Adventist HealthCare
Washington Adventist Hospital

COMMUNITY BENEFIT NARRATIVE

Effective for FY2016 Community Benefit Reporting

Health Services Cost Review Commission

4160 Patterson Avenue
Baltimore, MD 21215

December 15, 2016

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

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

Table I

Bed Designation:	Inpatient Admissions (CY2015):	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Hospital's Uninsured Patients by County (CY2015):	Percentage of the Hospital's Patients who are Medicaid Recipients (CY2015):	Percentage of the Hospital's Patients who are Medicare Beneficiaries (CY2015):
232	12,211	20783 20912 20782 20903 20901 20904 20910 20906 20902 20740 20705	**Holy Cross of Silver Spring** 20912, 20903, 20901, 20904, 20910, 20906, 20902, 20783, 20782, 20705 **Montgomery General** 20906, 20904, 20902 **Suburban** 20906, 20902, 20904 **Union of Cecil County** 20906 **Laurel Regional**	16.5% of overall patients were uninsured. Of these patients: 7.70% were from PG County 6.32% were from Montgomery County 2.22% were from outside of Maryland *Source: review of hospital discharge data*	27.9% *Source: review of hospital discharge data*	21.8% *Source: review of hospital discharge data*

			20705, 20904, 20740 **Adventist Rehabilitation** 20783, 20912, 20901, 20904, 20906, 20902 **Adventist Behavioral Health** 20912, 20901, 20904, 20910, 20906, 20902			

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

a. Use Table II to provide a detailed description of the Community Benefit Service Area (CBSA), reflecting the community or communities the organization serves. The description should include (but should not be limited to):
   i. A list of the zip codes included in the organization's CBSA, and
   ii. An indication of which zip codes within the CBSA include geographic areas where the most vulnerable populations reside.
   iii. Describe how the organization identified its CBSA, (such as highest proportion of uninsured, Medicaid recipients, and super utilizers, i.e. individuals with > 3 hospitalizations in the past year). This information may be copied directly from the community definition section of the organization's federally-required CHNA Report (26 CFR § 1.501(r)–3).

Table II

Zip Codes included in the organization's CBSA, indicating which include geographic areas where the most vulnerable populations reside

Zip Codes in the CBSA

Primary Service Area

20737 – Riverdale, 20740 – College Park, 20782 – Hyattsville, 20783 – Hyattsville, 20901 – Silver Spring, 20902 – Silver Spring, 20903 – Silver Spring, 20904 – Siler Spring, 20906 – Silver Spring, and 20910 – Silver Spring, and 20912 – Takoma Park

Secondary Service Area

20011 – Washington, 20012 – Washington, 20018 – Washington, 20705 – Beltsville, 20706 – Lanham, 20707 – Laurel, 20708 – Laurel, 20710 – Bladensburg, 20712 – Mount Rainier, 20720 – Bowie, 20721 – Bowie, 20722 – Brentwood, 20743 – Capitol Heights, 20747 – District Heights, 20770 – Greenbelt, 20774 – Upper Marlboro, 20781 – Hyattsville, 20784 – Hyattsville, 20785 – Hyattsville, 20850 – Rockville, 20853 – Rockville, 20866 – Burtonsville, 20874 – Germantown, and 20905 – Silver Spring

Household income can be considered a barrier to health and wellness as income can affect a family's ability to pay for necessities including, but not limited to: healthcare services; healthy foods; and education. A wide body of research points to the fact that low-income individuals tend to experience worse health outcomes than wealthier individuals, clearly demonstrating that income disparities are tied to health disparities.

Median Household Income within CBSA (2015)		
Location	**Zip Codes**	**Median Household Income**
Montgomery County	20850	$107,170
	20853	$100,965
	20866	$101,358
	20874	$81,769
	20901	$97,454
	20902	$85,044
	20903	$58,342
	20904	$72,458
	20905	$116,141
	20906	$71,423
	20910	$77,986
	20912	$69,721
	Overall	$99,435
Prince George's County	20705	$74,022
	20706	$70,754
	20707	$75,742
	20708	$64,134
	20710	$42,226
	20712	$47,048

	20720	$133,641
	20721	$120,994
	20722	$60,900
	20737	$56,672
	20743	$57,671
	20747	$60,421
	20770	$62,909
	20774	$93,216
	20781	$67,000
	20782	$64,562
	20783	$60,958
	20784	$58,564
	20785	$60,883
	Overall	$74,260
Maryland	*Overall*	$74,551
District of Columbia	20011	$62,281
	20012	$80,991
	20018	$58,821
	Overall	$70,848

*Note: Household incomes by zip code values are compared to the overall county median household income. Green indicates the location's income is above the county value. Red indicates the location's income is below the county value (i.e. a potentially vulnerable population.)

Figure 1. Household Income by zip codes, Montgomery County, Prince George's County, Maryland, and District of Columbia, 2015
(Source: U.S. Census Bureau, 2015 ACS 5-Year Estimates)

Median Household Income within the CBSA

Median Household Income
Prince George's County: $76,741
Montgomery County: $98,917
Source: US Census Bureau, 2015 1-Year ACS Estimates

Household income has a direct influence on a family's ability to pay for necessities, including health insurance and healthcare services. Throughout the CBSA served by Adventist HealthCare Washington Adventist Hospital (Montgomery & Prince George's Counties), across racial and ethnic groups, non-Hispanic whites have the highest median household income, while Blacks and Hispanics have the lowest (see Figure 2). However, when looking at the state of Maryland as a whole, Asians have the highest median income.

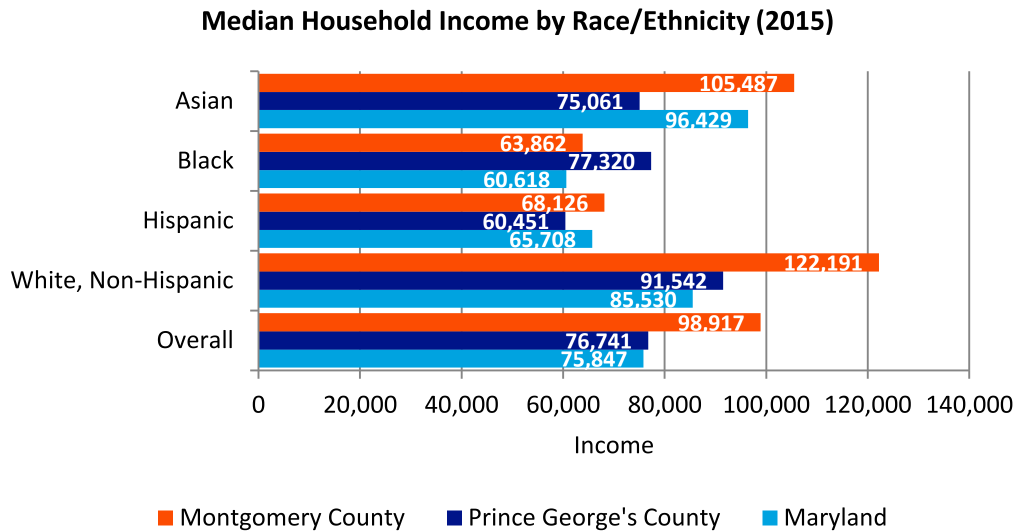

Figure 2. Median Household Income, Prince George's County, Montgomery County and Maryland by Race and Ethnicity 2015
(Source: U.S. Census Bureau, 2015 1-Year ACS Estimates)

Percentage of households with incomes below the federal poverty guidelines within the CBSA

In 2015, Montgomery County experienced poverty levels lower than that of the state of Maryland overall. According to the U.S. Census Bureau, 7.5 percent of Montgomery County residents and 9.3 percent of Prince George's County residents were living in poverty compared to 9.7 percent of Maryland residents.

Despite lower rates of poverty in Montgomery County compared to the state, racial disparities are still evident. Poverty levels among whites were the lowest at 3.6 percent and highest among Blacks at 12.1 percent and Hispanics at 13.1 percent (see Figure 3).

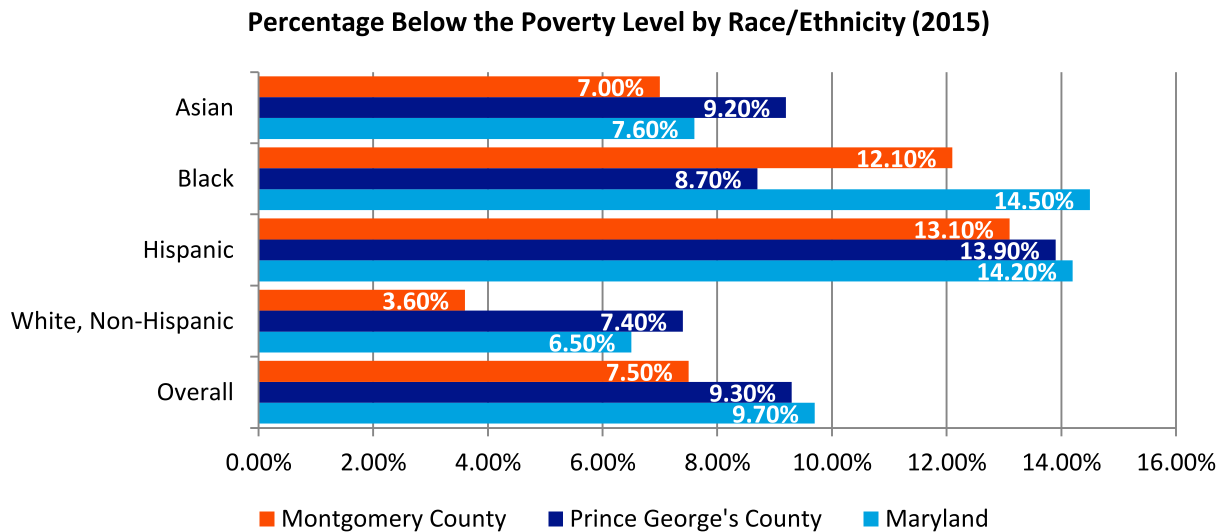

Figure 3. Poverty Status by Race and Ethnicity, Prince George's County, Montgomery County, and Maryland, 2015
(Source: U.S. Census Bureau, 2015 1-Year ACS Estimates)

Please estimate the percentage of uninsured people by County within the CBSA

Approximately 8.2 percent of all civilian non-institutionalized Montgomery County residents and 10.9 percent of Prince George's County residents are uninsured. This number is compared to 6.6 percent of Maryland residents (see Figure 4).

Across Montgomery County, Prince George's County, and Maryland, Hispanics are uninsured at rates significantly higher than whites, Blacks, and Asians. Approximately 32.5 percent of Hispanics are uninsured in Prince George's County, compared to 21.7 percent in Montgomery County and 23.6 percent in Maryland (see Figure 3). Whites are least likely to be uninsured across Prince George's County, Montgomery County, and Maryland.

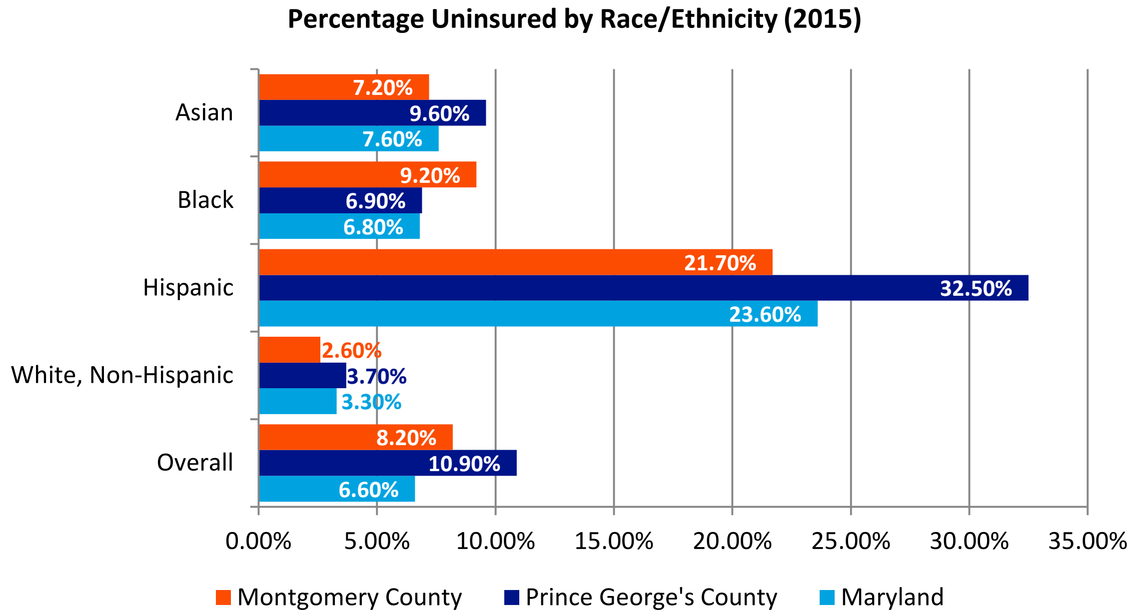

Figure 4. Percentage Uninsured by Race and Ethnicity, Prince George's County, Montgomery County, and Maryland, 2015
(Source: U.S. Census Bureau, 2015 1-Year ACS Estimates)

Percentage of Medicaid recipients by County within the CBSA.

Percentage of Medicaid Recipients by County within the CBSA:
Montgomery County: 9.90% (102,634)
Prince George's County: 16.7% (150,960)
Source: U.S. Census Bureau, 2015 1-Year ACS Estimates

Life Expectancy by County within the CBSA (including by race and ethnicity where data are available).

According to the 2013 Maryland State Health Improvement Process (SHIP), the overall life expectancy for Montgomery County is 84.6 years, 4.8 years greater than the Maryland 2017 target of 79.8 years (see Figure 5). However, when stratifying by race, a significant gap can be seen between Black and white residents. The life expectancy for white residents of Montgomery County is 84.4 years and 82.5 years for Black residents (see Figure 5). In Prince George's County, the overall life expectancy is 80 years, which is higher than that of Maryland (79.8 years). When stratifying by race, the life expectancy for white residents is 80.7 years, compared to only 79.3 years among Black residents of Prince George's County (see Figure 5).

County	SHIP Objective	SHIP 2013 County Baseline	SHIP 2014 County Update	SHIP 2014 County Update (Race/ Ethnicity)	SHIP 2014 Maryland Update	SHIP 2014 Maryland Update (Race/ Ethnicity)	Maryland SHIP 2017 Target
Prince George's	Increase life expectancy in Maryland	79.6	80	Black – 79.3 White – 80.7	79.8	Black – 77.5 White – 80.4	79.8
Montgomery		84.3	84.6	Black – 82.5 White – 84.4			

Figure 5. Life expectancy at Birth (in years), Prince George's and Montgomery Counties, 2014
(Source: Maryland Department of Health and Mental Hygiene (DHMH) Vital Statistics Administration, 2014)

Mortality Rates by County within the CBSA (including by race and ethnicity where data are available).

The mortality rate in Montgomery County is 573.2 per 100,000 population and 593.6 per 100,000 population in Prince George's County. These rates are lower than the mortality rate for the state of Maryland overall (764.5 per 100,000) (see Figure 6). Whites have the highest death rates in both counties and the state of Maryland overall while Hispanics have the lowest death rates.

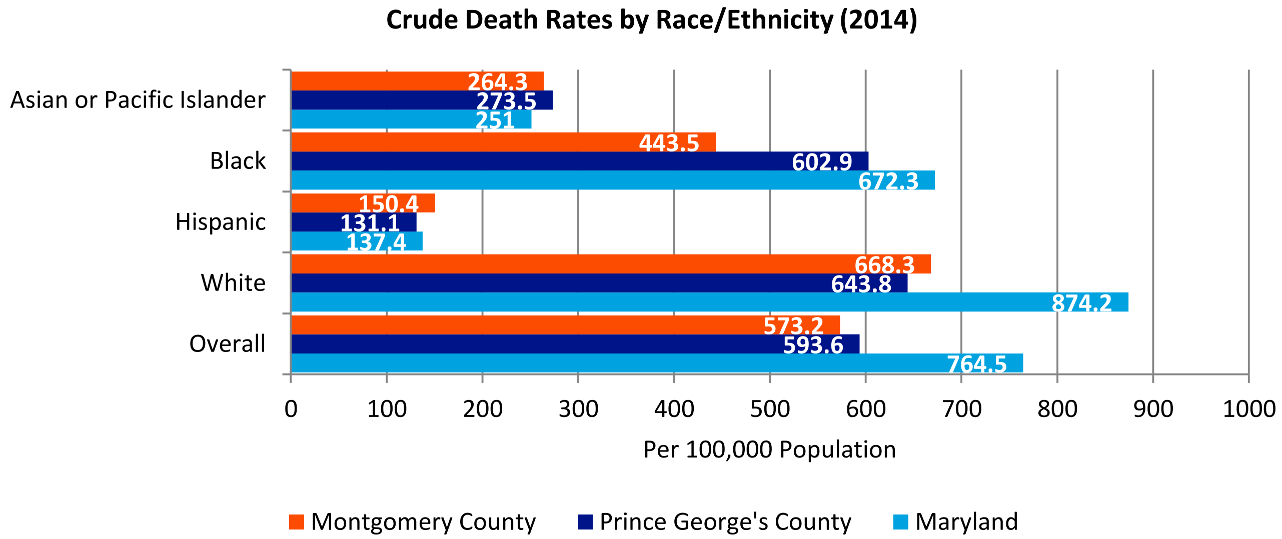

Figure 6. Crude Death Rate by Race and Ethnicity for Prince George's County, Montgomery County, and Maryland, 2014
(Source: Maryland Department of Health and Mental Hygiene, Maryland *Vital Statistics Annual Report, 2014*)

Infant Mortality Rate

Overall, Montgomery County (4.8 per 1,000 live births) has met the Maryland SHIP 2017 target (6.3 per 1,000 live births), but Prince George's County did not meet the target (6.9 per 1,000 live births). Blacks in Montgomery and Prince George's Counties and the state overall are disproportionately affected by high infant mortality rate. They failed to meet the Maryland SHIP 2017 target (6.3 infant deaths per 1,000 live births) while Hispanics and whites met the target (see Figure 7).

County	SHIP Objective	SHIP 2013 County Baseline	SHIP 2014 County Update	SHIP 2013 County Update (Race/ Ethnicity)	SHIP 2014 Maryland Update	SHIP 2014 Maryland Update (Race/ Ethnicity)	Maryland SHIP 2017 Target
Prince George's	Reduce Infant Deaths	7.8	6.9	NH Black – 8.2 Hispanic – 5.2 NH White – 5.2	6.5	NH Black – 10.7 Hispanic – 4.4 NH White -- 4.4	6.3
Montgomery		4.7	4.8	NH Black – 7.8 Hispanic – 4.4 NH White – 4.4			

Figure 7. Infant Mortality Rate (per 1,000 Live Births) by Race/Ethnicity in Prince George's and Montgomery Counties, 2014 (Source: DHMH State Health Improvement Process (SHIP), 2014)

Access to Healthy Food

Healthy Eating Behaviors

In Montgomery County, 66.7 percent of the adult population consumes less than five servings of fruits and vegetables daily. This proportion is lower than the Prince George's County average of 70.7 percent and Maryland's average of 72.4 percent (see Figure 8).

