner. Class includes anatomy, physiology of labor, and coping strategies for labor and birth.

Gender: Both Males and Females

Department: 8762 (Family Education)

Department Contact: Marian Malinski (410-337-1682)

Objective: To provide information concerning anatomy and physiology.

To provide knowledge of the stages and mechanisms of labor and the birth process.

To empower the mother to have confidence in her own ability to birth her child.

Baseline/Goal: The couple will verbalize confidence in their ability to cope with the labor and birth.

The couple will be able to verbalize the physiology of labor and birth and will be able to demonstrate at least three coping strategies for comfort in labor.

Persons: 6

Expenses: 78

Revenues: 0

Benefit: 78

CHILDBIRTH REVIEW CLASSES AT SJMC

Description: For couples who have given birth in the last four years. A review of the physiology of labor & delivery. Review and practice of coping techniques for childbirth.

Gender: Both Males and Females

Department: 8762 (Family Education)

Department Contact: Marian Malinski (410-337-1682)

Objective: Discuss anatomy and physiology of labor and birth. Demonstrate and have couples practice coping strategies for labor.
Discuss sibling adjustment.

Baseline/Goal: Expectant mothers and their coaches will be more comfortable with labor and delivery.

Persons: 20

Expenses: 707

Revenues: 180

Benefit: 527

CHOLESTEROL SCREENING

Gender: Both Males and Females

Department: 7113 (CV Fitness)

Department Contact: Ellen Gorman (410-337-1369)

Objective: *Provide the participant with the opportunity to evaluate one of the major coronary artery disease risk factors - elevated cholesterol.

*Provide participant with recommendations for further follow up and ways to reduce elevated cholesterol levels.

Partners: SJMC laboratory - provides equipment and staff to conduct the actual test.

Baseline/Goal: Early detection of potentially elevated cholesterol levels

Persons: 291

Expenses: 6,208

Revenues: 0

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Benefit: 6,208

CLINICAL STUDENTS

Description: ADMINISTER PLACEMENT OF CLINICAL AND NON-CLINICAL STUDENTS AT SJMC (NOT RESTRICTED TO RN'S)

Gender: Both Males and Females

Department: 8722 (CENTER FOR CLINICAL EXCELLENCE)

Department Contact: BONNIE THOMSON (410-337-1335)

Objective: TO PROVIDE PRACTICAL EXPERIENCE TO CLINICAL AND NON-CLINICAL STUDENTS, BEYOND THEIR CLASSROOM STUDIES.

Partners: APPROXIMATELY 20 COLLEGES AND UNIVERSITIES

Baseline/Goal: ASSIST STUDENTS IN LEARNING JOB APPROPRIATE SKILLS. PROVIDE OPPORTUNITY TO SEE SJMC AS AN OPTION FOR EMPLOYMENT WHEN EDUCATION IS COMPLETE.

Persons: 195

Expenses: 4,063

Revenues: 0

Benefit: 4,063

COMMUNITY BENEFIT PLANNING TIME (ADMINISTRATIVE)

Description: Time spent in planning, collaborating, implementing and evaluating community programs for services to the poor and community broader benefit by the VP of Mission/Ministry and Executive Assistant, and Director of Community Outreach/St. Clare Medical Outreach

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Bernie White (410-337-1254)

Objective: To develop health related programs benefiting the poor and the broader community.

To maintain programs identified as benefiting the poor and broader community

To research community resources that may benefit in the provision of healthcare needs of the poor

Partners: Baltimore County and Baltimore City Departments of Health, MedBank

Baseline/Goal: Improved access to health information and healthcare

Programs which meet the health related needs of the poor and broader community.

Persons: 1

Expenses: 550

Revenues: 0

Benefit: 550

COMMUNITY CPR

Description: CPR Classes taught by certified instructors according to the standards of the American Heart Association. Classes are held @ SJMC, in the Community, or health care providers' offices.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Bernadette White (410-337-1254)

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Objective: To provide current and up-to-date education regarding CPR for personal and professional use.

To offer certification in CPR to those individuals whose jobs require certification.

Partners: American Heart Association

Baseline/Goal: This is an ongoing program. The course is held at least monthly and at the request of various churches, school, or other groups.

Attendees receive certification and completion cards as indicated by the American Heart Association.

Class attendees demonstrate verbal and behavioral competency in performing the particular type of CPR studied.

Persons: 20

Expenses: 316

Revenues: 0

Benefit: 316

COMMUNITY REGISTRATION/SCHEDULING/INFORMATION WORK

Description: Time committed by Community Outreach Registration and Scheduling representative to take registrations and provide scheduling and information for community programs and prepare mailings for programs and events. Also, time devoted to inputting data to ensure continuation of program and event quality.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Bernie White (410-337-1254)

Objective: Provide information to community regarding community health programs and health screenings.

Facilitate attendance by community members at health programs, events, screenings.

Register community members at health programs, events, and screenings.

Partners: Public Relations/Marketing Department

Baseline/Goal: Appropriate participation in health screenings by community members who are appropriate for the screenings.

Adequate attendance by community members at health programs and events.

Persons: 3,302

Expenses: 16,633

Revenues: 0

Benefit: 16,633

DONATIONS/CONTRIBUTIONS TO COMMUNITY ORGANIZATIONS

Description: Donations/contributions to community organizations

Gender: Both Males and Females

Department: 8670 (Mission/Ministry)

Department Contact: Angela Moralis (410-337-4872)

Objective: SJMCs participation in outside organization by donations/contributions

Baseline/Goal: Organizations are helped through donations/contributions.

Persons: Unknown

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Expenses: 25,000
Revenues: 0
Benefit: 25,000

ETHICS SYMPOSIUM

Description: Annual Institutional Ethics Symposium - Physicians, Social Workers, Nurses, Chaplains - continuing education on ethical issue.
Gender: Both Males and Females
Department: 8672 (Institutional Ethics)
Department Contact: Angela Moralis (410-337-4872)
Persons: 75
Expenses: 3,674
Revenues: 0
Benefit: 3,674

FETAL BURIAL

Description: Cemetery Service for pregnancy losses
Gender: Both Males and Females
Department: 8671 (Spiritual Care Department)
Department Contact: Nancy Conner (410-337-1706)
Objective: To help bring closure to parents of pregnancy loss
Baseline/Goal: Parents are comforted.
Persons: 80
Expenses: 942
Revenues: 0
Benefit: 942

FLU IMMUNIZATIONS

Description: RNs will provide vaccination against influenza to senior citizens and other high risk individuals at no charge. The immunizations are given at churches, schools, senior community centers and homeless shelters.
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Karen Zink Brown/Gloria Webste (410-337-1012)
Objective: To provide influenza vaccine to senior citizens and other high risk individuals

To provide education regarding the important of influenza and pneumococcal vaccination.
Partners: Baltimore City Health Dept, ACE, MPP
Baseline/Goal: To provide influenza vaccinations to free to those individuals who may not otherwise be able to be vaccinated.
Persons: 2,844
Expenses: 45,596
Revenues: 0
Benefit: 45,596

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

FREE MEALS AND PARKING FOR CLERGY

Gender: Both Males and Females
Department: 8671 (Spiritual Care Department)
Department Contact: Nancy Conner (1706)
Persons: 1
Expenses: 157
Revenues: 0
Benefit: 157

FRESH START CLASS

Description: 7 Smoking cessation programs held at community and business locations.
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Christine Duke (410-337-1555)
Objective: 1. Participants will devise a quit plan in conjunction with the class.
2. Participants will change their tobacco use behaviors
3. Participants will stop smoking.
Partners: ACS
Baseline/Goal: Decrease tobacco use in community members.
Increase awareness of tobacco and health issues.
Persons: 166
Expenses: 3,358
Revenues: 995
Benefit: 2,363

FRESH START FACILITATOR TRAINING

Description: Five hour training for community volunteers and employees to prepare them to run and facilitate Fresh Start smoking cessation programs
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Christine Duke (410-337-1555)
Objective: 1. Participants will understand behavioral change as it relates to tobacco addiction and cessation.
2. Verbalize and understand the content, format, and processes of the Fresh Start Program
Partners: ACS
Baseline/Goal: Participants will have requisite skills and knowledge to facilitate groups attending Fresh Start Smoking Cessation program
Persons: 15
Expenses: 295
Revenues: 0
Benefit: 295

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

GRANDPARENTING CLASSES

Description: EDUCATIONAL EVENT FOR EXPECTANT GRANDPARENTS OFFERING UP-TO- DATE INFORMATION ON LABOR AND DELIVERY AND CHILDCARE.

Gender: Both Males and Females

Department: 8762 (Family Education)

Department Contact: Marian Malinski (410-337-1682)

Objective: GRANDPARENTS WILL BE ABLE TO DEMONSTRATE INFANT CPR AND HOW TO HANDLE A CHOKING BABY.

GRANDPARENTS WILL HAVE KNOWLEDGE OF CURRENT CAR SEAT LAWS.

GRANDPARENTS WILL HAVE A UNDERSTANDING OF THE USE OF THE EPIDURAL IN OB.

GRANDPARENTS WILL HAVE AN UNDERSTANDING OF THE "BACK TO SLEEP" CAMPAIGN AND HOW THIS HAS LOWERED THE RATE OF SIDS IN THE USA.

Baseline/Goal: THE GRANDPARENTS WILL HAVE A BETTER UNDERSTANDING OF MATERNAL CHILD CARE.

Persons: 59

Expenses: 785

Revenues: 590

Benefit: 195

GRANT REVIEW FOR CRF FUNDS

Description: Review and score goals submitted to city and county health departments for consideration to receive Cigarette Restitution Funding.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Christine Schutzman (4103371555)

Objective: Review grants submitted for funding.
Eliminate programs not fitting best practices guidelines.
Network with community participants.

Partners: ALA, Baltimore County Health Dept.

Baseline/Goal: Best programs for community are funded. Decreased incidence of tobacco use.

Persons: 12

Expenses: 436

Revenues: 0

Benefit: 436

HEAD & NECK CANCER SCREENINGS

Description: The screening, performed by a physician, consists of visual inspection and palpation of the head, neck, and mouth. Patient education, referral, and counseling are provided by RNs.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Mary Jo Huber (410-337-1960)

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Objective: To identify early lesions/conditions of the head, neck, mouth, or throat that may be cancerous.

To provide education regarding the signs and symptoms of cancer in the head, neck, mouth, and throat.

To provide referral information to those individuals that require additional follow-up.

Baseline/Goal: To assist in the early detection of mouth, throat, and neck cancer.

Persons: 36

Expenses: 1,294

Revenues: 0

Benefit: 1,294

HEALTH FAIRS

Description: Health events scheduled at churches, businesses or schools where staff present health information, education, counseling and/or screenings

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Bernadette White (410-337-1282)

Objective: To educate participants regarding health related topics

To provide health related screenings and counsel participants regarding their degree at risk for certain health problems and methods of prevention/treatment

To inform participants regarding relevant health resources

Partners: Churches, schools, businesses

Baseline/Goal: Participant will have increased health knowledge
Participant will have knowledge of their relative risk for selected health problems and how to modify risk and/or seek treatment for further evaluation
Participants will be more knowledgeable regarding health resources

Persons: 3,683

Expenses: 6,676

Revenues: 0

Benefit: 6,676

HEALTHY PREGNANCY CLASSES

Description: Education for expectant mothers and their partners focusing on healthy lifestyles

Gender: Both Males and Females

Department: 8762 (Family Education)

Department Contact: Marian Malinski (410-337-1682)

Objective: Discuss healthy lifestyles regarding food, exercise, sleep, toxics, and medical care for the expectant mother

Baseline/Goal: The client will be able to verbalize healthy eating habits and a healthy exercise plan for the expectant mother. The mother will be more aware of the effects of smoking, alcohol, drugs, and environmental changes on her and the fetus.

Persons: 55

Expenses: 352

Revenues: 0

Benefit: 352

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

HEARING SCREENINGS - PEDIATRICS

Description: Screening children PK-12 grade for hearing acuity. Children are screened according to the standards of the American Audiologic Society. Screening is conducted by RN, community health specialist, student interns, and volunteers.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Karen Zink Brown/Gloria Webste (410-337-1012)

Objective: To identify at an early age children at risk for hearing impairment.

To provide accuracy and consistency in the screening process for children.

To provide consistency in the referral process for children with possible hearing impairment.

Persons: 2,493

Expenses: 12,830

Revenues: 0

Benefit: 12,830

HEART RISK SCREENINGS

Description: Screenings provide an analysis of each participants modifiable risk factors including total cholesterol, HDL cholesterol and ratio; blood pressure; body weight; body comp; exercise status and smoking status. Participants receive results immediately and speak with a counselor who discusses results and recommendaion for follow-up

Gender: Both Males and Females

Department: 7113 (CV Fitness)

Department Contact: Ellen Gorman (410-337-1369)

Objective: Povidе community with means of evaluating modifiable risk factors so they can address any areas requiring attention, and therefore, reduce their risk for complications (or future compliations if already diagnosed) or heart disease.

Partners: SJMC's Lab and various other departments with the Medical Center.

Baseline/Goal: Early detection of heart disease

Persons: 269

Expenses: 15,257

Revenues: 0

Benefit: 15,257

HERNIA SCREENING

Description: Screening for all community members, >18 y.o., that consists of a visual inspection and plapation of the abdomen to determine the presence of absence of hernia.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Gloria Webster (410-337-1012)

Objective: To detect hte presence of hernia which may require surgical intervention.

Partners: Community Outreach will do the marketing, registration and facilitate the screening process.

SJMC physicians will perform the abdominal examination.

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Persons: 63
Expenses: 2,735
Revenues: 0
Benefit: 2,735

KANGAROO KAPERS

Description: K.K. SIBLING PREP PROGRAM
Gender: Both Males and Females
Department: 8762 (Family Education)
Department Contact: Marian Malinski (410-337-1682)
Objective: To prepare children for the birth of a sibling, the mother's hospital stay, and to familiarize the child with normal newborn behaviors.
Baseline/Goal: The older sibling will be more comfortable with the hospital setting. The child will view becoming an "older" sibling as a positive life change.
Persons: 105
Expenses: 1,313
Revenues: 390
Benefit: 923

LABOR & DELIVERY TOURS

Description: Walking tour of the Labor and Delivery Area and the Mother/Baby Unit
Gender: Both Males and Females
Department: 8762 (Family Education)
Department Contact: Marian Malinski (410-337-1682)
Objective: To allow expectant parents a chance to become familiar with SJMC
Baseline/Goal: Couples will be more comfortable with the environment of SJMC
Persons: 390
Expenses: 1,888
Revenues: 0
Benefit: 1,888

LACTATION CONSULT

Description: Meeting with mothers and infants regarding breastfeeding issues/problems. A consult may consist of a weight check, observation of a feeding, interventions, and education.
Gender: Both Males and Females
Department: 6230 (Maternal Child Health)
Department Contact: Connie Getz (410-337-3994)
Objective: To assist mothers who are unable to pay our fee for an outpatient consult with breastfeeding issues/problems.

To improve a mother's breastfeeding relationship with her infant.

To support a mother's breastfeeding efforts.
Partners: Utilize the facility at Stevenson and York Road.
Persons: 58

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Expenses: 1,201
Revenues: 0
Benefit: 1,201

LECTURES - HEALTH RELATED ISSUES

Description: Presentation of health related topics to members of the community
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Andrea Mocca (410-337-1473)
Objective: To increase community members' awareness of, knowledge of, or interest in health related topics
To motivate community members to maintain or improve their health status
Partners: Baltimore County Dept. of Aging for some lectures
Baseline/Goal: Community members will have increased awareness of health topics and will use it to maintain or improve their health.
Persons: 814
Expenses: 6,454
Revenues: 0
Benefit: 6,454

MEMORIAL SERVICE

Description: To invite families of deceased patients for comfort and support in a spiritual setting - Mass and Reception
Gender: Both Males and Females
Department: 8671 (Spiritual Care Department)
Department Contact: Nancy Conner (410-337-1706)
Objective: To bring closure to families who have lost loved ones.
Baseline/Goal: Families are able to express their sorrow and grief in a community setting.
Better community relations
Good communication with family members
Persons: 122
Expenses: 3,571
Revenues: 0
Benefit: 3,571

MEN'S BLUE SUIT HEALTH AWARENESS WEEKEND

Description: A community-wide church-based health education and screening event for men.
Gender: Males
Department: 8761 (Community Outreach)
Department Contact: Bernie White (410-337-1254)
Objective: Increase awareness among men of the need to pay more attention to their health with special emphasis on prostate and colo-rectal cancer.
Partners: Bon Secours Health System, Baltimore City Health Department, NAACP, American Cancer Society, Mercy Hospital, St. Agnes HealthCare, LifeBridge Health System
Baseline/Goal: Health awareness will be increased among men.

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Persons: 220
Expenses: 1,298
Revenues: 0
Benefit: 1,298

MOOD DISORDER SUPPORT GROUP

Description: Free support group for individuals diagnosed with a mood disorder run by the Department of Psychiatry.
Gender: Females
Department: 6220 (Acute Psych)
Department Contact: Grace Serafini (410-337-1580)
Persons: 22
Expenses: 392
Revenues: 0
Benefit: 392

MOTHERING MATTERS

Description: A support group for new mothers and their infants. Infant care, growth and development postpartum depression and adjustment to motherhood are discussed
Gender: Males
Department: 8762 (Family Education)
Department Contact: Marian Malinski (410-337-1682)
Persons: 490
Expenses: 6,437
Revenues: 0
Benefit: 6,437

MUSIC THERAPY - HARP

Description: Provide music therapy to patients to effect positive changes in emotional, physical, mental and/or spiritual functioning of individuals with health problems.
Gender: Both Males and Females
Department: 8670 (Mission/Ministry)
Department Contact: Angela Moralis (410-337-4872)
Objective: Provide harp therapy to TCU and NICU patients
Persons: 482
Expenses: 5,917
Revenues: 0
Benefit: 5,917

NURSING HOME FORUM

Description: Monthly meeting of SJMC with local nursing homes in the Baltimore County area.
Gender: Both Males and Females
Department: 8671 (Spiritual Care Department)

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Department Contact: Nancy Conner (410-337-1706)
Objective: To improve communication and services between SJMC and other facilities.
Partners: Nursing homes in Baltimore area
Baseline/Goal: Improve patient care
Persons: 14
Expenses: 118
Revenues: 0
Benefit: 118

PARENTING CLASSES 101 & 102

Description: I-This class provides information on basic baby care, including instructions on bathing, diapering, laundry, normal newborn appearance, circumcision, cord care, general guidelines on calling Pediatrician, temperature taking, equipment needed, organizational skills, etc. II-American Heart Ass., Pediatric basic life course, Safety issues.
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Jackie Bailey (410-532-1027)
Persons: 44
Expenses: 471
Revenues: 0
Benefit: 471

PAYING OF PRESCRIPTIONS, MEDICAL EXPENSES FOR INDIGENT PATIENTS

Description: SJMC, through its Mission/Ministry fund, agrees to assist in the payment of prescriptions, medical expenses, etc. for indigent patients.
Gender: Both Males and Females
Department: 8619 (INTEGRATED CARE MGMT)
Department Contact: DIANE SKILLE (1748)
Objective: To assist low income patients with their medical expenses
Baseline/Goal: Low income patients are able to receive medical treatment that they could not ordinarily afford.
Persons: 124
Expenses: 25,270
Revenues: 0
Benefit: 25,270

PHYSICIAN TIME ON ST. CLARE VAN

Description: Time spent on St. Clare Van by Dr. Rich Boehler.
Gender: Females
Department: 8610 (Administration)
Department Contact: Robin Deares (410-337-1205)
Persons: Unknown
Expenses: 7,846
Revenues: 0
Benefit: 7,846

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

PROSTATE CANCER SCREENINGS

Description: Screening consists of PSA blood test and DRE. PSA is done prior to screening so that the results are available to physician at the screening site. DRE is performed by the physician. Counseling & education are provided as indicated by the participant's need.

Gender: Males

Department: 8761 (Community Outreach)

Department Contact: Karen Zink Brown/Gloria Webste (410-337-1012)

Objective: To provide PSA and DRE to eligible men to detect unknown case of cancer of the prostate.

To provide education and counseling about prevention and need for professional, annual examination and self-examination

Baseline/Goal: Possible prevention and early detection of prostate cancer

Persons: 88

Expenses: 5,110

Revenues: 0

Benefit: 5,110

RAISE

Description: Three sessions - tobacco education and behavior modification program for adolescents mandated through the school, legal, or family system

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Christine Duke (410-337-1555)

Objective: 1. Participants will demonstrate an increased knowledge of tobacco facts and risks.

2. Participants will contract for behavioral change related to their tobacco use with their parents.

3. Pparticipants will verbalize resources for completing their contract.

Baseline/Goal: Decreased tobacco use among participants and their family (if applicable).

Increased family cohesion and functioning.

Persons: 48

Expenses: 1,021

Revenues: 50

Benefit: 971

RED DRESS SUNDAY

Description: A church-based education and screening outreach program aimed at addressing disparities in cardiovascular care amongst the African American community by heightening awareness of cardiovascular health, especially in women.

Gender: Females

Department: 8761 (Community Outreach)

Department Contact: Bernie White (410-337-1254)

Objective: Implement evidence-based guideline prevention with church health ministries and provide continued support throughout the year.

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Partners: St. Agnes HealthCare, American Heart Association, Baltimore County Health Department, MD Department of Health and Mental Hygiene, Pfizer, local government representatives, etc.

Baseline/Goal: African American women will increase their knowledge about and participation in heart healthy behaviors.

Persons: 30

Expenses: 1,504

Revenues: 0

Benefit: 1,504

SAFE SITTER

Description: Baby Sitting class for students ages 11-13 years of age.

Safe Sitter at Winston Middle School - International Safe Sitter Basic Course is taught by 2 certified instructors. It is 4 sessions, 2 1/2 hrs. per session.

Gender: Both Males and Females

Department: 8762 (Family Education)

Department Contact: Marian Malinski (410-337-1682)

Objective: To teach young babysitters how to avoid emergencies, how to handle emergencies.

To teach safety while alone or babysitting

To teach basic child care skills.

Baseline/Goal: The student will be able to provide emergency assistance to a child who is choking. The sitter will be able to do rescue breathing. The student will have confidence in his/her ability to call emergency for help. The student will demonstrate knowledge of child growth and development and be able to entertain children.

Persons: 58

Expenses: 4,788

Revenues: 900

Benefit: 3,888

SCOLIOSIS SCREENING

Description: Nurses from Community Outreach will provide scoliosis screening by means of usual inspection for 6,7,8th grade boys and girls.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Gloria Webster (410-337-1012)

Objective: To identify those at risk for scoliosis.

To make early referral for those exhibiting possible signs of scoliosis

Baseline/Goal: possible early detection

Persons: 65

Expenses: 590

Revenues: 0

Benefit: 590

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

SKIN CANCER SCREENING

Description: Performed by 6 of SJMC's physicians, this screening was performed to detect pre-cancerous or cancerous lesions on the community participants.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Rashi Agarwal (410-337-1473)

Objective: To detect early signs of melanoma skin cancer.

Baseline/Goal: To educate the community on prevention and to save lives by early detection.

