COMMUNITY BENEFIT NARRATIVE

Effective for FY2017 Community Benefit Reporting

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

December 15, 2017

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

1. **Please <u>list</u> 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 (CY2016):	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Hospital's Uninsured Patients (CY2016):	Percentage of the Hospital's Patients who are Medicaid Recipients (CY2016):	Percentage of the Hospital's Patients who are Medicare Beneficiaries (CY2016):
87	1,862	20878 20906 20854 20874 20850 20902 20852 20877 20817 20904 20853 20783 20910 20901 20855 20886 20782 20912 20832 20815	**Holy Cross of Silver Spring** 20906, 20910, 20901, 20783, 20853, 20912, 20874 **Washington Adventist** 20783, 20912, 20782, 20901, 20904, 20910 **Medstar Montgomery** 20906, 20832, 20853, 20904, 20905, 20902, 20874 **Suburban**	0.5% of overall patients were uninsured. Of these patients: 0.19% were from Montgomery County *Source: review of hospital discharge data*	8.8% *Source: review of hospital discharge data*	50.1% *Source: review of hospital discharge data*

		20814 20876 20905	20852, 20854, 20817, 20814, 20815, 20906, 20902, 20878, 20853, 20910 **Union of Cecil County** 20876, 20817, 20910, 20886, 20906 **Holy Cross Hospital-Germantown** 20874, 20877, 20886, 20876, 20878			

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

Adventist Healthcare Rehabilitation primarily serves residents of Montgomery and Prince George's Counties, Maryland. Below, Figure 1 shows the percentages of discharges by county for Adventist HealthCare Rehabilitation:

County	Percentage
Montgomery	67.58%
Prince George's	17.50%
District of Columbia	3.50%

Figure 1. Adventist HealthCare Rehabilitation discharges by county, 2015

Approximately 85.0 percent of discharges come from our Total Service Area, which is considered Adventist HealthCare Rehabilitation's Community Benefit Service Area "CBSA" (see Figure 2). Within that area, 60.0 percent of discharges are from the Primary Service Area including the following zip codes/cities:

20705 – Beltsville, 20783 – Hyattsville, 20815 – Chevy Chase, 20817 – Bethesda, 20850 – Rockville, 20852 – Rockville, 20853 – Rockville, 20854 – Potomac, 20855 – Derwood, 20874 – Germantown, 20876 – Germantown, 20877 – Gaithersburg, 20878 – Gaithersburg, 20879 – Gaithersburg, 20886 – Montgomery Village, 20895 – Kensington, 20901 – Silver Spring, 20902 – Silver Spring, 20904 – Silver Spring, 20906 – Silver Spring, 20910 – Silver Spring, and 20912 – Takoma Park.

We draw 25.0 percent of discharges from our Secondary Service Area including the following zip codes/cities:

20011 – Washington, 20016 – Washington, 20020 – Washington, 20706 – Lanham, 20707 – Laurel, 20708 – Lanham, 20721 – Bowie, 20737 – Riverdale, 20740 – College Park, 20743 – Capitol Heights, 20744 – Fort Washington, 20746 – Suitland, 20747 – District Heights, 20748 – Temple Hills, 20770 – Greenbelt, 20772 – Upper Marlboro, 20774 – Upper Marlboro, 20782 – Hyattsville, 20784 – Hyattsville, 20785 – Hyattsville, 20814 – Bethesda, 20816 – Bethesda, 20832 Olney, 20833 – Brookeville, 20837 – Poolesville, 20841 – Boyds, 20851 – Rockville, 20871 – Damascus, 20882 – Gaithersburg, 20903 – Silver Spring, 20905 – Silver Spring, 21701 – Fredrick, 21702 – Frederick, and 21771 – Mount Airy (see Figure 2).