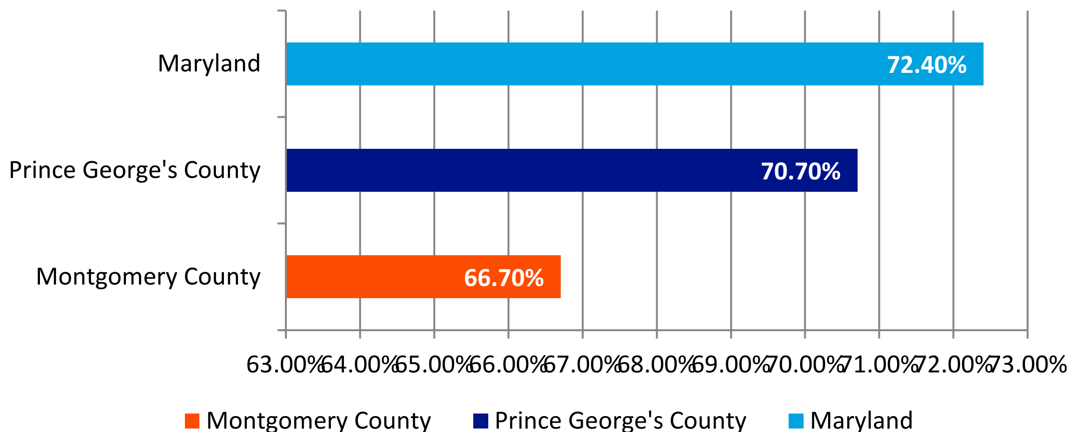

Figure 8. Adults Consuming Less Than 5 Servings of Fruits & Vegetables Each Day (Source: Community Commons Community Health Needs Assessment, 2013)

Fruit and vegetable consumption varies among racial and ethnic groups in Montgomery County. A higher percentage of white (33 percent) and Asian (31 percent) residents consume the recommended five or more servings of fruits and vegetables daily, as opposed to the county as a whole (29.6 percent). However, Hispanics have the lowest percentage of adult fruit and vegetable consumption within the county at 14.2 percent (see Figure 9).

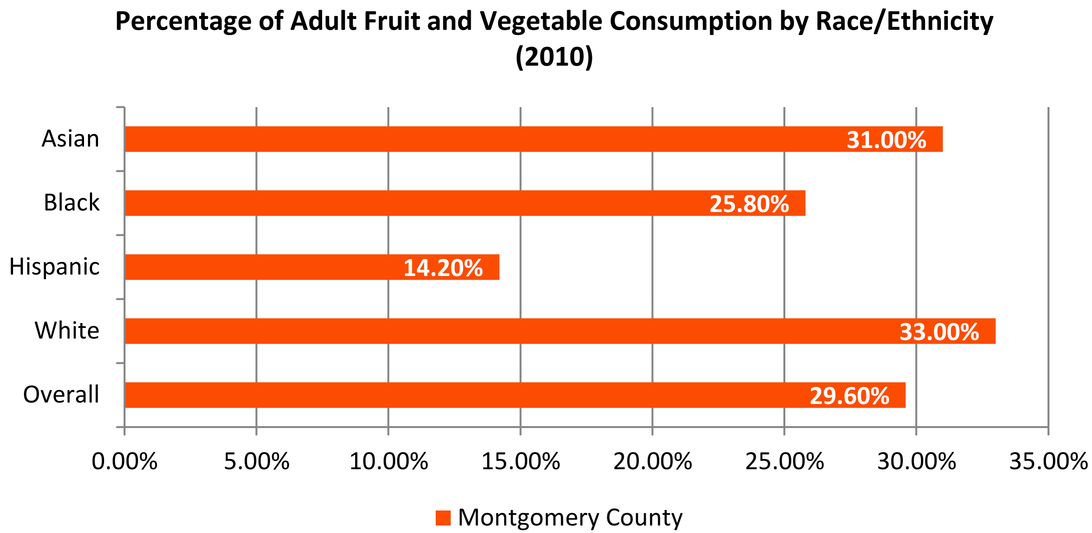

Figure 9. Fruit and Vegetable Consumption by Race and Ethnicity, Montgomery County, 2010
(Source: Healthy Montgomery)

Food Environment

The USDA defines food insecurity as the lack of access to enough food necessary for a healthy life, and limited or uncertain availability of adequately nutritious foods[1]. In 2014, 7.0 percent of Montgomery County experienced food insecurity which is lower than Maryland (12.7 percent) as a whole. In comparison, Prince George's County had a higher food insecurity rate (15.5 percent) than both Montgomery County and the state (see Figure 10).

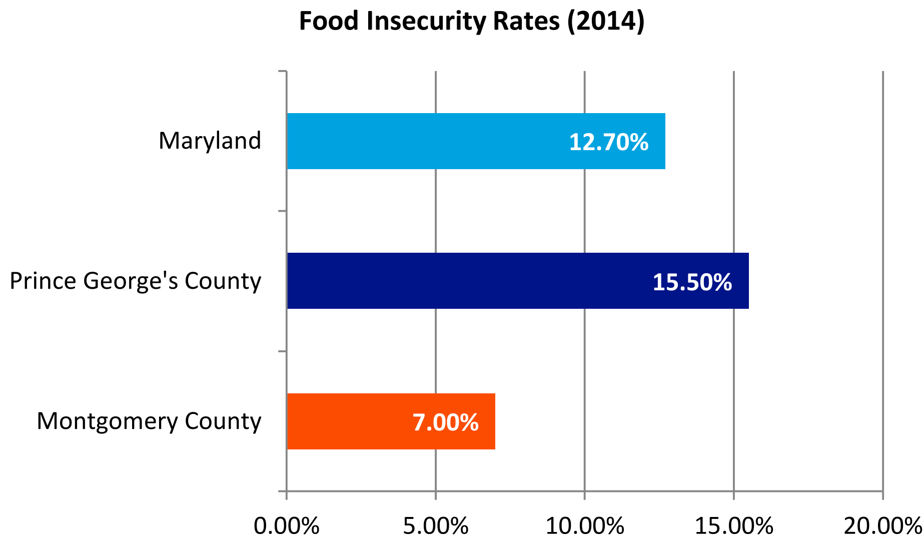

Figure 10. Percentage of Food Insecure Population, 2014
(Source: Feeding America, *Map the Meal Gap*, 2014)

One measure of healthy food access and environmental influence on healthy behavior is access to grocery stores. The Community Commons defines grocery stores as supermarkets and smaller grocery stores primarily engaged in retailing a general line of food, such as canned and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. In Montgomery County there are 20.79 grocery stores per 100,000 population, a rate similar

[1] Feeding America (2016). Map the Meal Gap. Retrieved from: http://map.feedingamerica.org/county/2014/overall/maryland

to Maryland (21.3 per 100,000 population). However, there are only 18.53 grocery stores per 100,000 population in Prince George's County (see Figure 11).

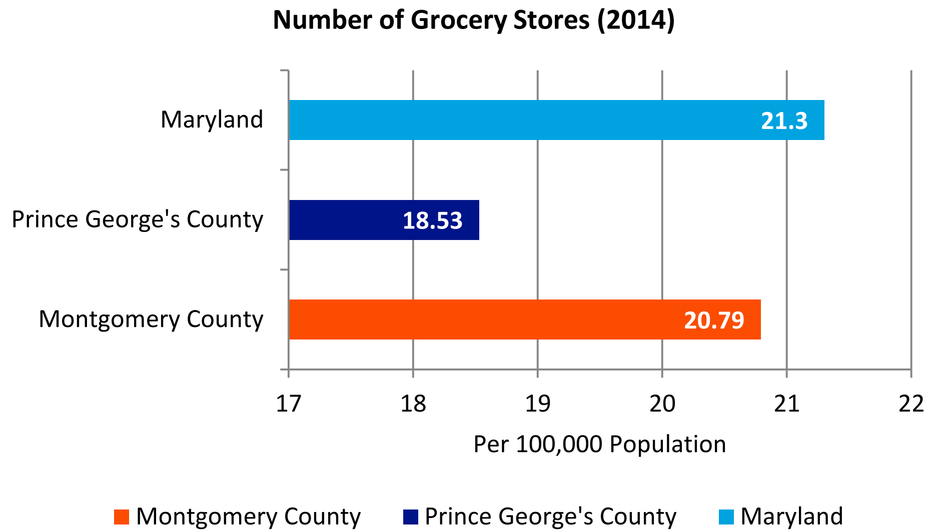

Figure 11. Number of Grocery Stores per 100,000 Population, 2014
(Source: [Community Commons. Community Health Needs Assessment, 2014])

Fast food restaurant access has been rising at the local and national levels for the past several years. From 2009 to 2013, the rate in Maryland increased from 78.37 to 86.64 per 100,000 population[2]. In Prince George's County, residents have a higher rate of access to fast food restaurants (87.21 per 100,000 population) than both Montgomery County (81.71 per 100,000 population) and Maryland (84.8 per 100,000) (see Figure 12).

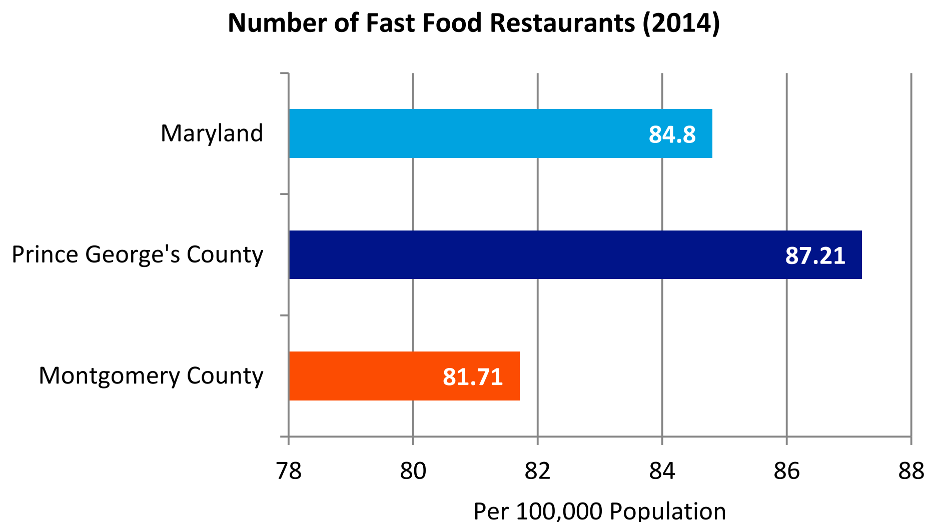

Figure 12. Number of Fast Food Restaurants per 100,000 Population, 2014
(Source: [Community Commons. Community Health Needs Assessment, 2014])

[2] Community Commons. *Community Health Needs Assessment*. (2014). Retrieved from: http://assessment.communitycommons.org/CHNA/report?page=3&id=401&reporttype=libraryCHNA

Transportation

Commuting

The majority of both Montgomery and Prince George's Counties drive alone to work (65.6 percent and 61.1 percent, respectively) or utilize public transportation (15.9 percent and 17.1 percent, respectively) (see Figure 13).

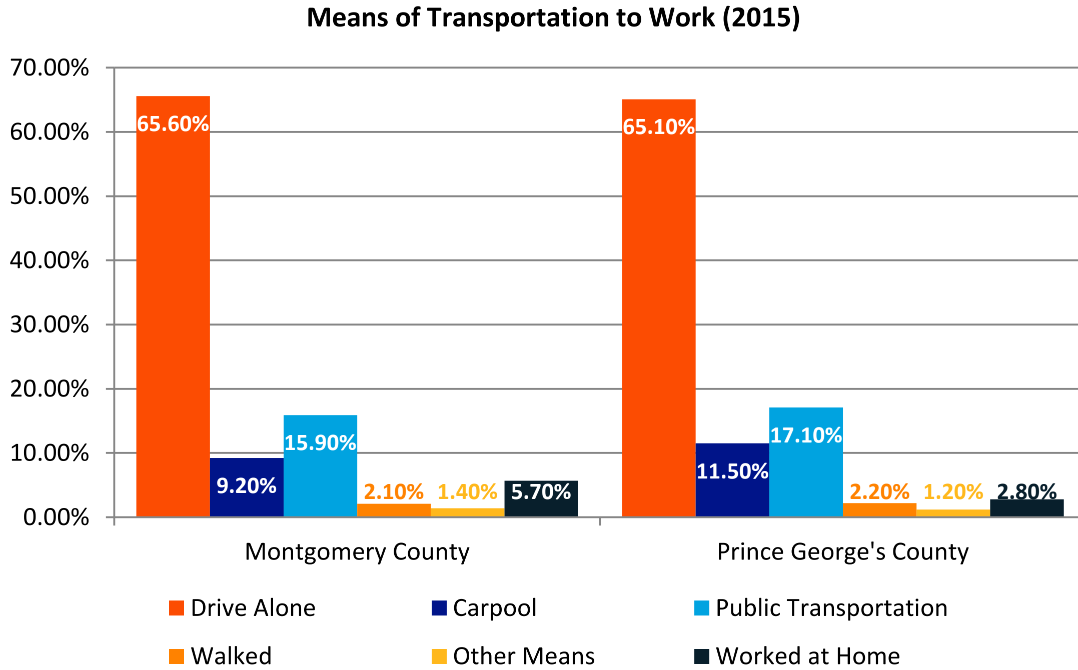

Figure 13. Means of Transportation to Work, Montgomery and Prince George's Counties, 2015
(Source: US Census Bureau, 2015 ACS 1-Year Estimates)

The mean travel time to work for Montgomery County is 34.4 minutes; whereas the mean travel time for Prince George's County is 36.2 minutes (see Figure 14).

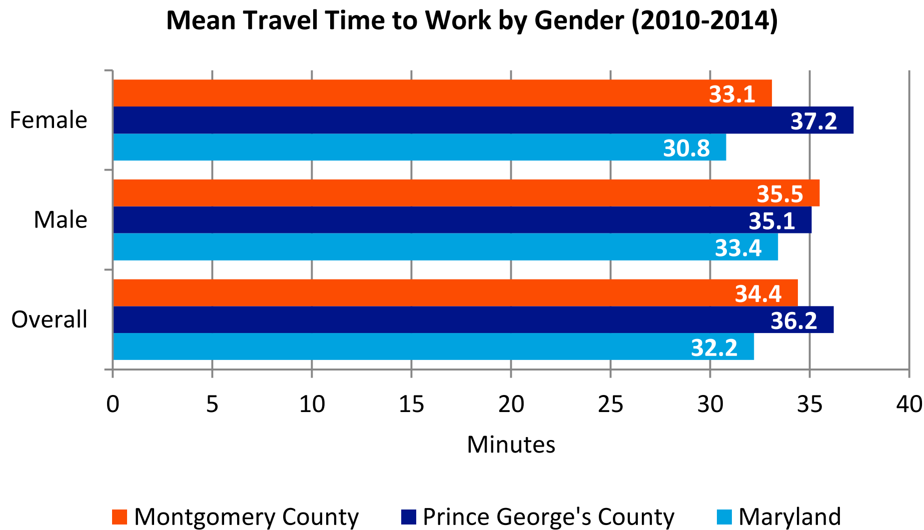

Figure 14. Mean Travel Time to Work by Gender for Prince George's County and Montgomery County, 2015
(Source: Healthy Montgomery, 2010-2014; PGC Health Zone, 2010-2014)

Pedestrian Safety

The rate of pedestrian injuries on public roads in Montgomery County (41.3 per 100,000 population) is nearly equivalent to that of the state (42.6 per 100,000 population), whereas the rate in Prince George's County is slightly lower at 39.6 per 100,000 population. The rates have increased since the 2013 County measures and they remain higher than the SHIP 2017 target of 35.6 per 100,000 population (see Figure 15).

<table>
<tr><th>County</th><th>SHIP Objective</th><th>SHIP 2012 County Measure</th><th>SHIP 2013 County Measure</th><th>SHIP 2014 County Update</th><th>SHIP 2014 Maryland Update</th><th>Maryland SHIP 2017 Target</th></tr>
<tr><td>Prince George's</td><td rowspan="2">Reduce rate of pedestrian injuries</td><td>35.4</td><td>37.2</td><td>39.6</td><td rowspan="2">42.6</td><td rowspan="2">35.6</td></tr>
<tr><td>Montgomery</td><td>40.1</td><td>35.6</td><td>41.3</td></tr>
</table>

Figure 15. Rate of Pedestrian Injuries per 100,000 Population, Prince George's and Montgomery Counties, 2014
(Source: Maryland SHIP, 2014)

The pedestrian death rate in Montgomery County at 1.18 deaths per 100,000 population, is higher than that of Maryland (0.91 per 100,000 population)[3] and the Healthy People 2020 target of 1.4 deaths per 100,000 population; however, the pedestrian death rate in Prince George's County at 1.69 deaths per 100,000 population is higher than both state and national rates[4].

From 2011 to 2014 in Montgomery County, white non-Hispanic individuals experienced the highest number of traffic fatalities among both vehicle occupants and non-occupants (see Figure 16-A).