Persons: 71

Expenses: 874

Revenues: 0

Benefit: 874

SOCIAL ACCOUNTABILITY CONTRIBUTIONS

Description: Contributions to Community Organizations and Agencies

Gender: Females

Department: 8670 (Mission/Ministry)

Department Contact: Sharon Connolly (410-337-1923)

Persons: Unknown

Expenses: 118,576

Revenues: 0

Benefit: 118,576

SOCIAL ACCOUNTABILITY REPORT

Description: Time involved in preparing the Social Accountability Report

Gender: Both Males and Females

Department: 8610 (Administration)

Department Contact: Beth Kelly (410-337-1507)

Persons: Unknown

Expenses: 1,492

Revenues: 0

Benefit: 1,492

SPIRITUAL CARE GRIEF AND LOSS GROUPS

Description: Spiritual listening, grief processing

Gender: Both Males and Females

Department: 8671 (Spiritual Care Department)

Department Contact: Nancy Conner (410-337-1706)

Objective: To facilitate expression/working through grief and loss

Baseline/Goal: Appreciation/expression of grief/life story comfort/gratitude, decrease stress, increase energy

Persons: 14

Expenses: 156

Revenues: 0

Benefit: 156

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

SPIRITUAL CARE ORTHOPAEDIC GROUP

Description: Presentation and group discussion on "Spiritual Wholeness" integrating the emotional, physical, and spiritual concerns and resources for available for orthopaedic patients.

Gender: Both Males and Females

Department: 8671 (Spiritual Care Department)

Department Contact: Nancy Conner (410-337-1706)

Objective: Orthopaedic: Assess, identify, and demonstrate the surgical patients spiritual coping skills while facing life altering events.

Baseline/Goal: To bring a sense of spiritual wholeness and well being to patients coping with emotional, physical, and spiritual concerns.

Persons: 492

Expenses: 1,170

Revenues: 0

Benefit: 1,170

SPIRITUAL CARE PARKING SUBSIDY - CLERGY

Description: Free parking is extended to needy family members of patients; clergy; religious people visiting patients.

Gender: Both Males and Females

Department: 8671 (Spiritual Care Department)

Department Contact: Nancy Conner (410-337-1706)

Objective: This activity provides free parking to needy family members of patient, clergy, and visiting religious people.

Baseline/Goal: Extend parking courtesy to visiting clergy and needy family members

Persons: 251

Expenses: 12,094

Revenues: 0

Benefit: 12,094

SPIRITUAL CARE PARKING SUBSIDY FOR NEEDY

Description: Free parking is extended to needy patients/family members

Gender: Both Males and Females

Department: 8671 (Spiritual Care Department)

Department Contact: Nancy Conner (410-337-1706)

Objective: This activity provides free parking to needy family members of patient, clergy, and visiting religious people.

Baseline/Goal: Provide parking for family members of patients who are needy.

Persons: 9

Expenses: 2,826

Revenues: 0

Benefit: 2,826

SPIRITUAL CARE PREGNANCY LOSS SUPPORT GROUP

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Gender: Both Males and Females
Department: 8671 (Spiritual Care Department)
Department Contact: Nancy Conner (410-337-1706)
Persons: 2
Expenses: 39
Revenues: 0
Benefit: 39

SPIRITUAL CARE WORKSHOP

Description: Parish nurses have been asking for spiritual direction. This 3 hour workshop will:
1. Help distinguish between spirituality and religion
2. Develop a personal plan for spiritual kindness and growth.
3. Awareness of spirituality to an active parish nurse

Gender: Both Males and Females
Department: 7750 (Unknown Department)
Department Contact: Geraldine Moxey, RN (410-532-1027)
Objective: Foster integration of mind, body, spirit. Incorporate spirituality into all aspects of the parish nurse's ministry.
Partners: Good Samaritan Hospital
Baseline/Goal: 80% of parish nurses will attend.
The parish nurse will become more aware of their own spirituality and thus assist members of the congregation and the pastor.
Persons: 1
Expenses: 118
Revenues: 0
Benefit: 118

ST CLARE MEDICAL OUTREACH

Gender: Both Males and Females
Department: 7756 (St. Clare Medical Outreach)
Department Contact: ()
Persons: 2,111
Expenses: 610,556
Revenues: 0
Benefit: 610,556

STROKE SCREENING

Description: Carotid artery ultrasound to identify those at high risk for stroke due to significant occlusion.
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Gloria Webster (410-337-1012)
Objective: To detect critical lesions in carotid arteries which could lead to stroke.
Persons: 101
Expenses: 4,091
Revenues: 0

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Benefit: 4,091

SUBSIDIZED TRANSPORTATION SERVICES BY ICM

Description: Provide transportation for indigent patients to and from hospital - cab fare, county ride, ambo, bus tokens
Gender: Both Males and Females
Department: 8619 (INTEGRATED CARE MGMT)
Department Contact: DIANE SKILLE (1748)
Partners: Jimmys Cab
Baltimore County Ride
Persons: **2,400**
Expenses: **243,833**
Revenues: **0**
Benefit: **243,833**

SUPPORT GROUPS-ALL TYPES EXC SPIRITUAL CARE,MOTHERMATTERS,LUNGS

Description: Groups conducted for community members to increase their psychosocial, educational and spiritual understanding of specific health or life conditions, e.g. diabetes, Crohn's and Colitis, Caregivers', Cardiac, Bereavement (Widow/Widower's, etc), tobacco use, arthritis
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Bernadette White (4103371254)
Objective: Provide psychosocial/spiritual support and education related to community members' health and/or life conditions.
Partners: Diabetes Support - Sodexo
Crohn's & Colitis - Crohn's & Colitis Foundation of America
Baseline/Goal: Members will verbalize increased comfort level or knowledge level in dealing with specific health or life condition.
Persons: **147**
Expenses: **1,653**
Revenues: **0**
Benefit: **1,653**

TOBACCO CONTROL MEETINGS

Description: Meetings with community coalitions, local Health Depts., businesses, schools, and other entities regarding tobacco control issues, policies, strategies, and funding.
Gender: Both Males and Females
Department: 8761 (Community Outreach)
Department Contact: Christine Duke (410-337-1555)
Objective: Network and collaborate with outside agencies and organizations to support efforts to reduce costs caused by tobacco use.
Partners: Local schools, community coalitions, agencies, and businesses.
Baseline/Goal: Decrease rate of smoking initiation and increase rates of smoking cessation and regulation.
Persons: **379**
Expenses: **1,793**

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Revenues: 0
Benefit: 1,793

TOBACCO EDUCATION- EXCLUDING FRESH START

Description: Education community members, students, on the effects of tobacco.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Christine Schutzman (4103371555)

Objective: To increase the public's general knowledge about the health, social and economic problems associated with tobacco use.

To encourage tobacco users and their associates to work toward a tobacco-free lifestyle and community

Persons: 123
Expenses: 705
Revenues: 0
Benefit: 705

VILLAGE WELLNESS PROGRAM

Description: Improve health status of people in Tanzania, East Africa

Gender: Both Males and Females

Department: 8800 (TANZANIA)

Department Contact: Anthony La Porta (4103371923)

Objective: Screenings and development of village health leaders

Partners: CHI & Sisters of St. Francis - Funding
Karatu Lutheran Hospital Personnel
Lutheran World Relief & Catholic Relief Services - Materials

Baseline/Goal: 1. Improve health status
2. Train Village Wellness Leaders

Persons: Unknown
Expenses: 21,969
Revenues: 0
Benefit: 21,969

VISION SCREENINGS - PEDIATRICS

Description: Children PK-12 grade screened for usual acuity. Screenings include RNs, student interns, community health specialists, and volunteers certified by Prevent Blindness of America.

Gender: Both Males and Females

Department: 8761 (Community Outreach)

Department Contact: Karen Zink Brown/Gloria Webste (410-337-1012)

Objective: To identify at an early age children at risk for visual impairments.

To provide consistency and accuracy in the screening process for children.

To provide consistency in the referral process for children with visual impairment.

12/15/2008

St. Joseph Medical Center - Towson

Activity Detail Full

For period from 7/1/2007 through 6/30/2008

Baseline/Goal: This program is aimed at preventing learning and developmental problems related to visual impairment.

Persons: 2,075

Expenses: 8,598

Revenues: 0

Benefit: 8,598

WHA

Description: Women's Health Associates provides low risk obstetrical and gynecological care to adolescents, adult and geriatric women.

Gender: Both Males and Females

Department: 7480 (Women's Health Assoc)

Department Contact: KATHY PERRETT (4103374986)

Persons: Unknown

Expenses: 801,177

Revenues: 0

Benefit: 801,177

WIDOW / WIDOWERS SUPPORT GROUP

Description: Bereavement Support Group for those whose spouses have died. Includes grief education, support, uses small-group discussion, video and speakers.

Gender: Both Males and Females

Department: 8671 (Spiritual Care Department)

Department Contact: S. Evelyn Grudza (337-1706)

Objective: To offer education, reassurance, support and information to widowed population. Assist them in establishing new friendships, new "connections" in the community, e.g. programs for seniors.

Partners: Sister Anne Conrad, Spiritual Care

Baseline/Goal: Very positive feedback from members. Many groups still meet regularly for dinner and other social activities.

Persons: 37

Expenses: 629

Revenues: 0

Benefit: 629

Totals:

Number of Activities: 74

Persons: 28,284

Expenses: 2,494,204

Revenues: 4,055

Benefit: 2,490,149

GAPS IN SPECIALIST PROVIDERS

St. Mary's Hospital is located in a rural area in Southern Maryland. The population of the community is over 100,000. Recruiting specialists for the area has proven to be quite challenging. The greatest needs in specialty care are in the areas of general surgery, ophthalmology, gastroenterology and orthopaedic surgery, in addition to needing primary care. Due to the small number of specialists on staff, these physicians are required to provide an exorbitant amount of emergency call coverage to St. Mary's Hospital's Emergency Department. This is likewise true for the six obstetricians currently on staff.



St. Mary's Hospital

PAYMENT ASSISTANCE PROGRAM

St. Mary's Hospital offers a Payment Assistance Program for hospital services to those persons who are determined eligible. If you are eligible, you may receive services at no charge or at a discounted rate.

For more information or an application, please contact the Financial Assistance Counselor's office at 301-475-6039.

We are here to serve all your health care needs, regardless of your ability to pay.



Hospital de St. Mary's

PROGRAMA DE ASISTENCIA DE PAGO

El Hospital de St. Mary's ofrece un programa de asistencia de pago por servicios hospitalarios a personas a las que se ha determinado elegibles.

Si usted es elegible para este programa, podria recibir servicios a no costo o a un cargo con descuento.

Para mas informacion o para obtener una aplicacion, comuniquese con la oficina del Consejero de Asistencia Financiera (Financial Assistance Counselor), al (301) 475-6039.

Estamos aqui para servirle en sus necesidades del cuidado de salud, sin importar su habilidad para pagar.

St. Mary's Hospital offers a payment assistance program to patients who are deemed eligible upon completion of a Payment Assistance/Reduced Charges application form. The application forms help to determine a patient's eligibility based on income, amount of the bill and the ability to pay. The Reduced Charges Program is for patients whose religious beliefs prohibit them from participation in any type of payment assistance programs and/or insurance coverage. The Payment Assistance Program applies to all other applicants.

Information on the hospital's Payment Assistance Program is posted at every point of service for patients. Point of service areas includes all registration/admission areas, Emergency Department, and all other inpatient and outpatient service areas. Copies of informational cards shown above are available for patients in English and Spanish.

Patient Registrars as well as nursing and other staff involved in patient care will refer patients to the hospital's Financial Assistance Counselor when they are made aware of a patient's inability to pay for medical care. The Financial Assistance Counselor will visit the patient in his/her patient care area in order to inform them of available options for payment assistance. Patients who are being discharged or are leaving after receiving an outpatient service and have not met with the Financial Assistance Counselor are given contact information to call at a later time.

The Financial Assistance Counselor works closely with an onsite Social Worker from the St. Mary's County Department of Social Services. The Social Worker assists patients by providing information and assisting with applications for Medical Assistance and Healthshare of St. Mary's. Healthshare of St. Mary's is a non-profit program that assists individuals and families who cannot afford the cost of medical service but do not qualify for Medical Assistance. The goal of Healthshare of St. Mary's is to serve people who are above the Medical Assistance Level but are below the Federal Poverty Level.



Administrative Policy and Procedure Manual

SUBJECT: FINANCIAL AID PROGRAM
DATE: November 2007
SUPERSEDES: April 2005
MANUAL CODE: 10-L
REFERENCE: LD.3.20, LD.3.90; RI.1.10

I. POLICY

St. Mary's Hospital (SMH) will provide financial aid for hospital care that is determined to be medically necessary by the Hospital. In determining eligibility for financial aid options, the Hospital will consider the patients' income, the size of the bill, and the ability to pay. The program will be known as "Reduced Charge Program" for those patients whose religious beliefs prohibit participation in such programs and as "Payment Assistance Program" for all others. The amount of financial aid provided will be within Hospital budgetary constraints. The purpose of this policy is to describe the St. Mary's Hospital Payment Assistance/Reduced Charge Program and establish criteria to determine those patients who would be eligible under the program.

II. PROCEDURE

A. Guidelines

Write-offs will be based on the guidelines for financial aid indicated in the "Payment Assistance Program," (Attachment I) or "Reduced Charge Program" (Attachment II). The Hospital may consider assets on a case-by-case basis.

B. Requests

Patient Accounting employees who staff the Credit Office will initiate the process for financial aid. The form entitled "Application for Reduced Charge Program" will be used for those patients whose religious

beliefs prohibit participation in charity programs. Patient Accounting employees will have the patient complete an Application for Payment Assistance (or an Application for Reduced Charges, if applicable) and a Statement of Assets, and then request proof of income. All potential cases will be reviewed to determine if they are eligible to have payment made on their behalf by another source or program.

C. Medical Assistance Eligible Patients

Patients must demonstrate, or hospital staff have knowledge, that they are ineligible for Medical Assistance before a determination can be made for payment assistance/reduced charges. Patient Accounting employees will refer uninsured patients and patients who have large co-payments to the SMH Medical Assistance Representative and/or outside counseling contractor to explore if the patient is eligible for Medical Assistance. If the bill is for emergency room or outpatient diagnostic services, the SMH Medical Assistance Representative or Patient Accounting employee must refer the patient to apply for Health Share, if applicable.

D. Health Share of St. Mary's Eligible Patients

Low income patients who receive emergency room or outpatient diagnostic services, and are ineligible for Medical Assistance, may be eligible for Health Share. These types of patients must demonstrate that they are ineligible for Health Share before a determination can be made for payment assistance/reduced charges.

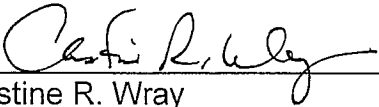
E. Authorization of Payment

For those patients that meet the eligibility requirements established herein, the Director of Revenue Cycle Management or his/her designee will approve all write-offs under \$5,000, and the Vice President for Finance will approve write-offs over \$5,000.

F. Patient Registration and Patient Accounting

1. If at the time of admission, the registration clerk determines that the patient does not have insurance coverage, the patient will be directed to the Credit Office of the Patient Accounting Department.
2. Upon determination that the patient would not qualify for payment from other third party sources, and circumstances exist that make patient payment unrealistic; payment assistance/reduced charges may be considered.
3. The patient will be asked to complete an Application for the Payment Assistance (or an Application for Reduced Charges if applicable), an Asset Statement, and provide verification of household income.
4. Patient Accounting employees who staff the Credit Office will calculate income; and the amount of tentative write-off based on the payment assistance guidelines.

5. All documentation will be provided to the Credit Office/Patient Accounting Department Employee who will be responsible for review of the application, its approval or denial, and return of written determination of eligibility within two (2) working days of receiving the complete patient application. The Director of Revenue Cycle Management or their designee will credit the patient accounts for properly authorized charge write-offs under this program.
6. Patient Accounting employees who staff the Credit Office are responsible to set up a payment plan for any amount of disposable income, if applicable, to be applied to the hospital bill.



Christine R. Wray
President and Chief Executive Officer

11/1/07

Date

Original: 12/95
Revised: 03/98; 02/01; 02/04; 4/05; 11/07

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Final.doc (ayt)



St. Mary's Hospital

Our Mission: St. Mary's Hospital is a community hospital that upholds its tradition of caring by continuously promoting, maintaining and improving health through education and services while insuring fiscal integrity.

Our Vision: St. Mary's Hospital is an integral partner in the Southern Maryland healthcare continuum.

- ◆ SMH is recognized as the leader in healthcare
- ◆ SMH is proactive in furthering the health of all in the community
- ◆ The hospital provides excellence in care, service and education
- ◆ Our future is built on welcoming positive change and innovation
- ◆ We are valued and recognized as the employer of choice

Our Values: St. Mary's has adopted CARE with RESPECT as a framework of essential values to carry out its mission and vision.

Customer Service Regardless

Actions Speak Louder than Words

Respect is the Golden Rule

Excellence in All We Do

R esponsibility

E ducation/Information

S afety

P ride

E mpathy

C ourtesy

T eamwork

SUBURBAN HOSPITAL

Community Benefit Report FY 08

© Suburban Hospital
8600 Old Georgetown Rd • Bethesda, MD
Phone 301.896.3572 • Fax 301.896.7894

Community Benefit Report FY 08

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SUBURBAN HOSPITAL

Community Benefit Report FY 08

Community Benefit Narrative

Community Benefit Narrative



1. Quick Stats:

The licensed bed designation for Suburban Hospital is 238 beds. In fiscal year 2008, there were 14,787 patients admitted to Suburban Hospital. An additional 12,128 patients had outpatient surgery at the main hospital.

2. Our Community:

Suburban Hospital is a community owned, not-for-profit hospital serving Montgomery County, MD, and the greater Washington, DC, region since 1943. As a healthcare provider, we are guided by the needs of our patients and community. We distinguish ourselves through service and clinical excellence, affiliations with the National Institutes of Health (NIH) and Johns Hopkins Medicine, and state-of-the-art technology and facilities.



Suburban serves patients from rural, suburban and urban populations, from all socioeconomic levels, and from all racial and ethnic groups. Suburban's community outreach programs extend well beyond the hospital's inpatient service area to the region. Suburban Hospital is committed to promoting wellness, encouraging prevention and empowering individuals to maintain healthier lifestyles.

Suburban Hospital collaborates with health professionals in Montgomery and Prince George's County to provide free health screenings and health information for vision, hearing, diabetes, colorectal cancer, oral cancer, cholesterol, breast health, blood pressure and smoking cessation at county community centers. To reach minority and indigent populations, Suburban Hospital collaborates with organizations that have recognized relationships in these communities.

In FY 08, Suburban Hospital supported 427 events reaching 19,303 individuals in Prince Georges, Calvert, Charles, and St.

Suburban Hospital's Primary Service Area (PSA) accounts for approximately 57% of the hospital's total inpatient discharges and 63% of emergency/trauma visits. The PSA includes areas predominantly in southern Montgomery County: Bethesda, Rockville and Potomac. Suburban Hospital's Secondary Service Area (SSA) accounts for approximately 21% of its inpatient discharges and 17% of emergency/trauma visits. This area extends slightly northward into upper Montgomery County and southward into Northwest Washington, DC.



Cities and towns within the hospital's secondary service area include Gaithersburg, Germantown, Montgomery Village, Wheaton, Silver Spring Northwest Washington, DC and underserved areas of Southern Maryland in Prince Georges, Calvert, Charles and St. Mary's Counties.

Like the rest of the Country, Maryland, in particular Montgomery County is experiencing dramatic growth in the proportion of residents belonging to racial and ethnic minority groups. Given the racial and ethnic transformation, there are increasing challenges in addressing the health disparities that tend to affect these rapid growing populations. Racial subgroups include Latino, Asian American and African American residents which evolve from varied backgrounds. For example, most Latino residents are from Central America, specifically El Salvador, and Mexico. Chinese residents represent the most populous Asian group, followed by Korean, Asian Indians and Vietnamese residents. While most African American community members were not born in the United States, many originated from the Caribbean and African countries.



In Montgomery County, the median household income for Asian Americans is \$78,000, for Latinos \$57, 000, for African Americans \$58,000 and \$94,500 for Caucasians. In fiscal year 2008, there were 7,001 uninsured cases recorded at Suburban Hospital. The charge to provide services to these residents was just under \$8.7 million dollars.



---Suburban's Community Health and Wellness Department conducted nearly 2,500 community health activities reaching 126,000 citizens.

3. Community Needs:

A recent article in *CNN Money* magazine highlighted Montgomery County as the place where one can expect the longest lifespan in the United States. However, there are still serious health issues that face Montgomery County residents. The most common diagnoses for Suburban Hospital inpatients are the same as those for all Montgomery County hospitals, excepting obstetrics, and reflect the health issues in the population. Chart 1 demonstrates the distribution of Suburban Hospital inpatients by primary diagnosis and contrasts that distribution with the County overall.

Chart 1. FY2008 Inpatient Discharges by Top Primary Diagnosis for Suburban Hospital and Montgomery County

	Total Montgomery	
	Suburban	County Patients *
Diseases of the Circulatory System	19%	12%
Injury and Poisoning	16%	7%
Diseases of the Musculoskeletal System and Connective Tissue	10%	5%
Mental Disorders	10%	5%
Diseases of the Digestive System	8%	8%
Diseases of the Respiratory System	7%	6%

Cancer is also a serious health issue for our population. The incidence is not captured in inpatient discharge figures because most cancer treatment, such as radiation therapy or chemotherapy, is delivered in outpatient settings. In 2006, the leading causes of death in Montgomery County for both men and women were heart disease and cancer.

Chart 2. MONTGOMERY COUNTY, MARYLAND - LEADING CAUSES OF DEATH, 2006

MONTGOMERY COUNTY CAUSE OF DEATH (TENTH REVISION INTERNATIONAL CLASSIFICATION OF DISEASES, 1992)	ALL RACES ¹		
	BOTH SEXES	MALE	FEMALE
ALL CAUSES	6,389	2,501	2,898
DISEASES OF THE HEART	1,383	863	720
MALIGNANT NEOPLASMS	1,325	611	714
CEREBROVASCULAR DISEASES	300	124	176
CHRONIC LOWER RESPIRATORY DISEASE	209	101	108
INFLUENZA AND PNEUMONIA	186	84	112
ACCIDENTS	181	107	54
SEPTICEMIA	141	64	77
DIABETES MELLITUS	126	63	63
ALZHEIMER'S DISEASE	105	28	77
NEPHRITIS, NEPHROTIC SYNDROME, AND NEPHROSIS	72	38	35
CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD	60	31	29
INTENTIONAL SELF-HARM (SUICIDE)	50	35	15
ESSENTIAL (PRIMARY) HYPERTENSION AND HYPERTENSIVE RENAL DISEASE	48	17	31
PNEUMONITIS DUE TO SOLIDS AND LIQUIDS	42	24	18
CHRONIC LIVER DISEASE AND CIRRHOSIS	38	25	13
AORTIC ANEURYSM AND DISSECTION	30	14	16
ASSAULT (HOMICIDE)	24	17	7
HUMAN IMMUNODEFICIENCY VIRUS (HIV) DISEASE	24	18	8

Source: Maryland Vital Statistics Administration - <http://www.vsa.state.md.us/deaths/Montgomery.pdf>

Suburban Hospital works closely with the Montgomery County Department of Health and Human Services, health officers and community health coalitions to identify community health needs and set community benefit strategic programs and activities.



4) Many Maryland residents are affected by chronic illness like heart disease, stroke, diabetes and developed of several cancers as a result of tobacco use. Access to primary and specialty care for under and uninsured community members is another identified health need based on the growing number of individuals served through our partnership safety net clinics.