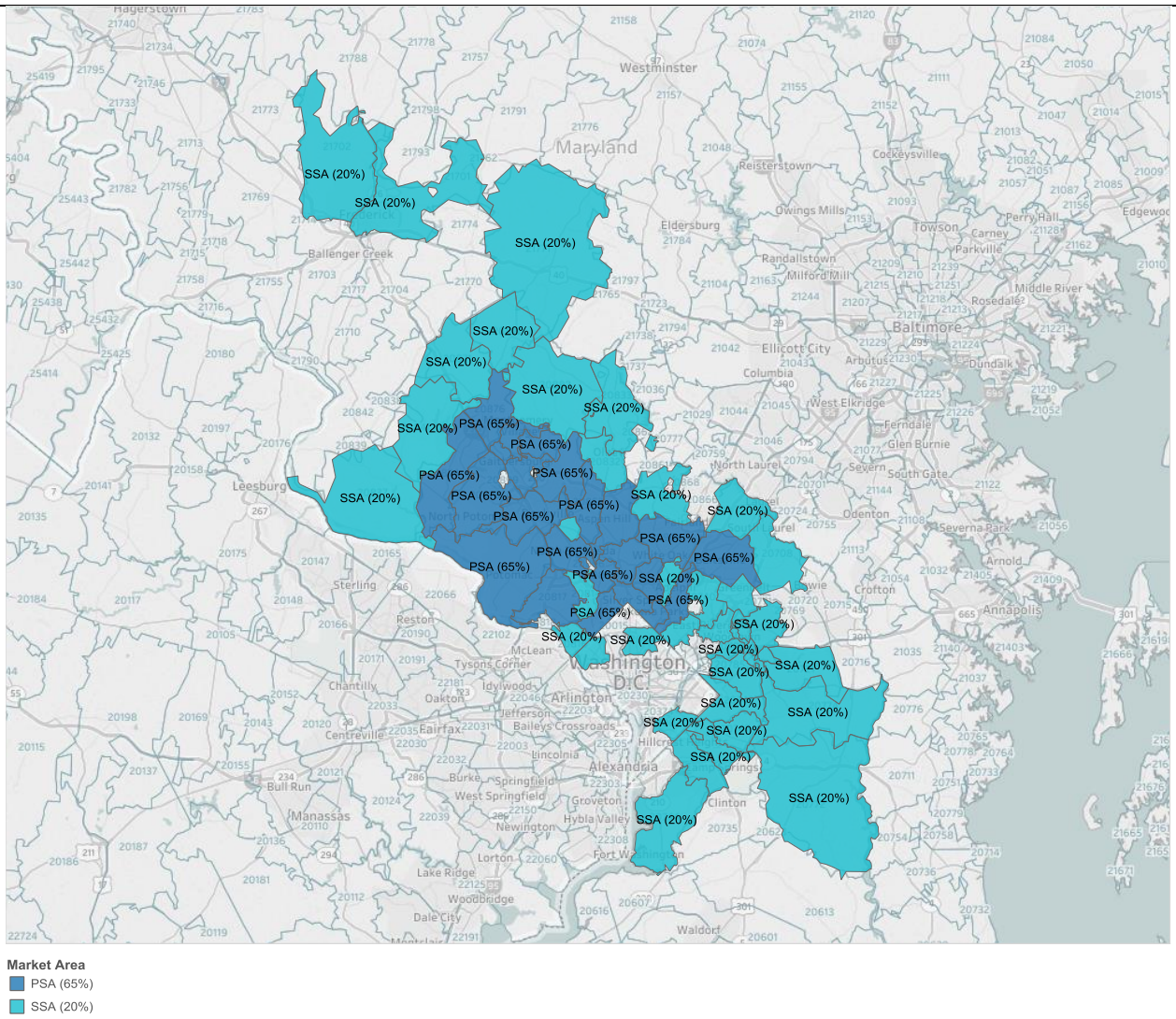

Figure 2. Map of Adventist HealthCare Rehabilitation's
Primary and Secondary Service Areas based on 2015 inpatient discharges

There are many different factors that can impact health which can include, but aren't limited to: education, the physical environment (e.g. availability of healthcare services and grocery stores), and income. Income can be considered a large barrier to health and wellness as income can affect a family's ability to pay for necessities such as 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. Over 100,000 deaths in the U.S. can be prevented annually if individuals receive the recommended clinical preventative care[1]. A study by the CDC on the relationship between income and healthcare coverage found that a majority of adults are not receiving recommended clinical preventative care; however, those with insurance are more likely to receive care than the uninsured while individuals with higher

[1] Fox, J. B., & Shaw, F. E. (2014). Relationship of Income and Health Care Coverage to Receipt of Recommended Clinical Preventive Services by Adults — United States, 2011–2012. *Morbidity and Mortality Weekly Report (MMWR),63*(61), 666-670. Retrieved December 16, 2016, from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6331a2.htm.

income are most likely to receive recommended preventative care.[2] Therefore, the criteria used to identify vulnerable populations within Adventist HealthCare Rehabilitation's CBSA are median household income and insurance status (see Figure 3).

Adventist HealthCare Rehabilitation CBSA			
Population	**Zip Codes**	**Median Household Income (2015)**	**Percent Uninsured (2015)**
District of Columbia	20011	$62,281	10.70%
	20016	$124,080	2.50%
	20020	$34,797	5.60%
	Overall	$70,848	5.80%
Frederick County	21701	$71,393	7.70%
	21702	$70,783	8.60%
	21771	$113,502	4.10%
	Overall	$83,700	6.80%
Montgomery County	20814	$115,359	2.80%
	20815	$140,803	3.80%
	20816	$173,438	2.10%
	20817	$169,485	2.40%
	20832	$126,762	3.60%
	20833	$140,885	4.90%
	20837	$145,518	5.60%
	20841	$152,853	7.50%
	20850	$107,170	7.10%
	20851	$82,017	19.60%
	20852	$97,151	6.30%
	20853	$100,965	11.50%
	20854	$192,649	3.50%
	20855	$120,060	6.40%
	20871	$126,543	6.00%
	20872	$108,995	4.60%
	20874	$81,769	11.40%
	20876	$91,359	10.80%
	20877	$65,853	20.60%
	20878	$117,261	7.00%
	20879	$88,777	8.30%

[2] Fox, J. B., & Shaw, F. E. (2014). Relationship of Income and Health Care Coverage to Receipt of Recommended Clinical Preventive Services by Adults — United States, 2011–2012. *Morbidity and Mortality Weekly Report (MMWR),63*(61), 666-670. Retrieved December 16, 2016, from https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6331a2.htm.