[3] U.S. Department of Transportation National Highway Traffic Safety Administration. *2013 Ranking of COUNTY Pedestrian Fatality Rates – Maryland*. Accessed from: http://www-fars.nhtsa.dot.gov/States/StatesPedestrians.aspx

[4] U.S. Department of Transportation National Highway Traffic Safety Administration. *2013 Ranking of COUNTY Pedestrian Fatality Rates – Maryland*. Accessed from: http://www-fars.nhtsa.dot.gov/States/StatesPedestrians.aspx

Montgomery County Traffic Fatalities (2011-2014)					
Person Type by Race/Hispanic Origin		**2011**	**2012**	**2013**	**2014**
Occupants (All Vehicle Types)	Hispanic	0	2	5	4
	White Non-Hispanic	9	11	12	13
	Black, Non-Hispanic	1	7	6	4
	Asian, Non-Hispanic/Unknown	0	0	0	0
	All Other Non-Hispanic or Race	1	3	3	4
	Unknown Race and Unknown Hispanic	19	7	1	3
	Total	30	30	27	28
Non-Occupants (Pedestrians, Pedal cyclists and Other/Unknown Non-Occupants)	Hispanic	0	0	1	1
	White Non-Hispanic	2	4	6	4
	Black, Non-Hispanic	1	2	4	1
	Asian, Non-Hispanic/Unknown	0	0	1	1
	All Other Non-Hispanic or Race	0	0	0	0
	Unknown Race and Unknown Hispanic	7	1	1	4
	Total	10	7	13	11
Total	Hispanic	0	2	6	5
	White Non-Hispanic	11	15	18	17
	Black, Non-Hispanic	2	9	10	5
	Asian, Non-Hispanic/Unknown	0	0	1	1
	All Other Non-Hispanic or Race	1	3	3	4
	Unknown Race and Unknown Hispanic	26	8	2	7
	Total	40	37	40	39

Figure 16-A. Montgomery County Fatalities by Person Type, Race and Ethnicity, 2011-2014
(Source: National Highway Traffic Safety Administration, Traffic Safety Facts, 2014)

Prince George's County Traffic Fatalities (2011-2014)					
Person Type by Race/Hispanic Origin		**2011**	**2012**	**2013**	**2014**
Occupants (All Vehicle Types)	Hispanic	3	5	7	3
	White Non-Hispanic	13	7	8	8
	Black, Non-Hispanic	26	36	35	47
	All Other Non-Hispanic or Race	1	0	3	1
	Unknown Race and Unknown Hispanic	31	15	17	9
	Total	74	63	70	68
Non-Occupants (Pedestrians, Pedal cyclists and Other/Unknown Non-Occupants)	Hispanic	2	1	0	4
	White Non-Hispanic	5	4	1	6
	Black, Non-Hispanic	9	14	10	12
	All Other Non-Hispanic or Race	0	0	0	0
	Unknown Race and Unknown Hispanic	15	5	6	8
	Total	31	24	17	30
Total	Hispanic	5	6	7	7
	White Non-Hispanic	18	11	9	14
	Black, Non-Hispanic	35	50	45	59
	All Other Non-Hispanic or Race	1	0	3	1
	Unknown Race and Unknown Hispanic	46	20	23	17
	Total	105	87	87	98

Figure 16-B. Prince George's County Fatalities by Person Type, Race and Ethnicity, 2011-2014
(Source: National Highway Traffic Safety Administration, Traffic Safety Facts, 2014)

Maryland Traffic Fatalities (2011-2014)					
Person Type by Race/Hispanic Origin		**2011**	**2012**	**2013**	**2014**
Occupants (All Vehicle Types)	Hispanic	7	20	22	14
	White Non-Hispanic	179	234	192	176
	Black, Non-Hispanic	60	90	83	93
	American Indian, Non-Hispanic/Unknown	1	2	0	1
	Asian, Non-Hispanic/Unknown	1	4	1	1
	All Other Non-Hispanic or Race	4	12	18	10
	Unknown Race and Unknown Hispanic	122	46	32	38
	Total	374	408	348	333
Non-Occupants (Pedestrians, Pedal cyclists and Other/Unknown Non-Occupants)	Hispanic	3	3	5	6
	White Non-Hispanic	40	49	54	57
	Black, Non-Hispanic	21	35	42	27
	Asian, Non-Hispanic/Unknown	0	0	1	1
	All Other Non-Hispanic or Race	1	2	2	0
	Unknown Race and Unknown Hispanic	46	14	13	18
	Total	111	103	117	109
Total	Hispanic	10	23	27	20
	White Non-Hispanic	219	283	246	233
	Black, Non-Hispanic	81	125	125	120
	American Indian, Non-Hispanic/Unknown	1	2	0	1
	Asian, Non-Hispanic/Unknown	1	4	2	2
	All Other Non-Hispanic or Race	5	14	20	10
	Unknown Race and Unknown Hispanic	168	60	45	56
	Total	485	511	465	442

Figure 16-C. Maryland Fatalities by Person Type, Race and Ethnicity, 2011-2014
(Source: National Highway Traffic Safety Administration, Traffic Safety Facts, 2014)

Education

Graduation and Educational Attainment

In 2015, 89.36 percent of Montgomery County students graduated high school within four years. The four-year graduation rate for the county is lower than that of the state (86.98 percent. While both the state overall and Montgomery County surpassed the Health People 2020 high school graduation goal of 82.4 percent[5], Prince George's County (78.75 percent) did not (see Figure 17).

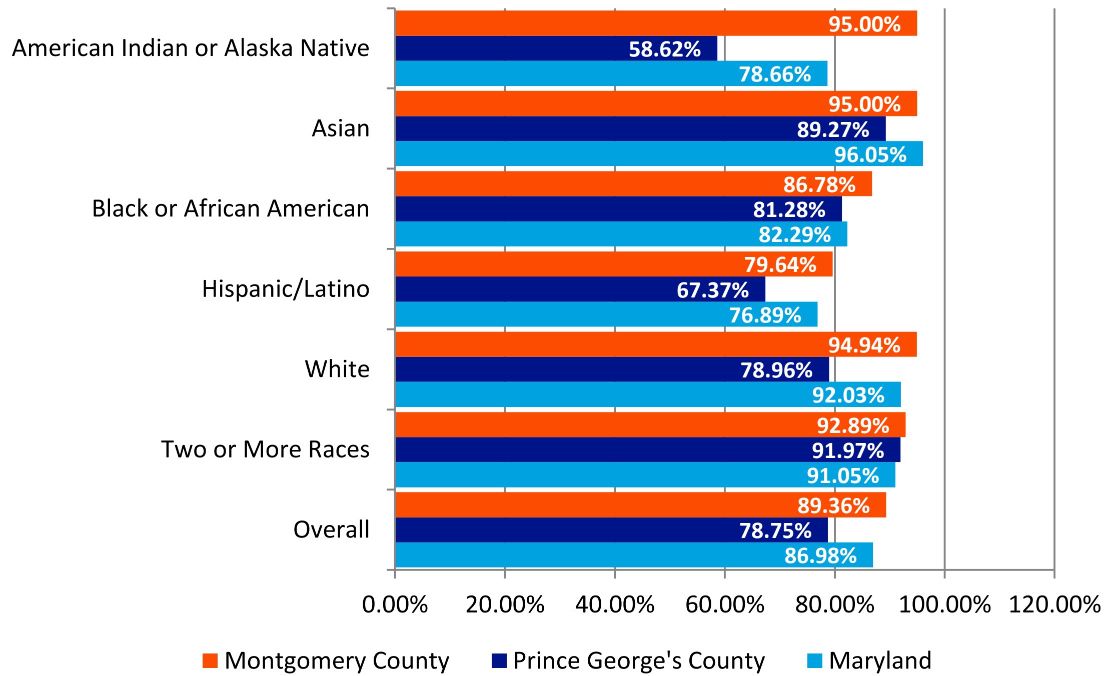

Figure 17. High School Graduation Rates by Race/Ethnicity in Montgomery and Prince George's Counties and Maryland, 2015
(Source: [2016 Maryland Report Card])

Disparities in education and ethnicity become even more apparent at the college level. The overall percentage of adults 25+ in Montgomery County with a bachelor's degree or higher is 27.15 percent which is higher than both the state (21.12 percent) and Prince George's County (18.94 percent). However, when stratified by race and ethnicity, Whites have the highest percentage in Montgomery County (71.14 percent), but more Asians over 25 have a bachelor's degree in both Prince George's County (54.72 percent) and Maryland (63.72 percent) than any other racial or ethnic group. There are large disparities within Prince George's County as well, with 54.72 percent of Asians obtaining a bachelor's degree compared to 10.52 percent of Hispanics (see Figure 18).

[5] Healthy Communities (2016). Montgomery County: High school graduation rate. *Healthy Montgomery.* Retrieved from: http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=13&localeId=1259

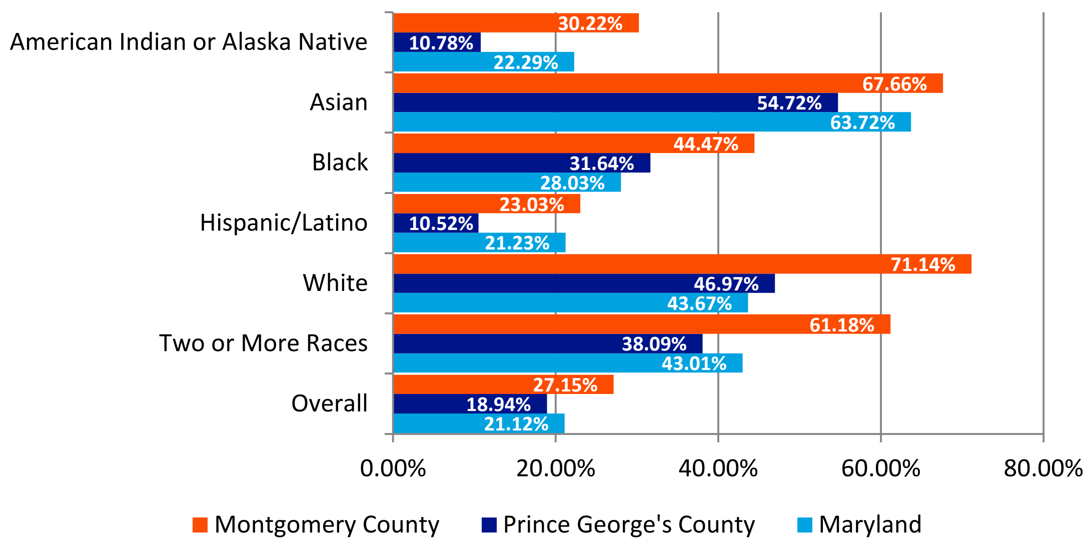

Figure 18. People 25 and Over with a Bachelor's Degree or Higher by Race/Ethnicity, Montgomery and Prince George's Counties and Maryland, 2015
(Source: U.S. Census Bureau, 2015 1-Year Estimates)

English and Algebra Proficiency

Based on student scores on the Maryland High School Assessment (HSA), 95 percent of white and approximately 93 percent of Asian 12th graders are proficient in English compared to 78 percent of Hispanic and about 80 percent of Black students in Montgomery County. In Prince George's County, there are also racial and ethnic disparities among 12th graders in English proficiency, with white 12th graders testing highest at 89.4 percent and Hispanic students testing at 67.3 percent proficient. More Asian 12th graders in Maryland (91.5 percent) test proficient in English in Maryland than all other racial and ethnic groups while Black 12th graders have the lowest proficiency rate (73.1 percent) (see Figure 19).

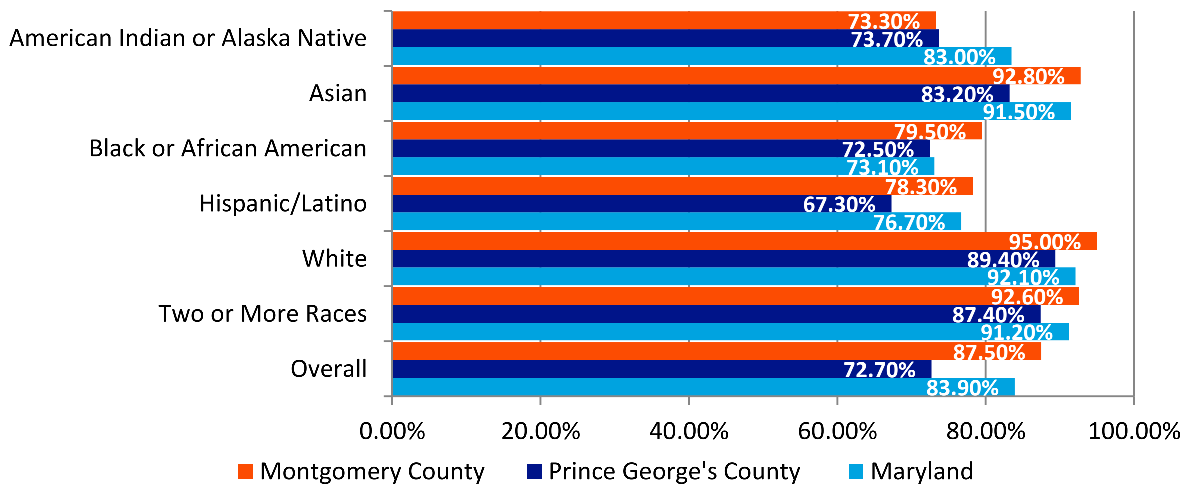

Figure 19. 12th Grade Students Proficient in English by Race/Ethnicity, Montgomery and Prince George's Counties and Maryland, 2015
(Source: 2016 Maryland Report Card)

A similar trend can be seen for algebra proficiency among 12th graders. In Montgomery County, at least 95 percent of both white and Asian 12th graders are proficient in algebra compared to 82.4 percent of American Indian or Alaska Native and 84.5 percent of Black students. In Prince George's County, 89.4 percent of white students are proficient in algebra compared to 70.4 percent of Black students. Regarding the state overall, 87.4 percent of 12th graders are proficient in algebra. More white (96 percent) and Asian students (96.3 percent) have tested proficient in algebra than all other racial or ethnic groups within Maryland while Black students (75.3 percent) have the lowest proficiency rate (see Figure 20).

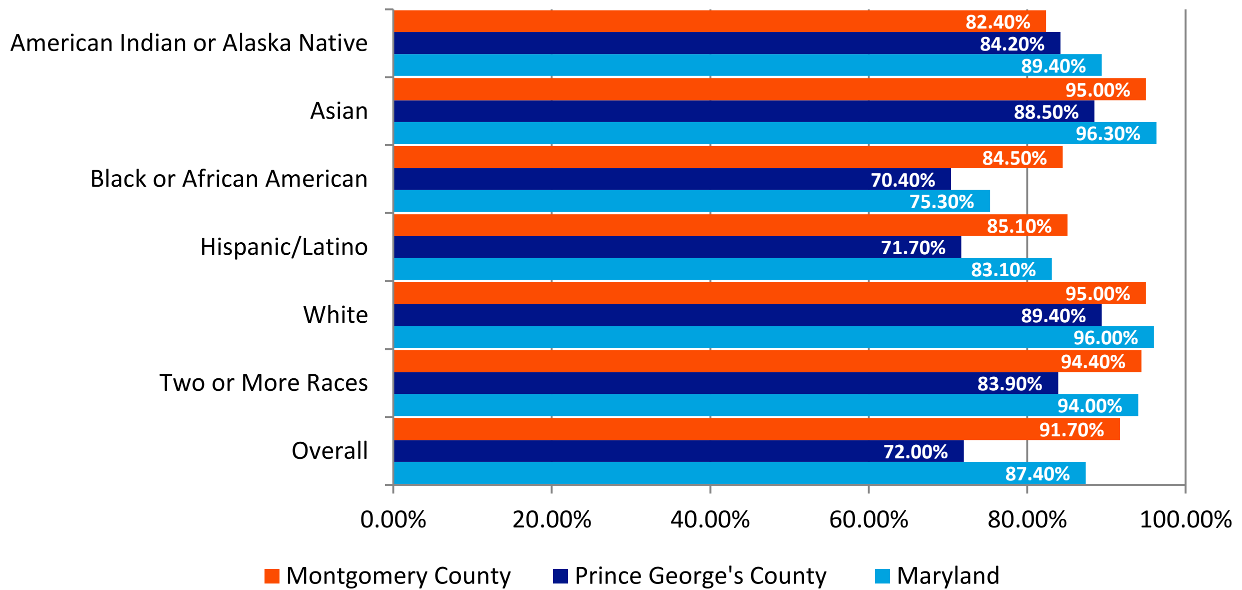

Figure 20. 12th Grade Students Proficient in Algebra by Race/Ethnicity, Montgomery and Prince George's Counties and Maryland, 2015
(Source: 2016 Maryland Report Card)

Readiness for Kindergarten

The percentage of children who enter kindergarten ready to learn in Montgomery County increased from 48 percent in 2014 to 49 percent in 2015, but is still higher than Maryland overall (45 percent). Hispanic children were among those least likely to be prepared for kindergarten in Montgomery County (28 percent). White (68 percent) and Asian (58 percent) children were among those most prepared to enter kindergarten in Montgomery County (see Figure 20).

The percentage of children who enter kindergarten ready to learn in Prince George's County increased from 34 percent in 2014 to 38 percent in 2015, but remained lower than that of the state overall (45 percent). Hispanic children were the least likely to be prepared for kindergarten at 22 percent, while Asian and white children were among those most prepared to enter kindergarten in Prince George's County at 46 percent and 59 percent, respectively (see Figure 21).

County	SHIP Measure	County 2014 Measure	SHIP 2015 County Update	SHIP 2014 County Update (Race & Ethnicity)	SHIP 2015 Maryland Update	Maryland Target 2017
Prince George's County	Percentage of children who enter kindergarten ready to learn	34%	38%	Asian–46%; AA-45% Hispanic-22% White-59%	45%	85.5%
Montgomery County		48%	49%	Asian–58%; AA-40% Hispanic-28% White-68%		

Figure 21. Percentage of Children Entering Kindergarten Ready to Learn, Prince George's and Montgomery Counties (Source: Maryland SHIP, 2015)

Housing Quality

Housing Quality

A person's living situation – the condition of their homes and neighborhoods – is a crucial determinant of health status. Across the U.S., a disproportionate percentage of minority households are affected by moderate and severe housing problems (see Figure 22).

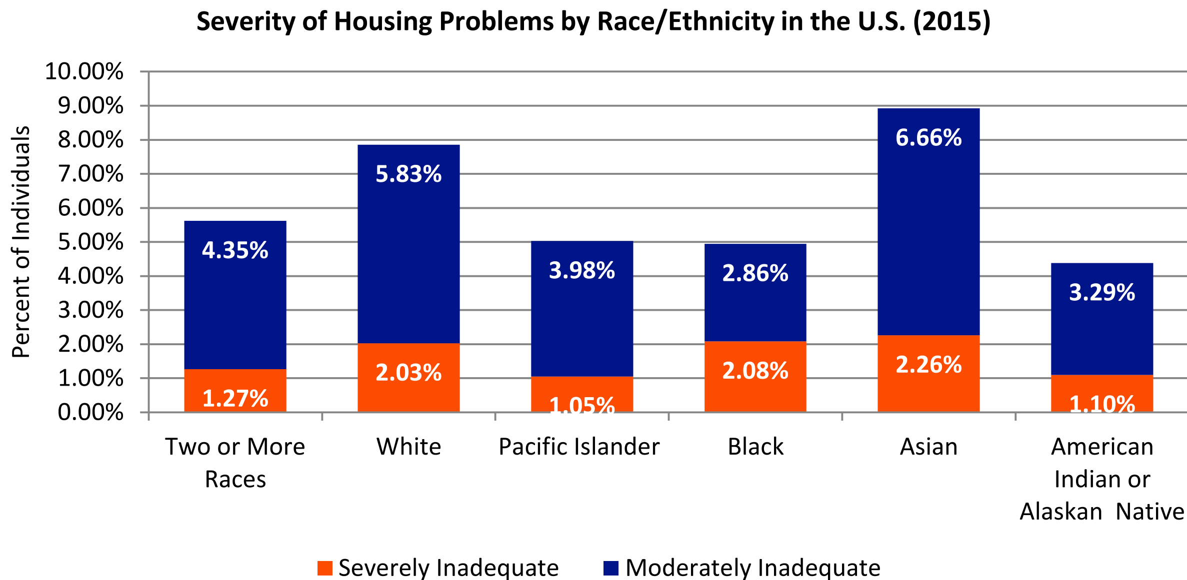

Figure 22. Severity of Housing Problems by Race/Ethnicity in the U.S., 2015
Note: Physical problems include plumbing, heating, electrical and upkeep
(Source: U.S. Census Bureau, American Housing Serving, 2015)

At the local level, 17 percent of households in Maryland, 18 percent of households in Montgomery County, and 20 percent of households in Prince George's County were identified as having at least 1 of 4 severe housing problems: overcrowding; high housing costs; and lack of kitchen or plumbing facilities[6].