5 & 6. Addressing the needs

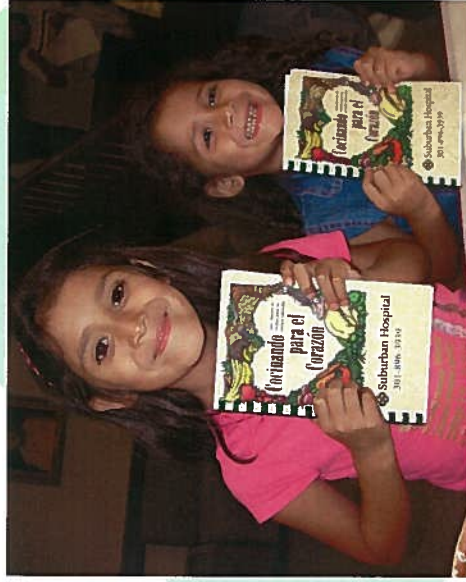
Suburban Hospital's Board of Trustees is actively engaged in an ongoing dialogue of how the organization broadly serves its community. Equally supportive is the Organization's President and CEO, who leads a motivating role in the System's planning of Community Benefit initiatives. Other hospital operations, finance, and nursing leadership along with all levels of hospital staff are equally involved in developing a community benefit plan and have historically embraced the opportunity and responsibility of reaching out to serve the community.

In addition, a Community Advisory Board was established in 1998 composed of several public and private health officials along with other outside organization leaders. The Community Advisory and Visioning team identified four specific target areas of need: A focus on health access of minority populations, underserved seniors, at-risk youth, and management of chronic diseases like Diabetes for the under/uninsured.



7. Evaluating Our Progress

See detailed descriptions of efforts taken to evaluate and assess the effectiveness of major Community Benefit program initiatives in questions 6 & 7 in the evaluation framework section.



8. Filling the Gap

Suburban Hospital is concerned about patient access to care which is endangered by an identified shortage of physicians in Montgomery County practicing in primary care and in several specialties including, hematology/oncology, psychiatry, anesthesiology, diagnostic radiology, pathology, general surgery, and neurosurgery. A recent study of the physician workforce in Maryland predicts that these shortages are expected to grow over the next ten years.

To expand access to care and alleviate the gap in specialty providers, Suburban Hospital operates one specialty cardiac clinic on-site on Thursday evenings with our partners Mobile Medical Care, Inc. and the National Heart, Lung and Blood Institute of the NIH.



The MobileMed/NIH Heart Clinic at Suburban Hospital welcomed our first patient in October 2007. Patients are referred from safety net clinics in the County operated by MobileMed, Clinica Proyecto Salud and the Holy Cross Hospital Health Clinic. Each patient is seen by a Suburban cardiologist and the clinical staff at NIH. In addition to coordinating the cardiologists who volunteer at the clinic, Suburban provides a variety of free cardiovascular specialty diagnostic screenings, and open heart surgery for patients that require advanced care. The Mobile Med/NIH Heart Clinic has provided care to 411 patients to date and conducted four open heart surgeries at no cost to the patient.

Another significant partnership is with the Proyecto Salud Clinic. Since 2004, Suburban Hospital has supported numerous initiatives targeted at Proyecto Salud patients, including diabetes education and prostate cancer screenings. In addition, Suburban Hospital has provided a bilingual patient navigator to facilitate routine health screenings for Clinic patients. The diabetes school has enrolled over 500 participants and we have screened 50 clinic patients for prostate cancer.

In June 2008, a formal agreement was signed to enable Suburban Hospital to support Proyecto Salud in achieving Montgomery Cares' goal of increasing uninsured adult patients' access to primary care. Specifically, Suburban Hospital's financial support will enable the Clinic to employ additional healthcare providers, extend their hours, and provide approximately 1,680 additional patient appointments. Uninsured adult patients who come to Suburban Hospital's Emergency Department will be referred to the Clinic for primary care and follow up.

Proyecto Salud's established patient population will benefit from the expansion of services at the Clinic's existing site in Wheaton, MD given its convenient location and access to public transportation. The partnership also provides Proyecto Salud's patients with access to needed cardiac specialty care through the MobileMed/NIH Heart Clinic at Suburban Hospital. To strengthen the collaboration, Dr. Robert Rothstein, Chair of Suburban Hospital's Department of Emergency Medicine, joined Proyecto Salud's Board of Directors.



Community Benefit Report FY 08

**Suburban
Hospital
Mission
Statement**



Suburban Hospital is a community-based hospital serving Montgomery County and the surrounding area since 1943. We are a not-for-profit healthcare provider guided by the needs of our patients and community. Suburban Hospital distinguishes itself through service and clinical excellence, affiliations with NIH and Johns Hopkins Medicine, and state-of-the-art technology and facilities. It is committed to continuous improvement and appropriate use of resources, and creates an environment that encourages the success and fulfillment of our physicians, staff, and volunteers.

Suburban Hospital will set the standard for excellence in healthcare in the Washington metropolitan region. Through our affiliations, we aspire to provide world-class patient care, technology, and clinical research.

Vision

Suburban Hospital will set the standard for excellence in healthcare in the Washington Metropolitan region. Through our affiliations, we aspire to provide world-class patient care, technology, and clinical research.

Mission

We are a not-for-profit healthcare provider guided by the needs of our patients and community. We distinguish ourselves through service and clinical excellence, affiliations with NIH and Johns Hopkins Medicine, and state-of-the-art technology facilities. We are committed to continuous improvement and appropriate use of resources. We create an environment that encourages the success and fulfillment of our physicians, staff, and volunteers.

Values

- Compassion
 - Excellence
 - Integrity
 - Teamwork
 - Accountability
-

Key Statistics About Suburban Hospital

- Suburban Hospital is an acute-care, medical-surgical hospital featuring all major services except obstetrics. Admissions total more than 14,000 annually.
- Fully accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- Serves as the designated regional trauma center for Montgomery County, one of nine regional trauma centers in Maryland. Fully equipped with an elevated helipad. Treats about 1,300 trauma patients each year.
- Certified as a Primary Stroke Center by The Joint Commission and the Maryland Institute for Emergency Medicine Systems Services.

- Major services: comprehensive cancer and radiation oncology center accredited by the American College of Surgeons Commission on Cancer; NIH Heart Center at Suburban Hospital providing cardiac surgery, elective and emergency angioplasty as well as inpatient, diagnostic, and rehabilitation services; orthopedics with joint replacement and physical rehabilitation; behavioral health; neurosciences including a designated Primary Stroke Center and 24/7 stroke team; and senior care programs.
 - Other services include NIH-Suburban MRI Center; a center for sleep disorders; a 24-hour stroke team; state-of-the-art diagnostic pathology and radiology departments; an Addiction Treatment Center offering detoxification, inpatient and outpatient programs for adolescents and adults; prevention and wellness programs; a free physician referral service; and 24-hour nurse advice line (Suburban On-Call).
 - Suburban Hospital enjoys a solid financial position, including an "A" rating of its bonds from Moody's and Standard and Poor's.
 - Suburban Hospital has various strategic partnerships with local and national healthcare providers including Johns Hopkins Medicine and the National Institutes of Health.
 - Governance by 18-member volunteer Board of Trustees from the community
Chairman: Barry K. Rogstad, PhD
President & CEO: Brian A. Gagnolati
 - Medical Staff: 900+
 - Hospital Employees: 1,400+
 - Nursing Staff: 450+
 - Volunteers: 430+
-

Suburban Hospital Joint Ventures and Affiliations

- Johns Hopkins Medicine
 - The National Institutes of Health
 - Suburban Endoscopy Center
 - NRH/Suburban Regional Rehab (A physical rehabilitation network of Suburban Hospital and the National Rehabilitation Hospital)
 - Potomac Home Health Care and Potomac Home Support (with Sibley Memorial Hospital)
 - GCM-Suburban Imaging
-

Statistical Data

(Fiscal Year Ending June 30, 2008)

- Admissions: 14,787
 - Bed Count: 238
 - Average length of stay (days): 4.26
 - Emergency room visits: 43,160
 - Outpatient Vistis: 87,770
-

Community Benefit Report FY 08

Charity Care Policy

Community Benefit Report FY08

Charity Care and Financial Assistance

Suburban Hospital provides quality care to all patients regardless of their ability to pay. Free or partially discounted care and extended payment plans are offered to eligible patients. Approvals for these discounts or payment plans are based on evaluation of the financial status of the patient/guarantor, regardless of their age, sex, race or religion.

Suburban Hospital informs each self pay patient of the availability of financial assistance by posting signs in both English and Spanish. The signs are labeled "Financial Assistance" and state: "Suburban Hospital provides quality care to all patients regardless of their ability to pay. If you would like information about applying for financial assistance, please speak to a Registration Assistance Coordinator at 301-896-6088". These signs are posted at the admissions desk and the Emergency Department waiting room and registration desks. An overview of Suburban Hospital's financial assistance policy with instructions on how to apply and contact information and a financial assistance application are provided to every self pay patient. The same information is provided to all other patients upon request. This information is also available in Spanish.

In addition, financial counselors and social workers work with these patients to ensure they receive financial counseling and assistance as well as linkage to other community aid resources prior to discharge. Suburban Hospital also has separate contractors who assist patients who request help in applying for Maryland Medical Assistance. A contractor from Financial Health assists the patient throughout the application process including initial consultation while in the hospital and follow-up in the community.

SUBURBAN HOSPITAL
Patient Financial Services Policy and Procedure Manual

FINANCIAL ASSISTANCE POLICY Policy No.

POLICY:

Suburban Hospital Healthcare System has established policies and procedures to reflect its intention to vigorously and fairly collect all patient accounts. Guidelines have been developed whereby an accurate and fair assessment can be made to differentiate between a *patient's/guarantor's/household's inability to pay versus their unwillingness to pay* outstanding debts.

Suburban Hospital Healthcare System offers free or partially discounted care and extended payment plans to eligible patients. Approval for these discounts or payment plans are based on evaluation of the financial status of the patient/guarantor, regardless of their age, sex, race, or religion.

PROCEDURE:

FINANCIAL ASSISTANCE

- 1) Suburban Hospital Healthcare System does offer partial and full financial assistance for qualified individuals and families.
- 2) If a patient/guarantor/household express the inability to pay for services based on lack of income or resources, the patient/guarantor/household may be offered consideration for a financial assistance adjustment.
- 3) An application for financial assistance (financial profile) must be completed and the appropriate documentation (as defined on the application) attached to be considered for a financial assistance adjustment. The Corporate Director of PFS must approve any exception to this requirement.
- 4) The following conditions must be met to be eligible for charity care:
 - Service must be medically necessary (i.e. not elective);
 - Patient/Guarantor/Household whose income level is at or below the current Federal Poverty Level (FPL) as published in the Federal Register; a sliding scale up to at least 200 percent of the FPL.
 - Patient/Guarantor/Household whose income level is above the current Federal Poverty Guidelines as published in the Federal Register and whose financial profile indicates that expense related to the necessities of life (food, housing, utilities, medications, etc.) consume most or all of their income. In addition, the following criteria must be met:
⇒ No ownership of real estate, other than primary residence; and no available equity in

Approved:	Date Issued: 11/1/96	Date Revised: 12/11/08	Date Reviewed:
Name of Policy: Credit and Collections	Policy No.	Page 1 of 3	

SUBURBAN HOSPITAL

Patient Financial Services Policy and Procedure Manual

- ⇒ Such real estate; no ownership of stocks, bonds, and other assets that affects the net worth of patient/guarantor/household.
 - ⇒ Fixed income such as Social Security, retirement, or disability with no other sources of income that would create a financial hardship;
 - ⇒ Medical expenses which exceed 50% of monthly income;
 - Patient is homeless, whereby a Medical Assistance application cannot be completed;
 - Patient is deceased with no person designated as Executor, or no estate on file with the appropriate agency in the appropriate jurisdiction;
 - The balance remaining is after Medical Assistance has adjudicated the claim.
- 5) Approvals for financial assistance adjustments must be made by the appropriate individuals as defined below:
- | | |
|--|---------------------------|
| • Adjustments below \$5,000 | Patient Accounts Manager; |
| • Adjustments between \$5,000 and \$25,000 | Corporate Director, PFS; |
| • Adjustments between \$25,000 and \$100,000 | VP, Finance |
| • Adjustments over \$100,000 | Senior VP, Finance. |
- 6) All financial assistance write-offs under this policy shall be adjusted using the adjustment code "A000070".
- 7) Preliminary determination of probable Medical Assistance or Financial Assistance will be made within two business days of a returned completed application.

<i>Approved:</i>	<i>Date Issued: 11/1/96</i>	<i>Date Revised: 12/11/08</i>	<i>Date Reviewed:</i>
<i>Name of Policy: Credit and Collections</i>	<i>Policy No.</i>	<i>Page 2 of 3</i>	

SUBURBAN HOSPITAL

Patient Financial Services Policy and Procedure Manual

2008 HHS Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$ 10,400	\$13,000	\$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

SOURCE: *Federal Register*, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972.

The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. Note that the poverty thresholds — the original version of the poverty measure — have never had separate figures for Alaska and Hawaii. The poverty guidelines are not defined for Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam, the Republic of the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, and Palau. In cases in which a Federal program using the poverty guidelines serves any of those jurisdictions, the Federal office which administers the program is responsible for deciding whether to use the contiguous-states-and-D.C. guidelines for those jurisdictions or to follow some other procedure.

The poverty guidelines apply to both aged and non-aged units. The guidelines have never had an aged/non-aged distinction; only the Census Bureau (statistical) poverty thresholds have separate figures for aged and non-aged one-person and two-person units.

Programs using the guidelines (or percentage multiples of the guidelines — for instance, 125 percent or 185 percent of the guidelines) in determining eligibility include Head Start, the Food Stamp Program, the National School Lunch Program, the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program. Note that in general, cash public assistance programs (Temporary Assistance for Needy Families and its predecessor Aid to Families with Dependent Children, and Supplemental Security Income) do NOT use the poverty guidelines in determining eligibility. The Earned Income Tax Credit program also does NOT use the poverty guidelines to determine eligibility.

The poverty guidelines (unlike the poverty thresholds) are designated by the year in which they are issued. For instance, the guidelines issued in February 2003 are designated the 2003 poverty guidelines. However, the 2003 HHS poverty guidelines only reflect price changes through calendar year 2002; accordingly, they are approximately equal to the Census Bureau poverty thresholds for calendar year 2002. (The 2002 thresholds are expected to be issued in final form in September or October 2003; a preliminary version of the 2002 thresholds is now available from the Census Bureau.)

The [computations for the 2003 poverty guidelines](#) are available.

The poverty guidelines may be formally referenced as “the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2).”

Approved:	Date Issued: 11/1/96	Date Revised: 12/11/08	Date Reviewed:
Name of Policy: Credit and Collections	Policy No.	Page 3 of 3	



Financial Assistance

How to Apply

Suburban Hospital provides quality care to all patients regardless of their ability to pay. Suburban Hospital offers free or partially discounted care and extended payment plans to eligible patients. Approvals for these discounts or payment plans are based on evaluation of the financial status of the patient/guarantor, regardless of their age, sex, race or religion. If you would like to apply for financial assistance, please complete the attached application and return it to:

Suburban Hospital, Inc.
P.O. Box 79216
Baltimore, MD 21279
Attention: Financial Assistance Coordinator

Please be sure to complete the application in its entirety and provide all of the substantiating documentation needed to process the application. Failure to fully complete the application and/or send in complete substantiating documentation will delay the processing of your application. Once the Financial Assistance Coordinator receives a completed application, the application will be processed and a written decision will be mailed to you within 7-10 business days. **If you have a question regarding the status of your application, please call the Financial Assistance Coordinator at 301-896-6088.**

Eligibility Criteria

- The service must be medically necessary.
- Patient/Guarantor/Household's income level must be at or below the current Federal Poverty Level (FPL) as published in the Federal Register; a sliding scale is offered up to at least 200 percent of the FPL.
- Patient/Guarantor/Household's income level is above the current FPL as published in the Federal Register and whose expenses for the necessities of life (food, housing, utilities, medications, etc.) consume most or all of their income. In addition, the following criteria must be met:
 - Do not own real estate, other than a primary residence; hold no available equity in such real estate; do not own stocks, bonds, and other assets that affect the net worth of patient/guarantor/household;
 - Have only a fixed income such as Social Security, retirement, or disability with no other sources of income; and
 - Medical expenses exceed 50 percent of monthly income.
- Patient/Guarantor is homeless, whereby a Medical Assistance application cannot be completed.
- Patient is deceased with no person designated as Executor, or no estate on file with the appropriate agency in the appropriate jurisdiction.
- Medical Assistance has adjudicated the claim and there is a remaining balance.



Application for Financial Assistance

PLEASE RETURN ALL REQUESTED DOCUMENTATION TO:

Suburban Hospital, Inc.
P.O. Box 79216
Baltimore, MD 21279
Attention: Financial Assistance Coordinator

If you have questions, please call the Financial Assistance Coordinator
@ 301-896-6088

Please complete this application if you are interested in applying for financial assistance with Suburban Hospital. Please complete this application and return it to Suburban Hospital at the address above with all required substantiating documentation. It is your responsibility to complete this form in an accurate, honest, and complete manner. Failure to do so may result in denial of your application.

If you are eligible to apply for Medical Assistance (Medicaid) benefits, you may be required to do so before Financial Assistance will be granted. For questions regarding Medical Assistance eligibility and the application process, please contact your **Local Department of Social Services (LDSS)**. To find your LDSS, please call **1-800-332-6347**.

This application will be denied if not returned within 15 days of the date of service with complete substantiating documentation. Please note that this is a four page document; please complete all four pages.

Account Information:

ACCOUNT #: _____ SERVICE DATE(S): _____
 PATIENT'S NAME _____

Personal Financial Statement:

1. Full Name: _____ Date of Birth: _____
 Other names by which you have been known or used: _____
 Are you a US Citizen: YES ___ NO ___ Are you a Permanent Resident: YES ___ NO ___
 Social Security No. _____ Marital Status: _____
 Present Address: _____
 Apt# _____ City _____
 State _____ Zip Code: _____ Phone No. _____
 Your Drivers License # _____ State of Drivers License. _____
 Your Car:
 Year & Make of Car _____ Tag No. _____ State _____
 2. Name of Spouse _____ Spouse's DOB: _____
 Spouse's SSN# _____
 Spouse's Drivers License # _____ State of Drivers License _____
 Spouse Car:
 Year & Make of Car _____ Tag No. _____ State _____

Medical Assistance:

Have you applied for Medical Assistance: YES _____ NO _____
 If yes, what was the date you applied? ____/____/____
 If yes, what was the determination? _____

Household Members:

Name	Age	Your Relation	Dependent	
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No
			Yes	No

Banking Information

Checking Account # _____	Bank Name _____
Bank Address _____	Current Balance \$ _____
Savings Account # _____	Bank Name _____
Bank Address _____	Current Balance\$ _____

Personal Injury Claims

Do you have a personal injury claim pending? _____ Court Case# _____	
Court _____	Attorneys Name _____
Address _____	Phone _____
Insurance Name, Address _____	Address: _____ Phone: _____
Adjuster's Name _____	Address _____
Phone _____	Insurance Claim # _____

Other Assets:

Stocks, bonds, CD, or money market _____
Other Accounts _____
Other Property _____

Please list your debts and regularly monthly expenses (use the back of this sheet if you need more room).

Monthly Debts

Name/Type	Total Due	Monthly Payment
Utilities		
Car Payments - Car #1		
Car Payments - Car #2		
Credit Cards		
Car Insurance		
Health Insurance		
Other Medical Expenses		
Alimony		
Child Support		
Other Expenses:		
Other Expenses:		

Please attach the following required substantiating documentation. Your application will be denied if all required documents are not supplied

- a) Copies of your LAST TWO PAY STUBS
- b) Copy of your W-2 for the LAST TAX PERIOD
- c) Copies of your SPOUSE'S LAST TWO PAY STUBS
- d) Copy of your SPOUSE'S W-2 for the LAST TAX PERIOD
- e) Copy of your last INCOME TAX RETURN
- f) Please add a separate sheet of paper if there is any additional information you would like to be considered to help achieve a more complete understanding of your financial situation.

THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

APPLICANT NAME

APPLICANT SIGNATURE

DATE

RELATIONSHIP TO PATIENT

SUBURBAN HOSPITAL HEALTHCARE SYSTEM

ASISTENCIA FINANCIERA

Como Aplicar

Suburban Hospital brinda cuidado de calidad a todos sus pacientes sin tener en cuenta si el paciente tiene posibilidades de pagar ó no. Suburban Hospital ofrece a las personas que califican servicio gratuito ó descuentos especiales, como también plan de pagos a largo plazo. La aprobación para estos descuentos ó pagos a largo plazo están basados en la evaluación del estado financiero del paciente ó garante, sin ser tratados diferente por razones de raza, sexo, o religión. Si Ud quiere aplicar para obtener asistencia financiera, por favor completar el formulario adjunto y envíelo a:

Suburban Hospital, Inc
P.O. Box 79216
Baltimore, MD 21279
Atencion: Coordinador de Asistencia Financiera

Por favor, complete todas las preguntas del formulario adjunto y proporcione los comprobantes necesarios para determinar su elegibilidad. Su aplicación tendrá muchas demoras si no completa el formulario en su totalidad y no envía la documentación requerida. Una vez que el Coordinador de Asistencia Financiera reciba la aplicación completa, éste seguirá sus proceso y la decisión se notificará por escrito en un plazo de 7 a 10 días útiles. Si **tiene preguntas con relación al estado de su aplicación, por favor comuníquese con el Coordinador de Asistencia Financiera al teléfono 301-896-6088.**

¿Cómo califico para esta ayuda?

- El servicio debe ser medicamento necesaria
- El ingreso del paciente ó garante debe ser igual ó más bajo que el nivel de Pobreza Federal (FPL) como indica el Registro Federal; un ajuste a esta escala es ofrecida por lo menos hasta el 200 por ciento del FPL.
- El ingreso del paciente ó garante es más alto que el FPL existente como se publica en el Registro Federal y los gastos de necesidad personal (comida, casa, utilidades medicamentos etc) consumen la mayor parte ó la totalidad de sus ingresos. A parte se ésto, también deben calificar en lo siguiente:
 1. No ser dueño de una propiedad a parte del de su residencia primaria; no tener ninguna ganancia sobre el valor neto en esa propiedad. No ser dueño de acciones, bonos ó cualquier otra inversión que afecte el valor del ingreso neto del paciente ó garante.
 2. Tener un ingreso fijo como Seguro Social, retiro ó incapacitación, sin tener ningún otro ingreso.
 3. Los gastos médicos excedan 50 por ciento del ingreso mensual.
- El paciente ó garante vive en la calle, por lo que no puede aplicar a Medical Assistance.
- El paciente es difunto sin tener una persona designada como Ejecutora ó ningún bien ó propiedad esté registrado con una agencia en la correspondiente jurisdicción.
- Medical Assistance ha adjudicado el reclamo y existe un balance en la cuenta.

**SUBURBAN HOSPITAL
HEALTHCARE SYSTEM**

FORMULARIO PARA ASISTENCIA FINANCIERA

POR FAVOR DEVOLVER TODA LA DOCUMENTACION REQUERIDA A:

**Suburban Hospital, Inc.
P.O. Box 79216
Baltimore, MD 21279
Atención: Coordinador de Asistencia Financiera**

**Si tiene alguna pregunta, por favor llamar al
301-896-6088**

Por favor complete éste formulario si esta interesado en aplicar por asistencia financiera con el Suburban Hospital por los Servicios Medicos recibidos hoy. Por favor completar éste formulario y devuélvalo al Suburban Hospital a la dirección que se indica arriba con los comprobantes necesarios para su elegibilidad. Es su responsabilidad llenar éste formulario en forma exacta, honesta y completa. Si la información no es verdadera y completa resultará en la negación a su aplicación.