	20882	$145,054	3.60%
	20886	$75,593	15.90%
	20895	$130,130	6.70%
	20901	$97,454	14.20%
	20902	$85,044	19.60%
	20903	$58,342	30.80%
	20904	$72,458	13.40%
	20905	$116,141	9.10%
	20906	$71,423	16.50%
	20910	$77,986	7.70%
	20912	$69,721	16.00%
	Overall	$99,435	10.30%
Prince George's County	20705	$74,022	14.20%
	20706	$70,754	15.40%
	20707	$75,742	11.70%
	20708	$64,134	13.50%
	20721	$120,994	5.80%
	20737	$56,672	27.80%
	20740	$59,633	10.90%
	20743	$57,671	12.60%
	20744	$88,384	10.20%
	20746	$64,959	11.70%
	20747	$60,421	9.70%
	20748	$62,720	9.70%
	20770	$62,909	16.00%
	20772	$98,147	6.90%
	20774	$93,216	7.60%
	20782	$64,562	21.70%
	20783	$60,958	38.70%
	20784	$58,564	19.00%
	20785	$60,883	13.70%
	Overall	$74,260	13.80%
Maryland	*Overall*	$74,551	9.00%

*Note: Household income by zip code values are compared to the overall county median household income.
Income: Green indicates the location's income is equal to or above the county value. Red indicates the location's income is below the county value (i.e. a potentially vulnerable population.)
Insurance status: Green indicates the location's uninsurance percentage is below the county value. Red indicates the location's uninsurance percentage is above the county value (i.e. more uninsured without the zip code location than the county overall.)

Figure 3. Median household income and percentage uninsured by zip code, 2015
(Source: Median Household Income in the Past 12 Months 15 ACS 5-Year Estimates; Selected Characteristics of Health Insurance Coverage 2015 ACS 5-Year Estimates)

Median Household Income within the CBSA

Median Household Income
Montgomery County: $99,763
Prince George's County: $79,184
Source: US Census Bureau, 2016 1-Year ACS Estimates

Household income directly influences a family's ability to pay for healthcare services and health insurance. Throughout the CBSA of Adventist HealthCare Washington Adventist Hospital and across racial and ethnic groups, Hispanics and Blacks have the lowest household income while non-Hispanic whites have the highest. However, in the state of Maryland overall, Asians have the highest median household income (see Figure 4).

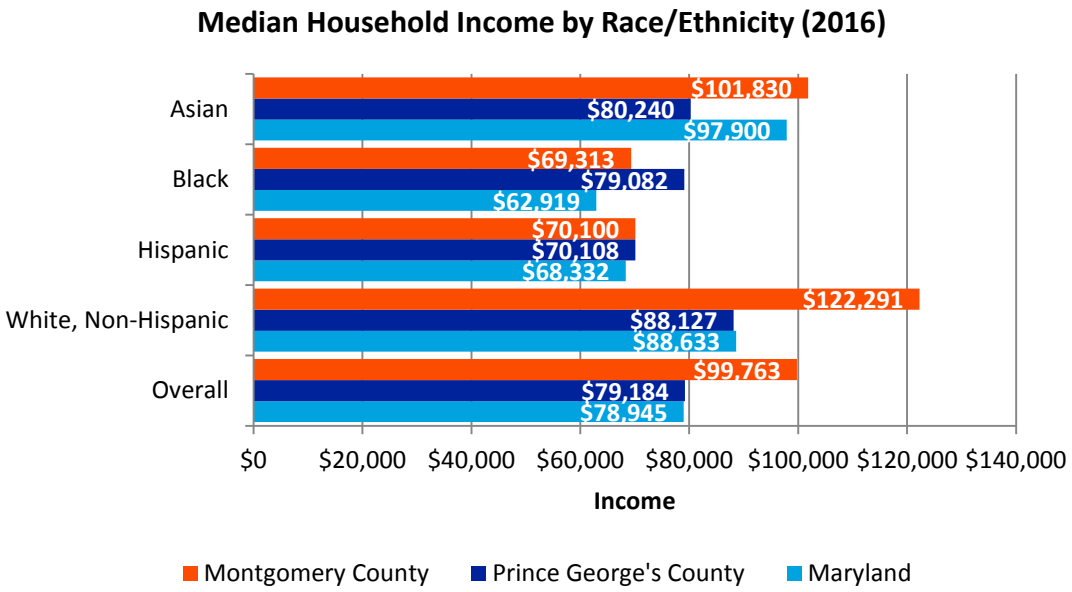

Figure 4. Median Household Income, Prince George's County, Montgomery County, and Maryland by Race and Ethnicity 2016
(Source: U.S. Census Bureau, 2016 1-Year ACS Estimates)