[6] University of Wisconsin – Population Health Institute. (2016). Compare counties. *County Health Rankings*. Retrieved from: http://www.countyhealthrankings.org/app/maryland/2016/compare/snapshot?counties=24_031%2B24_033

Montgomery County Housing Statistics

- Renters spending 30 percent or more of household income on rent: 52.7 percent
- Homeowner vacancy rate: 0.8
- Housing units in multi-unit structures: 34.3 percent
- Housing units: 389,030 (2015)
- Homeownership rate: 64.3 percent
  Median value of owner-occupied housing units: $474,900
  (Source: U.S. Census Bureau, ACS, 1-Year Estimate, 2015)
- Households: 365,235
- Persons per household: 2.76
  (Source: U.S. Census Bureau, QuickFacts, 2011–2015)

Prince George's County Housing Statistics

- Renters spending 30 percent or more of household income on rent: 52.4 percent
- Homeowner vacancy rate: 1.7
- Housing units in multi-unit structures: 32.5 percent
- Housing units: 331,294
- Homeownership rate: 61.3 percent
  Median value of owner-occupied housing units: $272,200
  (Source: U.S. Census Bureau, ACS, 1-Year Estimate, 2015)
- Households: 305,610
- Persons per household: 2.86
  (Source: U.S. Census Bureau, QuickFacts, 2011–2015)

Spotlight on Homelessness

Perhaps the most extreme case of living situation having a negative impact on health is that of homelessness. Homelessness amplifies the threat of various health conditions and introduces new risks, such as exposure to extreme temperatures. People who experience homelessness have multidimensional health problems and often report unmet health needs, even if they have a usual source of care.

In January 2016, a Point-In-Time Enumeration survey found there has been a decrease in the homeless population in both Montgomery County and Prince George's County (Figure 23).

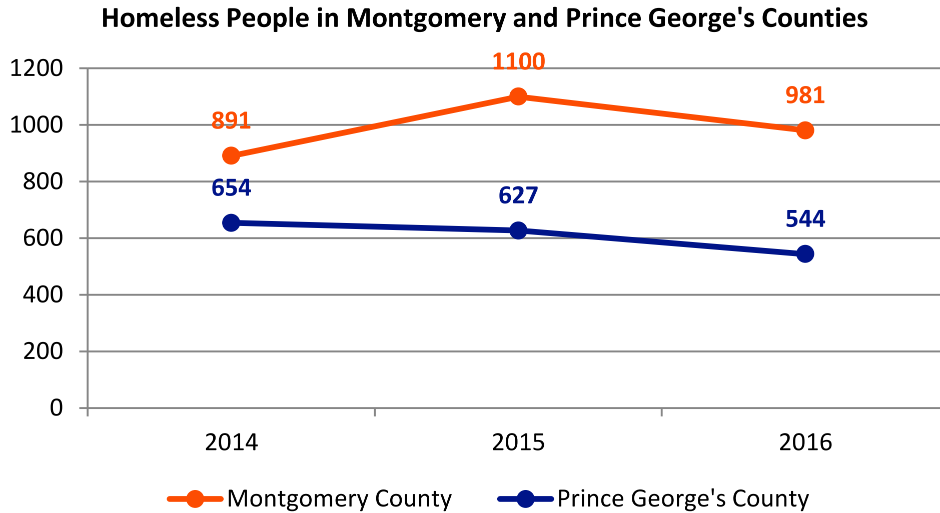

Figure 23. Number of Homeless People in Montgomery County and Prince George's County from 2014 to 2016
(Source: Metropolitan Washington Council on Governments Point-In-Time Survey, 2016)

In Montgomery County, the homeless population in 2016 included 109 homeless family units, made up of 128 adults and 230 children (Figure 24-A). Prince George's County's homeless population comprised of 105 family units, which included 118 adults, and 190 children (Figure 24-B).

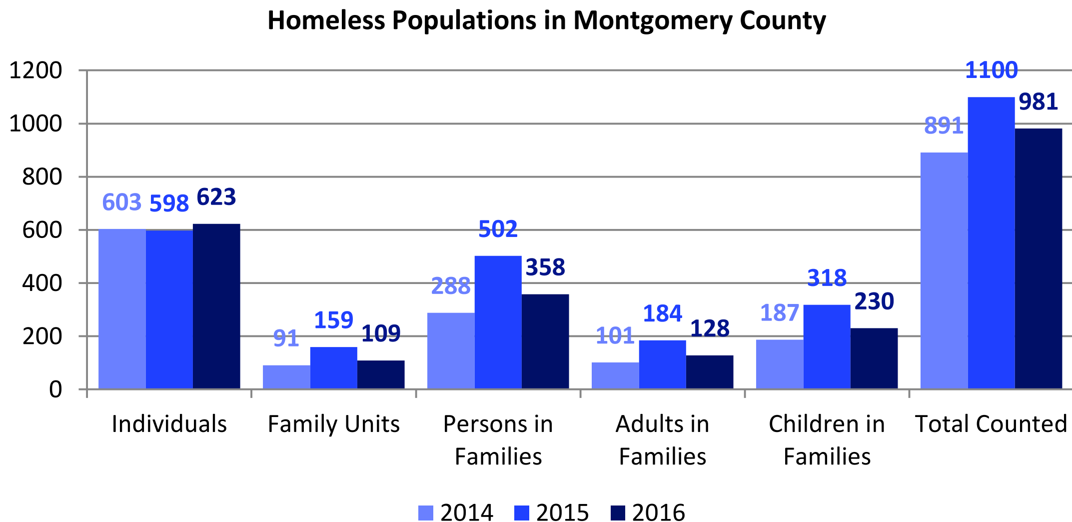

Figure 24-A. Homeless Populations in Montgomery County, 2014-2016
(Source: Metropolitan Washington Council on Governments Point-In-Time Survey, 2016)

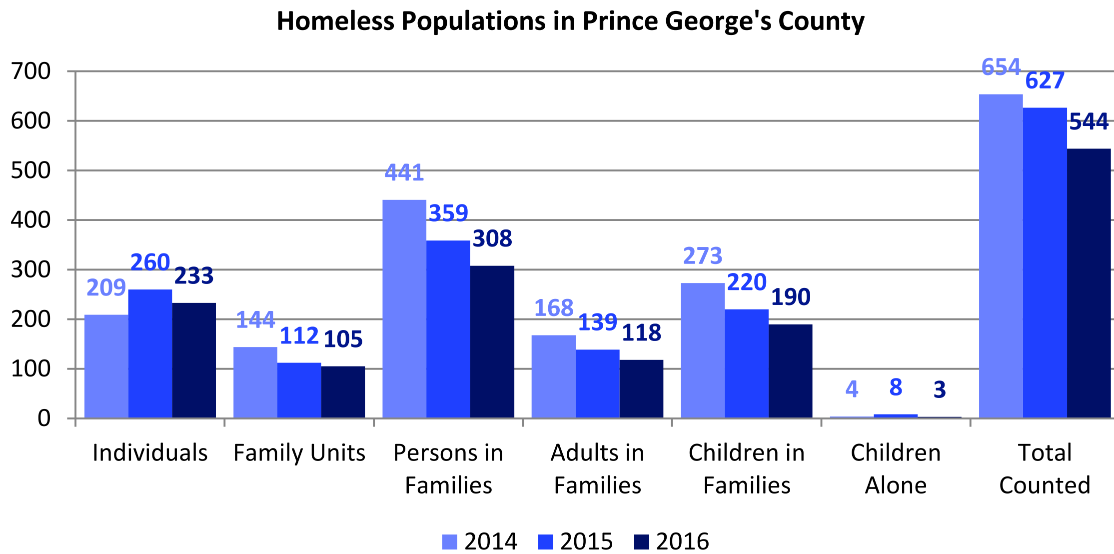

Figure 24-B. Homeless Populations in Prince George's County, 2014-2016
(Source: Metropolitan Washington Council on Governments Point-In-Time Survey, 2016)

Among the homeless populations, numerous individuals reported various health, mental, and physical issues. In Montgomery County, 151 individuals were chronically homeless, 17 were US veterans, 127 were victims of domestic violence, 114 were suffering from co-occurring disorders (mental and substance abuse), 80 were physically disabled, and 85 were individuals with limited English proficiency. Similar issues were found among the Prince George's County homeless population (Figure 25).

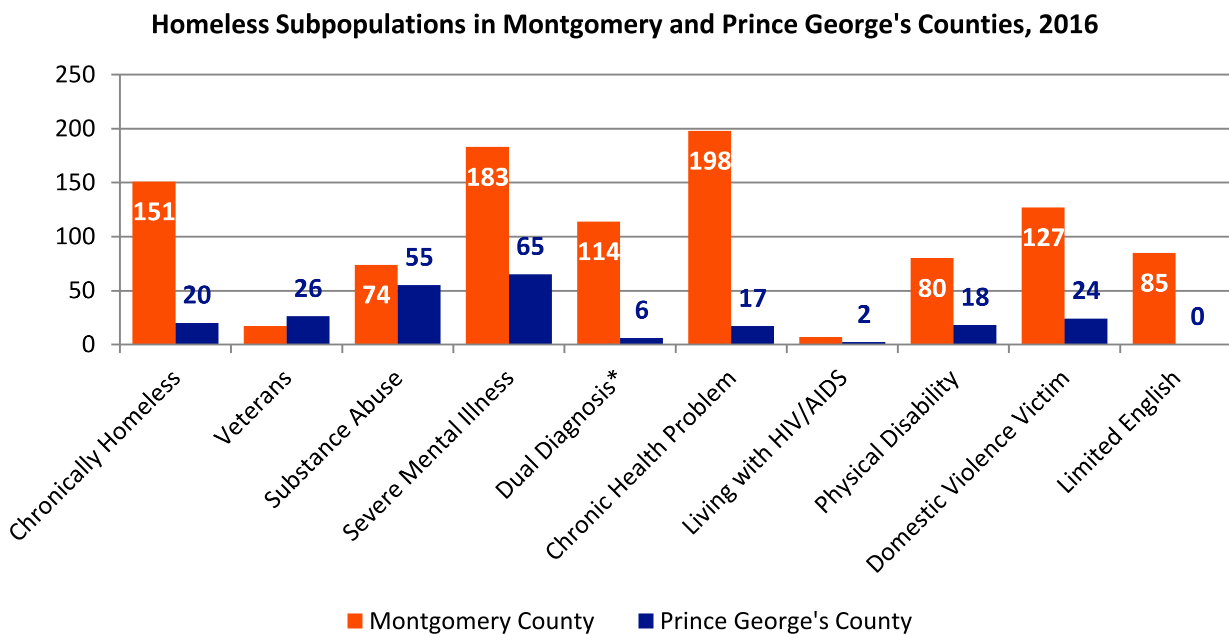

Figure 25. Homeless Subpopulations in Montgomery County and Prince George's County in 2016
(Source: Metropolitan Washington Council on Governments Point-In-Time Survey, 2016)

Exposure to Environmental Factors that Negatively Affect Health Status

Air Pollution

Air pollution, measured by ozone levels, poses a serious threat in both Montgomery and Prince George's Counties. Ozone is an extremely dangerous gas that attacks lung tissues when breathed in. Based on the number of days its ozone levels surpass the U.S. standards in three years, Montgomery County received a grade of D from the American Lung Association[7]; Prince George's County received a grade of F.[8] Prince George's County also has a high quantity (1,540lbs) of carcinogens released into the air[9].

Available detail on race, ethnicity, and language within CBSA

See SHIP County profiles for demographic information of Maryland jurisdictions.

Demographics	Montgomery County	Prince George's County	Maryland
Total Population*	1,040,116	909,535	321,418,820
Age, %*			
Under 5 Years	6.5%	6.6%	6.2%
Under 18 Years	23.4%	22.5%	22.9%
65 Years and Older	14.1%	11.7%	14.1%
Race/Ethnicity, %*			
White	45.2%	13.9%	61.6%
Black or African American	19.1%	64.6%	12.6%
Native American & Alaskan Native	0.7%	1.0%	1.2%
Asian	15.2%	4.7%	5.6%
Native Hawaiian & Other Pacific Islander	0.1%	0.2%	0.2%
Hispanic	19.0%	17.2%	17.6%
Language Other than English Spoken at Home, % age 5+*	39.3%	21.3%	20.9%
Median Household Income*	$98,704	$73,856	$53,482
Persons below Poverty Level, %*	7.2%	10.3%	13.5%
Pop. 25+ Without H.S. Diploma, %*	8.7%	14.4%	13.7%
Pop. 25+ With Bachelor's Degree or Above, %*	57.4%	30.4%	29.3%

Sources:
* U.S. Census Bureau. (2015). QuickFacts. Retrieved from:
https://www.census.gov/quickfacts/table/PST045215/24031,24033,00

[7] Healthy Communities Institute. (2016). Annual ozone air quality, 2012-2014. *Healthy Montgomery*. Retrieved from: http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=167&localeTypeId=2&localeId=1259

[8] Healthy Communities Institute (2016). Annual ozone air quality, 2012-2014. *PGC HealthZone*. Retrieved from: http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=167&localeId=1260

[9] Healthy Communities Institute (2016). Recognized carcinogens released into air, 2014. *PGC HealthZone*. Retrieved from: http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=389&localeId=1260

II. COMMUNITY HEALTH NEEDS ASSESSMENT

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

   _X_Yes
   ___No

   Provide date here. 04/18/2013 **(mm/dd/yy)**

   If you answered yes to this question, provide a link to the document here. (Please note: this may be the same document used in the prior year report).
   http://www.adventisthealthcare.com/app/files/public/3167/2013-CHNA-WAH.pdf

   New CHNA will be completed and made available by December 31, 2016.

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

   _X_Yes 10/23/2013 **(mm/dd/yy) Enter date approved by governing body here**
   ___No

   If you answered yes to this question, provide the link to the document here.
   http://www.adventisthealthcare.com/app/files/public/3338/2013-CHNA-WAH-ImplementationStrategy.pdf

   New Implementation Strategy will be completed and made available by May 15, 2017.

III. COMMUNITY BENEFIT ADMINISTRATION

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

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

      _X_**Yes**
      ___**No**

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

      As a part of Adventist HealthCare, Washington Adventist Hospital is dedicated to Community Benefit which aligns with the system's core mission and values. Within Washington Adventist Hospital's strategic plan, the hospital's commitment to Community Benefit is outlined and an overview of the infrastructure is described. Stemming from the upcoming CHNA (2017-2019) which will be released in December 2016, the strategic plan also outlines the health needs prioritization as was approved by the Board of Trustees. As the implementation strategy is developed and put into place in the spring of 2017, the Community Benefit

section of the strategic plan will be updated to include the specific initiatives, objectives and committed resources. The section of the strategic plan applying to Community Benefit is included below.

Community Benefit

Washington Adventist Hospital is dedicated to its mission of "demonstrating God's care by improving the health of people and communities through a ministry of physical, mental, and spiritual healing." Community benefit is an embodiment of WAH's dedication to enacting its community-based mission and improving the health and wellbeing of the communities it serves.

As a hospital and part of the Adventist HealthCare system, WAH is committed to:

- Continually developing infrastructure to improve the implementation, evaluation, and reporting of its community benefit activities
- The alignment of clinical service lines and community benefit focus areas with needs identified through the community
- An investment of resources to improve population health (one of the 6 Pillars of Excellence) in the communities it serves

System-Wide Infrastructure

Center for Health Equity & Wellness (The Center): The Center aims to improve the health of communities by raising awareness of community health needs and local disparities, improving access to culturally appropriate care, and providing community wellness outreach and education.

Community Benefit Council (CBC): Composed of representatives from each of the four hospitals as well as from system wide-departments, the CBC functions to ensure that Adventist HealthCare is meeting all of the requirements for Community Benefit both on the state and federal levels.

Community Partnership Fund (CPF): The CPF provides funding for organizations whose activities support AHC's mission to improve the health and wellbeing of the community, especially for those that have poor access to care and poor health outcomes. Funding requests must align with AHC's funding objectives and priorities as outlined below:

- **Funding objectives**: health and wellness, partnerships, and capacity building
- **Priorities**: addressing a priority area of need identified in our hospitals' Community Health Needs Assessment, targeting populations in AHC's service area that are socially and economically disadvantaged or medically underserved, aligning with AHC's community-based mission, and having a measurable impact

Community Health Needs Assessment Prioritization: 2017-2019

The prioritization of community health needs for the 2017-2019 time-frame was determined by WAH's President's Council. The Council took the following factors into consideration: incidence and prevalence of the need in the community, presence and size of disparities, changes over time, alignment with county priority areas, existing resources and partnerships, needed resources and gaps, and potential for measurable and achievable outcomes. This prioritization will guide WAH's planning, development and resource allocation for community benefit activities, including the Implementation Strategy, for 2017-2019.

Final Prioritization

1. Obesity
2. Cardiovascular
3. Diabetes
4. Maternal/Child
5. Housing
6. Food Access
7. Behavioral Health
8. Breast Cancer
9. Prostate Cancer
10. Lung Cancer
11. Colorectal Cancer
12. Cervical Cancer
13. Thyroid Cancer
14. Flu
15. Asthma
16. Education
17. HIV

AHC Community Benefit Implementation & Reporting Process Overview

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

i. **Senior Leadership**

1. **_X_CEO**
2. **_X _CFO**
3. **_X_Other (please specify:** President's Council**)**

Describe the role of Senior Leadership.
The senior leaders listed above as well as the other members of the president's council play a role in the community benefit planning for Washington Adventist Hospital. The president's council played a lead role in completing the prioritization of needs process and provided input and approval on the implementation strategy prior to board approval for the 2014-2016 CHNA cycle. For the 2017-2019 CHNA, the President's Council was presented with the key data findings. A sub-committee of the group then reviewed the data in more detail and completed the prioritization process for the hospital. This group, will also be taking the lead in the hospital's implementation strategy development.

The Director of Population Health Management acts as a champion for community benefit initiatives and servs on the AHC Community Benefit Council on behalf of Washington Adventist Hospital. The CFO works closely with finance and provides final approval of financials submitted.

ii. **Clinical Leadership**

1. **___Physician**
2. **___Nurse**
3. **___Social Worker**
4. **_X_Other (please specify:** Director of Case Management**)**

Describe the role of Clinical Leadership
The Director of Case Management assists with planning and implementation of community benefit activities and plays a large role in community building as well.

iii. **Population Health Leadership and Staff**

1. **_X_Population Health VP or equivalent (please list:** Sr. VP, Physician Networks & President, Adventist Medical Group**)**
2. **_X_Other population health staff (please list:** Director of Population Health Management**)**

Describe the role of population health leaders and staff in the community benefit process
The Sr. VP, Physician Networks & President, Adventist Medical Group is directly over the Center for Health Equity and Wellness which coordinates and manages AHC's community benefit efforts and reporting. He plays a large role in big picture community benefit planning including resource allocation and determining directions for community benefit investments. The Director of

Population Health Management for AHC acts as a community benefit champion and is a member of AHC's Community Benefit Council.

iv. Community Benefit Operations

1. **_X_Individual (please specify FTE:** Project Manager, Community Benefit: .85FTE; Research Assistant: .5 FTE**)**
2. **_X_Committee (please list members:** Community Benefit Council & Community Partnership Fund Board. Members listed below for both**)**
3. **_X_Department (please list staff:** Center for Health Equity & Wellness**)**
4. **___Task Force (please list members)**
5. **___Other (please describe)**

Briefly describe the role of each CB Operations member and their function within the hospital's CB activities planning and reporting process.
The Adventist HealthCare Center for Health Equity and Wellness coordinates the implementation and reporting of community benefit for the entire hospital system. This includes compliling the Community Health Needs Assessments and the annual Community Benefit Reports, as well as acting as the administrators for CBISA. The Center for Health Equity and Wellness also conducts a large number of community benefit initiatives including health education and screenings. This department includes the Project Manager, Community Benefit and the Research Assistant listed above. These individuals take the lead role in CHNA development, implementation strategy coordination with each of the hospitals, and community benefit reporting.