Si Ud es elegible para obtener beneficios de Medical Assistance (Medicaid), Ud deberá aplicar primero a Medicaid antes de que se le pueda otorgar ayuda financiera. Para preguntas con relación a su elegibilidad y el proceso para aplicar a Medical Assistance, por favor contactar su **Departamento Local de Servicios Sociales (LDSS)**. Para encontrar su LDSS, por favor llamar al 1-800-332-6347.

Esta aplicación será rechazada si no es devuelta en un periodo de 15 días a partir del día en que recibió los servicios médicos, con los comprobantes necesarios para determinar su elegibilidad. Por favor completar este formulario que es de seis páginas.

INFORMACIÓN DE LA CUENTA

NÚMERO DE CUENTA _____ **FECHA DEL SERVICIO** _____
NOMBRE DEL PACIENTE _____

**SUBURBAN HOSPITAL
HEALTHCARE SYSTEM**

ESTADO FINANCIERO PERSONAL:

1. Nombre Completo: _____ Fecha de Nacimiento: _____	
Otros nombres que haya utilizado anteriormente _____	
Es Ud Ciudadano (a) Americano(a): SI _____ NO _____	
Es Ud Residente Permanente: SI _____ NO _____	
Número de Seguro Social _____	Estado Civil: _____
Dirección Actual _____	
Apt # _____	Ciudad _____
Estado _____	Código Postal _____ Teléfono _____
Número de Licencia de Conducir: _____	
Estado de la Licencia de Conducir: _____	
Su Vehículo	
Año y Marca del Vehículo _____	Placa del vehículo _____
	Estado _____
2. Nombre del Cónyuge _____ Fecha de Nacimiento _____	
Número de Seguro Social del Cónyuge : _____	
Número de Licencia de Conducir _____	
Estado de la Licencia de Conducir _____	
Vehículo del cónyuge _____	
Año y Marca del Vehículo _____	Placa del vehículo _____
	Estado _____

Asistencia Médica

¿Ha aplicado Ud por Medical Assistance: SI _____ NO _____	
Si es afirmativo ¿ Cuando aplicó? _____	
Si es afirmativo ¿Se le notificó la decisión? _____ ¿Cuál fue? _____	

**SUBURBAN HOSPITAL
HEALTHCARE SYSTEM**

Miembros del Hogar

Nombre	Edad	Su Relación	Dependiente	
			Si	No
			Si	No
			Si	No
			Si	No
			Si	No
			Si	No

Su Casa y Empleo

¿Es dueño de su casa ó renta? _____ ¿Cuanto paga mensualmente? _____
 ¿Cuál es la porción de pago mensual de la casa que Ud tiene? _____

¿Quién es su
 Empleador _____ Dirección _____

Nombre del Supervisor _____ Teléfono _____

Su puesto _____ ¿Cuanto tiempo trabaja allí? _____

¿Cuanto es su pago neto mensual? _____

Empleador del Cónyuge _____ Dirección _____

Nombre del Supervisor _____ Teléfono _____

¿Cuanto tiempo ha trabajado allí? _____ ¿Cuanto es su pago neto mensual? _____

¿Hay algún embargo de dinero en alguno de los dos salarios? _____
 ¿Por Quién? _____

Por favor haga una lista de cualquier otro ingreso que recibe mensualmente(Por ejemplo: ayuda con la mensualidad del pago de la casa, fondo fiduciario, inversiones, pensión de divorcio,manutención de hijo, bonos, comisiones,etc.) Si Ud no tiene ningún ingreso, por favor envíe una carta de mantenimiento de la persona que le provee casa y comida. Si necesita más espacio, utilice la parte de atrás de este formulario.

**SUBURBAN HOSPITAL
HEALTHCARE SYSTEM**

Recursos é Ingresos

INGRESOS	UD	CÓNYUGE
Retiro/Beneficios de Pensión		
Beneficios de Seguro Social		
Asistencia Pública		
Beneficios de Incapacidad		
Beneficios de Desempleo		
Beneficios para Veteranos		
Pensión de Divorcio		
Ingresos de inmueble rentado		
Beneficios por Huelga de trabajo		
Ingresos si trabaja por su cuenta		
Pensión Militar		
Otros tipos de ingreso		
Por favor Describa		

INFORMACIÓN BANCARIA

Número de cuenta de la Chequera: _____
Nombre del Banco _____
Dirección del Banco _____
Balance actual en su cuenta _____
Número de Cuenta de Ahorros _____
Nombre del Banco _____
Dirección del Banco _____
Balance Actual en su cuenta _____

**SUBURBAN HOSPITAL
HEALTHCARE SYSTEM**

RECLAMOS POR ACCIDENTES PERSONALES

¿Tiene Ud un reclamo por accidente personal pendiente? _____
¿Cuál es le Número del Caso en la Corte? _____
Nombre de su Abogado _____
Dirección _____
Teléfono _____
Dirección del Seguro _____
Teléfono _____
Nombre del representante en el seguro _____
Dirección _____
Número de reclamo _____

OTROS RECURSOS ECONÓMICOS

Acciones, bonos, certificados de depósito, anualidades _____
Otras cuentas _____
Otras propiedades _____

Por favor llene la lista de cuentas y gastos mensuales regulares (use la parte de atrás si si necesita más espacio)

GASTOS MENSUALES

NOMBRE/TIPO	CUENTA TOTAL	PAGO MENSUAL
Utilidades		
Pago del Vehículo #1		
Pago del Vehículo #2		
Tarjeta de Crédito		
Seguro de Vehículo		
Seguro de Salud		
Otros gastos médicos		
Pensión de divorcio		
Manutención de hijo (s)		
Otros gastos (especificar)		

**SUBURBAN HOSPITAL
HEALTHCARE SYSTEM**

POR FAVOR ENVIAR LOS SIGUIENTES COMPROBANTES PARA DETERMINAR SU ELIGIBILIDAD. SU APLICACIÓN SERA NEGADA SI DICHS COMPROBANTES NO SON PROPORCIONADOS.

- a. Copias de los comprobantes de sus dos últimos pagos
- b. Copia de su forma W-2 del último año
- c. Copias de los comprobantes de los últimos dos pagos de su cónyuge
- d. Copia de la forma W-2 del último año de su cónyuge
- e. Copia de su ultima declaración de impuestos
- f. Por favor, incluya en una hoja separada cualquier información adicional que considere sea importante para que su caso sea aprobado.

ESTAMOS TRATANDO DE COLECTAR PAGO DE SU DEUDA Y CUALQUIER INFORMACIÓN RECIBIDA SERÁ UTILIZADA PARA ESE PROPOSITO.

Firmando este formulario, Ud esta certificando que la información dada es veraz y que cualquier cambio en su situación informará al Hospital inmediatamente dentro de un periodo máximo de diez días de su cambio.

NOMBRE DEL APLICANTE

FIRMA DEL APLICANTE

FECHA

RELACION AL PACIENTE

Community Benefit Report FY 08

Community Benefit Evaluation



Suburban Hospital Community Benefit Evaluation Framework

1. Community giving is a fundamental activity that has historically shaped Suburban Hospital's operation and outreach efforts for the past 65 years. In fact, aligning community health initiatives, charitable programs, and wellness activities that benefit our community through prevention, education and outreach are included in the organization's annual long term strategic plan. Given the opportunity to report community benefit services required by Maryland law to the HSCRC, Suburban Hospital has structured a strategic plan integrating community benefit with the organization's strategic goals. The scorecard incorporates a formal Community Benefits plan and data collection model that can easily be shared with the public and used as a benchmark for department reporting.

For example, last year, Suburban Hospital's Community Benefit Report was presented to the Board of Trustees, senior leadership, nursing directors and the organization's management team. This year, a formal data collection module was implemented for improved tracking and monitoring. Since FY07, the Community Health and Wellness department was formally incorporated into the Hospital's strategic planning process and is regularly represented at hospital operations meetings.

2. Suburban Hospital's Board of Trustees is actively engaged in an ongoing dialogue of how the organization broadly serves its community. Equally supportive is the Organization's President and CEO, who leads a motivating role in the System's planning of Community Benefit initiatives. Other hospital operations, finance, and nursing leadership along with all levels of hospital staff are equally involved in developing a community benefit plan and have historically embraced the opportunity and responsibility of reaching out to serve the community. For years, the Community Health and Wellness Department has documented community impact data. Given the instituted state requirement of Community Benefit reporting, the structured format of tracking and reporting data has afforded a natural weaving of community benefit productivity into hospital policy and operation and has been integrated in the hospital's overall scorecard. Over the last three years, Suburban Hospital's Community Benefit data has taken centerfold and formally incorporated into Suburban Hospital's quarterly newsletter, *New Directions*. Over 250,000 homes receive this publication thus resulting in positive feedback from other health officials, the hospital's System Board, and individual community members who were previously unaware of the diligent scope of Suburban's outreach and community benefit efforts.

3. Suburban Hospital's Community Benefit plan targets very specific areas of community need. For example, a Community Advisory Board was established in 1998 composed of several public and private health officials along with other outside organization leaders. The Community Advisory and Visioning team identified four specific target areas of need: A focus on health access of minority populations, underserved seniors, at-risk youth, and management of chronic diseases like Diabetes for the under/uninsured.

4. Healthy People 2010 guidelines established by the Maryland DHHS are among vital information sources used to identify community needs. Additional tools used to identify specific health challenges include analyzed utilization patterns in the hospital, data and statistics compiled by county, state and the federal government. In addition, Suburban Hospital also regularly consults with local leaders, community members, other not for profit organizations, health officers and local health providers and the use of focus groups. FY08, the department of Community Health and Wellness conducted several focus groups with members of the Hispanic community. Results from these studies have been incorporated to strengthen and customize our Latino Diabetes education and outreach programs. In addition, graduate students from the American University conducted health surveys from the Scotland teen community to identify which at risk teen behaviors were most prevalent in the target population. The result of these surveys enabled the Department of Community Health and Wellness to design future teen health programs for this unique community.

To date, Suburban Hospital continues to engage community involvement and feedback through the hospital's efforts to organize a *Community Panel for a Healthy Future* which includes a variety of hospital leadership and is composed of several community representatives from the hospital's neighborhoods and businesses with a common goal to work collaboratively on health advocacy, enhancement of services, and other community initiatives.

5. Suburban Hospital identifies its community based initiatives in great detail. (*See Community Outreach Activities & Dates Section*)

6. Suburban Hospital's community benefit initiatives reflect evidence-based needs which can be described from both a macro and micro perspective. For example, health priorities established at a macro level are guided by the State of Maryland's Department of Health and Human Services who set large scope perspectives on health priorities such as those outlined in the Healthy People 2010. Whereas a micro perspective approach may be more specifically targeted to immediate community needs as established by health partners who design Montgomery County Health Initiatives and those that comprise local health coalitions. A further example would be recognized in Suburban's role and health partnership with the *Montgomery County Cancer Crusade*. In addition to describing such micro level community based initiatives, Suburban Hospital also identifies those community needs established by individual community enclaves that approach the hospital in support of specific health disparities. For example, Suburban has continued it's partnership with *Clinica Proyecto Salud* to offer Diabetes education classes in Spanish to help control and manage the rising number of diabetics identified on a daily basis. Another evidence-based need example is Suburban's active collaboration in serving on the African American Health Program's Cardiovascular Disease Coalition to design targeted educational programs for the African American community. This innovative partnership addresses the growing numbers of individuals with hypertension which is known to lead or contribute to additional chronic diseases and health risks for this particular population.

7. Many of Suburban Hospital's community benefit initiatives are performance-based and include process and outcome measures. For example, in order to improve access to health care for the uninsured, Suburban Hospital provides free diagnostic services to community clinic patients. Since 1995 Suburban Hospital has committed to providing free diagnostic services to all *Mobile Medical Care, Inc.* patients. Suburban experiences targeted outcomes through support to several safety net providers that use valuable results from lab work and diagnostic testing provided by Suburban Hospital to treat, educate,

and manage specific illness of clinic patients before such illnesses evolve into chronic diseases and then only become treatable through long-term care which would result in an even greater cost to our healthcare system. As a result of providing free services upfront, Suburban Hospital in partnership with safety net clinics like *MobileMed*, *Clinica Projecto Salud*, and *Catholic Charities* prevent long-term effects of illness that may otherwise go untreated or unattended. As a result, measurable outcomes are observed in lower rates of emergency room visits by uninsured individuals with advanced illness that are also likely to drive costs of unforeseen hospital and physician expenses.

8./9. When addressing Community Collaboration, Suburban Hospital never engages a community health initiative alone. For example, In FY08, Suburban Hospital's Department of Community Health and Wellness conducted over 2,400 health activities. Each initiative is partnered with a school, a recreation or senior center, a County or State health coalition, other charitable organizations, community service groups, a corporate company, and even other hospitals. Suburban Hospital finds strength in numbers and therefore never commits to engaging any community activity without the support of other community participants. Therefore, the implementation of community benefit initiatives is clearly based on community feedback and involvement as they are the hospital's primary source of identifying specific community needs. For example, since 1993 Suburban Hospital regularly partners with the Greater Washington Area Chapter of Hadassah to bring the *Check It Out* program to 11 and 12 grade girls in 21 Montgomery County Public Schools to educate over 4,000 young women about the importance of early detection of breast cancer. Another example of Suburban's participation with community organizations to plan and/or implement its community benefit activities is its longstanding health partnership with the Scotland Community. The Scotland Community, which is located near the intersection of Seven Locks Road and Democracy Boulevard, includes approximately 100 low-income African-American families. Established in 1993, the Scotland Community Health Partnership addresses unmet health care needs and focuses on improving the quality of life for these families.

A partnership with the Scotland Community was formed with \$66,000 of seed money from Suburban, and is guided by a steering committee of Scotland residents; religious, governmental, and elected officials; and hospital representatives. In early 1994, this group worked with the Scotland Civic Association to conduct a community needs assessment survey. Four areas were identified as concerns: (i) primary care and wellness; (ii) addiction prevention and intervention; (iii) cardiac care; and (iv) access to a modern exercise facility. In FY08, Suburban's Department of Health and Wellness Staff in partnership with the Scotland Community Center and graduate students from American University conducted a needs assessment from health behaviors surveys of the teen population. From these surveys, a teen health promoter program was designed and implemented this past spring.

10. Caring for our community through prevention, outreach, and education have long traveled through the veins of Suburban's walls. In fact, long before the State of Maryland established the criteria for Community Benefit reporting, the Hospital's department of Community Health and Wellness historically played an integral role in involving fellow employees in serving the community, volunteering their expertise and time to benefit those in need. From adopting families for the holidays to dedicating hospital work hours to conducting health screenings, mentoring at risk youth at the local elementary schools, and teaching young individuals interested in medical careers through shadowing and interactive training.

11. Hospital leadership and management receive monthly updates of Community Benefit activities and are also given reminders regarding reporting requirements and deadlines. Community Benefit results and data are shared with the Hospital's Board of Trustees and leadership team upon the report's submission. In addition, highlights from the report are published in Suburban's quarterly newsletter that reaches 250,000 homes.

The Director of Community Health and Wellness along with the Corporate Director of Reimbursement work collaboratively to collect and calculate Community Benefit data. Given the most recent initiatives to incorporate a formal data collection process, leaders in Suburban's Management Communication team also hold an integral role in the implementation, operation, and maintenance of data collection. Furthermore, the Director of Community Health and Wellness reports to Senior Vice President of Patient Care, thereby affording steadfast support from hospital leadership in the operation, implementation, and evaluation of Community Benefit initiatives.

The Community Benefit report has been included as part of the hospital's official scorecard with targeted goals to be measured semiannually.



Listed below are the specialties that we have limited providers to serve the uninsured at Union Hospital:

- Dermatology – No providers
- Ear, Nose and Throat – 2 providers
- Endocrinology – 1 provider
- Gastroenterology –3 providers
- Rheumatology – No providers
- Oral Maxillofacial Surgeons – No providers
- Pediatricians – 4.5 providers
- Thoracic Surgery - 1 provider
- Vascular Surgery - .75 FTE providers

Appendix 2

The purpose of Union Hospital's Community Assistance (Charity Care) policy is to ensure that hospital staff follows a consistent and equitable process in granting charity/financial assistance to appropriate patients while respecting the individual's dignity and that the hospital's policy is in agreement with the established Maryland State Financial Assistance Guidelines regarding charity care.

This policy describes the application process for the Community Financial Assistance Program, the information required to verify income and assets, the timeline for application review, and the tiered adjustments based on the Federal Poverty Guidelines.

The application for Community Assistance is available to all underinsured and uninsured patients of Union Hospital. Applications are located throughout the hospital, emergency room, and outpatient areas. In addition, the Community Assistance application and brochure are available on the hospital's website. All inpatient, self pay patients are visited by finance staff and screened for the Community Assistance program as well as for Medicaid and other state and county programs. Following discharge from the hospital, each patient receives a summary of charges which includes notice of the Community Assistance program and a designated contact telephone number.

UNION HOSPITAL		Policy Number:	F-415
Elkton, Maryland		Effective Date:	03/2006
Hospital Policies and Procedures			
Community Assistance Policy and Procedure			
Developed / Edited By:	Charles A. Poggioli, Dir., Revenue Cycle	Date:	03/2006
Reviewed By:	Laurie Beyer, S.V.P. & CFO	Date:	03/2006
Approved By:	Laurie Beyer, S.V.P. & CFO	Date:	03/2006
		Established Date:	03/2004
Departments Affected:	Patient Financial Services		
Reviewed Dates:	03/2004, 6/2004, 9/2004, 3/2006		
Revised Dates:	03/2004 (replaces Charity Care Policy and Procedure), 6/2004; 9/2004; 3/2006		
JCAHO Standard(s):	N/A		
HIPAA Standard(s):			

POLICY:

It is the policy of Union Hospital of Cecil County to assist underinsured or uninsured patients by offering services to patients at a reduced cost based on demonstrated inability to pay. Determination shall be based on the Federal Poverty Guidelines.

PURPOSE:

To ensure that hospital staff follows a consistent and equitable process in granting charity/financial assistance to appropriate patients while respecting the individual's dignity and that the hospital's policy is in agreement with the established Maryland State Financial Assistance guidelines regarding charity care.

PROCEDURE:

Patient shall make application for the Community Financial Assistance Program using the Maryland State approved hospital form. The form must be accompanied by verification of income and assets (if requested). Applications returned without requested information may be denied pending receipt.

Appropriate verification may include:

- a. Pay stubs, unemployment benefits, social security checks, cash assistance checks, alimony or child support checks
- b. Federal or state tax returns
- c. Bank statements or financial records
- d. If the patient resides at a shelter, written verification of active residence and the provision of room and board must be obtained from the shelter Administrator/Director.
- e. Medical Assistance Denial Letter
- f. MA denial may not be required if the hospital representative determines that the patient will not qualify based on an initial interview.

Items needed for approval are also listed on the Financial Assistance Application. If the patient does not provide complete verification of income and assets within 30 days of the application, the request for aid through the Community Assistance Program may be rejected. Additionally, the patient may be required to apply for Medicaid prior to the hospital accepting the patient's application for services at a reduced cost. If approved for Medicaid, the patient will qualify for financial aid for any spend-down amount determined by the State.

Within two (2) business days following a patient's request for charity care services, application for Medical Assistance (Medicaid), or both, the hospital will make a determination of probable eligibility.

Once appropriate verification of income has been provided, the patient's income shall be compared to the current published Federal Poverty Guidelines based on specific family size. If the patient's income is at/or below the appropriate amount on the table, financial assistance will be granted and tiered up to a 100% adjustment for the services rendered. Final determination of eligibility will be made based upon a complete and accurate application. Should insufficient information be provided, the Financial Counselor will contact the patient to obtain additional documentation. All applications will be acknowledged; patients will be contacted by telephone, if possible, and a follow up letter will be sent indicating the level at which the application was approved or the reason for denial.

Tiered adjustments based on the Federal Poverty Guidelines are as follows:

- Up to 150% of the Poverty Level = 100% Adjustment
- 151% to 160% above Poverty Level = 85% Adjustment
- 161% to 170% above Poverty Level = 70% Adjustment
- 171% to 180% above Poverty Level = 55% Adjustment
- 181% to 190% above Poverty Level = 40% Adjustment
- 190% to 200% above Poverty Level = 25% Adjustment
- 201% to 300% above Poverty Level = 10% Adjustment

The Federal Poverty Guidelines will be updated annually based on changes by the Department of Health and Human Services.

Once eligibility for financial aid has been established the period of eligibility shall include medical care up to three months prior to and continue for six months following the date of application.

Appendix 4

The Union Hospital mission, vision, and values statement identifies the importance of providing safe, high-quality, personalized services conducted by professional, trained staff while demonstrating collaboration among all providers and prudent management of our resources.

It is the vision of Union hospital that the provision of services in this manner will result in our being the first choice for health care by community residents seeking superior quality services and personalized care in a convenient, cost-effective community setting.

Appendix 5

HOSPITAL MISSION

Our mission is to provide safe, high-quality health and wellness services to the residents of Cecil County and neighboring communities.

VISION

Residents throughout our market will turn first to Affinity Health Alliance for health care because we provide superior quality services and personalized care in a convenient, cost-effective community setting.

VALUES

- We will maintain operational excellence in the provision of high **quality** care in a safe environment.
- We are committed to providing **personalized service** treating patients and their families with compassion and superb care.
- We support the **personal and professional development** of our workforce.
- We seek **collaboration** with our staff, physicians, management, trustees, volunteers, partners, and the communities we serve.
- We **prudently manage our resources** to ensure the continuity of our services to the community.



Union Memorial
Hospital

Experience Matters
MedStar Health

UNION MEMORIAL HOSPITAL COMMUNITY BENEFIT REPORTING EVALUATION FOR FY 2008

Union Memorial Hospital, a member of MedStar Health, is one of the top specialty hospitals in Baltimore and a valued member of the communities it serves. For more than 150 years it has provided exceptional health service to the local community and beyond. The affiliation with MedStar Health assures top quality medical services are provided in the community, within an integrated health care system offering advanced care, medical research, education and community outreach.

The hospital is currently licensed to operate 301 beds and is accredited by the Joint Commission. Our annual patient volumes include more than 20,700 inpatient admissions and 175,400 outpatient and emergency department visits. Today, the hospital's main campus at 201 E. University Parkway consists of a nine-story hospital with an emergency department, one medical office building, one outpatient clinic and two other service and administrative buildings.

Approximately 50 percent of Union Memorial's total patients come from its primary service area in northeastern Baltimore City and County. This includes communities of Bolton Hill, Charles Village, Clifton, Govans, Hamilton, Hampden, Loch Raven, Overlea, Parkville, Pimlico and Roland Park. Among the hospital's well-known centers of excellence are: Curtis National Hand Center, Decker Orthopaedic Institute, Harry and Jeanette Weinberg Heart Institute and Union Memorial Sports Medicine.

To enhance the wellness of its community, Union Memorial provides an array of community-based services designed to improve the health of area residents. Working with various organizations, hospital employees and medical staff, Union Memorial participates in health education and screenings as well as provides support activities for individuals in the community living with chronic health conditions.

Union Memorial reinvests revenues in excess of expenses to enhance its capability to deliver high-quality care. These resources provide for a long-term focus on recruitment and retention of outstanding medical professionals, enhancing research and technology, and new facilities and services. In addition, such resources enable Union Memorial to provide numerous other services that benefit the community.