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

Overall, the state of Maryland experienced the highest percentage of residents living below the poverty level (9.7 percent) while Prince George's County experienced the least (6.7 percent). However, income disparities are evident when broken down by racial and ethnic groups. Asians make up the highest percentage of residents living below the poverty level (12.3 percent) in Prince George's County while there are more Hispanics living below the poverty level in Montgomery County (10.7 percent). The fewest number of residents living below the poverty level is seen among whites in Montgomery County (5.3 percent) compared to Blacks in Prince George's County (8.6 percent) (see Figure 5).

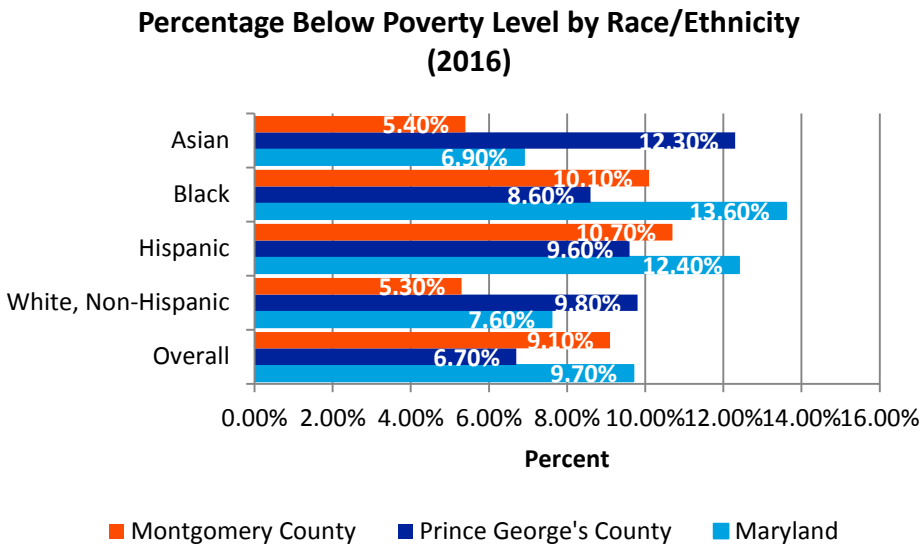

Figure 5. Poverty Status by Race and Ethnicity, Prince George's County, Montgomery County, and Maryland, 2016
(Source: U.S. Census Bureau, 2016 1-Year ACS Estimates)

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

Approximately 6.5 percent of all civilian non-institutionalized Montgomery County residents and 10.3 percent of Prince George's County residents are uninsured. In comparison, 6.1 percent of Maryland residents overall are uninsured (see figure 6).

Throughout Montgomery County, Prince George's County, and Maryland, whites are uninsured at lower rates than other racial groups. Hispanics are uninsured at significantly higher rates in both Montgomery (19.1 percent) and Prince George's Counties (28.7 percent) compared to all other racial and ethnic groups. Asians have the second highest rates of uninsured residents (Montgomery County: 10.2 percent; Prince George's County: 6.5 percent) (see Figure 6).

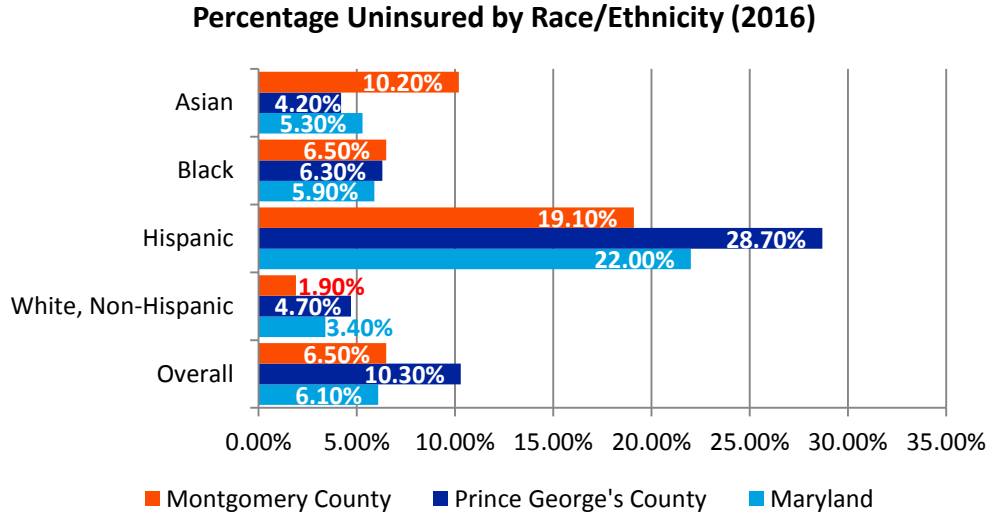

Figure 6. Percentage uninsured by Race and Ethnicity, Prince George's County, Montgomery County, and Maryland 2016
(Source: U.S. Census Bureau, 2016 1-Year ACS Estimates)

Percentage of Medicaid recipients by County within the CBSA.