Adventist HealthCare has a Community Benefit Council with representatives from each of the 5 hospital entities in addition to key departments from the corporate office. The Council meets 4-6 times per year and takes part in the planning, execution, and monitoring of the community benefit activities taking place at their entities and across AHC. They also play a large role in the development of each hospital's CHNA, Implementation Strategy, and Community Benefit Reports. Members of the council include:

- Executive Director, Center for Health Equity and Wellness - CHAIR
- Project Manager for Community Benefit, Center for Health Equity and Wellness
- Director of Operations, Center for Health Equity and Wellness
- Research Assistant, Center for Health Equity and Wellness
- CFO, Shady Grove Medical Center
- Director of Case Management for SGMC and Washington Adventist
- Director of Population Health, Adventist HealthCare
- AVP, Rehabilitation at Adventist Rehabilitation
- Cultural Diversity Liaison at Adventist Rehabilitation
- Manager, Business Development at Behavioral Health and Wellness Rockville
- Project Accountant, Adventist HealthCare
- Senior Tax Accountant, Adventist HealthCare
- Financial Services Project Manager, Adventist HealthCare
- PR Marketing Coordinator, Adventist HealthCare

The Community Partnership Fund provides funding for organizations whose activities support the Adventist HealthCare Mission, especially those that have poort access to care and poor health outcomes. Funding priorities for the fund include:

- Activities that address a priority area of need identified in our hospitals' Community Health Needs Assessment
- Activities that target populations in Adventist HealthCare's service area that are socially and economically disadvantaged or medically underserved
- Activities that align with Adventist HealthCare's community-based mission
- Activities that have a measurable impact on the community being served

The Community Partnership Fund Board is in charge of setting funding priorities, managing application processes (application, selection, etc.), and reviewing funding requests. Members include:

- CEO, Adventist HealthCare
- Chief Development Officer
- Director of Public Policy
- President, Adventist Behavioral Health
- Executive Director, Center for Health Equity and Wellness
- Director of Operations, Center for Health Equity and Wellness
- Sr. VP/Chief HR Officer
- Vice President of Business Development
- Sr. VP/CQIO
- VP Public Relations/Marketing
- CMO, Shady Grove Medical Center
- VP, Mission Integration and Spiritual Care
- AVP, Rehabilitation

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

Spreadsheet	**__X__yes**	**_____no**
Narrative	**_____yes**	**___X_no**

If yes, describe the details of the audit/review process *(Who does the review? Who signs off on the review?)*
Prior to finalizing the spreadsheet, the finance team meets in person with the CFO to go over the spreadsheet in detail. The narrative is not formally audited; however, it is put together and reviewed in partnership with key hospital staff and leadership.

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

Spreadsheet	**_____yes**	**__X__no**
Narrative	**_____yes**	**__X__no**

If no, please explain why.

The hospital's Board reviewed and approved the Community Health Needs Assessment and Implementation Strategy. The Adventist HealthCare Board of Trustees only meets twice per year so they

have not yet had a chance to review this report, but they will review this Community Benefit report when they next meet in Q1 2017.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

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

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

Organization	Healthy Montgomery
Name of Key Collaborator	Healthy Montgomery Steering Committee Co-Chairs: • Mr. George Leventhal, Council Member, Montgomery County Council • Ms. Sharon London, Vice President, ICF International Additional Committee Members can be found here: http://www.healthymontgomery.org/index.php?module=htmlpages&func=display&pid=5000
Title	*See previous row*
Collaboration Description	Shady Grove Medical Center collaborates with Healthy Montgomery (HM), which serves as the Local Health Improvement Coalition in Montgomery County. SGMC contributes $25,000 annually to support the infrastructure of HM. SGMC worked with

	HM to complete a 2011 Community Health Needs Assessment, which helped to inform our CHNA, and the website maintained by HM provides current data which was utilized by SGMC to identify needs and set priorities. SGMC was also represented on the HM Steering Committee, which sets the direction for the group, and the Data Project subcommittee, which selected core measure indicators in the identified priority areas.

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

_____yes __X__no

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

__X__yes _____no

Several Adventist HealthCare representatives take part in Healthy Montgomery. Marilyn Lynk, Executive Director of the Center for Health Equity and Wellness sits on the steering committee. Additional staff members also participate in committees such as the Community Health Needs Assessment Committee and the Chronic Disease Cluster planning group.

V. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

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

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

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

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

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

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

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

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

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

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

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

i. What were the measurable results of the initiative?

ii. For example, provide statistics, such as the number of people served, number of visits, and/or quantifiable improvements in health status.

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

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

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

Table III
Initiative: Help Stop the Flu (CHNA Implementation Strategy Initiative)

Identified Need Was this identified through the CHNA process?	Persons most at risk for contracting influenza include the elderly, the very young, and the immune-compromised. The ZIP code in which Adventist HealthCare Washington Adventist Hospital is located, 20912, had an immunization-preventable pneumonia and influenza rate of 12.1 ER visits/10,000 population (2009-2011), which is relatively high compared to 50% of Maryland counties, which have rates <8.9 ER visits/10,000 population. In Adventist HealthCare Washington Adventist Hospital's service area, the ZIP codes with the highest Emergency Room rates due to immunization preventable influenza and pneumonia included 20901, 20904, and 20912, with rates of 11.3, 11.2 and 12.1 ER visits/10,000 population, respectively (Healthy Montgomery, 2009-2011). A racial disparity exists within the population: the age-adjusted ER rate due to immunization-preventable pneumonia and influenza in Montgomery County was 17.5/10,000 among black residents compared to only 5.8/10,000 among white residents (Healthy Montgomery, 2009-2011). Although influenza vaccines (i.e., "flu shots") are widely available in Montgomery County, there are still many at-risk people who are not getting vaccinated due to barriers such as income, cultural barriers, and access to clinics. This need was identified in the 2013 CHNA.
Hospital Initiative	Help Stop the Flu
Total Number of People Within the Target Population	Adventist HealthCare Washington Adventist Hospital targeted the zip codes with the highest ER rates due to influenza. According to the 2014 U.S. Census data, the total population for the three ZIP codes (20901, 20904, 20912) was 117,696.
Total Number of People Reached by the Initiative Within the Target Population	**Total People Reached: 324** • Vaccine for 300 individuals was provided to Care for your Health, Community Clinic Inc., and Greenwood Terrace Apartments. • 24 individuals were educated about flu and/or received a glo germ screenings
Primary Objective of the Initiative	The primary objective of this initiative was to implement strategies to address high influenza-related Emergency Room rates in the population served by Adventist HealthCare Washington Adventist Hospital, in particular in the 20901, 20904, amd 20912 zip codes. Strategies for this initiative included: • Partnering with Community Clinic, Inc. (a local FQHC located in ZIP code 20912 serving uninsured patients) and community organizations to provide free flu shots to residents with a greater need in ZIP codes with the highest ER rates due to immunization preventable influenza (20912, 20901, and 20904). • Partnering with Care For Your Health (Dr. Anna Maria Izquierdo-Porrerra) to provide vaccine for micropractice patients. o Practice located in ZIP code 20904; secondary practice area to be covered includes 20901 and 20912. The patient population served by the Care for Your Health micropractice is 75% Hispanic, 12% Black, 5% White, 4% Asian, and 4% Other. The majority of patients are Spanish-speaking.

	• Partnering with Greenwood Terrace Apartments, a low-income housing complex, located in 20912 to provide free flu shots to residents.	
Single or Multi-Year Initiative Time Period	Washington Adventist Hospital works with the community each year to increase access to flu shots for residents in its service area. For the years 2014, 2015, and 2016, based on findings from the CHNA, free flu shots were offered in the targeted zip codes where an increased need was identified.	
Key Collaborators in Delivery of the Initiative	**Flu shots were provided at the following locations in 2016:** • Care For Your Health Micropractice (Dr. Anna Maria Izquierda-Porrera) • Community Clinic, Inc. • Greenwood Terrace Apartments **Flu Health Education was provided at the following locations/events in 2016:** • Long Branch Community Center • Victory Tower Apartments • Crossroads Farmers Market	
Impact/Outcome of Hospital Initiative	In 2016, Adventist HealthCare Washington Adventist Hospital provided a total of **300 free** flu vaccines for the community through partnerships with Community Clinic, Inc., Care for Your Health, and Greenwood Terrace Apartments. • 150 free flu shots (regular dose) were provided to the micropractice Care For Your Health (Dr. Anna Maria Izquierda-Porrera) located in ZIP code 20904. • 80 free flu shots (regular dose) were provided to Greenwood Terrace Apartments in Takoma Park, located in ZIP code 20912. • 70 free flu shots (regular dose) were provided to Community Clinic Inc. in ZIP code 20912. In addition to providing free flu shots, health education on cold and flu prevention was provided at three community locations within the target ZIP code of 20912. Education included presentations and glo germ demonstrations. There were approximately 24 encounters for these events.	
Evaluation of Outcomes	Maryland SHIP indicators show that the percentage of Montgomery County adults vaccinated has decreased from 48.7% in 2013 to 45.8% in 2014; in Prince George's County, the percentage was steadily increasing between 2011 and 2013, but recently decreased from 36.9% in 2013 to 34.4% in 2014. The state of Maryland has set a SHIP target of 49.1% vaccinations for 2017, while Healthy People 2020 set 70% as the target percentage of adults who are annually vaccinated against seasonal influenza. This CHNA implementation strategy initiative, Help Stop the Flu, has been targeting at-risk people in high risk areas to increase their vaccination percentages and to decrease the high rate of ER visits due to immunization-preventable pneumonia and influenza in those areas.	
Continuation of Initiative	This was a three year initiative and will not be continuing in 2017. However, Washington Adventist Hospital will continue to offer flu shot clinics in the community that it serves.	
A. Total Cost of Initiative for Current	**A. Total Cost of Initiative** **Flu Shots Total Estimated Costs: $5,314.25**	**B. Direct offsetting revenue from Restricted Grants**

Calendar Year B. What amount is from Restricted Grants/ Direct offsetting revenue	• 300 regular dose vaccines at $16.39 a piece: $4,917 • Staff time (administrative coordination time & nurse time for vaccine administration): $397.25 **Community Education: $245** • Staff time: $245	**Flu Shots: $0.00** **Education: $0.00**

Table III
Initiative: Breast Cancer Screening and Support Program

Identified Need Was this identified through the CHNA process?	Breast cancer is the leading cause of cancer death for women in the United States, with 1 in 8 women developing breast cancer at some point in their lifetime and about 1 in 36 dying from it[10]. Age, genetic disposition, obesity, and alcohol use are risk factors for breast cancer. The rates have declined in the past two decades due to early detection and advanced treatment. In Montgomery County, the breast cancer incidence rate is 128.8 per 100,000 women[11], whereas Prince George's County's incidence rate is 124.4 per 100,000[12]. A disproportionately high breast cancer death rate exists in the African American population. The Black age-adjusted breast cancer death rate in Montgomery County is 23.1 per 100,000, which is much higher than the White rate of 18.5[1]; in Prince George's County, the black age-adjusted death rate due to cancer is similarly disproportionate for Blacks (29.1) compared to whites (21.1)[13]. Lack of medical coverage, late detection and screening, and unequal access to advanced cancer treatments may contribute to the lower survival rates for African American women[14]. Lack of health insurance is the main barrier to breast cancer screening in the United States[15]. The need was identified prior to the CHNA but was reinforced by the 2013 CHNA findings.
Hospital Initiative	Adventist HealthCare Washington Adventist Hospital Breast Cancer Screening and Support Program
Total Number of People Within the Target Population	According to the US Census Bureau, Montgomery County has a population of 270,619 women over the age of 40, whereas Prince George's County has 225,013 women over the age of 40. The Breast Cancer Screening and Support Program specifically targets uninsured or underinsured women within this population.
Total Number of People Reached by the Initiative Within the Target Population	**Total People Reached: 589** **Total Encounters: 816** • 784 screening and diagnostic services were provided to 557 unique individuals through the Breast Cancer Screening Program • 32 individuals participated in Look Good Feel Better
Primary Objective of the Initiative	The primary objectives of the initiative are: • To implement strategies that address breast cancer needs in the uninsured or underinsured population served by Adventist HealthCare Washington Adventist Hospital. • To reduce the incidence, prevalence, and mortality rates of breast cancer in Montgomery County and Prince George's County by increasing access to preventive breast care and

[10] Healthy Montgomery. (2016). Age-Adjusted Death Rate due to Breast Cancer. Retrieved from http://www.healthymontgomery.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=18904705
[11] Healthy Montgomery. (2016). Breast Cancer Incidence Rate. Retrieved from http://www.healthymontgomery.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=18855415
[12] PGC Health Zone (2016). Breast Cancer Incidence Rate. http://www.pgchealthzone.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=18855417
[13] PGC Health Zone (2016). Age-Adjusted Death Rate due to Breast Cancer. Retrieved from http://www.pgchealthzone.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=18904707
[14] National Cancer Institute. (2008). Cancer Health Disparities. Retrieved from http://www.cancer.gov/about-nci/organization/crchd/cancer-health-disparities-fact-sheet#q6
[15] Susan G. Komen Foundation. (2015). Disparities in breast cancer screening. Retrieved from http://ww5.komen.org/BreastCancer/DisparitiesInBreastCancerScreening.html

	follow-up treatment for uninsured or underinsured women over 40. • To decrease the intervals between screening, diagnosis and treatment through cancer navigation. Adventist HealthCare Washington Adventist Hospital has implemented the following strategies to address the breast cancer screening and support needs of the population it serves. **Breast Cancer Screening Program**: The Breast Cancer Screening Program provides free, comprehensive breast cancer services to women 40 years and over with limited or no health insurance in Montgomery County and Prince George's County. Patients are educated about the importance of breast health and given access to free mammograms and cancer treatment services. These services include mammograms, biopsies, ultrasounds, diagnostic and treatment services, and patient navigation to women in need. **Look Good Feel Better:** Through a partnership with the American Cancer Society, Adventist HealthCare brings quarterly Look Good Feel Better sessions to the community it serves. The program is aimed at improving self-image appearance through free group, individual, and self-help beauty sessions that create a sense of support, confidence, courage and community. The two-hour sessions are led by a certified cosmetologist who teaches make-up tips, turban use, wig care, and beauty-related information to women undergoing cancer treatment. Participants are also given a free makeup kit.
Single or Multi-Year Initiative Time Period	The implemented initiatives are multi-year initiatives.
Key Collaborators in Delivery of the Initiative	**Key partners involved in the outreach for, and implementation of, this initiative include:** • Muslim Community Clinic • Mary Center • Community Clinic, Inc. • Spanish Catholic Center • Mobile Med • Women's Cancer Control Program • American Cancer Society • Avon Foundation (Funder) • Montgomery Cares Primary Care Coalition (Funder)

Impact/Outcome of Hospital Initiative	**Breast Cancer Screening Program (January-December 12, 2016)**
	• A total of 784 breast cancer screening and diagnostic services were provided among 557 individuals
	  ○ Screening Mammograms: 440
	  ○ Diagnostic Services including Mammograms and Sonograms: 344
	• Demographics:
	  ○ Age
	    ▪ <40: 2.17%
	    ▪ 40-49: 44.64%
	    ▪ 50-64: 44.13%
	    ▪ 65 and over: 9.06%
	  ○ Race

        - White: 1%
        - Black: 33.9%
        - Asian: 4.6%
        - Native Hawaiian/Pacific Islander: 0.3%
        - Other: 60.2%
    - Ethnicity
        - Hispanic: 59.18%
        - Non-Hispanic: 40.82%
- Time to Follow-Up: Screening to Diagnostic Mammogram (January-October 2016)
    - The screening to diagnostic mammogram patient call back time frame has been on a downward trend this year, starting at 33 days in January and decreasing to 24 days in September.
    - Monthly Average for the year: 25.7 days (compared to 35.5 days in 2015)
    - While the numbers have been improving consistently, WAH continues to work toward the American Society of Clinical Oncology standard of 15 days followed by "world class" status which is reached at 5 days.

Look Good, Feel Better

- Look Good Feel Better was held 5 times in 2016.
- There were a total of 32 participants for the year.

Evaluation of Outcomes

Healthy People 2020 has set a target of 20.7 deaths per 100,000 females[16] for breast cancer. Neither Montgomery County nor Prince George's County have met this target, with a mortality rate 22.6 per 100,000 and 26.2 per 100,000, respectively. According to the National Cancer Institute, recent trends show breast cancer incidence rates in both counties to be stable. The Breast Cancer Screening and Support Program at WAH has been targeting specific populations with health care access barriers and providing them with the necessary screenings and diagnostic services. Additionally, the breast cancer initiative at WAH has been navigating the patients in their cancer screening, diagnosis and follow-up processes in order to lower the call back rate to the 15-day standard set by the American Society of Clinical Oncology.

Continuation of Initiative

Yes, the program will continue into 2017. The need remains and positive results have been seen.

- Despite the Affordable Care Act, referrals for the Breast Cancer Screening Program have remained relatively consistent over the past three years.
- With additional patient navigation efforts put into place, a significant decrease in time to follow-up has been seen among screening participants. Processes have also been changed to improve follow-up time. At each initial appointment, WCCP applications are completed for the participant so that follow-up is not delayed if needed. If no follow-up is required, the application is disposed of. In 2016, a Process Improvement project using the Baldrige model was initiated in order to continue to decrease follow-up time for patients.