Our Mission

Union Memorial Hospital is a comprehensive hospital with regional specialty services of distinction and quality community services, all enhanced by clinical education and research.

Our Vision

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

Community Benefits Plan

Union Memorial's community benefits plan regularly aligns with its strategic initiatives. The plan is developed with the guidance of key stakeholders and assessment of state reports and patient data. Priorities and programs are developed to serve demonstrated needs, with a special focus on populations who are known to have difficulty accessing care and programs that improve overall health.

Community benefit encompasses a wide variety of resources and programs; highlights include:

Charity care

Union Memorial treats all patients, regardless of their ability to pay. It provides care without charge, or at a discounted rate, to patients who meet certain criteria. The hospital's financial aid policy is consistent with our mission and vision and takes into account each patient's ability to contribute to the cost of his or her care. During fiscal year 2008, Union Memorial provided more than 9.4 million in charity care.

Services and medical specialties

In fiscal year 2008, the Cancer Program at Union Memorial continued its commitment to the community through numerous outreach services including screenings for breast and cervical, colorectal, lung and prostate cancer. Some screenings are provided free of charge for individuals who meet certain criteria.

Support groups offer patients and the community a way to cope with the issues they face with the comfort of knowing others are there to help. Union Memorial offers various support groups conducted at the hospital and supported by staff members who organize, facilitate and lecture. Examples of 2008 support groups are:

- Breast cancer
- Prostate cancer
- Cancer
- Smoking Cessation education
- Firefighter Assessment Program
- Yoga for Senior

Union Memorial Sports Medicine provided countless hours of free medical care for student athletes and athletic events throughout the community, such as the physician coverage for Ripken Baseball team and Baltimore Mariners AIFA football team, as well as provided the financial support for the Athlete Training Program at Loyola College.

Continuing Education

As a teaching hospital, continuing education for nurses and physicians, as well as educating the next generation of health care providers is a priority for Union Memorial.

Resident and fellowship training

Union Memorial is committed to training the health care leaders of tomorrow. We strive to provide excellent training for residents and medical students, while offering high-quality medical care. A wide variety of specialties, advanced technology and innovative research combine to promote health education and the well-being of patients.

70 residents were trained at Union Memorial in fiscal year 2008. Fellowships provide advanced training in the specialties of hand surgery, foot and ankle surgery, adult reconstruction, rhinology and sports medicine. Union Memorial also provides the CPR education for related healthcare personnel to maintain their CPR and ACLS status.

Community Service Activities

Union Memorial encourages volunteerism among its employees, physicians and auxiliaries. Each year, our staff volunteers its time and other resources to make a positive impact and build safe and healthy communities. Examples of community services projects in fiscal year 2008 included:

Physicians from department of medicine provided voluntary health care in Shepherd's Clinic for the individuals who do not have health insurance and are not eligible for government-assisted health care, such as Medicare or Medicaid.

Through the Camp Sunrise, employee deals with the special needs of the children and teenagers with pediatric oncology and helped them to build self-confidence and independence, emotional and social development and well being, and learn and share support with others who has similar conditions.

Sponsorships

Union Memorial also provides financial support to other non-profit community causes, such as the Baltimore Heart Walk. In fiscal year 2008, Union Memorial was again a proud sponsor of the annual walk, which raises money to support the American Heart Association's research, education and advocacy efforts. The Union Memorial team was comprised of 249 employees, family and friends. Collectively, the team raised \$22,200.

Union Memorial also offer financial support to the Shepherd's Clinic, a non-profit clinic provides health care to individuals who do not have health insurance and are not eligible for government-assisted health care, and to Big Brother Big Sister, an non-profit agency that provides the influence of positive adult role models and the friendship of caring adult mentors to children whose education, health, and safety are threatened.

Summary of Net Community Benefits

Category	# of Served	Net Benefit
Community Health Services	151,792	2,091,827
Health Professions Education	1,368	13,499,340
Mission Driven Health Care Services	N/A	5,926,795
Research	N/A	147,230
Financial Contributions	N/A	453,690
Community Building Activities	793	212,873
Community Benefit Operations	N/A	5,890
Charity Care	N/A	9,403,600
Foundation Funded Community Benefit	N/A	0
Total	153,953	31,741,246

Appendix 1

MedStar Health FY 2008 Community Benefit Report Specialist Gaps

The HSCRC has requested that hospitals document gaps/shortages in our communities with regard to specialists. Gaps exist in the availability of both primary care and specialist providers to serve the uninsured in the hospital.

Diminishing the gaps in specialty services for all patients (uninsured and insured) is very important to MedStar. By operating as a system, which includes Franklin Square Hospital Center, Good Samaritan Hospital, Harbor Hospital, Montgomery General Hospital¹, Union Memorial Hospital, Georgetown University Hospital, National Rehabilitation Hospital, and Washington Hospital Center, our goal is to ensure all sites access to MedStar's entire medical staff, including specialty resources when required. Our sites utilize current and planned office space on their campuses to encourage physicians to treat and follow-up with patients in close proximity to the hospital. Our current and planned Emergency Department improvements allow for state of the art treatment of more patients with enhanced care.

Per physician leadership and case management staff, there remain several areas of concern in our communities:

- a) Limited availability of inpatient and outpatient psychiatry services, including substance abuse
- b) Medication assistance for patients
- c) Transportation assistance
- d) Limited durable medical equipment providers
- e) Limited skilled nursing services in the home and/or at rehab facilities
- f) Limited availability of hospice care
- g) Limited health care services for the homeless and undocumented residents

¹ Note: Since joining MedStar in February of 2008, the affiliation has already significantly increased Montgomery General Hospital's specialty resources for neurosurgeons, orthopedic, including rehabilitative services.

Appendix 2

MedStar Health Financial Assistance Policy HSCRC Community Benefit Response

MedStar Health provides financial assistance to the uninsured patients based on income and family size starting at 100% up to 200% of the federal poverty level and a sliding scale for those between 201-400% of the federal poverty levels. Patients must reside in our defined primary and secondary service areas but exceptions can be made for patients treated in one of our specialty services as well as any extenuating circumstances. In addition, patients have the responsibility to comply with our requirements in completing a Medicaid application if deemed eligible through our financial screening and must provide all necessary information for final determination. MedStar Health's facilities will assist uninsured patients who reside within the community to enroll in publicly-funded entitlement programs, publicly funded programs for the uninsured, assist with consideration of funding available from other charitable organizations or offer periodic payment plans to assist patients with financing their healthcare services.

All self pay patients that are either scheduled admissions or ambulatory surgeries receive a thorough financial screening from our on site advocates including Medicaid eligibility or any other federal or state funded program. In addition, they are screened for financial assistance. Emergency admissions are also screened in this manner after the admission occurs. Other outpatients may receive screening afterward their services if they fall into defined criteria for potential MCHIP program. In addition, outpatients may be screened if they identify the inability to pay or the desire to apply for either Medicaid or financial assistance.

Appendix 2

Signs are posted in all registration areas in both English and Spanish. There are patient advocates located on sight during normal business hours to assist patients at the facilities in their application process. In addition, each hospital funds a portion of the State case workers' salary to have that individual available on-sight to work in conjunction with the patient advocate staff and patients to complete the application process. Any patient that completes the application process will be given a list of items that they must provide in order to complete the eligibility process before or at time of discharge. Additional outreach services are provided after discharge and agencies are used for those patients that are less corporative or that need assistance in securing documents or transportation for application completion. These agencies also assist in the appeal process for both Medicaid and Social Security Disability denials.

Each facility provides brochures and or admission packets advising them of the financial assistance policy and where they can inquiry for further information. Applications will be provided at time of registration if the patient makes a request. Our statements provide a number (local and toll free) for patients to contact.

Upon receipt of eligibility determination, the financial services department will either process the claim for billing and reimbursement to the appropriate federal or state program identified and or process the financial assistance application. A final determination letter will be sent to the patient from both the program for which he applied as well as the financial services department at MedStar regarding their financial assistance disposition.

Appendix 2

Lastly, an automated file is run on a weekly basis to validate Medicaid eligibility on any self-pay patients that the patient has been uncooperative and we have been unsuccessful in completing the application for Medicaid on their behalf in the event that they have done so and failed to notify us.

Appendix 3

MedStar Health

Financial Assistance for Uninsured Patients Policy Statement

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

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

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

- Assist with enrollment in publicly-funded entitlement programs (e.g., Medicaid).
- Assist with enrollment in publicly-funded programs for the uninsured (e.g., D.C. Healthcare Alliance).
- Assist with consideration of funding that may be available from other charitable organizations.

¹ This policy does not apply to insured patients who may be "underinsured" (e.g., patients with high-deductibles and/or coinsurance). This policy also does not apply to patients seeking non-medically-necessary services (including cosmetic surgery).

Appendix 3

- Provide charity care and financial assistance according to applicable guidelines.
- Provide financial assistance for payment of facility charges using a sliding scale based on patient family income and financial resources.
- Offer periodic payment plans to assist patients with financing their healthcare services.

Each MedStar Health facility (in cooperation and consultation with the finance division of MedStar Health) will specify the communities it serves based on the geographic areas it has served historically for the purpose of implementing this policy. Each facility will post the policy, including a description of the applicable communities it serves, in each major patient registration area and in any other areas required by applicable regulations, will communicate the information to patients as required by this policy and applicable regulations and will make a copy of the policy available to all patients.

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

- Completing financial disclosure forms necessary to evaluate their eligibility for publicly-funded healthcare programs, charity care programs, and other forms of financial assistance. These disclosure forms must be completed accurately, truthfully, and timely to allow MedStar Health's facilities to properly counsel patients concerning the availability of financial assistance.
- Working with the facility's financial counselors and other financial services staff to ensure there is a complete understanding of the patient's financial situation and constraints.
- Completing appropriate applications for publicly-funded healthcare programs. This responsibility includes responding in a timely fashion to requests for documentation to support eligibility.

Appendix 3

- Making applicable payments for services in a timely fashion, including any payments made pursuant to deferred and periodic payment schedules.
- Providing updated financial information to the facility's financial counselors on a timely basis as the patient's circumstances may change.

Charity Care and Sliding-Scale Financial Assistance

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

The determination of eligibility will be made as follows:

1. Based on family income and family size, the percentage of the then-current federal poverty level for the patient will be calculated. If this percentage exceeds 400%, the patient will not be eligible for charity care or sliding-scale financial assistance unless determined eligible in step 3. If the percentage is less than or equal to 400%, the patient is provisionally eligible, subject to the financial resources test in step 2.
2. The patient's financial resources will be evaluated by calculating a pro forma net worth for the patient and her family, excluding (a) funds invested in qualified pension and retirement plans and (b) the first \$100,000 in equity in the patient's principle residence.² The pro forma net worth will include a deduction for the anticipated medical expenses to be incurred during the twelve months commencing on the date of the patient's admission to the facility. If the pro forma net worth is less than \$100,000, the patient is eligible for

² Net worth calculations will incorporate the inclusions and exclusions used for Medicaid. Anticipated recoveries from third parties related to a patient's medical condition (*i.e.* recovery from a motor vehicle accident that caused the injuries) may be taken into account in applying this policy.

Appendix 3

charity care or sliding-scale financial assistance; if the pro forma net worth is \$100,000 or more, the patient will not be eligible for such assistance.

3. For patients whose family income exceeds 400% of the federal poverty level, adjusted family income will be calculated by deducting the amount of medical expenses for the subject episode of care anticipated to be paid during the ensuing twelve month period. This calculation will consider any periodic payment plan to be extended to the patient. Based on this adjusted family income, the adjusted percentage of the then-current federal poverty level for the patient will be calculated. If this percentage exceeds 400%, the patient will not be eligible for charity care or sliding-scale financial assistance. Periodic payment plans may be extended to these patients.

For patients who are determined to be eligible for charity care or sliding-scale financial assistance, the following will be applicable based on the patient’s percentage of the federal poverty level (or adjusted percentage, if applicable):

<i>Adjusted Percentage of Poverty Level</i>	<i>Financial Assistance Level</i>	
	<i>HSCRC-Regulated Services³</i>	<i>Washington Facilities and non-HSCRC Regulated Services</i>
0% to 200%	100%	100%
201% to 250%	40%	80%
251% to 300%	30%	60%
301% to 350%	20%	40%
351% to 400%	10%	20%
more than 400%	no financial assistance	no financial assistance

³ The assistance levels described above for HSCRC-regulated services do not include any discounts that may be applicable under the HSCRC’s prompt payment regulations.

Appendix 3

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

Appendix 4a

MedStar Health FY 2008 Community Benefit Report Vision, Mission, & Values

MedStar Health has adopted a vision and mission, along with the six values shown below. All MedStar hospitals, including the five hospitals in Maryland (Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, Montgomery General Hospital, and Union Memorial Hospital) share the same MedStar Health Vision and Values. See Appendix 4b for each hospital mission statement.

Mission:

To serve our patients, those who care for them, and our communities

Vision:

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

SPIRIT Values:

S = SERVICE

P = PATIENT FIRST

I = INTEGRITY

R = RESPECT

I = INNOVATION

T = TEAMWORK

Appendix 4b

MedStar Health FY 2008 Community Benefit Report Hospital Mission Statements

Hospital Mission Statements Include:

Franklin Square Hospital:

Franklin Square Hospital Center, a member of MedStar Health, provides the highest quality healthcare and education to our communities.

Good Samaritan Hospital:

We are Good Samaritans, guided by Catholic tradition and trusted to deliver ideal healthcare experiences.

Harbor Hospital:

Harbor Hospital is committed to quality, caring and service for our patients and our communities.

Montgomery General Hospital:

Montgomery General Hospital, a member of MedStar Health, is dedicated to enhancing our community's health & well-being by offering high-quality, compassionate, and personalized care.

Union Memorial Hospital:

Union Memorial Hospital is a comprehensive hospital with regional specialty services of distinction and quality community services, all enhanced by clinical education and research.

**MedStar Health
FY 2008 Community Benefit Report
Subsidy Justification**

The Catholic Health Association guidelines for Community Benefit Reporting allow inclusion of losses for services defined as subsidized care, broadly defined as services that are “needed in the community and other providers are unwilling to provide the services, or the services would otherwise not be available to meet patient demand.” In most cases, these subsidies directly relate services for uninsured or underinsured patients.

The HSCRC has addressed the treatment of these services, requiring that hospitals clearly explain all subsidies included within Category C of their Community Benefit Report.

Category 1 Subsidies:

Hospital-based physicians with whom the hospital has an exclusive contract and/or subsidy IN ORDER TO RETAIN SERVICES THAT REPRESENT A COMMUNITY BENEFIT

- a) Primary Care Subsidies, including Diabetes – These are clinic-based physician practices that provide primary health care services. Most of the patients are from the local community and are low-income families. This service generates a negative margin; however, the practice addresses a community need and supports the hospital’s mission of commitment to patients, communities, physicians and employees. Providing this service allows the local community access to health care services, and therefore more preventive measures and an improvement of the patients’ health status are achieved.
- b) OB and Pediatric Subsidies, including Breast Surgery – These represent physician practices providing health care services for obstetrics, gynecology, and pediatrics where a negative margin is generated. A large number of our patients receiving these services are from minority and low-income families. Prenatal care is provided and OB/GYN and pediatric coverage is provided 24 hours/day. Preventive measures and improvement of the patient’s health status are achieved. The services address a community need for women’s health and children’s services for lower income and minority families.
- c) Radiology Subsidies - For certain sites, payment is made to radiologists to provide services on a 24-hour basis generating a negative margin. These specialists are difficult to recruit due to extreme shortage and nature of the services and the 24-hour availability commitment. The community needs for these services are being met. Our community includes many low- income and minority families.
- d) Surgical House Subsidies - For certain sites with a higher percentage of indigent patients, private physicians often are not willing to provide 24 hour on-call

service. The hospital absorbs these costs and has a negative margin. The community's needs are met.

- e) Psychiatric/Behavioral Health Subsidies - The overall cost of 24/7 Psychiatry physician coverage is disproportionate to the total collections from the patients seen by these physicians during off hours. Many of these patients are uninsured. Our hospital absorbs the cost of providing psychiatric supervision for the Emergency Department on a 24/7 basis. If these services were not provided, the patient would be transported to another facility to receive these services. The community needs are being met and commitment to patients is exhibited by providing these services.

Category 2 Subsidies:

Non-Resident house staff and hospitalists

- a) Hospitalist Subsidies - Payments are made to an inpatient specialist group to provide 24/7 services in the hospital; resulting in a negative profit margin. The service focuses on preventive health measures and health status improvement for the community.
- b) ENT Subsidies - Payments are made for a non- resident ENT fellowship to provide 24/7 services in the hospital; resulting in a negative profit margin. The service focuses on preventive health measures and health status improvement for the community.

Category 3 Subsidies:

Coverage of Emergency Department call

- a) ER Subsidies - These include the cost of providing on-call specialists for the Emergency Department for certain surgical specialties. These specialists otherwise would not provide the services because of the low volumes and a large number of indigent patients served. If these services were not provided, the patient would be transported to another facility to receive the specialty services. The community needs are being met and commitment to patients is exhibited by providing these services.

Category 4 Subsidies:

Physician provision of financial assistance to encourage alignment with hospital financial assistance policies

No subsidies reported.

Category 5 Subsidies:

Recruitment of physicians to meet community need as shown by a hospital's medical staff development plan

- a) Anesthesiology Subsidies - This subsidy relates to payments made to anesthesiologists to provide services generating a negative margin. These specialists are difficult to recruit due to extreme shortage and nature of the services and the 24-hour availability commitment. The community needs for health services are being met.

Other Subsidies:

Non-Physician Subsidies

- a) Adult Day Care Subsidies - Adult Day Care services are provided at a negative margin. The community has a need for patient care related to the elderly and disabled. The needs of the participants' family are met. Family members can feel confident that their relatives are being cared for when they cannot be there. Again, a majority of people receiving this service come from low income and minority families.
- b) Cardiac Rehabilitation - One of our sites subsidizes cardiac rehabilitation services to the community.
- c) Community HIV Services Support Subsidies – HIV clinic services are provided at a negative margin. These services include nurse care management, social work, and medical services and help over 200 people who are mostly indigent.
- d) Child Development Center Subsidies - Good Samaritan's Child Development Center opened in 1990 to serve a large number of employee parents by caring for their children ages two to four. The Center also serves parents in the community by providing an environment that is supportive, consistent, and attentive to their needs. Services are provided at a negative margin.
- e) Renal dialysis Program - Good Samaritan Hospital operates the largest not-for-profit dialysis center in the Baltimore area. The Program offers a complete range of renal dialysis services. A social worker is assigned to each patient to address issues such as education, transportation and support. The Program includes a monthly class where, patients and their families can learn more about hemodialysis, peritoneal dialysis and transplantation. These Program services are provided at a negative margin.
- f) Low Income Housing - Sponsored and managed by Good Samaritan Hospital, the facilities of Belvedere Green and Woodbourne Woods provide rent-subsidized apartments and many other features for its residents. Services provided include transportation to doctors' offices, social work consultation, and assistance with healthcare needs, including educational programs, health screenings, and medication schedules. These senior living services operate at a negative margin.

- g) Pharmacy Care Counseling – For patients concerned about their ability to afford their medication, Good Samaritan Hospital provides an advocate who helps them apply for and manage the many programs that provide medication patient assistance.

- h) Subacute Program - Transitional care, sometimes called sub-acute or extended care, is designed for patients who are too sick to go home, but not sick enough to remain in a traditional hospital bed. Patients benefit from the transitional care setting because it provides them with the care and education they need while preparing them to return to their previous living situations. Many times, Rehabilitation services are provided to maximize each patient's level of function and assist patients and their families to cope with the physical limitations secondary to illness or injury. These services are provided at a negative margin.

UMMC FY08 COMMUNITY BENEFIT REPORT

1. University of Maryland Medical Center is a 698 licensed bed facility with 35,982 inpatient admissions in FY08.

2. The University of Maryland Medical Center (UMMC) serves Baltimore City and the greater metropolitan region, including patients with in-state and out-of-state referrals for tertiary and quaternary care. UMMC is a private, non-profit acute care hospital and is affiliated with the University of Maryland School of Medicine, as well as the surrounding professional schools on campus. It is the second leading provider of healthcare in Baltimore City and the state of Maryland, and has served the state's and city's populations since 1823.¹

According to U.S. Census Bureau 2007 population estimates, Baltimore City's population was at 637,455. Forty two percent of UMMC's patients reside in Baltimore City. While UMMC serves all of Baltimore City, many of the patients reside in West Baltimore City. According to the Baltimore City Health Status Report 2008, African Americans or Blacks make up 64% of Baltimore City's population. Whites comprise 32.5% of the population followed by Hispanic or Latino representing 2.5%. The remaining racial makeup is comprised of Asian, American Indian, Native Hawaiian/Pacific Islanders and other races. The total population is shown in the chart below.

Baltimore City Population by Race/Ethnicity, 2007		
<i>Total Population</i>	<i>637,455</i>	<i>Percent</i>
Black or African American alone	407,851	64.0%
White alone	206,921	32.5%
Asian alone	13,077	2.1%
American Indian and Alaska Native alone	2,176	0.3%
Native Hawaiian and Other Pacific Islander alone	295	0.0%
Two or more races	7,135	1.1%
Not Hispanic or Latino	621,602	97.5%
Hispanic or Latino	15,853	2.5%

Source: U.S. Census Bureau, 2007 Population Estimates
Source: Baltimore City Health Status Report 2008

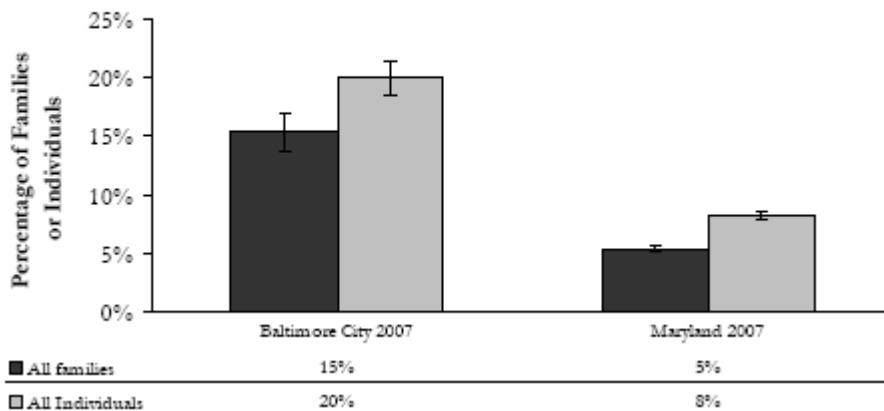
Forty percent of Baltimore City households reported an income of less than \$30,000 in 2007. Statewide, 20% of households reported an income in this range. The 2007 median household income in Baltimore City for all races was \$36,949; approximately half of the statewide median income.