Percentage of Medicaid Recipients by County within the CBSA:
Montgomery County: 10.2% (105,935)
Prince George's County: 15.7% (141,765)
Source: U.S. Census Bureau, 2016 1-Year ACS Estimates

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

According to the Maryland Department of Health's 2015 Vital Statistics Report, Montgomery County residents have a the higher life expectancy (84.6 years) than Prince George's County residents (79.9 years). The life expectancy of all Maryland residents overall is 79.7 years. Whites have a higher life expectancy in Montgomery County (84.5 percent), Prince George's County (80.5 percent), and Maryland (80.3 percent) than Blacks (see Figure 7).

Life Expectancy	Montgomery County (in years)	Prince George's County (in years)	Maryland (in years)
Overall	84.6	79.9	79.7
Race/Ethnicity			
Black	82.7	79.3	77.3
White	84.4	80.5	80.3

Figure 7. Percentage uninsured by Race and Ethnicity,
Prince George's County, Montgomery County, and Maryland 2013-2015
(Source: Maryland Department of Health, *Maryland Vital Statistics Annual Report 2015*)

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 630 per 100,000 population in Prince George's County. These rates are lower than the mortality rate for Maryland overall (786.4 per 100,000). Non-Hispanic whites have the highest death rates in both counties and the state of Maryland overall while Hispanics have the lowest rates (see figure 8).

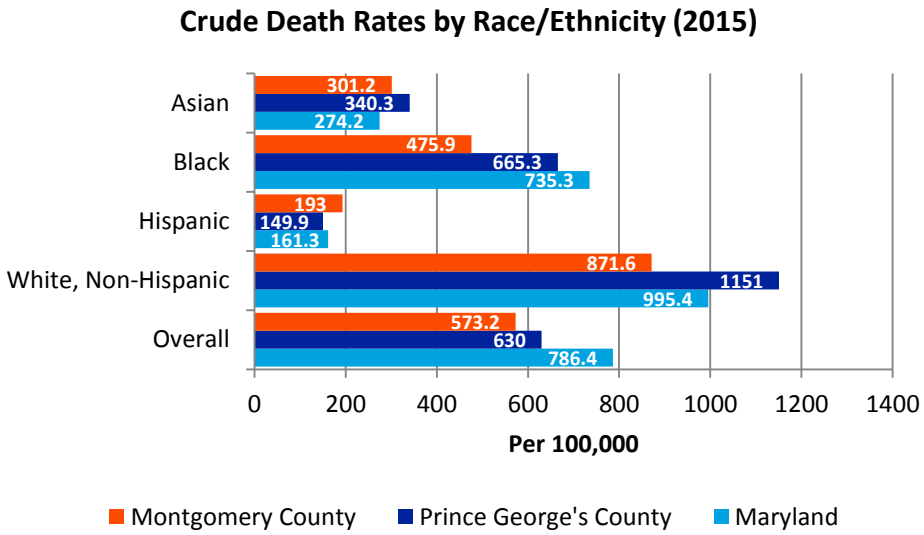

Figure 8. Crude Death Rate by Race and Ethnicity,
Prince George's County, Montgomery County, and Maryland, 2015
(Source: Maryland Department of Health, *Maryland Vital Statistics Annual Report 2015*)

Infant Mortality Rate

In 2015, Montgomery County had lower infant mortality rates (5.3 per 1,000 live births) than both Prince George's County (8.9 per 1,000 live births) and Maryland (6.7 per 1,000 live births). Blacks in Montgomery County, Prince George's County and the state overall are disproportionally affected by high infant mortality rates compared to all other racial and ethnic groups. The highest rate of infant deaths is among Blacks for Montgomery County (8.1 per 1,000 live births), Prince George's County (13.2 per 1,000 live births), and Maryland (11.3 per 1,000 live births). Overall, the lowest infant mortality rates are among non-Hispanic whites (see Figure 9).

Infant Mortality Rates by Race and Ethnicity (2015)			
Race/Ethnicity	**Maryland**	**Prince George's County**	**Montgomery County**
Overall	6.7	8.9	5.3
White, Non-Hispanic	4	*	2.2
Hispanic	4.4	2.6	7.5
Black	11.3	13.4	8.1
Asian	4.6	*	4
*Rates based on <5 events are not presented			

Figure 9. Infant Mortality Rates by Race and Ethnicity, Prince George's County, Montgomery County, and Maryland, 2015)
(Source: Maryland Department of Health, Maryland Vital Statistics Annual Report 2015)

Access to Healthy Food

Healthy Eating Behaviors

In Maryland, 72.4 percent of adults consume less than five servings of fruits and vegetables daily. This proportion is higher than the Prince George's County average of 70.7 percent. Montgomery County has the lowest proportion of adults not consuming at least five servings of fruits and vegetables each day (66.7 percent) (see Figure 10).