C. Total Cost of Initiative for Current Calendar Year	C. Total Cost of Initiative	D. Direct offsetting revenue from Restricted Grants
	Breast Cancer Screening Program Total Estimated Costs (January – November 2016): $307,353.10	**Breast Cancer Screening Program (January-November 2016):** $92,363.53

[16] Healthy People 2020 (2015). Cancer. Accessed: http://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives

D. What amount is from Restricted Grants/ Direct offsetting revenue	• Staff Time (program coordination and administration; patient navigation): $64,945.84 • Program Intern: $600 • Mammography Tech: $63,648 • Mammography Screening and Diagnostic Services: $178,159.26 **Look Good Feel Better Total Estimated Costs: $243.75** • Staff Time: $243.75	• Grant Funding and reimbursements from Avon, Montgomery County Cigarette Restitution Fund, and the Primary Care Coalition **Look Good Feel Better: $0.00**

Table III
Initiative: Parent Education Programs

Identified Need Was this identified through the CHNA process?	<u>Infant Mortality</u> – The Maryland SHIP 2017 target is to reduce the infant mortality rate in Maryland to 6.3 deaths per 1,000 live births. The Healthy People 2020 national health target infant mortality rate is 6 deaths per 1,000 live births. Montgomery County exceeds both these goals by far, with an infant mortality rate of 4.8 deaths per 1,000 live births. Although the overall infant mortality rate in Montgomery County is relatively low, a disproportionately high rate exists in the African American population. The Black, non-Hispanic infant mortality rate is 7.8, almost twice the Hispanic and non-Hispanic White rates (both 4.4 per 1,000)[17]. In contrast, Prince George's County has a high infant mortality rate, 6.9 deaths per 1,000 live births[18]. The Black, non-Hispanic infant mortality rate is 8.2 deaths per 1,000 live births, which is higher than the Hispanic and non-Hispanic White rates (both 5.2 per 1,000)[2]. <u>Breastfeeding</u> – According to the World Health Organization, exclusive breastfeeding reduces infant mortality caused by childhood illnesses and helps for faster recovery during illness[19]. Despite these recommendations, breastfeeding remains low in the Black community. In 2008, the percentage of Black babies who were ever breastfed was 59%, which is significantly lower than the 75.2% of White babies and 80% of Hispanic babies[20]. In 2011, the exclusive breastfeeding rate at 3 months was 43.6% for all of Maryland[21]. The need was identified prior to the CHNA but was reinforced by the 2013 CHNA findings.
Hospital Initiative	Adventist HealthCare Washington Adventist Hospital Parent Education
Total Number of People Within the Target Population	WAH primarily serves Montgomery and Prince George's Counties. Montgomery County has an estimated 204,825 women of childbearing age (15 to 44 years old). Prince George's County has an estimated 193,550 women of childbearing age[22].
Total Number of People Reached by the Initiative Within the Target Population	An exact count of unique individuals across all of the programs listed below is unknown. Where available, unique individuals are listed below in addition to encounters. • 259 encounters at Hecho de Pecho • 455 individuals and 605 encounters on the Warm Line • 31 encounters at Black Mothers Breastfeeding Club meetings **Total encounters: 749**

[17] Healthy Montgomery. (2016). Infant Mortality Rate. Retrieved from http://www.healthymontgomery.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=65
[18] PGC Health Zone. (2016). Infant Mortality rate. Retrieved from http://www.pgchealthzone.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=17507107
[19] World Health Organization. (2015). Nutrition. Retrieved from http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/
[20] Centers for Disease Control and Prevention. (2013). Morbidity and Mortality Weekly Report. Progress in Increasing Breastfeeding and Reducing Racial/Ethnic Differences – United States, 200-2008 Births. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a1.htm
[21] Centers for Disease Control and Prevention (2014). *Breastfeeding Report Card.* https://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf
[22] U.S. Census Bureau*,* 2015 American Community Survey 1-Year Estimates

Primary Objective of the Initiative	Adventist HealthCare Washington Adventist Hospital has implemented programs to address the maternal and child health needs of the community it serves by providing education, support, and resources to mothers and families. The primary objectives of the initiative are to: • continue employing strategies that address maternal/child health needs, particularly around breastfeeding and infant mortality, in the population served by Washington Adventist Hospital • increase access to breastfeeding support programs and services for mothers in Montgomery County and Prince George's County • reduce infant mortality rate disparities in Montgomery County and Prince George's County, particularly among the Black and Hispanic populations **Hecho de Pecho**: Through Hecho de Pecho, Adventist HealthCare Washington Adventist Hospital provides a free, weekly, breastfeeding support group for Spanish-speaking mothers. It is a safe space for mothers to share their experiences and participate with other mothers in a cordial and informative meeting to promote breastfeeding. While the focus of each session is to address questions and concerns of the attendees, a curriculum and interactive activities are planned for each session as well. For the majority of the year (February-September) the group was peer led. Beginning in October 2016, the group was led by an International Board Certified Lactation Consultant. Refreshments are provided at each meeting and mothers are encouraged to bring their baby, older children, or a support person. **Warm Line**: Through the Warm Line, Adventist HealthCare Washington Adventist Hospital and Shady Grove Medical Center provide telephone assistance for breastfeeding questions and concerns, as well as evidence-based information for breastfeeding mothers and families. The Warm Line is staffed by an IBCLC (International Board Certified Lactation Consultant) and is available 7 days a week/365 days a year at (240) 826-6667. **Black Mothers' Breastfeeding Club:** Through the Black Mothers' Breastfeeding Club, Adventist HealthCare Shady Grove Medical Center and Washington Adventist Hospital provide a monthly community-based, peer-led, and culturally-tailored support group for expecting and new Black/African-American mothers in order to promote breastfeeding in the Black communities of Montgomery and Prince George's counties. At each meeting participants are provided with a hot meal and have the opportunity to win door prizes. Children and partners are welcome to attend.
Single or Multi-Year Initiative Time Period	The Warm Line is an ongoing multi-year initiative. Hecho de Pecho was initiated in 2015, and is a multiyear initiative. Black Mother's Breastfeeding Club was a one-year initiative.
Key Collaborators in Delivery of the Initiative	**Key partners involved in the outreach for, and implementation of, this initiative include:** • Montgomery County Health Department • The Women's Center Program • The National Association of County and City Health Officials (NACCHO) • Black Mother's Breastfeeding Association (BMBFA)
Impact/Outcome of Hospital Initiative	**Hecho de Pecho** • Hecho de Pecho met 11 times in 2016. Sessions were held each month with the exception of January. Each session is approximately 2 hours.

	• There were a total of 259 encounters. Of these, 113 encounters were mothers and 146 were babies, children, and support persons.
	• In the fall of 2016, a process improvement project was initiated for Hecho de Pecho utilizing the Baldrige model.
	  ○ Two evaluation metrics were put into place:
	    ▪ Mothers in attendance at each session – target set at 9
	      • Each session ranged from 8-20 mothers with an average of 11 mothers per session. With the exception of March which had 20 mothers in attendance, the numbers have held steadily between 8 and 9 from July through December.
	    ▪ Participants in attendance at each session – target set at 20
	      • Each session ranged from 18 to 38 participants, with an average of 24 at each session. Participant numbers ranged from 23-38 from March to August, and have held steady at 18 from October to December.
	  ○ Improvements were put into place in order to increase participation and better meet the needs of participants. An International Board Certified Lactation Consultant began leading classes starting in October. A curriculum of pre-natal and breastfeeding information has been put into place which includes interactive activities for participants. This has been well received by participants, showing an eagerness to participate and engage in further discussions.
	
	Warm Line*
	A total of 455 individuals have called into the warm line and received breastfeeding support from January through December 8, 2016. There have been a total of 605 calls/encounters.
	
	BMBFC*
	• Each Black Mother's Breastfeeding Club meeting is held for approximately 2 hours. There have been a total of 5 group meetings in 2016.
	• There have been a total 31 encounters.
	
	***BMBFC and the Warm Line are AHC programs that are a joint effort between Shady Grove Medical Center and Washington Adventist Hospital. The description and outcomes for these programs have been listed on the reports for both hospitals. The costs and offsetting revenue for these programs have been split accordingly between the two reports.*

Evaluation of Outcomes	Maryland SHIP measures show infant death rates among Blacks in Montgomery have fluctuated in recent years, going from 7.2 per 1,000 in 2010 to 10.4 per 1,000 in 2011 to 9.9 per 1,000 in 2013 to 7.8 per 1,000 in 2014. In Prince George's County, infant mortality among black residents has fallen from 11.5 per 1,000 in 2010 to 8.2 per 1,000 in 2014. The SHIP measures also show that Black residents in Montgomery County and Prince George's County experience higher rates of babies with low birth weight (approximately 11.3% and 11%, respectively) than their racial counterparts. The Parent Education initiatives at Adventist HealthCare Washington Adventist Hospital have been working towards the reduction of infant mortality and babies with low birth weight by targeting the specific populations most affected.
Continuation of Initiative	Hecho de Pecho and the Warm Line will be continued into 2017. The BMBFC concluded in May 2016 and will not be continued.

E. Total Cost of Initiative for Current Calendar Year F. What amount is from Restricted Grants/ Direct offsetting revenue	**E. Total Cost of Initiative** **Hecho de Pecho Total Estimated Costs: $1,793** • Staff Time (admin and planning): $775 • Peer Leader Time: $308 • IBCLC Leader Time (curriculum planning and time leading sessions): $500 • Refreshments: $210 **Warm Line Total Estimated Costs: $4,701.05** • Staff Time: $4,701.05 **Black Mother's Breast Feeding Club Total Estimated Costs: $2,953.64** • Staff time: $1,815 • Supplies and Catering: $1,138.64	**F. Direct offsetting revenue from Restricted Grants** **Hecho de Pecho: $0.00** **Warm Line: $0.00** **Black Mother's Breastfeeding Club: $2,131.50** • Grant from NACCHO

Table III
Initiative: Victory Tower Wellness Partnership

Identified Need Was this identified through the CHNA process?	In Adventist HealthCare Washington Adventist Hospital's service area, ZIP code 20912 had, by far, the highest Emergency Room rate due to alcohol abuse (121.2 compared to an average of 20.3 per 10,000 residents in CBSA) and hospitalization rate due to alcohol abuse (20.7 compared to an average of 6.6 per 10,000 residents in CBSA) (Healthy Montgomery, 2013). In Montgomery County, more men reported binge drinking (17.2%) than women (11.5%), and White adults (at 15.8%) were more likely than adults of other racial/ethnic groups to report engaging in binge drinking (BRFSS, 2010; accessed via Montgomery County Behavioral Health Profile, 2012). Nearly 40% of Montgomery County Medicaid recipients between 14-20 years of age received inpatient, outpatient, and/or professional services for substance abuse in 2011, and patients receiving these services were more likely to be Black (41.0%) than other groups (34% White, 18% Hispanic) (Montgomery County Behavioral Health Profile, 2012). In particular at Victory Tower, a low-income senior housing complex in ZIP code 20912, there is a great need to behavioral and mental health services. Management and staff at the housing complex have reported that significant numbers of residents struggle with one or more of the following: clinical depression, clinical anxiety, alcohol use, cannabis use, hoarding, and psychosis. This need was identified both through the latest CHNA as well as through an ongoing partnership with Victory Tower.
Hospital Initiative	Victory Tower Wellness Partnership
Total Number of People Within the Target Population	There are approximately 187 residents in the Victory Tower housing complex
Total Number of People Reached by the Initiative Within the Target Population	An exact count of unique individuals across all of the programs listed below is unknown. • 130 encounters at the wellness circle sessions • 89 encounters for monthly blood pressure screenings • 121 encounters at the spring health fair • 75 encounters for the Healthy You, Healthy Talk lecture series **Total encounters: 415**
Primary Objective of the Initiative	The primary objective of this initiative is to enhance the health, wellness, and quality of life of the residents of Victory Tower, a low income senior housing complex in Takoma Park. In particular, Adventist HealthCare Washington Adventist Hospital has been working to address the mental and behavioral health needs of the residents. Hospital staff have engaged in regular contact with staff and management at Victory Tower in order to ensure that specific health needs and interests of residents were being addressed, and in order to evaluate progress and outcomes.

<table>
<tr><td></td><td>Strategies for this initiative include:

• A weekly wellness circle organized by a certified substance abuse counselor. Weekly sessions are approximately 1.5 hours in length. The purpose of the wellness circle is to enhance quality of life and assist participants with sobriety and mental health maintenance. Weekly discussions focus on The Substance Abuse and Mental Health Services Administration's (SAMHSA) 8 Dimensions of Wellness, adapted from their Wellness Initiative:
  o Emotional: coping effectively with life and creating satisfying relationships
  o Financial: satisfaction with current and future financial situations
  o Spiritual: expanding our send of the purpose and meaning in life
  o Occupational: personal satisfaction and enrichment derived from one's work
  o Physical: recognizing the need for physical activity, diet, sleep, and nutrition
  o Intellectual: recognizing creative abilities and finding ways to expand knowledge and skills
  o Environmental: good health by occupying pleasant, stimulating environments that support well-being
• Provision of regular screening, health education, and resources. By maintaining a regular presence at Victory Tower, hospital staff has been able to build both rapport and trust among the residents.
  o Monthly blood pressure screenings and heart health education.
  o Health fairs including screenings, education, and lectures
  o Healthy You, Healthy Talk lecture series</td></tr>
<tr><td>Single or Multi-Year Initiative Time Period</td><td>This is a multi-year initiative that began in 2014.</td></tr>
<tr><td>Key Collaborators in Delivery of the Initiative</td><td>Key collaborators involved in this initiative include:

• Victory Tower, low-income senior housing complex</td></tr>
<tr><td>Impact/Outcome of Hospital Initiative</td><td>Weekly Wellness Circle (January-November, 2016)

• A total of 26 wellness circle sessions led by a certified substance abuse counselor were held
• There were a total of 130 encounters across the 26 sessions

Monthly Blood Pressure Screenings (January-November, 2016)

• 9 blood pressure screenings have been held thus far this year. An additional screening is scheduled for December 16th.
• There have been 89 encounters thus far
  o Systolic readings:
    ▪ 21.9% have been normal
    ▪ 50% have been in the prehypertension range
    ▪ 23.4% have been in the stage 1 hypertension range
    ▪ 4.7% have been in the stage 2 hypertension range
    ▪ 0 % have been in the hypertensive crisis range</td></tr>
</table>

- Diastolic readings:
  - 79.7% have been normal
  - 14% have been in the prehypertension range
  - 4.7% have been in the stage 1 hypertension range
  - 1.6 % have been in the hypertensive crisis range

Health Fair

- The "2nd Annual Spring into Health" event was held at Victory Tower on April 29, 2016. There were 37 community members in attendance with a total of 121 screenings completed:
  - Blood pressure screenings: 32
  - BMI/Body composition: 18
  - Carbon monoxide screenings: 33
  - Grip strength screening: 33
  - Waist to hip: 5

Healthy You, Healthy Talk - Lecture Series

- There were a total of six health education lectures given at Victory Tower in 2016. There were 75 total encounters.
  - January: Colorectal and Breast Cancer
    - 8 community members attended the lecture
  - February: Diet
    - 18 community members attended the lecture
  - June: Men's Health
    - 24 community members attended the lecture
  - August: Preventing the Flu
    - 7 community members attended the lecture
  - October: Alzheimer's Awareness
    - 12 community members attended the lecture
  - December: Sexual Health
    - 6 community members attended the lecture

Evaluation of Outcomes	According to the Maryland State Health Improvement Program, emergency department visits related to mental health conditions and substance abuse have been increasing in both Montgomery and Prince George's Counties since 2008. This initiative addresses the senior residents' substance abuse and mental health needs through professional counseling, free health education and screenings. The Victory Tower Wellness Partnership aimed to deliver much-needed counseling and health services for the senior residents, and it did so successfully.	
Continuation of Initiative	This initiative will be continuing into 2017 based on the positive outcomes that have been achieved thus far. Feedback from Victory Tower management and residents has been incredibly positive as well.	
G. Total Cost of Initiative for Current Calendar Year H. What	**G. Total Cost of Initiative** **Wellness Circle Total Estimated Costs: $4,758.85**	**H. Direct offsetting revenue from Restricted Grants** **Total Offsetting Revenue for all initiatives:**

amount is from Restricted Grants/ Direct offsetting revenue	• Staff time (certified substance abuse counselor – time planning and running the group): $4,658.85 • Materials (handouts): $100.00 **Blood Pressure Screenings & Health Fair Total Estimated Costs: $475.88** • Staff time: $475.88 **Health Fair Total Estimated Costs: $1,235.25** • Staff time: $1,235.25 **Lecture Series Total Estimated Costs: $575.75** • Staff time: $575.75	**$0.00**

Adventist HealthCare Washington Adventist Hospital's Additional Community Programs addressing Identified Community Health Needs				
Focus Area	**CHNA Findings***	**Goal**	**Action**	**Evaluation of Outcomes**
Cancer: Lung, Prostate, Cervical, Skin, Oral, and Thyroid	**General** – Prince George's County has higher mortality rates than the state of Maryland for most cancers. **Lung cancer –** incidence and mortality rates among black residents of Montgomery County are higher than among white residents. In Prince George's County, white residents have highest lung cancer incidence and death rates. **Prostate cancer** – in Prince George's County, Black men are affected at significantly higher rates, with 93.08% higher incidence rates and 87.02% higher death rates than white men. In Montgomery County, 61.39% more black men died of prostate cancer than white men. **Cervical cancer** – incidence rate is greatest among Hispanic women (7.7 per 100,000), compared to black women (6.6 per 100,000) or white women (4.5 per 100,000) in Montgomery County. Similarly, the incidence rate in Prince George's County is highest for Hispanic women (10.5 per 100,000) in comparison to white women (7.1 per	Provide screenings and educational lectures to target populations as well as education to the community at health fairs and various community locations.	**Colorectal –** WAH works with the Montgomery County Cancer Crusade to provide free colon cancer screenings to uninsured and underinsured individuals 50 years of age or older. **Cancer Overall –** Our cancer outreach team works with community organizations such as housing units, community centers and faith based organizations to provide cancer education. This may include presentations, demonstrations and screenings such as carbon monoxide.	**Colorectal –** Tracking referrals for screenings made by SGMC **Cancer Overall –** Tracking numbers of presentations and demonstrations as well as encounters. Tracking Carbon Monoxide screenings and health education counseling sessions.

Adventist HealthCare Washington Adventist Hospital's Additional Community Programs addressing Identified Community Health Needs				
Focus Area	**CHNA Findings***	**Goal**	**Action**	**Evaluation of Outcomes**
	100,000) or black women (6.8 per 100,000). **Oral Cancer** – Prince George's and Montgomery Counties have the lowest incidence rates among Maryland's counties. In Prince George's County, whites have the highest oral cancer incidence rates at 11.5 per 100,000 population, and males have higher incidence rates than females. **Thyroid Cancer** – Montgomery County has a higher incidence rate (19.3 per 100,000) than the state average (15 per 100,000) for thyroid cancer. Prince George's County has the lower rate at 12.1 per 100,000.			
Diabetes	Diabetes is the 5th leading cause of death in Prince George's County and the 6th leading cause of death in Montgomery County. Diabetes disproportionately affects minority populations and the elderly. It is predicted to rise as these populations continue to increase in Montgomery and Prince George's Counties.	Encourage prevention of diabetes through community health education at health fairs, senior and community centers. Ensure that patients at WAH who are diagnosed with diabetes receive appropriate education on how to manage their disease.	WAH will provide inpatient and outpatient services and education for diabetes, and its Center for Advanced Wound Care & Hyperbaric Medicine treats wounds due to complications of diabetes. Provide diabetic education classes. Encourage diabetes prevention through education at community health fairs and community locations.	Track and analyze numbers of participants encountered and educated through inpatient and outpatient diabetes education and through community outreach. Monitor rates of ER visits and hospitalizations due to diabetes.