2007 Median Household Income in the Past 12 months (in 2007 Inflation Adjusted Dollars), Baltimore City	Estimate	Margin of Error*
All Households	36,949	+/-896
Black or African American Alone	32,023	+/-1,276
White Alone	51,584	+/-2,805
Asian Alone	48,689	+/-11,504
Native Hawaiian and Other Pacific Islander Alone	61,711	+/-1,486
Two or More Races	34,860	+/-6,279
Hispanic or Latino	33,890	+/-5,883
White Alone, Not Hispanic or Latino	52,638	+/-3,624

Source: Baltimore City Health Status Report 2008

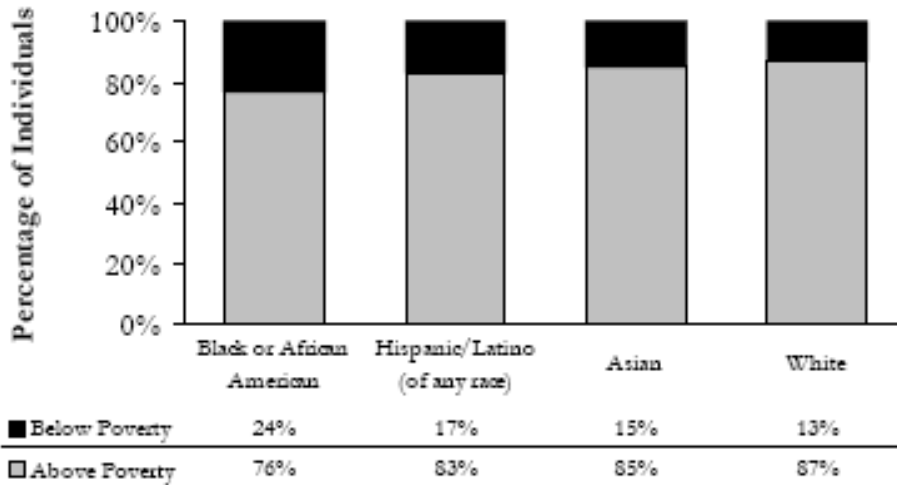
In 2007, the U.S. Census Bureau Poverty Threshold stated a family of four with two adults and two children under 18 years would be considered “below poverty” if their annual income was less than \$21,027. Three times as many families living in Baltimore City had an income that was below the poverty level compared to Maryland families in 2007. More than three-quarters of Baltimore City residents of all races were above the poverty level, however, African American residents of Baltimore City were almost two times more likely than White residents to have a median income below the poverty level.

Percentage of Families and Individuals Whose Income is Below Poverty Level (and 90% CI), Baltimore City vs. Maryland 2007



Source: Baltimore City Health Status Report 2008

**Percent of Individuals Above and Below Poverty by
Race/Ethnicity, Baltimore City, 2007**



Source: Baltimore City Health Status Report 2008

In FY2008, University of Maryland Medical Center had over 35,000 discharges. Approximately 20% of the hospital's discharges had Medicaid as a financial payor. Thirteen percent of the patients are considered uninsured.

In 2006, heart disease, cancer and cerebrovascular disease were the top three leading causes of death in Baltimore City and nationwide. There were 7,017 deaths among Baltimore City residents, resulting in an all-cause mortality rate of 1083.4 per 100,000. Among race/ethnic groups, African Americans had the highest mortality rate both in Baltimore and statewide.

- UMMC commissioned the Jackson Organization to conduct a telephone market research survey of consumers living in its service area. Interviews were conducted with the household's main healthcare decision maker from June 10 through July 1, 2005. These interviews were conducted with residents in a number of zip codes (see Chart 1 below). The survey was conducted to develop a profile of the health status, concerns, and needs of the community served by UMMC.

Chart 1 describes the geographic area under investigation.

Chart 1
Survey Area
(n=300)

Area	Zip Code	Sample Percent	Households In The Area
West Baltimore City	21207, 21211, 21215, 21216, 21217, 21223, 21225, 21229, 21230	48%	138,431
Other Baltimore City	21202, 21206, 21212, 21213, 21218, 21224, 21239	28	107,542
Surrounding	21045, 21093, 21117, 21144, 21208, 21227, 21228	24	100,635
		Total	346,608

Source: The Jackson Organization UMMC 2005 Needs Assessment

4. UMMC commissioned the Jackson Organization to conduct a telephone market research. The issues identified that correlated most highly to consumers' health status were stroke, diabetes, high blood pressure and incontinence. These were considered services of importance to UMM in terms of increasing community awareness and access to care.
5. UMMS created the University of Maryland Community Outreach and Advocacy team that meets bi-monthly to address the health care needs of the West Baltimore community. The group is comprised of community outreach management and staff, social workers, directors, vice president's, and physicians from UMMS system hospitals. The group determines what needs are addressed as well as community involvement and activities each year.
6. ***From the Heart...An Afternoon of Heart Health and Education for the Entire Family***

The UMMS Community Outreach and Advocacy team, hosted "*From the Heart, An Afternoon of Heart Health Education for the Entire Family,*" The event was held at the Reginald F. Lewis Museum of Maryland African American History and Culture in recognition of National Heart Month and drew hundreds of Baltimore City community members. We emphasized the importance of living a heart healthy lifestyle by offering heart-related health screenings and information, stroke and diabetes prevention, and fun heart-related activities for children. The main attraction of the day was the heart-healthy cooking demonstrations, by 3 well known Baltimore chefs, while the chefs prepared healthy dishes, Yvette Rooks, M.D. presented mini- health seminars on the importance of maintaining a healthy lifestyle with food choices, portion control, and preparation.

The event was very well received from the community and we are currently planning to make this an annual event.

Take a Loved One to the Doctor Day

Take a Loved One to the Doctor Day is an annual event focused on improving health in the West Baltimore community. This year's event was held in the heart of Baltimore City at the War Memorial Building. We choose this particular location because of the convenient accessibility to all forms of public transportation and local businesses. Baltimore City employees we allowed 2 hours off from work to attend and many of them brought family members who are in need of healthcare. From community resources, to on site screening for vascular disease and glaucoma, to prevention and wellness information, and testing for cholesterol, HIV, and diabetes, this event had it all! Something new this year was the team of UMMC Family and Community Medicine residents that were on site for one-on-one consultations. The attendees could feel free to ask questions about specific health concerns, and how to access care.

An estimated 2,500 community members attended the event, making this another great UMMS sponsored event.

In addition to the large community events, the UMMS Community Outreach and Advocacy team participate and coordinate the following: employee health fairs, blood pressure screenings, physician lead health and wellness talks for local businesses, churches, senior & community centers, and many community events and fairs each year. Cancer, diabetes, and heart disease prevention are the main focus of these events.

7. At each of our larger UMMS Community Outreach events, we currently ask each participant for their demographic information and the following: do they currently see a UMMS or other physician, have health insurance, and if they would like to receive information on our up-coming events or other health related information. This information is then put into a database and our business development team is in the process of developing a tracking system when participants go to a UMMS hospital either as inpatient or outpatient care.

Our team performs "on the spot" evaluations by asking various attendees their thoughts about the events, what they liked, disliked, was the location satisfactory, what would they also like to see, etc. Our team then compiles this information in a written summary and shares it with the team at up-coming committee meetings.

We ask our vendors to rate the event by the following; location, time, attendance, how many people they saw, etc. The response from vendors has been overwhelmingly positive, and feels that our events are a true benefit to the community.

8. As an academic medical center, there are no gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured cared for by the hospital.
-

Appendix 1

Description of Charity Care Policy

University of Maryland Medical Center's Financial Clearance Program Policy is a clear, comprehensive policy established to assess the needs of particular patients that have indicated a possible financial hardship in obtaining aid when it is beyond their financial ability to pay for services rendered.

UMMC makes every effort to make financial assistance information available to our patients including, but not limited to:

- Signage in main admitting areas of the hospital
- Brochures explaining financial assistance are made available in all patient care areas
- Appearing in print media through local newspapers

Appendix 2

**UNIVERSITY OF MARYLAND MEDICAL
CENTER
JAMES LAWRENCE KERNAN HOSPITAL
UNIVERSITY SPECIALTY HOSPITAL**

FINANCE POLICY AND PROCEDURE MANUAL

Effective Date: September 2008

Revision: December 2008

**SUBJECT:
FINANCIAL CLEARANCE PROGRAM**

APPROVALS:

- **SVP & Chief Financial Officer**
-

POLICY STATEMENT

This policy outlines the principles of the Financial Clearance Program, also formerly known as the Financial Assistance Program. The Financial Clearance Program is available to all legal residents of the State of Maryland who demonstrate an inability to pay for all or a portion of their prospective or outstanding hospital bill.

SCOPE

The Financial Clearance Program may cover all medically necessary and appropriate hospital-based services provided by the Hospital (which for this policy includes the University of Maryland Medical Center, University Specialty Hospital, and Kernan Hospital) when ordered by a physician on the Hospital's medical staff.

The Financial Clearance Program does not cover the following:

- Services provided by healthcare providers not affiliated with the Hospital (e.g., durable medical equipment, home health services).
- Insurance co-payments for need-based programs such as Medicaid.
- Unpaid balances resulting from cosmetic or other non-medically necessary services.
- Patient convenience items.
- Patient meals and lodging.
- Physician bills.

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The Patient Financial Services (PFS) staff administers the Financial Clearance Program and evaluates each application in a fair and equitable manner. If PFS staff is unable to review and financially clear a non-emergent/urgent service *before* it has been scheduled to be provided, such service may be subject to rescheduling, after consultation with Hospital Management and the patient's physician. The Hospital 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.

PROCEDURE

1.1 The Financial Clearance Program is available to all legal residents of the State of Maryland who demonstrate an inability to pay for all or a portion of their outstanding hospital bill. In order to be eligible, patients must complete an application and provide all required documentation.

1.2 Individuals are ineligible for the Financial Clearance Program if they:

- 1.2.1 Refuse to provide requested documentation or provide incomplete information.
- 1.2.2 Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Hospital due to insurance plan restrictions/limits.
- 1.2.3 Fail to pay co-payments as required by the Financial Clearance Program.
- 1.2.4 Fail to keep current on existing payment arrangements with the Hospital or one of its affiliate Hospitals.
- 1.2.5 Fail to make appropriate arrangements on past payment obligations owed to the Hospital or one of its affiliate Hospitals (including those patients who were referred to an outside collection agency for a previous debt).
- 1.2.6 Refuse to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.

1.3 Before scheduling hospital based, non-emergent/urgent services for individuals indicating an inability to pay, staff from the faculty practice plans will contact the Hospital's Financial Counseling team to inform them that a patient is being referred for Financial Clearance.

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- 1.3.1 Patients must have a referring/attending physician on staff at the Hospital before they may be evaluated for Financial Clearance eligibility.
- 1.3.2 Patients can call Financial Counseling staff directly at (410) 821-4140. Hours of operation are Monday – Friday from 8:00 a.m. to 9:00 p.m.
- 1.3.4 The Financial Counselor will work with the patient to determine if he/she qualifies for Financial Clearance. A determination of probable eligibility will be made within two business days following a patient's initial completed request for Financial Clearance services, application for Medical Assistance, or both.
- 1.3.5 Notice of the availability of Financial Clearance/Financial Assistance shall be posted in the Admissions Office, Business Office, and Emergency Areas of the Hospital. Such notice will be posted in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing Hospital services.
- Individual notice of the availability of Financial Clearance/Financial Assistance, the potential for Medicaid eligibility, and the availability of assistance from other government funded programs shall be provided to each person who seeks services in the Hospital at the time of community outreach efforts, prenatal services, preadmission, or admission. Such notice will be printed in English, Spanish, and/or any other language that will be understandable to target populations of patients utilizing Hospital services.
- 1.3.6 The Hospital will publish notice of the availability of Financial Clearance/Financial Assistance annually in the Baltimore Sun Paper.
- 1.3.7 If the patient does qualify for Financial Clearance, the Financial Counselor will notify the physician and/or physician office staff who may then schedule the patient for the appropriate Hospital-based service.
- 1.3.8 If the patient does not qualify for Financial Clearance, the Financial Counselor will notify the physician and/or physician office staff of the determination and the non-emergent/urgent Hospital-based services will not be scheduled.
- 1.3.9 A decision that the patient may not be scheduled for Hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Physician Leader/Clinical Chair. The Financial Clearance Executive Committee is comprised of the Medical Center Chief Financial Officer and Chief Medical Officer or their designees.

1.4 If there is a change in the patient's financial circumstances, an updated or new application must be completed.

2.0 GUIDELINES

2.1 For emergent/urgent services, applications to the Financial Clearance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving these types of services.

2.2 For scheduled/elective appointments or admissions, all applications to the Financial Clearance Program must be evaluated and approved prior to the patient's date of service.

2.3 The Hospital reserves the right to request and review all pertinent information, including a review of an applicant's credit report history, for purposes of processing the application.

2.4 All applicants will be screened for other programs before screening for the Financial Clearance Program can begin. The other programs are as follows (in order of screening):

2.4.1 Maryland Medicaid—A denial letter may be required, if appropriate.

2.4.2 Other needs based assistance programs.

2.5 Applicants or family members are not eligible for the Financial Clearance Program if they qualify for Medicaid.

2.6 Unemployed applicants who have been unemployed for more than six (6) months and who have no custodial dependents under the age of 12 must provide proof of disability, as evidenced by a physician's certification, prior to qualifying for the Plan. Exceptions to this rule may be considered in accordance with Section 2.19 below.

2.7 Patients who falsify the Financial Clearance Program application or related documentation will be excluded from the Program and will be held responsible for all charges incurred while enrolled in the Program retroactively to the first day that charges were incurred under the Program.

2.8 One hundred percent Financial Clearance may be granted to uninsured patients whose sources of income is less than two times the federal poverty income level and who have less than \$10,000 in total assets. Financial Clearance will be granted on a sliding scale to uninsured patients with incomes more than two times the federal poverty income level.

2.9 Cost of care will be included in the determination of patient's eligibility for Financial Clearance.

2.10 The amount of uninsured medical costs will be considered in determining a patient's eligibility for the Financial Clearance Program, (*e.g.*, a patient whose income is \$40,000 a year but whose child recently incurred \$200,000 in uninsured medical costs).

2.11 The Financial Clearance Program decisions are valid for a six-month period. In order to continue in the Program, each patient must reapply before the end of each six month period. In addition, patients who have been approved for the Program must inform the Hospital of any changes in income, assets, expenses, or family status within 30 days of such change(s).

2.12 The patient must fulfill all co-payment obligations. Co-payments are due at the time of service. If a patient fails to pay the required co-payment at the time of service, he/she will no longer qualify for the Financial Clearance Program.

2.13 The Financial Clearance Program will not cover co-insurance or deductibles for patients who have insurance, including Medicare.

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

2.15 Patients whose insurance program or policy denies coverage for services at the Hospital by their insurance company (*e.g.*, HMO, PPO, Workers Compensation, or Medicaid), are not eligible for the Financial Clearance Program.

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

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

2.18 Where there is a compelling educational and/or humanitarian benefit, School of Medicine faculty or Hospital faculty may request the Financial Clearance Executive Committee to consider exceptions to the Financial Clearance Program guidelines.

2.18.1 Faculty/Physicians requesting Financial Clearance on an exception basis must submit appropriate justification to the

Financial Clearance Executive Committee in advance of the patient receiving services.

- 2.18.2 The Chief Medical Officer will notify the attending physician and the Financial Counseling staff of the Financial Clearance Executive Committee determination.

Appendix 3

Description of Hospital's Mission, Vision and Value Statements

UMMC's mission statement could best be defined as a formal written document intended to capture our organization's unique and enduring purpose, practices, and core values. We communicate our organization's desire to produce high-quality patient care that result in high patient satisfaction locally, statewide and throughout the region. It reflects our commitment to offering world class training for health care providers, while focusing on our commitment to excellence through the five pillars UMMC identified as core values: innovation, people, safety and quality, service and stewardship.

The vision statement highlights how key partnerships are instrumental to impacting patient care in Maryland, nationally and internationally. It signifies how the institution will continue to promote the growth and success of our broad network of acute care, specialty and tertiary care.

Appendix 4

Mission Statement

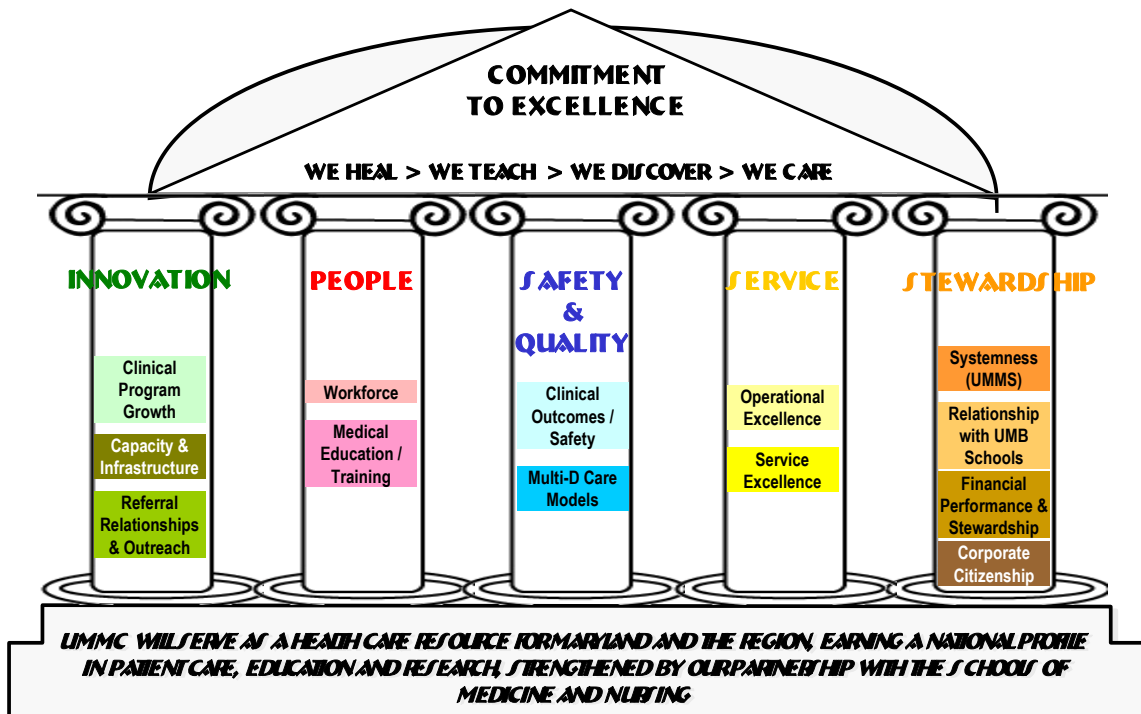
The University of Maryland Medical Center exists to serve the state and the region as a tertiary/quaternary care center, to serve the local community with a full range of care options, to educate and train the next generation of health care providers, and to be a site for world class clinical research.

Vision Statement

UMMC will serve as a health care resource for Maryland and the region, earning a national profile in patient care, education and research, strengthened by our partnership with the Schools of Medicine and Nursing.

Core Values

UMMC has integrated its Objectives and Goals into its *Commitment to Excellence* framework as a foundation for advancing organizational transformation.



FY 2008 UPPER CHESAPEAKE HEALTH NARRATIVE REPORT

1. What is the licensed bed designation and number of inpatient admissions for this fiscal year at your facility?

Harford Memorial Hospital (Provider # 21-0006)

- Licensed Beds – 104
- Inpatient Admissions – 7,352

Upper Chesapeake Medical Center (Provider # 21-0049)

- Licensed Beds – 182
- Inpatient Admissions – 15,803

2. Describe the community your organization serves.

Harford County is a suburban county situated between Baltimore County and the mostly rural Cecil County. Having grown 24% between 1990 and 2007, Harford County is one of the fastest growing counties in the state. The 1990 population was 182,132; the 2007 estimated population is 239,993.

The US Department of Defense recommendations of military base changes across the nation have identified Aberdeen Proving Ground as a primary location for Base Realignment and Closure (BRAC). According to state and local planning experts, Harford County's population is expected to increase as much as an additional 19% over the next 10 years in conjunction with activities related to BRAC alone. The recent past and anticipated growth will provide a serious challenge for residents seeking services in a jurisdiction already experiencing difficult access to care issues. A portion of the resulting population growth will be in hourly wage service sector jobs designed to accommodate the base expansion. Many of these jobs will not include health insurance.

With respect to the demographics of the county, the US Census Bureau in 2005 estimates that 84% of residents are White, 11% are Black, and 2% are Latino, though the actual number of Latino residents is thought to be drastically under-reported. The total number of children receiving MCHP benefits in Harford County is 9,458. Of that total, 5,094 are White; 2,968 are Black, and 450 are Latino; 232 are Asian; and 30 are Native American/Pacific Islander.

Harford County has roughly 87,000 households, of which 31,000 (or 29%) have children under the age of 18. The median household income is \$65,000. Poverty households are those that make less than 30% of the county median income. According to the US Census 2005 American Community Survey, an estimated 5% of family households (approximately 12,000 people) in Harford County live below the poverty level. Approximately 38% of the population has attained only a high school degree or lower.

According to the US Census Bureau Small Area Health Insurance Estimates program, approximately 21,000 residents, or nearly 10% of the County is uninsured, though some estimates put that number as high as 34,000. With potential funding cuts to Medicaid and

rising health care premiums, this group is likely to increase. Additional evidence of the loss of health insurance by many residents is the unprecedented 238% growth in MCHP enrollment in Harford County since the year 2000. In addition, underinsurance is known to exist, but is very difficult to measure.

Who are the Uninsured?

Harford County, as is true across Maryland and the Nation, experiences health disparities in several domains of population demographics including health insurance status, income level, race, and ethnicity. Overall, approximately 12,000 county residents have incomes below 200% of the federal poverty level, and an estimated 21,000-34,000 residents are uninsured.

A 2005 Robert Wood Johnson Foundation study shows that the percent rate of uninsured Blacks in Maryland is 17% and 32% for Latinos, much higher than the 10% rate for Whites. While this data is not broken down at the local level, these figures likely provide a reasonable proxy for the racial and ethnic disparity in access to health care in Harford County.

Data analyzed by the DHMH Office of Minority Health Disparities show that in Harford County from 2001 to 2003, the age adjusted death rate in blacks exceeded that of whites, and that this excess in death rate of Harford County blacks compared to whites is greater than twelve other jurisdictions in Maryland, including Baltimore City. This data can have many implications, ranging from lack of minority access to health care, to the neglect of health concerns, and improper health maintenance. All of these issues can be translated to the less than ideal care received by low-income minority children and adults.

The increase in the rate of minority population growth in Harford County is outstripping that of the white population. According to a US Census report, between 2000 and 2007, Harford County's minority population increased quickly while the rate of growth of its white population slowed. In addition, the availability of medical and mental health care in poor neighborhoods is limited. This requires patients to travel or book months in advance for appointments. Transportation and time off from work is always a difficult obstacle and, in the end, care is often delayed until urgent. With our continued population growth and increasing diversification, access to care will become even more challenging.

While most citizens have health insurance through their employer as a benefit, being employed no longer guarantees that a person will have health coverage. This can be from a variety of reasons. Health benefits may not be offered by the employer or workers may not be eligible to receive benefits. Employee contributions towards health insurance premiums make employer offered health coverage unaffordable for many low wage workers. According to the Kaiser Commission, more than 80% of the uninsured come primarily from working families with low and moderate incomes. Only 19% come from families that have no connection to the workforce.

Local Health Services for the Uninsured

For those individuals who do not have commercial health insurance, there are a number of government or public programs, state and federal, which provide health coverage to the County's residents. Medicaid covers three main groups of non-elderly low-income people:

children, their parents, and persons with disabilities. The Maryland Children's Health Program (MCHP), extends Medicaid benefits to children up to 19 years of age whose families have incomes at or below 200% of the Federal Poverty Level (FPL). Pregnant women are covered up to 250% of the FPL. In addition, under MCHP Premium, health coverage is provided to children under age 19 with family incomes up to 300% of the FPL, if the family pays a small premium. In contrast, the role of Medicaid for adults under the age of 65 is extremely limited. Most low-income adults without dependent children, regardless of how poor they are, do not qualify for Medicaid.