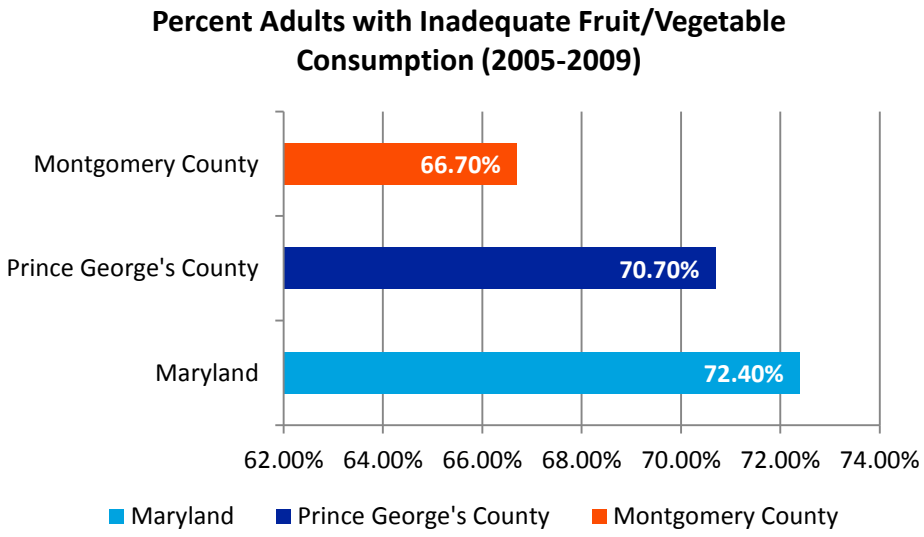

Figure 10. Adults Consuming Less than 5 Servings of Fruits and Vegetables Each Day, Prince George's County, Montgomery County, and Maryland
(Source: Community Commons, Community Health Needs Assessment, 2005-2009)

Fruit and vegetable consumption also varies by race and ethnicity. Blacks (32.5 percent) are more likely to consume fruits and vegetable at least five times a day than whites (28.6 percent) in Prince George's County whereas whites (33 percent) are more likely to consume more fruits and vegetables than Blacks (25.8 percent) in Montgomery County (see Figure 11).

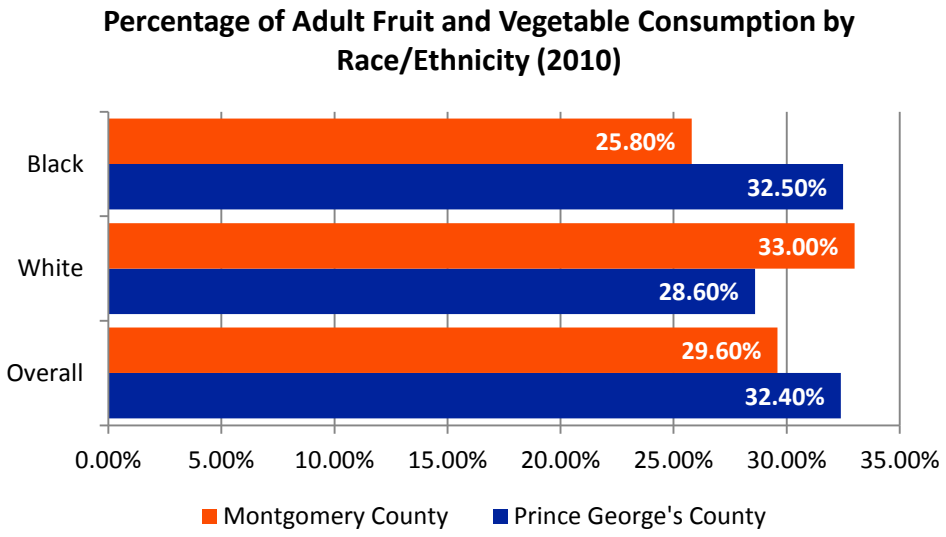

Figure 11. Percentage of Adults Consuming at Least Five or More Times a Day, Prince George's County and Montgomery County, 2010
(Source: Healthy Montgomery, 2017 & PGC Health Zone, 2017)

Food Insecurity Rates

Food insecurity is the USDA's measure for the lack of access to food necessary for a healthy life, and limited or uncertain availability of nutritionally sufficient foods.[3] In 2015, 14.4 percent of Prince George's County experienced food insecurity which is more than twice as much as the food insecurity rate in Montgomery County (6.3 percent). Although lower than Prince George's County, the state of Maryland still experienced food insecurity rates (11.4 percent) higher than that of Montgomery County.