Adventist HealthCare Washington Adventist Hospital's Additional Community Programs addressing Identified Community Health Needs				
Focus Area	**CHNA Findings***	**Goal**	**Action**	**Evaluation of Outcomes**
	The total health care related costs for the treatment of diabetes runs about $245 billion annually in the U.S., much of that is spent on hospitalizations and medical care.			
Heart Disease and Stroke	**Heart Disease –** Heart disease was ranked as number one cause of death in U.S. by the CDC. The death rate from heart disease was higher in Prince George's County (172.5 per 100,000) than in Maryland (169.9 per 100,000). Although on the decline in Maryland and Montgomery County due to improvements in treatment, it remains the leading cause of death in Montgomery County, killing blacks (123.4 per 100,000) at a higher rate than whites (114 per 100,000). **Stroke –** One of the top five leading causes of death in the U.S. Mortality rates in Montgomery County have met the HP 2020 target, but health disparities between racial/ethnic groups persist. Black residents have the	Provide strong cardiovascular community outreach, to include the following screenings to community: blood pressure, glucose and A1C. Provide free cardiovascular educational materials, blood pressure screenings and body composition screenings (BMI, weight, % body fat, % muscle) at health fairs, churches, senior centers, and various community locations.	WAH will continue to hold its annual "Love Your Sweetheart" screening event to provide free screenings to community members for: blood pressure, cholesterol, glucose, waist circumference, BMI, body composition, and sleep apnea, as well as 1:1 counseling with a clinician. WAH will continue offering Lipid Profile, Vertical Auto Profile, Homocysteine, HsCRP, blood pressure, glucose and A1C screenings, as well as providing free educational lectures to the community.	Track and analyze numbers of screenings and findings from screenings. Track the number of participants encountered and educated through community outreach. **Community Heart Health Screenings** Adventist HealthCare Washington Adventist Hospital provides thousands of free heart health screenings at over 200 community events/activities each year. Heart health screenings include: • Blood pressure • Body Composition ○ Body mass index (BMI) ○ Body fat percent There were a total of 1,034 blood pressure screenings in the WAH CBSA: • Normal range ○ 28.63% (296) systolic ○ 73.89% (764) diastolic • Prehypertension

Adventist HealthCare Washington Adventist Hospital's Additional Community Programs addressing Identified Community Health Needs				
Focus Area	**CHNA Findings***	**Goal**	**Action**	**Evaluation of Outcomes**
	highest stroke death rate in the County at 27.96/100,000 compared to whites at 24.7, Asian/Pacific Islanders at 22.4, and Hispanics at 20.8. Prince George's County, which has a stroke mortality rate of 35.1/100,000, has not met Healthy People 2020 goal of 34.8.			○ 43.62% (451) systolic ○ 16.25% (168) diastolic • Stage 1 Hypertension ○ 20.89% (216) systolic ○ 6.58% (68) diastolic • Stage 2 Hypertension ○ 4.64% (48) systolic ○ 1.55% (16) diastolic • Hypertensive Crisis ○ 0.77% (8) systolic ○ 0.01% (1) diastolic There were 141 BMI readings: • Underweight: 0 • Normal: 26.24% (37) • Overweight: 36.17% (51) • Obese: 36.88% (52) There were 132 body fat percentage screenings: • Low fat: 0.76% (1) • Normal fat: 28.03% (37) • High fat: 30.30% (40) • Very high fat: 33.33% (44) There were 31 Waist to Hip screenings: • Low risk: 38.71% (12) • Moderate Risk: 22.58% (7) • High risk: 38.71% (12)
Obesity	According to Healthy Montgomery, 20.3% of	Provide both individual (1:1) and group nutrition	Provide 1:1 health education and group presentations about healthy	Track the number of participants encountered and educated through

Adventist HealthCare Washington Adventist Hospital's Additional Community Programs addressing Identified Community Health Needs				
Focus Area	**CHNA Findings***	**Goal**	**Action**	**Evaluation of Outcomes**

	County resident adults are either overweight or obese, with Blacks (27.2%) and Hispanics (18.8%) being disproportionately more obese than their racial counterparts. Twenty percent of high school students in Montgomery County are overweight, with Hispanic (29.7%) and Black (25.8%) teens being overweight at higher rates than other races/ethnicities. In Prince George's County, 34.5% of resident adults are overweight or obese, with Hispanics (44.9%) having the highest rate of obesity. Approximately 15% of adolescents ages 12 to 19 are overweight or obese.	counseling, and health education related to exercise and nutrition to the community at a variety of community locations.	nutrition and the importance of exercise at health fairs, senior and community centers, and faith-based organizations. Provide affordable individual nutrition counseling to the community.	community outreach. Monitor rates of obesity and overweight at the county level.
				
				Adventist HealthCare Washington Adventist Hospital provides thousands of free weight related screenings at over 200 community events/activities each year. Relevant screenings include:
				• Body composition
				  ○ Body mass index (BMI)
				  ○ Body fat percent
				
				(See Heart Disease and Stroke above for outcomes)

Senior Health	According to the Maryland Department of Aging, the percentage of Maryland residents over the age of 60 is expected to increase from 18.6% in 2010 to 25.8% by 2030. In Montgomery County, 6.7% of seniors live below the poverty level, with higher percentages among minority seniors and women. Similarly, 7.6% of seniors in	Continue to provide community health outreach programs, education and health screenings to seniors at a variety of locations in the community served by WAH.	WAH offers community health programs for seniors at: Long Branch Community Center, Takoma Park Community Center, Mid-County Community Center, Victory Towers, Springvale Terrace, as well as numerous other subsidized senior apartment complexes. WAH's community health education and outreach to seniors covers a variety of topics such as: heart health, cholesterol screenings, blood	Track the number of participants encountered and educated through community outreach. Continue to monitor and assess senior health status in Montgomery and Prince George's Counties to assure needs are being met and addressed. **Monthly Blood Pressure Screenings** Free monthly blood pressure screenings are offered at various sites in the community such as:

Adventist HealthCare Washington Adventist Hospital's Additional Community Programs addressing Identified Community Health Needs				
Focus Area	**CHNA Findings***	**Goal**	**Action**	**Evaluation of Outcomes**
	Prince George's County live below the poverty line, with higher percentages among minority seniors and women.		pressure screenings, healthy nutrition, fall prevention, summer safety, disease prevention, cancer screening education, brain health, osteoporosis screenings and bone health, flu and pneumonia shots, education on the importance of exercise, lay person CPR and Basic First Aid instruction.	• Mid County Community Center • Long Branch Senior Center • Takoma Park Community Center • White Oak Community Recreation Center • Victory Tower Apartments • Adventist HealthCare Washington Adventist Hospital **Cardiovascular Support and Activity Groups** Groups meet at least monthly to promote both disease prevention and disease management. The groups at Adventist HealthCare Washington Adventist Hospital include Women and Heart Disease, as well as Mended Hearts.

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

Areas of Need Not Directly Addressed by Adventist HealthCare Washington Adventist Hospital (WAH) & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
Asthma	Montgomery County has lower asthma prevalence (9.9%) than Prince George's County (14.3%) or the state (13.5%). Prince George's County has a much higher ER rate due to asthma (52.8 per 10,000) compared to Montgomery County (17.4 per 10,000). Both counties have lower ER rates than the state (68.3 per 10,000).	Provide community members with resources on asthma through community outreach.	Montgomery County has established The Asthma Management Program, which focuses on reaching out to Latino Children. This program provides education, support and follow-up care. Additionally, the following organizations provide the community with asthma resources: American Lung Association of Maryland, Asthma and Allergy Foundation of America (Maryland Chapter), and the Maryland Asthma Control Program.	WAH does not currently provide community outreach and educational programs specifically for asthma because there are other asthma resources available in the County. WAH will continue to monitor trends in asthma to determine whether future reallocation of resources is needed to provide asthma-related community programs.
HIV/AIDS	Prince George's County has higher HIV/AIDS incidence rates (48.8 per 100,000) than Montgomery County (21.9 per 100,000) or the state (24.6 per 100,000). In both	Continue to support other organizations that provide services related to HIV and AIDS.	Treatment and support of those with HIV or AIDS is provided by both private and public health care providers. The safety net clinics serving Montgomery County provide	WAH does not currently provide community outreach and educational programs for HIV/AIDS due to limited financial

Areas of Need Not Directly Addressed by Adventist HealthCare Washington Adventist Hospital (WAH) & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
	counties, Blacks are disproportionately burdened by HIV/AIDS.		diagnostic services and treatment. Montgomery County Health Department provides HIV Case Management (including dental care, counseling, support groups, home care services, education and outreach to at-risk populations), clinical services, lab tests, and diagnostic evaluations. Prince George's County Health Department provides testing in locations throughout the County, as well as health assessments, physical exams, lab tests, and case management services. Whitman Walker Clinic offers a variety of services. Maryland AIDS Administration educates public and health care professionals.	resources, and because many HIV/AIDS services are provided by other local organizations.
Social Determinants of Health • Food Access • Housing Quality • Education • Transportation	**Food Access** – Montgomery County performs better than state and national baselines with regard to food deserts, while Prince George's County performs worse than state but better than national baselines. **Housing Quality** – 51.6 percent of renters in	Partner with and support other organizations in the community that specialize in addressing needs related to food access, housing quality, education, transportation, and other social determinants of health.	**Food Access** – *Manna Food Center is a central food bank in Montgomery County that provides direct food assistance at 14 locations, assisting approximately 5% of Montgomery County residents. In Prince George's County, Community Support System's pantry serves over 7,000 people each year.*	WAH does not directly address many of the social determinants of health because those are not specialty areas of the hospital and WAH does not have the resources or expertise to meet many of these needs. Instead, WAH partners with and

Areas of Need Not Directly Addressed by Adventist HealthCare Washington Adventist Hospital (WAH) & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
	Montgomery County spend 30% or more of household income on rent. The rate in Prince George's County is similar with 52.8 percent of renters spending 30% or more of household income on rent. In 2016, an annual survey found there were 981 homeless people in Montgomery County and 544 in Prince George's County. **Education** – The percentage of children who enter kindergarten ready to learn in Montgomery County (81%) and in Prince George's County (80%) is lower than the state of Maryland baseline (83%). The percentage of students who graduate high school in 4 years is also lower in Prince George's County (76.6%) than in the state (86.4%). **Transportation** – Montgomery County ranks in the top quartile of longest commute times among all U.S. counties. The rate of pedestrian injuries on public roads in Montgomery County (41.3/100,000) is lower than		**Housing Quality** – *WAH supports* and partners with a local non-profit organization called Interfaith Works, which provided shelter to 824 homeless men, women, and children, while providing 13,073 income-qualified residents with free clothing and household goods in 2014 alone. Additionally, the Montgomery County Coalition for the Homeless has shelters and emergency housing as well as programs to provide permanent housing for families. This organization also assists with applying for Medicaid, food stamps, and other entitlement programs, as well as transportation, education completion, and vocational assistance. The Housing Initiative Partnership in Prince George's County helps low-income residents buy homes, prevents foreclosure, and helps people stay in their homes through tax assistance and loan modification programs. **Education** – The Housing	supports other organizations in the community that specialize in addressing needs related to food access, housing quality, education, transportation, and other social determinants of health.

Areas of Need Not Directly Addressed by Adventist HealthCare Washington Adventist Hospital (WAH) & Rationale				
Topic Area	**CHNA Findings***	**Goal**	**Resources**	**Rationale**
	that of the state (42.5/100,000) but remains higher than the SHIP 2017 target of 35.6/100,000 population. In Prince George's County, the rate of injuries on public roads is 39.6 per 100,000 population, a rate lower than the state, but higher than SHIP 2017 target.		Initiative Partnership sponsors a 'Reading is Fundamental' program encouraging families to read together, has a free library, sponsors summer reading programs, and offers an English as a Second Language (ESL) program for adults. Local community colleges offer low-cost higher education opportunities. The Interagency Coalition to Prevent Adolescent Pregnancy works to reduce teen pregnancy – a common reason teenagers drop out of school. **Transportation** – For community members relying on public transportation, there is a Ride On bus stop located right next to WAH and Ride On Bus 17 will drop off passengers directly at the main entrance to the hospital. WAH also helps to arrange transportation home for many patients upon discharge.	

3. How do the hospital's CB operations/activities work toward the State's initiatives for improvement in population health?

The State's initiatives for improvement in population health include efforts to integrate medical care with community-based resources, a framework and measures (with targets) in distinct focus areas to continue to promote optimal health for all Maryland residents, promoting programs that enhance patient care and population health, and efforts to expand access to health care in underserved communities. Also, in the context of the State's unique all-payer rate setting model, hospitals are tasked with improving quality, including decreasing 30-day readmissions. Adventist HealthCare Washington Adventist Hospital's community benefit operations/activities are aligned with many of these initiatives. For example, WAH's "Help Stop the Flu" initiative, in partnership with local safety-net clinics, reached over 300 people with flu vaccinations and/or education about the flu, in order to address high rates of flu in the population, as evidenced by high flu-related emergency department visits. Also, in efforts to reduce cancer-related mortality and survival, WAH offers free cancer screenings to community members. Also, free cardiovascular screenings (e.g. blood pressure and body composition) are offered at various health fairs, houses of worship, senior centers, etc., to reach populations that may not otherwise have access to these kinds of services. The Breast Cancer Screening program, which provides free, comprehensive breast cancer services to women over 40 with limited or no insurance, serves many African American and Latino women from underserved areas. Hecho de Pecho, a Spanish mother-baby support group led by a Spanish-speaking lactation counselor, is WAH's initiative to provide breastfeeding support to combat the low breastfeeding rates and low/very low birth weights among Latinos. Patients at risk for diabetes, or with a diagnosis of diabetes, may be referred to one of several free diabetes programs, including a pre-diabetes class, a 6-week diabetes self-management program, and an ongoing support group for persons wishing to adopt a healthier lifestyle to reduce their risk or improve management of chronic disease; these programs illustrate the integration of health care with various community resources, which, in turn, can lower readmission rates.

VI. PHYSICIANS

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

Adventist HealthCare Washington Adventist Hospital is committed to addressing access to care and has noted an increase in the number of specialties where there are not enough physicians willing to treat uninsured and underserved patients in our service area. The lists included below in question VI.2 include physician specialties and services the hospital provides to ensure access to care for all in our community, including the uninsured.

Published reports by health care advocacy organizations have noted that the capital area, including Montgomery County and Prince George's County, has shortages in 8 of 30 physician specialty groups[23]. Shortages were identified among hematology/oncology, anesthesiology, diagnostic radiology, general surgery, and neurosurgery. A borderline physician supply was found in dermatology, physical medicine, radiation oncology, and vascular surgery. Across the state, medical specialists are projected to decrease from 40 per 100,000 state residents to 37 per 100,000 in 2015. However, the capital region is projected to be less significantly affected compared to other regions of the state due to lower retirement rates and higher rates of medical residents. Washington Adventist Hospital is augmenting this information by conducting a Medical Staff Development plan to determine physician specialty needs in the community and at the hospital.

A Community and Physician Needs Assessment was conducted by the Advisory Board Company contracted by Washington Adventist Hospital to further define surpluses or deficits of physicians in the community it serves.

[23] Maryland Hospital Association & MedChi the Maryland State Medical Society. 2008. Maryland Physician Workforce Study.

Adventist HealthCare Washington Adventist Hospital partners with local safety net clinics including Community Clinic, Inc., Mobile Medical Care, Inc., and Mary's Center, as well as individual physician practices to narrow the gap in availability of specialist providers to serve the uninsured cared for by the hospital. Washington Adventist Hospital has subsidized 4,000 visits to maternal-fetal specialists in 2015 to meet the needs of high-risk uninsured prenatal patients. The partnership with Community Clinic Inc. includes a Federally Qualified Health Center (FQHC) developed on the hospital's campus to serve uninsured patients.

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

Table IV – Physician Subsidies

Category of Subsidy	Amount	Explanation of Need for Service
Hospital-Based physicians	$0.00	N/A
Non-Resident House Staff and Hospitalists	$9,989,943	Adults who do not have a primary care physician, and OB patients who do not have a designated OB physician are provided with 24/7 hospitalist coverage.
Coverage of Emergency Department Call	$1,753,811	Specialists are needed to cover Emergency Department Call to provide adequate specialty care to patients who present through Emergency Department.
Physician Provision of Financial Assistance	$0.00	N/A
Physician Recruitment to Meet Community Need	$5,586,076	Recruitment and employment of physicians enables greater success to recruit, retain, and develop physician practices, which in return reduce physician shortage in the community as identified.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	$0.00	N/A

VII. APPENDICES

<u>To Be Attached as Appendices</u>:

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

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

- Prepares its FAP, or a summary thereof (i.e., according to National CLAS Standards):
  - in a culturally sensitive manner,
  - at a reading comprehension level appropriate to the CBSA's population, and
  - in non-English languages that are prevalent in the CBSA.

- posts its FAP, or a summary thereof, and financial assistance contact information in admissions areas, emergency rooms, and other areas of facilities in which eligible patients are likely to present;
- provides a copy of the FAP, or a summary thereof, and financial assistance contact information to patients or their families as part of the intake process;
- provides a copy of the FAP, or summary thereof, and financial assistance contact information to patients with discharge materials;
- includes the FAP, or a summary thereof, along with financial assistance contact information, in patient bills; and/or
- besides English, in what language(s) is the Patient Information sheet available;
- discusses with patients or their families the availability of various government benefits, such as Medicaid or state programs, and assists patients with qualification for such programs, where applicable.

b. Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014 (label appendix II).

c. Include a copy of your hospital's FAP (label appendix III).

d. Include a copy of the Patient Information Sheet provided to patients in accordance with Health-General §19-214.1(e) Please be sure it conforms to the instructions provided in accordance with Health-General §19-214.1(e). Link to instructions: http://www.hscrc.state.md.us/documents/Hospitals/DataReporting/FormsReportingModules/MD_HospPatientInfo/PatientInfoSheetGuidelines.doc (label appendix IV).

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

Appendix I

Financial Assistance Policy Description

Adventist HealthCare Washington Adventist Hospital informs patients and persons of their eligibility for financial assistance according to the National CLAS standards and provides this information in both English and Spanish at several intervals and locations. The Hospital's Notice of Financial Assistance and Charity Care Policy is clearly posted in the emergency department 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 (FAP) at either the time of admission or discharge, a copy of the document is provided to them. The Financial Assistance Policy as well as the Patient Information Sheet is available in both English and Spanish.

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 reviewed for eligibility for Medical Assistance and informed 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 if the patient qualifies 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 and assist with the application process. Patients must first apply for Medical Assistance before applying for financial assistance from the hospital.

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 patient that financial assistance may be available if they do not have the financial means to pay their bill. If patients request financial assistance, at that time, a copy of the Hospital's financial assistance application will be sent to them.

The Hospital has an outside contractor experienced in qualifying patients for Medicaid to review potential emergency room patients who may qualify for Medicaid.

Appendix II

Provide a brief description of how your hospital's FAP has changed since the ACA's Health Care Coverage Expansion Option became effective on January 1, 2014.