One program which addresses the health care needs of uninsured adults whose incomes are too high to qualify for Medicaid yet too low to enable them to obtain individual and even employer-sponsored health insurance is the Maryland Primary Care (MPC) program. Through this state run program, the Harford County Health Department offers primary care coverage to eligible low income adults between the ages of 19 and 64 but they must have a qualifying chronic medical condition(s). Gross income for a family of four cannot be above \$1,571 per month or \$18,852 per year. Due to funding cuts, there have been times where new patients are not being accepted in the program. In addition, this program does not cover hospitalization or specialty care.

The Upper Chesapeake HealthLink Primary Care Clinic provides free primary care and extensive case management services on a sliding scale fee to eligible uninsured and underinsured Harford County residents ages 19 to 64 and whose income is less than 200% of the federal poverty level. This Clinic is currently able to provide primary care services to approximately 1,000 patients.

The Upper Chesapeake HealthLink Primary Clinic and the Harford County Health Department are Harford County's sources of primary care for the uninsured. The staff of each respective agency works interdependently often sharing resources, clinic space, and expertise as appropriate to provide the best overall health services to their cliental.

Health Consequences of being Uninsured

There is a strong relationship between health insurance and ones ability to access health care services. Uninsured people are less than half as likely as people with health insurance to have a primary care provider; to have received appropriate preventive care, such as recent mammograms or Pap tests; or to have had any recent medical visits. Evidence suggests that lack of insurance over an extended period significantly increases the risk of premature death and that death rates among hospitalized patients without health insurance are significantly higher than among patients with insurance.

According to the Maryland Health Insurance Commission, almost one of every two (49%) uninsured adults with chronic conditions reported forgoing needed medical care or prescription drugs due to cost; one-third reported unmet need for medical care and one of three reported unmet need for prescription drugs. More than 40 percent reported unmet need for dental care. Over six in 10 uninsured black adults who have a chronic condition received no dental care in the past 12 months.

Of special significance is the fact that the uninsured are less likely to have a usual source of care aside from the emergency department. It is estimated that 13% of all Harford County

Emergency Department visits are non urgent self pay patients who are using the ED as their primary care medical home. That is over 11,000 visits that are crowding our emergency rooms every year due to an immediate lack of access to primary care.

3. Identification of community needs. Describe the process(s) your hospital used for identifying the health needs in your community, including when it was most recently done.

In December 1993, a group of community leaders, spearheaded by Upper Chesapeake Health, the Harford County Health Department, and Harford County Government, formed Healthy Harford, the Healthy Communities Initiative of Harford County. Incorporated in 1995 as a 501(c)(3), the vision of Healthy Harford - *“to make Harford County the healthiest community in Maryland”* - has consistently motivated the development of this organization’s strategic goals, objectives and programs over the past 15 years. The current President/CEO of Upper Chesapeake Health serves as the President for Healthy Harford; the two primary members are Upper Chesapeake Health and the Harford County Health Department.

Over the years, Healthy Harford has hosted many events and programs designed to promote and improve the general health of adults and children living and working in Harford County. Some of these initial programs included a health carnival, free immunizations for school-aged children, and a Recycle Your Cycle project that encouraged residents to donate their used exercise equipment to benefit the public schools. With a strong commitment to education, Healthy Harford also published yearly health guides, beginning in 1995 with a nutrition “eating out” guide. Since this initial publication, fitness, wellness, healthy heart, substance abuse and cancer prevention guides have been produced and distributed free to the community.

In 1996, Healthy Harford conducted the first Community Health Assessment Project (CHAP), a randomized household phone survey designed to determine the overall health status of community residents based on key health indicators. A 36 member community committee directed this initial process and ultimately identified and prioritized health needs related to preventive health and wellness, heart disease, and cancer. The results of the CHAP assessment also served to align community stakeholders around the common goal of improving the overall health of county residents. Through the creation of Community Action Teams (CATs), Healthy Harford brought together relevant community organizations to develop shared strategies to address each of the top health priorities. Some examples include the “Cancer CAT” that was responsible for implementing a Kids Healthy Lifestyle Program in several Harford County middle schools and the “Heart CAT” that provided education regarding the signs and symptoms of heart attack and stroke to many groups in the community. CHAPs conducted in 2000 and 2005 have enabled Healthy Harford to monitor progress and gather additional information relevant to the community’s overall health. Following CHAP 2000, community report cards were developed with specific goals established for 2005 and 2010 focusing on preventive health and wellness, heart disease, and cancer. Following CHAP 2005, the report cards and 2010 goals were revised based on survey results. The Harford County Master Plan includes and tracks programs, initiatives and education efforts implemented by many organizations in Harford County in support of these goals.

4. Please list the major needs identified through the process explained in question #3.

The following are the report cards and 2010 goals that were developed following the CHAP 2005 survey:

**Healthy Harford, Inc.
Community Health Assessment Project (CHAP)
Report Cards and 2010 Goals**

Healthy Harford Community Report Card – Preventive Health and Wellness				
Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Flu Vaccine	66% of adults 65 years of age and older have had a flu vaccine within the past year.	80% of adults 65 years of age and older have had a flu vaccine within the past year.	77% of adults 65 years of age and older have had a flu vaccine within the past year.	Increase to 90% of adults 65 years of age and older who have had a flu vaccine within the past year.
Pneumonia Shot				75% of adults 65 years of age and older have had the recommended pneumonia shot.
Seatbelt Use While Driving	80% report they always wear their seatbelt while driving.	89% report they always wear their seatbelt while driving.	90% report they always wear their seatbelt while driving.	Increase to 92% of adults who report they always wear their seatbelt while driving.
Seatbelt Use While a Passenger	76% report they always wear their seatbelt while a passenger.	84% report they always wear their seatbelt while a passenger.	87% report they always wear their seatbelt while a passenger.	Increase to 90% of adults who report they always wear their seatbelt while a passenger.
Helmet Use	75% of parents with children under 20 years of age report their children wear a helmet while riding a bicycle or rollerblading.	64% of parents with children under 20 years of age report their children always or often wear a helmet while riding a bicycle or rollerblading.	79% of parents with children under 20 years of age report their children always or often wear a helmet while riding a bicycle, rollerblading or skateboarding.	Increase to 85% of parents with children under 20 that report their children always or often wear a helmet while riding a bicycle, rollerblading or skateboarding.
Sunscreen Use	30% of adults report they regularly wear sunscreen when outdoors.	34% of adults report they regularly wear sunscreen when outdoors.	46% of adults report they regularly wear sunscreen when outdoors.	Increase to 50% of adults who report they regularly wear sunscreen when outdoors.

Healthy Harford Community Report Card – Heart Disease

Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Cholesterol	<p>51% have had their cholesterol screened within the past two years.</p> <p>21% report they have been told by a doctor that they have/had high cholesterol.</p>	<p>95% have had their cholesterol screened within 0-3 years.</p> <p>75% have had their cholesterol screened within the past two years.</p> <p>24% report they have been told by a doctor that they have/had high cholesterol.</p>	<p>92% have had their cholesterol screened within 0-3 years.</p> <p>32% report they have been told by a doctor that they have/had high cholesterol.</p>	<p>90% of adults aged 18 years and older have had their blood cholesterol checked within the preceding 5 years. (2010 goal based on revised recommendations).</p>
Overweight	<p>39% of adults have a BMI >30.</p>	<p>26% of adults have a BMI >30.</p>	<p>32% of adults have a BMI >30.</p>	<p>Reduce to 25% of adults who have a BMI >30.</p>
Smoking	<p>18% of Harford County adults smoke.</p> <p>32% of Harford County youth report smoking. (1998 MYTS)</p>	<p>14% of Harford County adults smoke.</p> <p>21% of Harford County youth report smoking. (2000 MYTS)</p>	<p>9.5% of Harford County adults smoke.</p>	<p>Reduce to 9% the level of smoking among adults.</p> <p>Reduce to 10% the level of smoking among youth.</p>
Blood Pressure	<p>68% have had their blood pressure screened within the past two years.</p> <p>21% of residents report they have or have had high blood pressure.</p>	<p>99% have had their blood pressure screened within 0-3 years.</p> <p>86% have had their blood pressure screened within the past two years.</p> <p>31% of residents report they have or have had high blood pressure.</p>	<p>97% have had their blood pressure screened within 0-3 years.</p> <p>32% of residents report they have or have had high blood pressure.</p>	<p>50% of adults 18 years and older with high blood pressure will have their blood pressure under control. (2010 goal based on revised recommendations)</p>

Healthy Harford Community Report Card – Cancer

Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Cervical Cancer	57% of adult women have had a pap smear within the past two years.	97% of adult women have had a pap smear within 0-3 years. 74% of adult women have had a pap smear within the past two years.	93% of adult women have had a pap smear within 0-3 years.	Maintain 93% of women aged 18 to 70 years who received a pap test within the preceding 3 years.
Breast Cancer	74% of women 50 years of age and older have had a mammogram within the past two years.	51% of women 50 years of age to 69 have had a mammogram within the past year. 76% of women 50 years of age to 69 have had a mammogram within the last two years.	67% of women 50 years of age to 69 have had a mammogram within the past year.	70% of women aged 40 years and older have received a mammogram within the past year. <i>(2010 goal based on revised recommendations)</i>
Prostate Cancer	56% of men 50 years of age and older have had a digital rectal exam within the past year.	62% of men 50 years of age and older have had a digital rectal exam within the past year.	59% of men 50 years of age and older have had a digital rectal exam within the past year.	Increase to 70% of men 50 years of age and older who have had a digital rectal exam within the past year.
Skin Cancer	30% of adults report they regularly wear sunscreen when outdoors.	34% of adults report they regularly wear sunscreen when outdoors. 69% of adults with children <20 report their children regularly wear sunscreen when outdoors.	46% of adults report they regularly wear sunscreen when outdoors. 65% of adults with children <20 report their children regularly wear sunscreen when outdoors.	Increase to 50% of adults who report regularly wearing sunscreen when outdoors. Increase to 70% of adults with children <20 who report that their children regularly wear sunscreen when outdoors.
Colorectal Cancer	13% report they have been tested for colorectal cancer.	33% of respondents >50 have had a fecal occult blood test (FOBT) within the past year. 18% of respondents >50 have had a sigmoid/colonoscopy within the past year.	55% of respondents >50 have had a fecal occult blood test (FOBT) within the past year. 29% of respondents >50 have had a sigmoid/colonoscopy within the past year.	75% of adults 50 years and older report either having a FOBT in the past year or a colonoscopy within the last 10 years. <i>(2010 goal based on revised recommendations)</i>

Healthy Harford Community Report Card – Cancer

Health Indicator	CHAP Data			2010 Goal
	1996	2000	2005	
Oral Cavity and Pharynx	87% of adults report they have been to the dentist in the last two years. 88% of children go to the dentist for regular check-ups.	76% of adults report they have been to the dentist in the last year. 94% of parents report their children go to the dentist for regular check-ups.	79% of adults report they have been to the dentist in the last year. 88% of parents report their children go to the dentist for regular check-ups.	Increase to 90% of adults with dental screenings within the last year.

5. Who was involved in the decision making process of determining which needs in the community would be addressed through community benefit activities of your hospital?

Decisions to determine which needs in the community would be addressed through community benefits activities of the hospital was a collaborative effort of the following:

- The Director of Community Health Improvement chairs a community “Access to Care” Committee comprised of representatives from Upper Chesapeake Health, the Harford County Health Department, The Office of Mental Health/ - Core Services Agency, and the Department of Social Services. With the Upper Chesapeake HealthLink Primary Care Clinic serving as the sole provider of free primary care and specialty referral services in the County, the Committee works towards collaborative efforts to meet the comprehensive scope of access to care needs for those that are uninsured and underserved in the County. In 2007, the Committee was successful in obtaining an MUA designation for Harford County through a Governor’s Exceptional Designation; they also developed an Access to Care Strategic Plan that identified the strengths, challenges, opportunities and goals for enhanced Access to Care Services in Harford County.
- Through collaboration with the Healthy Harford Board, several community benefit programs were developed based on the CHAP Report Cards and 2010 goals.

6. Do any major Community Benefit program initiatives address the needs listed in #4, and if so, how?

The following are examples of community benefit programs that resulted from the needs and 2010 goals identified in the CHAP 2005 survey:

- Flu vaccine and pneumonia shots were offered directly in all Senior Centers and nursing homes as well as the majority of Assisted Living Facilities in Harford County.

- Working collaboratively with the State Highway Administration, safety helmets were given to youth and children for a nominal \$3 charge following a proper fitting at several large community events.
- Several community education programs focused on sunscreen use were conducted during May.
- Based on the results of the CHAP Survey with respect to the lack of proper nutrition and daily activity of Harford County residents, a major Healthy Harford Community Action Team has been developed and will begin the task of developing a comprehensive Nutrition and Physical Activity Plan for Harford County in January 2009. Support and direct participation for this project is community-wide and includes Upper Chesapeake Health, the Harford County Health Department, the Harford County Executive's Office, Harford County Council, the Town of Bel Air, Havre de Grace City Council, Aberdeen City Council, Harford County Chamber of Commerce, Harford Community College, the ARC Northern Chesapeake Region, Harford County Public Schools, Harford County Parks 'n Recreation, Harford County Public Libraries, Harford County Sheriff's Office, and the Boys and Girls Club of Harford County. This is a 12 to 18 month project.
- Free blood pressure screenings are offered throughout the County at alternating locations on an on-going basis.
- Through collaboration with Upper Chesapeake Health physicians, free screenings for prostate cancer, skin cancer, colorectal cancer, and oral cavity cancer are provided free of charge once a year at each hospital.

7. Please provide a description of any efforts taken to evaluate or assess the effectiveness of major Community Benefit program initiatives.

A primary evaluation strategy is through the Healthy Harford Community Health Assessment Project (CHAP) that is now conducted every 5 years to determine progress on the community report cards and 2010 goals. Planning for CHAP 2010 will commence in early 2009. On an on-going basis, evaluations are given to consumers at the HealthLink Primary Care Clinic and at all community-based events. These evaluations are reviewed on an on-going basis so that improvements and changes can be made based on feedback received.

8. 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.

The Upper Chesapeake HealthLink Primary Care Clinic (UC HealthLink PCC) is a primary care clinic that serves low income (200% of the Federal poverty level) uninsured and underinsured patients ages 19-64. Our patients, due to lack of previous regular health care, mental illness, substance abuse, developmental impairment, etc. often present at our clinic with multiple medical problems that require a variety of specialty care appointments. Since Harford County does not have an FQHC, a Community Health Center, links to a medical resident program, or an abundance of hospital owned physician practices, we are at the mercy of the generosity of local private physicians and medical service providers to donate pro-bono and reduced cost services to our patients. As our patient load increases (we are projecting a 4 fold increase within the next three years), the strain of continuously visiting the

same well of limited specialty care providers is becoming more strained. For the present, our system of case-by-case pro-bono or reduced cost referrals is functional, however, in preparing for the immediate future, the Strategic Plan for the Harford County Access to Care Committee has prioritized the development of a streamlined system that will meet the needs of our target population while maximizing the limited specialty care resources available to us in this county. The Committee will work towards this goal in 2009. The two most critical needs with respect to specialty care include OBGYN and Dental Services.

Appendix 1:

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.

The Upper Chesapeake HealthLink Primary Care Clinic (UC HealthLink PCC) is a primary care clinic that serves low income (200% of the Federal poverty level) uninsured and underinsured patients ages 19-64. Our patients, due to lack of previous regular health care, mental illness, substance abuse, developmental impairment, etc. often present at our clinic with multiple medical problems that require a variety of specialty care appointments. Since Harford County does not have an FQHC, a Community Health Center, links to a medical resident program, or an abundance of hospital owned physician practices, we are at the mercy of the generosity of local private physicians and medical service providers to donate pro-bono and reduced cost services to our patients. As our patient load increases (we are projecting a 4 fold increase within the next three years), the strain of continuously visiting the same well of limited specialty care providers is becoming more strained. For the present, our system of case-by-case pro-bono or reduced cost referrals is functional, however, in preparing for the immediate future, the Strategic Plan for the Harford County Access to Care Committee has prioritized the development of a streamlined system that will meet the needs of our target population while maximizing the limited specialty care resources available to us in this county. The Committee will work towards this goal in 2009. The two most critical needs with respect to specialty care include OBGYN and Dental Services.

Appendix 2:

Describe your Charity Care policy

A summary of Upper Chesapeake Health's Financial Assistance policy is available to every patient who registers for patient care services at Upper Chesapeake Medical Center and Harford Memorial Hospital. There are signs (written in both English and Spanish) located at every patient registration station that notifies a patient that Upper Chesapeake Health provides financial assistance to those patients who are eligible or who have concerns about paying their bill. Along with the Financial Assistance summary, patients who are registered as self-pay as well as any patient who expresses interest or concern receive an application and a cover letter that instructs the patient how to apply for government benefits (MD Medical Assistance) as well as the health system's charity program and who they should contact with questions.

Appendix 3:

Include a copy of your hospital's charity care policy

UPPER CHESAPEAKE HEALTH HOSPITALS
Patient Accounting Department Policy Manual

TITLE: FINANCIAL ASSISTANCE POLICY

Page 1 of 2

APPROVED BY:

Original Date: 02/99

Revised Date: 12/08

Next Scheduled Review Date: 12/09

Related JCAHO Functional Area Chapters: RI

PURPOSE:

The Financial Assistance Policy has been established to provide financial relief to those who are unable to meet their financial obligation to UCH.

POLICY:

Eligibility will be based on 150% of the Federal Poverty Level as published annually by the Federal Government. Percentage determination will be based on income and family size with net liquid assets not exceeding \$10,000.00.

PROCEDURE:

1. All income determinations will be based on Gross income with the exception of Social Security/Pension income which will be determined based on Net income. The patient's/guarantor's eligibility will be determined using the following as proof of income:
 - Employment (most current 3 paystubs)
 - Retirement/Pension Benefits
 - Social Security Benefits
 - Public Assistance Benefits
 - Disability Benefits
 - Unemployment Benefits
 - Veterans Benefits
 - Alimony
 - Rental Property Income
 - Strike Benefits
 - Military Allotment
 - Farm or Self-employment
2. Exclusions from requiring income information:
 - Deceased Patients
If it is determined that there is no estate on file, and the patient expired at either Upper Chesapeake Medical Center or Harford Memorial Hospital, the account will be referred for 100% Financial Assistance. If the patient expired anywhere else, a copy of the death certificate will be required before the write off.
 - Out of State Medical Assistance
If the patient's account balances total less than \$1000.00, the Medical Assistance Follow Up Representative must contact the out of state Medical Assistance plan to verify the patient's eligibility for that date of service. If the patient was eligible, the account will be referred to the Patient Financial Liaison to prepare the account for Financial Assistance. The account balances

will be eligible for 100% Financial Assistance. If the patient was not eligible with the out of state Medical Assistance plan for that date of service, the account balance will become Self Pay.

➤ Over 18 Being Supported by Others

If the patient is not working and has no proof of income, the account will be referred to the appropriate collection agency for verification. A notarized letter is required signed by the person who is providing for the patient.

3. With each application, all prior accounts with a patient liability for this guarantor must be identified and listed on the determination form with the exception of accounts in a Bad Debt status. Once a final determination is made, the Patient Financial Liaison will complete a *Financial Assistance Determination* form that will be submitted to the Patient Accounting Supervisor who will determine approval and forward for additional approval as follows:

Adjustments up to \$ 2,500.00 Patient Accounting Supervisor

Adjustments up to \$ 5,000.00 Patient Accounting Manager

Adjustments up to \$10,000.00 Patient Accounting Director

Adjustments over \$10,000.00 V.P. of Finance

4. After the final determination has been made, the patient will either receive a *Financial Assistance Patient Notification* letter to advise him of the Assistance he will receive or the *Financial Assistance Denial* letter to advise him of the reason that he did not qualify.
5. Any exceptions to the above must be authorized by the Supervisor and/or Director.

Appendix 4/5:

UPPER CHESAPEAKE HEALTH MISSION, VISION, VALUE

Vision: The Vision of Upper Chesapeake Health is to become the preferred, integrated health care system creating the healthiest community in Maryland.

Mission: Upper Chesapeake Health is dedicated to maintaining and improving the health of the people in its communities through an integrated health delivery system that provides high quality care to all. UCH is committed to service excellence as it offers a broad range of health services, technology and facilities. It will work collaboratively with its communities and other health organizations to serve as a resource for health promotion and education.

Excellence: We constantly pursue excellence and quality through teamwork, continuous improvement, customer satisfaction, innovation, education and prudent resource management.

Compassion: People are the source of our strength and the focus of our mission. We will serve all people with compassion and dignity.

Integrity: We will conduct our work with integrity, honesty, and fairness. We will meet the highest ethical and professional standards.

Respect: We will respect the work, quality, diversity, and importance of each person who works with or is served by Upper Chesapeake Health.

Responsibility: We take responsibility for our actions and hold ourselves accountable for the results and outcomes.

Trust: We will strive to be good citizens of the communities we serve and build trust and confidence in our ability to anticipate and respond to community and patient needs.

**Washington Adventist Hospital
Community Benefits Report
For the Year Ended June 30, 2008**

Appendix 1

Gaps in Specialty Services - Community

Washington Adventist Hospital has noted an increase in the numbers of specialties where there are not enough physicians willing to treat uninsured and underserved patients in our services area. Listed below are the specialties where we believe there are current gaps in availability of coverage for our underserved and uninsured population:

Family Practice
Internal Medicine and certain subspecialties
Obstetrics & Gynecology
Orthopedics
Urology
Neurology
Neurosurgery
General Surgery
Psychiatry
ENT

As the demographics of our service area continue to evolve we believe that there will be additional gaps in the availability of specialist providers.

**Washington Adventist Hospital
Community Benefits Report
For the Year Ended June 30, 2008**

Appendix 2

Charity Care Policy

Washington Adventist Hospital informs patients of their eligibility for financial assistance under its charity care policy at several intervals. The Hospital's charity policy is clearly posted in the emergency room and inpatient admitting areas so that patients are aware that they can request financial assistance if they do not have the resources necessary for the total payment of their bill. If a patient requests a copy of the Hospital's charity policy at either the time of admission or discharge a copy of the charity policy will be provided to them.

If the Hospital determines at the time a patient is admitted that they do not have the financial means to pay for their services the patient is told that they can apply for financial assistance from the Hospital. If a patient is admitted without resolving how their bill will be paid a financial counselor will visit their room to discuss possible payment arrangements. If the financial counselor determines that the patient may be eligible for Medicaid an outside contractor experienced in qualifying patients for Medicaid will speak to the patient to determine if the patient qualifies for Medicaid or some other governmental program.

As self pay and other accounts are researched by representatives from the billing department after no payments or only partial payments have been received, the billing department will explain to the patients that financial assistance may be available if they do not have the financial means to pay their bill. If patients request financial assistance a copy of the Hospital's charity application will be sent to them.

The Hospital has started an initiative with the outside contractor experienced in qualifying patients for Medicaid to review potential emergency room patients who may qualify for Medicaid.

ADVENTIST HEALTH CARE, INC.
CORPORATE POLICY MANUAL

CHARITY CARE

Effective Date	01/08	Policy No:	AHC 3.19
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Reviewed:		Authority:	EC
Revised:		Page:	Page 1 of 10

SCOPE:

A. The financial assistance policy applies to charges for medically necessary patient services that are rendered at one of the following facilities: Shady Grove Adventist Hospital, Washington Adventist Hospital, Potomac Ridge Behavioral Health, Hackettstown Community Hospital or Adventist Rehab Hospital of Maryland. A patient may apply for Financial Assistance at any time. Services not covered by the financial assistance policy:

1. Services not charged and billed by the hospital are not covered by this policy; i.e., private physician services.
2. Cosmetic, convenience and/or other hospital services, which are not medically necessary, are excluded from consideration as a free or discounted service.
3. Patients who qualify for County, State, Federal or other assistance programs are excluded from the Adventist HealthCare Financial Assistance Program to the extent that services would be provided under those programs.