[3] Feeding America (2017). Map the Meal Gap. Retrieved from: http://map.feedingamerica.org

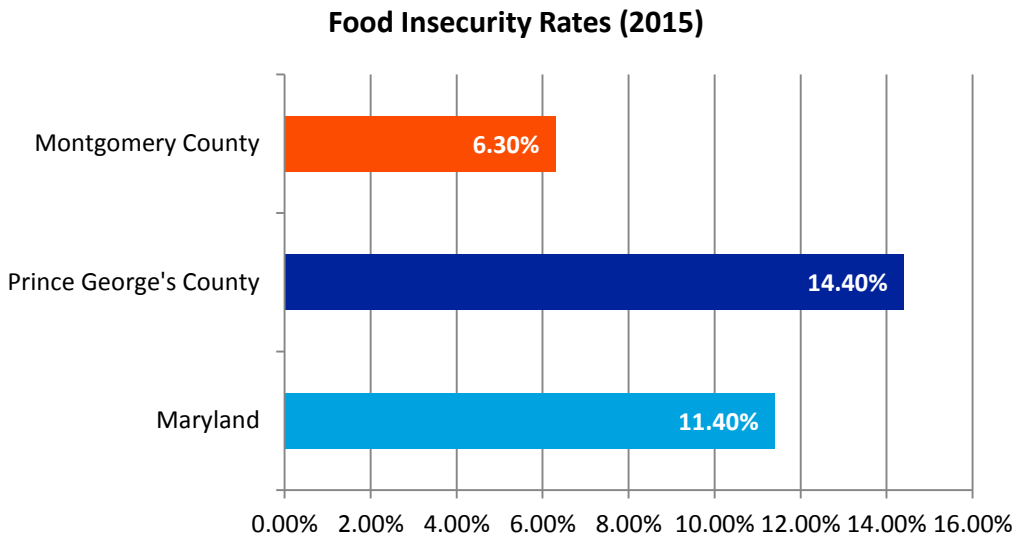

Figure 12. Food Insecurity Rates, Prince George's County, Montgomery County, and Maryland, 2015
(Source: Feeding America, *Map the Meal Gap*, 2015)

Healthy Food Access

A measure of healthy food access and of the environmental influences on healthy behaviors is access to grocery stores. Grocery stores, supermarkets and other similar food retailers serve as sources of fresh and frozen foods; fresh fruits and vegetables; and fresh and prepared meats, fish, and poultry. The state of Maryland overall has 21.39 grocery stores per 100,000 population and Montgomery County has a similar rate of 21.1 grocery stores per 100,000 population. However, Prince George's County has a slightly lower rate of 18.3 grocery stores per 100,000 population (see Figure 13).

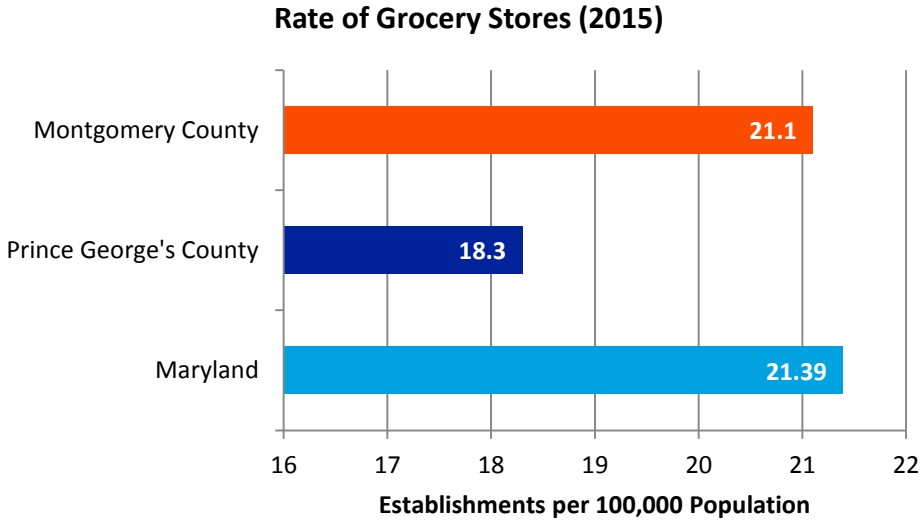

Figure 13. Number of Grocery Stores per 100,000 Population, Prince George's County, Montgomery County, and Maryland, 2015
(Source: Community Commons, Community Health Needs Assessment, 2015)

Access to fast food restaurant options has increased nationwide over the past few years to fulfill a niche for cheap and fast dining options despite often providing unhealthy foods. In 2015, there were 86.6 fast food restaurants per 100,000 population in Maryland. Prince George's County had more fast food restaurants at 88.6 establishments per 100,000 population. However, Montgomery County has fewer fast food restaurants than both Prince George's County and the state of Maryland overall at 82.32 establishments per 100,000 population (see Figure 14).