Adventist HealthCare Washington Adventist Hospital is committed to meeting the health care needs of its community through a ministry of physical, mental and spiritual healing. All patients, regardless of race, creed, sex, age, national origin or financial status, may apply for financial assistance at Adventist HealthCare Washington Adventist Hospital. Each application for Financial Assistance (charity care) will be reviewed based upon an assessment of the patient's and/or family's need, income and financial resources.

It is part of Adventist HealthCare Washington Adventist Hospital'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 programs (including Medicaid, workers compensation and other state and local programs) that might provide coverage for medical services.

The only change made to the financial assistance policy was the annual update to the Income Poverty Guidelines established by the Community Services Administration. It was not necessary to make any additional changes to the policy as the hospital considers Financial Assistance to any patient responsibility amount as long as the patient has followed our requirements.

Appendix III

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance – Decision Rules/Application

(Formerly known as Charity Care Policy)

DECISION RULES:

A. The patient would be required to fully complete an application for Charity Care and/or completion of the "Income" and "Family Size" portions of the State Medicaid Application could be considered as "an application for Charity Care." A final decision will be determined by using; an electronic income estimator, the state of Maryland poverty guidelines and the review of requested documents. An approved application for assistance will be valid for twelve (**12**) months from the date of service and may[1] be applied to any qualified services (see "A" above), rendered within the twelve (**12**) month period. The patient or Family Representative may reapply for Charity Care if their situation continues to merit assistance.

1. Once a patient qualifies for Charity Care under this policy the patient or any immediate family member of the patient living in the same household shall be eligible for Charity Care at the same level for medically necessary care when seeking subsequent care at the same hospital during the 12 month period from the initial date of service.
2. When the patient is a minor, an immediate family member is defined as; mother, father, unmarried minor natural or adopted siblings, natural or adopted children residing in the same household.
3. When the patient is not a minor, an immediate family member is defined as: spouse, minor natural or adopted siblings, natural or adopted children residing in the same household.

B. Where a patient is deceased with no designated Executor, or no estate on file within the appropriate jurisdiction(s), the cost of any services rendered can be charged to Charity Care without having completed a formal application. This would occur after a determination that other family members have no legal obligation to provide Charity Care. After receiving a death certificate and appropriate authorization, the account balance will be adjusted via the appropriate adjustment codes 23001 – Account in active AR, 33001 – Account in Bad Debt.

C. Where a patient is from out of State with no means to pay, follow instructions for "A" above.

D. A Maryland Resident who has no assets or means to pay, follow instructions for “a” above.

E. A Patient who files for bankruptcy, and has no identifiable means to pay the claim, upon receipt of the discharge summary to include debt owed to AHC, charity will be processed without a completed application and current balances adjusted as instructed in “b” above.

F. Where a patient has no address or social security number on file and we have no means of verifying assets or, patient is deemed homeless, charity will be processed without a completed application and current balances adjusted as instructed in “b” above.

G. A Patient is denied Medicaid but is not determined to be “over resource” follow instructions for “a” above.

H. A Patient who qualifies for federal, state or local governmental programs whose income qualifications fall within AHC Charity Care Guidelines, automatically qualifies for AHC Charity Care without the requirement to complete a charity application.

I. Patients with a Payment Predictability Score (PPS) of 500 or less, and more than 2 prior obligations in a Collection Status on their Credit Report and Income and Family Size are within the Policy Guidelines, charity will be processed without a completed application and current balances adjusted as instructed in “C” above.

J. If a patient experiences a material change in financial status, it is the responsibility of the patient to notify the hospital within ten days of the financial change.

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance – Decision Rules/Application

(Formerly known as Charity Care Policy)

Effective Date	01/08	Policy No:	AHC 3.19.0
Cross Referenced:	Financial Assistance - Decision Rules/Application (see Master Policy 3.19 Financial Assistance)	Origin:	PFS
Reviewed:	02/09, 06/15/10, 9/19/13	Authority:	EC
Revised:	05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13	Page:	3 of 12

ADVENTIST HEALTHCARE
NOTICE OF AVAILIBILITY OF CHARITY CARE

Shady Grove Adventist, Adventist Behavioral Health, Washington Adventist 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. Charity Care is available to patients whose family income does not exceed the limits designated 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 five time these amounts, you may qualify for Charity Care.

Size of Family Unit	Guideline
1	$11,670
2	$15,730
3	$19,790
4	$23,850
5	$27,910
6	$31,970
7	$36,030
8	$40,909

Note: The guidelines increase **$4,020** for each additional family member.

If you feel you may be eligible for Charity Care and wish to apply, 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 two business days of the receipt of your completed application.

Revised 3/2015

820 West Diamond Avenue, Suite 600
Gaithersburg, MD 20878
www.AdventistHealthCare.com

☐ Washington Adventist Hospital ☐ Adventist Behavioral Hospital
☐ Shady Grove Adventist Hospital ☐ Adventist Rehabilitation Hospital of Maryland

CHARITY CARE APPLICATION- DEMOGRAPHICS

Date: ___________Account Number(s)_____________________________

Patient Name: ________________ Birth Date: ________________

Address: ________________________________ Sex: _______

Home Telephone: ____________ Work Telephone: _______________ Cell Phone: _______________

Social Security #: ___________________ US Citizen: ______ No Residence: ______

Marital Status: ___ Married ___ Single ___ Divorced

Name of Person Completing Application________________________________

Dependents Listed on Tax Form:

Name: ______________________________ Age: ____Relationship:________

Name: ______________________________ Age: ____Relationship: ________

Name: ______________________________ Age: ____Relationship: ________

Name: ______________________________ Age: ____Relationship: ________

Employment: Patient employer **Spouse employer**

Name: __________________________ Name:______________________________

Address: __________________________ Address: ____________________________

Telephone #: ______________________ Telephone #:________________________

Social Security #: ___________________ Social Security #: ____________________

How long employed: ______________ How long employed: __________________

TOTAL FAMILY INCOME $________________

Note: All Financial applications must be accompanied by income verification for each working family member. Be sure you have attached income verification for all amounts listed above. This verification may be in the following forms: minimum of 3 months' worth of pay-stubs, an official income verification letter from your employer and/or your current taxes or W-2s. If you are not working and are not receiving state or county assistance, please include a "Letter of Support" from the individual or organization that is covering your living expenses. Any missing documents will result in a delay in processing your application or could cause your application to be denied. Thank you for your cooperation.

CHARITY CARE APPLICATION- LIVING EXPENSES

EXPENSES :

Rent / Mortgage _________________
Food _________________
Transportation _________________
Utilities _________________
Health Insurance premiums _________________
Medical expenses not covered by insurance _________________

Doctor: _________________
____
____
Hospital: _________________
____

TOTAL: __________________

Has the applicant ever applied or is currently applying for Medical Assistance?

Please Circle the appropriate answer: **YES or NO**

If yes, please provide the status of your application below (caseworker name, DSS office location, etc.)

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.

Applicant Signature: _________________________ **Date:** ____________

Return Application To: Adventist HealthCare
Patient Financial Services
Attn: Customer Service Manager
820 West Diamond Avenue. Suite 500
Gaithersburg, MD 20878

COMMUNITY CHARITY CARE APPLICATION- OFFICIAL DETERMINATION ONLY

This application was: **Denied / Approved /Need more information**

The reason for Denial:

What additional information is needed?:

Approval Details:

Patient approved for _________%
$_________ will be a Charity Care Adjustment
$_________ will be the patient's responsibility

Approval Letter was sent on ________________

AUTHORIZED SIGNATURES:

____
CS/COLLECTION SUPERVISOR
UP TO $5,000.00

____
REGIONAL DIRECTOR
UP TO $25,000.00

____
VP of Revenue Cycle or HOSPITAL CFO
OVER $25,000.00

Revised 3/2015

2015 POVERTY GUIDELINES

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
\1	100%	$11,670	100%	0%
2	100%	$15,730	100%	0%
3	100%	$19,790	100%	0%
4	100%	$23,850	100%	0%
5	100%	$27,910	100%	0%
6	100%	$31,970	100%	0%
7	100%	$36,030	100%	0%
8	100%	$40,090	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	125%	$14,588	100%	0%
2	125%	$19,663	100%	0%
3	125%	$24,738	100%	0%
4	125%	$29,813	100%	0%
5	125%	$34,888	100%	0%
6	125%	$39,963	100%	0%
7	125%	$45,038	100%	0%
8	125%	$50,113	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	150%	$17,505	100%	0%
2	150%	$23,595	100%	0%
3	150%	$29,685	100%	0%
4	150%	$35,775	100%	0%
5	150%	$41,865	100%	0%
6	150%	$47,955	100%	0%
7	150%	$54,045	100%	0%
8	150%	$60,135	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**

1	175%	$20,423	100%	0%
2	175%	$27,528	100%	0%
3	175%	$34,633	100%	0%
4	175%	$41,738	100%	0%
5	175%	$48,843	100%	0%
6	175%	$55,948	100%	0%
7	175%	$63,053	100%	0%
8	175%	$70,158	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	200%	$23,340	100%	0%
2	200%	$31,460	100%	0%
3	200%	$39,580	100%	0%
4	200%	$47,700	100%	0%
5	200%	$55,820	100%	0%
6	200%	$63,940	100%	0%
7	200%	$72,060	100%	0%
8	200%	$80,180	100%	0%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	225%	$26,258	90%	10%
2	225%	$35,393	90%	10%
3	225%	$44,528	90%	10%
4	225%	$53,663	90%	10%
5	225%	$62,798	90%	10%
6	225%	$71,933	90%	10%
7	225%	$81,068	90%	10%
8	225%	$90,203	90%	10%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	250%	$29,175	80%	20%
2	250%	$39,325	80%	20%
3	250%	$49,475	80%	20%

4	250%	$59,625	80%	20%
5	250%	$69,775	80%	20%
6	250%	$79,925	80%	20%
7	250%	$90,075	80%	20%
8	250%	$100,225	80%	20%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	275%	$32,093	70%	30%
2	275%	$43,258	70%	30%
3	275%	$54,423	70%	30%
4	275%	$65,588	70%	30%
5	275%	$76,753	70%	30%
6	275%	$87,918	70%	30%
7	275%	$99,083	70%	30%
8	275%	$110,248	70%	30%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	300%	$35,010	60%	40%
2	300%	$47,190	60%	40%
3	300%	$59,370	60%	40%
4	300%	$71,550	60%	40%
5	300%	$83,730	60%	40%
6	300%	$95,910	60%	40%
7	300%	$108,090	60%	40%
8	300%	$120,270	60%	40%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	350%	$40,845	50%	50%
2	350%	$55,055	50%	50%
3	350%	$69,265	50%	50%
4	350%	$83,475	50%	50%
5	350%	$97,685	50%	50%
6	350%	$111,895	50%	50%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
7	350%	$126,105	50%	50%
8	350%	$140,315	50%	50%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	400%	$46,680	40%	60%
2	400%	$62,920	40%	60%
3	400%	$79,160	40%	60%
4	400%	$95,400	40%	60%
5	400%	$111,640	40%	60%
6	400%	$127,880	40%	60%
7	400%	$144,120	40%	60%
8	400%	$160,360	40%	60%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	450%	$52,515	30%	70%
2	450%	$70,785	30%	70%
3	450%	$89,055	30%	70%
4	450%	$107,325	30%	70%
5	450%	$125,595	30%	70%
6	450%	$143,865	30%	70%
7	450%	$162,135	30%	70%
8	450%	$180,405	30%	70%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	500%	$58,350	20%	80%
2	500%	$78,650	20%	80%
3	500%	$98,950	20%	80%
4	500%	$119,250	20%	80%
5	500%	$139,550	20%	80%
6	500%	$159,850	20%	80%
7	500%	$180,150	20%	80%
8	500%	$200,450	20%	80%

FAMILY UNIT SIZE	INCOME GUIDELINE	ANNUAL INCOME	UNCOMPENSATED CARE AMOUNT	PATIENT RESPONSIBILITY AMOUNT
1	550%	$80,231	10%	90%
2	550%	$108,144	10%	90%
3	550%	$136,056	10%	90%
4	550%	$163,969	10%	90%
5	550%	$191,881	10%	90%
6	550%	$219,794	10%	90%
7	550%	$247,706	10%	90%
8	550%	$275,619	10%	90%
FAMILY UNIT SIZE	**INCOME GUIDELINE**	**ANNUAL INCOME**	**UNCOMPENSATED CARE AMOUNT**	**PATIENT RESPONSIBILITY AMOUNT**
1	600%	$105,030	5%	95%
2	600%	$141,570	5%	95%
3	600%	$178,110	5%	95%
4	600%	$214,650	5%	95%
5	600%	$251,190	5%	95%
6	600%	$287,730	5%	95%
7	600%	$324,270	5%	95%
8	600%	$360,810	5%	95%

PFS Current Manual Writeoff and Adjustment > $100 Process
Tuesday, November 25, 2008

EMDEON- ***Search America***- will develop automated write-off for charity approved accounts

PFS Collectors request adjustment amount **less than / equal $150**

Tier **1.2**- Third party Collections Manager review and approve all requests **greater than $150 and under / equal $1,500** from team (GOV and Non-Gov team)

Tier **1.1**- Selfpay collections Manager reviews and approves charity WOFF adjustment **greater than 150 and under / equal $1,500**

Tier **2**- Asst. Director review and approve all requests **greater than $1,500 and under/equal $2,500** from team (GOV and Non-Gov team)

Tier **3**- Requests **greater $2,500 and less than $25,000** will be approved by PFS Regional Director

Tier **4**- Requests **greater than $25,000** will be approved by Facility CFO, CFOs send approval back to PFS Reginal Director

Data Control to post approved charity writoff/ adjustment

Appendix IV

Patient Information Sheet

Maryland Hospital Patient Information

Hospital Financial Assistance Policy

Washington Adventist Hospital is committed to meeting the health care needs of its community through a ministry of physical, mental and spiritual healing. This hospital provides emergent and urgent care to all patients regardless of their ability to pay.
In compliance with Maryland law, Washington Adventist Hospital has a financial assistance policy and program.
You may be entitled to receive free or reduced-cost medically necessary hospital services.
This facility exceeds Maryland law by providing financial assistance based on a patient's need, income level, family size and financial resources.
Information about the financial assistance policy and program can be obtained from any Patient Access Representative and from the Billing Office.

Patients' Rights

As part of Adventist HealthCare's mission, patients who meet financial assistance criteria may receive assistance from the hospital in paying their bill.
Patients may also be eligible for Maryland Medical Assistance - a program funded jointly by state and federal governments. This program pays the full cost of healthcare coverage for low-income individuals meeting specific criteria (see contact information below).
Patients who believe they have been wrongly referred to a collection agency have the right to request assistance from the hospital.

Patients' Obligations

Patients with the ability to pay their bill have an obligation to pay the hospital in a timely manner.
Washington Adventist Hospital makes every effort to properly bill patient accounts. Patients have the responsibility to provide correct demographic and insurance information.
Patients who believe they may be eligible for assistance under the hospital's financial assistance policy, or who cannot afford to pay the bill in full, should contact a Financial Counselor or the Billing Department (see contact information below).
In applying for financial assistance, patients have the responsibility to provide accurate, complete financial information and to notify the Billing Department if their financial situation changes.
Patients who fail to meet their financial obligations may be referred to a collection agency.

Contact Information

To make payment arrangements for your bill, please call (301) 315-3660 for assistance.

To inquire about assistance with your bill, please call the Billing Office at (301) 315-3660.

To inquire about Medical Assistance, please call (301) 891-5250 for assistance.

Note: Physician services provided during your stay are not included on your hospital billing statement and will be billed separately.

Información del paciente de Maryland Hospital

Política de ayuda financiera del hospital

Washington Adventist Hospital está comprometido a cubrir las necesidades de salud de su comunidad a través de un ministerio de cuidado físico, mental y espiritual. Este hospital ofrece servicios de salud emergente y de urgencias a todos los pacientes, sin importar si tienen la capacidad de pagar. En cumplimiento con las leyes de Maryland, Washington Adventist Hospital tiene un programa y una política de ayuda financiera.

Usted podría tener el derecho a recibir servicios hospitalarios médicamente necesarios de manera gratuita o a un costo reducido.

Este hospital supera lo previsto en la ley de Maryland al ofrecer ayuda financiera con base en la necesidad, nivel de ingresos, tamaño de la familia y recursos financieros del paciente.

Para obtener información acerca del programa y de la política de ayuda financiera diríjase a cualquier representante de acceso de pacientes o a la oficina de cobranzas.

Derechos del paciente

Como parte de la misión de salud adventista, los pacientes que cumplan con los criterios para recibir ayuda financiera podrían recibir ayuda del hospital para el pago de su factura.

Los pacientes también podrían cumplir con los requisitos para participar en el programa Maryland Medical Assistance, financiado en conjunto por los gobiernos federal y estatal. Este programa paga el costo total de la cobertura de salud para individuos de bajos ingresos que cumplan con los criterios específicos (consulte la información de contacto que aparece más abajo).

Los pacientes que consideren que han sido remitidos por error a una agencia de cobranzas tienen derecho a solicitar ayuda al hospital.

Obligaciones del paciente

Los pacientes con capacidad de pagar sus facturas tienen la obligación de pagar a tiempo al hospital.

Washington Adventist Hospital se esfuerza en cobrar correctamente las cuentas de los pacientes. Los pacientes tienen la responsabilidad de entregar la información correcta acerca de sus datos demográficos e información de seguros.

Los pacientes que consideren que podrían calificar para el programa de ayuda financiera de acuerdo con las políticas del hospital o aquellos que no tengan capacidad de pagar la totalidad de la factura deberán contactar a un consejero financiero o al departamento de cobranzas (consulte la información de contacto que aparece más abajo).

Al solicitar ayuda financiera, los pacientes tienen la responsabilidad de entregar información financiera completa y veraz y de notificar al departamento de cobranzas si ocurren cambios en su situación financiera.

Aquellos pacientes que no cumplan con sus obligaciones financieras podrían ser remitidos a una agencia de cobranzas.

Información de contacto

Para solicitar un plan de pago de su factura llame al (301) 315-3660.

Para averiguar acerca de la ayuda financiera para el pago de su factura, llame a la oficina de cobranzas al (301) 315-3660.

Para averiguar acerca de ayuda médica llame al (301) 891-5250.

Nota: Los servicios que los doctores le proporcionen durante su estadía no están incluidos en su estado de cuenta del hospital y se le cobrarán por separado.

Appendix V

Hospital Mission, Vision, and Value Statements

Vision

Adventist HealthCare will be a high performance integrator of wellness, disease management and health care services, delivering superior health outcomes, extraordinary patient experience and exceptional value to those we serve.

Mission

We demonstrate God's care by improving the health of people and communities through a ministry of physical, mental and spiritual healing.

Values

Respect: We recognize the infinite worth of the individual and care for each one as a whole person.

Integrity: We are above reproach in everything we do.

Service: We provide compassionate and attentive care in a manner that inspires confidence.

Excellence: We provide world class clinical outcomes in an environment that is safe for both our patients and caregivers.

Stewardship: We take personal responsibility for the efficient and effective accomplishment of our mission.