B. Eligibility

The patient would be required to complete an application for Financial Assistance and be approved using established guidelines, completion of the “Income” and “Family Size” portions of the State Medicaid Application could be considered as “an application for Financial Assistance”. The application should expire six months from the effective date of its approval or denial-at which time the patient may reapply for Financial Assistance if their situation continues to merit assistance or changes so that they might qualify at that time.

This program provides free care to those most in need, based on Income and Family Size, i.e. individuals who have income that is less or equal to 100% of the federal poverty level with 0% patient responsibility. It also provides for a reduction of 90% to 20% for a patient whose income is 125% to 300% of federal poverty level. See attached Sliding Scale Chart.

C. Patient is deceased with no person designated as Executor, or no estate on file with the appropriate jurisdiction, write-off to Charity Care.

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D. Patient is from out of state with no means to pay, write-off to Charity Care.

E. Patient is residing in Maryland and has no assets or means to pay, write-off to Charity Care.

F. Patient is bankrupt and no means to pay the claim, write-off to Charity Care.

G. Patient has no address or social security number on file and we have no means of verifying assets, or patient is deemed homeless, write off to Charity Care.

H. Patient is denied for Medicaid but is not determined over-scaled, write off to Charity Care.

I. Patient is a participant of the Montgomery County Maternity Partnership Program but requiring services not covered under the program. Apply 100% Charity Care write off as patient is already qualified under the Montgomery County Program according to the Federal Poverty Guidelines.

BENEFITS:

Increase in uncompensated care for community residents. Decrease in bad debt placement of account with collection agency. Enhance community services by providing quality medical services regardless of patient's ability to pay.

PURPOSE:

To provide a systematic and equitable way to provide medical services to those who have medical need and lack adequate resources to pay for those services. To provide that service while recognizing the need to preserve the dignity of individuals in need of this assistance.

POLICY:

All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for charitable assistance. Printed public notification regarding the program will be made annually.

Each application for Financial Assistance will be reviewed based upon an assessment of the patient's and/or family's needs, income and financial resources. It is part of Adventist HealthCare's mission to provide necessary medical care to those who are unable to pay for that care. This policy requires patients to cooperate with and avail themselves of all available

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programs (including Medicaid, workers compensation, and other state and local programs) which might provide coverage for those services.

Each hospital's indigent care policy will be governed by their respective state's poverty guidelines and will become part of this policy as attachments.

PROCEDURE:

A. **Financial Counselor, registration and Patient Communication staff** should be thoroughly familiar with the availability of charitable assistance and the criteria for such assistance.

B. All inpatient self-pays are to be referred to vendor by the Admitting Office to complete the Medicaid application.

C. Once the patient/guarantor submits an application to Patient Financial Services, providing, at a minimum, information regarding the patient's income level, the **Customer Service Supervisor or Lead** will take the following actions:

1. Determine probable eligibility within two business days of the initial request.
2. Review application to ensure that all remaining information is complete and, if necessary, contact patient/guarantor specifying what information is still needed.
3. If the patient/guarantor is deemed overscale according to the federal poverty guideline, then a denial letter will be sent to the patient/guarantor specifying that they are overscale per the Federal Poverty Guidelines.
4. If the patient/guarantor qualifies according to their income, the C/Svc. Sup./Lead will review the patient accounting system to identify all of the patient or guarantor's accounts for patient responsibility balances.
5. Accounts still outstanding with the patient/guarantor's insurance carrier for payment will be held until the insurance either makes payment or denies, it will then be processed according to policy for Financial Assistance.

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6. The Sup./Lead will then complete the adjustment form.
Using the charity adjustment code, 23001, or 33001 if the account is in collections, and document the account using the following activity codes:
 - a. CHDN-charity denied-required more info
 - b. CHLT-charity approval sent to patient.
 - c. CHWO-charity write off approved

7. The Sup./Lead will notify any agencies who hold accounts for the patient/guarantor that they have been given Financial Assistance, outlining if there is any patient/guarantor responsibility.

8. The application will then be forwarded to imaging to be scanned into the patient folder.

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ADVENTIST HEALTHCARE
NOTICE OF AVAILABILITY OF UNCOMPENSATED CARE

Shady Grove Adventist, Potomac Ridge Behavioral Health System, Washington Adventist Hospital, Hackettstown Community Hospital and Adventist Rehab Hospital of Maryland will make available a reasonable amount of health care without charge to persons eligible under Community Services Administration guidelines. Uncompensated services are available to patients whose family income does not exceed the limits designed by the Income Poverty Guidelines established by the Community Services Administration. The current income requirements are the following. If your income is not more than twice these amounts, you may qualify for uncompensated services.

Each hospital's indigent care policy will be governed by their respective state's poverty guidelines and will become part of this policy as attachments.

2007 Poverty Guidelines

<u>Size of Family Unit</u>	<u>Guideline</u>
1 _____	\$10,210
2 _____	\$13,690
3 _____	\$17,170
4 _____	\$20,650
5 _____	\$24,130
6 _____	\$27,610
7 _____	\$31,090
8 _____	\$34,570

Note: The guidelines increase \$3,480 for each additional family member.

If you feel you may be eligible for uncompensated services and wish to request them, please obtain an application for Community Charity Care from the Admissions Office or by calling (301) 315-3660. A written determination of your eligibility will be made within thirty working days of your request.

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Expenses :

Rent / mortgage	_____
Food	_____
Transportation	_____
Utilities	_____
Health Insurance premiums	_____
Medical expenses not covered by insurance	_____
Doctor: _____	

Hospital: _____	

	TOTAL: _____

I hereby certify that to the best of my knowledge and belief, the information listed on this statement is true and represents a complete statement of my family size and income for the time period indicated.

Signed: _____ **Date:** _____

Return Application To:

Adventist HealthCare
Patient Financial Services
Attn: Customer Service Supervisor
1801 Research Blvd, Suite 300
Rockville, Maryland 20850

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	100%	\$10,210	100% ALLOWANCE	0%
2	100%	\$13,690	100% ALLOWANCE	0%
3	100%	\$17,170	100% ALLOWANCE	0%
4	100%	\$20,650	100% ALLOWANCE	0%
5	100%	\$24,130	100% ALLOWANCE	0%
6	100%	\$27,610	100% ALLOWANCE	0%
7	100%	\$31,090	100% ALLOWANCE	0%
8	100%	\$34,570	100% ALLOWANCE	0%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	125%	\$12,762	90% ALLOWANCE	10%
2	125%	\$17,112	90% ALLOWANCE	10%
3	125%	\$21,462	90% ALLOWANCE	10%
4	125%	\$25,812	90% ALLOWANCE	10%
5	125%	\$30,162	90% ALLOWANCE	10%
6	125%	\$34,512	90% ALLOWANCE	10%
7	125%	\$38,862	90% ALLOWANCE	10%
8	125%	\$43,212	90% ALLOWANCE	10%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	150%	\$15,315	80% ALLOWANCE	20%
2	150%	\$20,535	80% ALLOWANCE	20%
3	150%	\$25,755	80% ALLOWANCE	20%
4	150%	\$30,975	80% ALLOWANCE	20%
5	150%	\$36,195	80% ALLOWANCE	20%
6	150%	\$41,415	80% ALLOWANCE	20%
7	150%	\$46,635	80% ALLOWANCE	20%
8	150%	\$51,855	80% ALLOWANCE	20%

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	175%	\$17,867	70% ALLOWANCE	30%
2	175%	\$23,957	70% ALLOWANCE	30%
3	175%	\$30,047	70% ALLOWANCE	30%
4	175%	\$36,137	70% ALLOWANCE	30%
5	175%	\$36,195	70% ALLOWANCE	30%
6	175%	\$48,317	70% ALLOWANCE	30%
7	175%	\$54,407	70% ALLOWANCE	30%
8	175%	\$60,497	70% ALLOWANCE	30%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	200%	\$20,420	60% ALLOWANCE	40%
2	200%	\$27,380	60% ALLOWANCE	40%
3	200%	\$34,340	60% ALLOWANCE	40%
4	200%	\$41,300	60% ALLOWANCE	40%
5	200%	\$48,260	60% ALLOWANCE	40%
6	200%	\$55,220	60% ALLOWANCE	40%
7	200%	\$62,180	60% ALLOWANCE	40%
8	200%	\$69,140	60% ALLOWANCE	40%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	225%	\$22,972	50% ALLOWANCE	50%
2	225%	\$30,802	50% ALLOWANCE	50%
3	225%	\$38,632	50% ALLOWANCE	50%
4	225%	\$46,462	50% ALLOWANCE	50%
5	225%	\$54,292	50% ALLOWANCE	50%
6	225%	\$55,220	50% ALLOWANCE	50%
7	225%	\$69,952	50% ALLOWANCE	50%
8	225%	\$77,782	50% ALLOWANCE	50%

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FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	250%	\$25,525	40% ALLOWANCE	60%
2	250%	\$34,225	40% ALLOWANCE	60%
3	250%	\$42,925	40% ALLOWANCE	60%
4	250%	\$51,625	40% ALLOWANCE	60%
5	250%	\$60,325	40% ALLOWANCE	60%
6	250%	\$69,025	40% ALLOWANCE	60%
7	250%	\$77,725	40% ALLOWANCE	60%
8	250%	\$86,425	40% ALLOWANCE	60%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	275%	\$28,077	30% ALLOWANCE	70%
2	275%	\$37,647	30% ALLOWANCE	70%
3	275%	\$47,217	30% ALLOWANCE	70%
4	275%	\$56,787	30% ALLOWANCE	70%
5	275%	\$66,357	30% ALLOWANCE	70%
6	275%	\$75,927	30% ALLOWANCE	70%
7	275%	\$85,497	30% ALLOWANCE	70%
8	275%	\$95,067	30% ALLOWANCE	70%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	300%	\$30,630	20% ALLOWANCE	80%
2	300%	\$41,070	20% ALLOWANCE	80%
3	300%	\$51,510	20% ALLOWANCE	80%
4	300%	\$91,950	20% ALLOWANCE	80%
5	300%	\$72,390	20% ALLOWANCE	80%
6	300%	\$82,830	20% ALLOWANCE	80%
7	300%	\$93,270	20% ALLOWANCE	80%
8	300%	\$103,710	20% ALLOWANCE	80%

**Washington Adventist Hospital
Community Benefits Report
For the Year Ended June 30, 2008**

Appendix 4 – Description of Hospital’s Missions, Vision, and Value statement

Washington Adventist Hospital’s Missions, Vision, and Value statement was developed based on the following five concepts:

1. **Respect:** Recognize the infinite worth of each individual and care for each individual as a whole person.
2. **Integrity-** Be above reproach in all that we do.
3. **Service:** Provide compassionate and attentive care in a manner that inspires confidence.
4. **Excellence:** Provide world class clinical outcomes in an environment that is safe for both our patients and our caregivers.
5. **Stewardship:** Take personal responsibility for the efficient and effective accomplishment of our mission.

The overriding goal of our organization is to manage our staff and operations applying these concepts on a daily basis with no exceptions.



WASHINGTON COUNTY
HOSPITAL

CBR REQUIREMENT -FY2008

Appendix 1

“Provide a written description of gaps in the availability of specialist providers, including outpatient specialty care, to serve the uninsured in the hospital.”

The uninsured patients in the community served by Washington County Hospital have difficulty obtaining care for conditions treated by the providers in the following specialties:

General Surgery
Neuro Surgery
Plastic Surgery
Pain Management
Dermatology
Thoracic Surgery
Vascular Surgery

Also, patients insured through Maryland Physicians Care, an HMO serving the Medicaid population, have difficulty obtaining Podiatry care for related medical conditions. As a result, many patients go untreated for medical conditions requiring care by providers in the specialties identified above. Specialty care has been one of the ongoing challenges we face in making the effort to provide a full range of medical care to our uninsured patients.

WASHINGTON COUNTY HOSPITAL
FY2008 COMMUNITY BENEFIT REPORT
APPENDIX 2 – FINANCIAL ASSISTANCE POLICY DESCRIPTION

Washington County Hospital (WCH) is committed to providing quality health care for all patients regardless of their inability to meet the associated financial obligation and without discrimination on the grounds of race, color, national origin or creed. Financial assistance can be offered during, or after services are rendered. The Financial Assistance procedures are designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs, but whom residual "self-pay" balances exceed their own ability to pay.

WCH informs patients and/or their families of the hospital's financial assistance policy by providing a copy of the policy and contact information as part of the intake process. The financial assistance policy and contact information is posted in the admitting area, emergency room and other areas throughout the facility where eligible patients are likely to present. When applicable, a representative of the hospital discusses the availability of financial assistance as well as Medicaid and other governmental benefits with patients or their families. The hospital makes every effort to inform patients of this policy throughout their visit.

- 3.3 The Poverty Guidelines are available on-line at:
<http://aspe.dhhs.gov/poverty> then choose the guidelines you wish.
See Appendix 1.
- 3.4 Poverty Guidelines are updated each year by the Census Bureau thereby thresholds are used mainly for statistical purposes and weighted for the average poverty thresholds determination.
- 3.5 Public Assistance Programs are available to assist patients for services and specific diagnoses. Patients who present for services who may qualify for these public programs will be referred to the appropriate agency:
- a. Medicaid
 - b. Medicare
 - c. DHMH Woman's Breast/Cervical Cancer Program
 - d. DHMH Colorectal Cancer Program
 - e. Other
- 3.6 WCH will follow the Maryland Hospital Association Standards for Financial Assistance for Maryland.
- a. WCH will provide 100 percent free hospital care for patients below 150 percent of Federal Poverty levels and who have less than \$10,000 in net assets.
 - b. When a patient's income and/or net assets does not qualify them for 100 percent Financial Assistance, they may be eligible to qualify for financial assistance based on a sliding scale as referenced in Appendix 1.
 - c. WCH will consider the size of a patient's bill relative to their ability to pay in determining financial assistance and financial assistance options, which could include payment plans.
 - d. WCH will grant financial assistance for services determined to be medically necessary.
 - e. It is recognized that Old Order Amish and Old Order Mennonite patients do not rely on in any manner on any type of government programs or private insurance based upon their religious beliefs. These two Orders rely on their religious community to pull resources together to pay for healthcare bills for members of their community. These patients, who are 100% self-pay, will be granted a 25% discount when bill is paid in full within 30 days of service.

IV. POLICY:

- 4.1 This policy is to ensure established and standardized procedures for Financial Assistance. This policy will be uniform hospital wide, ensuring a satisfactory level of control is maintained over adjustments to accounts receivables.
- 4.2 Financial Assistance written notice, such as brochures and signs will be posted at all registration areas throughout the hospital and made available to a patient or family.
- 4.3 An annual notice will be published in the local newspaper, (The Herald Mail), to inform the public of the hospital's Financial Assistance program.
- 4.4 A Patient Financial Services Representative will use the criteria in this document for eligibility of Financial Assistance.
- 4.5 Eligible care covered under this program is deemed as all medically necessary medical care provided. CBR FY 2008 Washington County

V TEXT:

- 5.1 Financial eligibility criteria will be based on gross family income of the patient and/or responsible guarantor. Exception allowance will be deducted for each person living in the gross family income. Annual income criteria used will be 150% of the current poverty guidelines as published in the yearly Federal Register and those who have less than \$10,000 in net assets.
 - 5.1.a Adjustment of accounts meeting the criteria will be entered as Financial Assistance.
 - 5.1.b Some persons may exceed established income levels but still qualify for Financial Assistance with additional factors considered. These will be reviewed case by case.
- 5.2 Gross income, refers to money wages and salaries from all sources before deductions. Income also refers to social security payments, veteran's benefits, pension plans, unemployment and worker's compensations, trust payments, alimony, public assistance, union funds, income from rent, interest and dividends or other regular support from any person living in the home or outside of the home. Also, included as regular income is 100% of all liquid or near liquid assets, (i.e., certificates of deposit, stocks, money market funds, etc.)
- 5.3 Assets refer to real and chattel/personal property. These may be evaluated for inclusion as regular income.
- 5.4 All other third party resources will first be applied including Medicaid Medical Assistance, before a Financial Assistance adjustment will be granted. The individual must apply for available Medical Assistance funds as appropriate in each individual case.
- 5.5 Patients requesting Financial Assistance may apply prior to treatment by contacting a Patient Financial Services Representative for a Financial Application.
- 5.6 Probable determination for Financial Assistance eligibility will be completed within two (2) business days, depending upon the availability of the specific required documentation as covered in the HHS, U.S. Federal Poverty Measure guidelines.
- 5.7 Financial Assistance applications will also be considered for accounts final billed and aged in accounts receivable.
- 5.8 Request for Financial Assistance may not be considered for patients who are in bad debt and did not respond to collection activity or statements prior to an account referral to an outside collections agency.
- 5.9 A financial application form may be requested by a Patient Financial Services Representative from the patient or responsible party listing all available assets and expenses. All applications and attachments will be forwarded to the Customer Services Unit of the Patient Financial Services Department for review.
- 5.10 During the application process, one or more of the following specific documents must be submitted to gain sufficient information to verify income for each employed family member:
 - 5.10.a Copy of payroll stub to include year to date wages.
 - 5.10.b Letter from employer verifying gross income.

- 5.10.c Letter from federal or state agency indicating the amount of assistance received.
 - 5.11.d Copy of most recently filed federal income tax return.
 - 5.12.e Proof of other income for all persons living in the family.
- 5.11 Every effort will be made to identify a patient's qualifications/approval at or prior to time of admission of service. However, it is recognized that there will be cases in which accurate determinations, at time of admission are not possible and that events may occur subsequent to service with may affect a patient's ability to pay.
- 5.11.a Emergent or medically necessary services will not be delayed based on the financial status of the patient. WCH follows the federal EMTALA regulations for emergency services rendered.
- 5.12 An approval or denial letter will be mailed directly to the patient or responsible guarantor to inform of the final disposition of the request for Financial Assistance.
- 5.13 Open "self-pay" receivable balance of deceased patients for which no estate has been filed with the Register of Wills, may be considered for Financial Assistance without a financial assistance application on file.
- 5.14 Open "self-pay" balance of Medical Assistance patients for which have a valid Medical Assistance number and which Medical Assistance is active or eligible, may be considered for Financial Assistance without a financial assistance application on file.
- 5.15 A financial application that has been approved for Financial Assistance will remain eligible for a period of six months. Patients or guarantors incurring accounts after the six month period will be required to reapply so that any changes in their financial status can be reassessed.
- 5.16 Accounts receivable accounts approved for Financial Assistance will be reconciled by the Finance Department at fiscal year end and reported annually to the Health Services Cost Review Commission (HSCRC) of the State of Maryland.
- 5.17 If Financial Assistance is denied, a payment arrangement will be obtained on any balance due by the patient or the guarantor by a Patient Financial Services Representative.

VI. REFERENCE:

- 6.1 U.S. Department of Health and Human Services, U.S. Federal Poverty Measure Guidelines.
- 6.2 Administrative Policy 300
- 6.3 Maryland Hospital Association Standards

APPENDIX 1

WASHINGTON COUNTY HEALTH SYSTEMS FINANCIAL ASSISTANCE GUIDELINES
2008

FAMILY SIZE	100%	80%	60%	40%	20%	0%
1	0 - 15,600	15,601-19,500	19,501-23,400	23,401-27,300	27,301-31,200	31,200.01+
2	0 - 21,000	21,001-26,250	26,251-31,500	31,501-36,750	36,751-42,000	42,000.01+
3	0 - 26,400	26,401-33,000	33,001-39,600	39,601-46,200	46,201-52,800	52,800.01+
4	0 - 31,800	31,801-39,750	39,751-47,700	47,701-55,650	55,651-63,600	63,600.01+
5	0 - 37,200	37,201-46,500	46,501-55,800	55,801-65,100	65,101-74,400	74,400.01+
6	0 - 42,600	42,601-53,250	53,251-63,900	63,901-74,550	74,551-85,200	85,200.01+
7	0 - 48,000	48,001-60,000	60,001-72,000	72,001-84,000	84,001-96,000	96,000.01+
8	0 - 53,400	53,401-66,750	66,751-80,100	80,101-96,450	93,451-106,800	106,800.01+
9	0 - 58,800	58,801-73,500	73,501-88,200	88,201-102,900	102,901-117,600	117,600.01+
10	0 - 64,200	64,201-80,250	80,251-96,300	96,301-112,350	112,351-128,400	128,400.01+

SOURCE: Federal Register, Vol. 70, No. 33, March 1, 2006, pp. 8373-8375.

(com benefit report 2008/mission vision values for HSCRC report_12_08)
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The mission, vision, and values of Washington County Hospital are summarized in our pledge: *Responsiveness to need. Excellence in Care. Respect for All.* The pledge says quite simply that we strive to meet the healthcare needs of the citizens of the tri-state region, that we are dedicated to providing quality patient care in a safe and caring environment, and that we esteem the personal dignity of patients and staff alike.

Every day, the hospital's employees live out our values by treating others as we would like to be treated. We participate in a variety of activities that focus on the well-being of our patients, including committees and teams that evaluate our progress in the areas of quality patient care, patient safety, and professional development. Many staff members provide outreach to the community through educational offerings which have been identified by a survey of community health education needs.

Washington County Hospital is a vibrant healthcare facility, where dedicated staff engages patients and their families in their care, promoting a partnership that leads to improved patient outcomes. At the same time, employees work together to plan a future that focuses on the well-being of the citizens of our tri-state region.

POLICY: VISION, MISSION AND CORE VALUES OF WASHINGTON COUNTY HOSPITAL
POLICY NO.: ADMN 0145
ORIGINATOR: Senior Management
EFFECTIVE DATE: 3/01/92
REVISION DATE: 3/27/95, 4/1/98, 4/11/01, 7/18/03, 6/27/05
REVIEW DATE: 7/3/03
Signed Copy on file in Administration

- I. SCOPE: This policy applies to all members of the hospital family.
- II. PURPOSE: To define the mission and core values of Washington County Hospital.
- III. TEXT:

A. Mission Statement

The Mission of the Washington County Hospital is to be the most effective provider of health services in our service area through:

- . Leadership and responsiveness to our community's healthcare needs;
- . Accessibility to those services in partnership with our extended community;
- . The high level of respect we afford our patients, physicians, customers, and employees.

B. Vision

The Washington County Hospital will succeed in accomplishing its mission of ensuring it is the community's preeminent quality healthcare provider via a five-part strategy.

1. Create and enhance regional healthcare through an integrated delivery system.
2. Form a framework of partnerships and affiliations;
3. Establish centers of excellence in partnership with the medical community;
4. Provide excellent health education in cooperation with appropriate institutions; and
5. Ensure adequate Health Insurance coverage for the community that aligns incentives properly for payors and providers.

Approved by:

1. President _____ Date _____
2. Vice-President _____ Date _____

C. Core Values

Washington County Hospital holds the following values to be most important in the management of our corporation:

1. A caring and responsive attitude toward patients, their families and guests.
2. Respect for employees, volunteers and medical staff and their individual commitment and contributions.
3. Quality services through staff expertise and state-of-the art equipment and facilities.
4. Financial viability through the provision of services at a reasonable cost.
5. Anticipation of, and planning for the future health care needs of our service area.