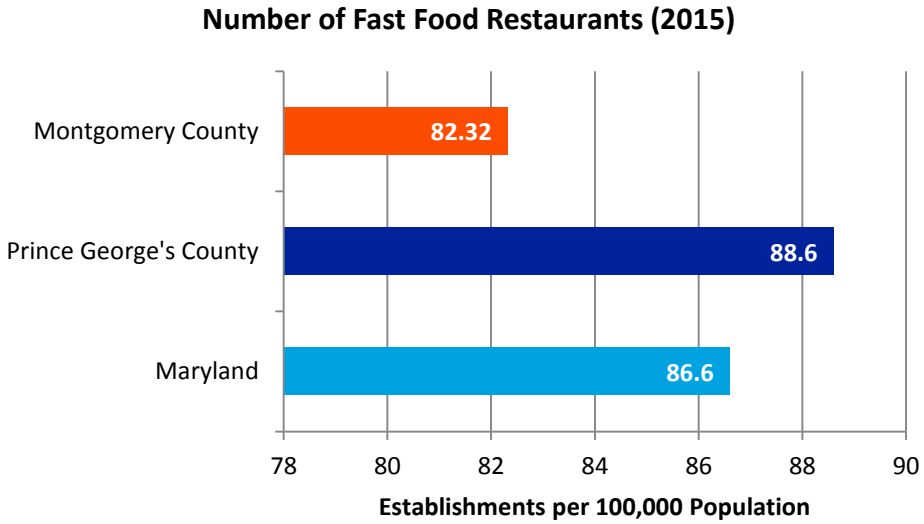

Figure 14. Number of Fast Food Restaurants per 100,000 Population, Prince George's County, Montgomery County, and Maryland 2015
(Source: Community, Commons, Community Health Needs Assessment, 2015)

Transportation

The majority of residents in both Montgomery and Prince George's Counties drive alone to work (65.3 percent and 65.5 percent, respectively), or utilize public transportation (15.5 percent and 15.6 percent, respectively) (see Figure 15).

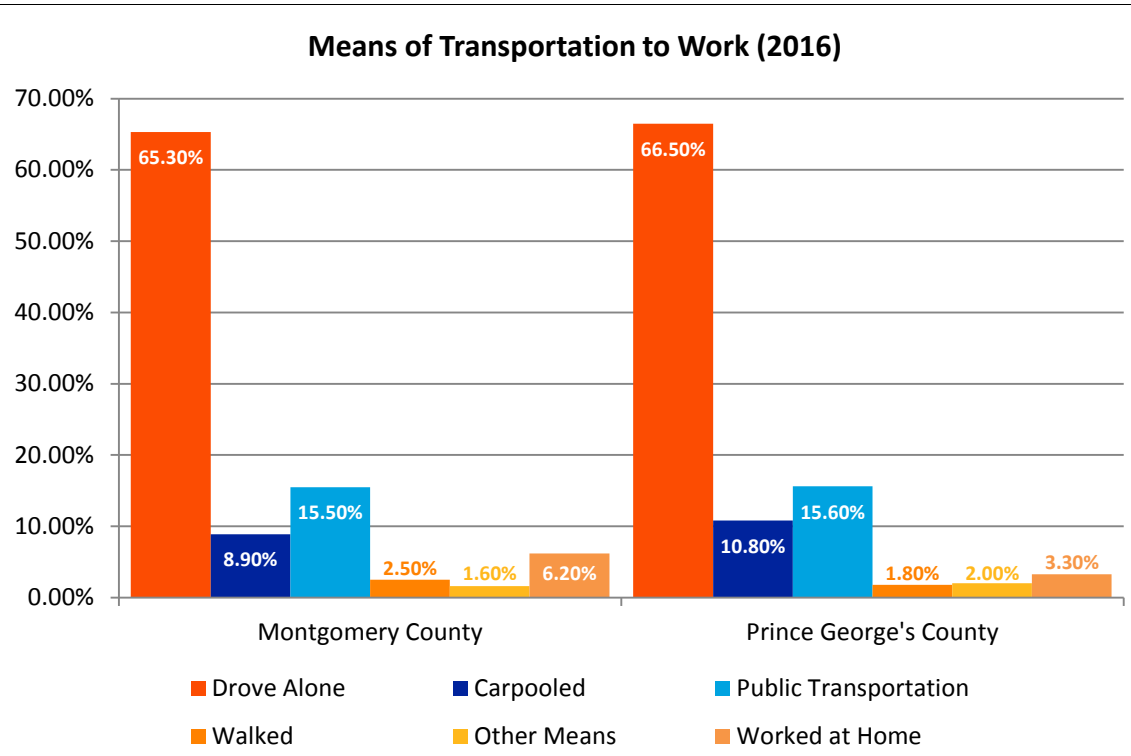

Figure 15. Means of Transportation to Work, Prince George's and Montgomery Counties, 2016
(Source: U.S. Census Bureau, 2016 1-Year ACS Estimates)

The mean travel time to work for all residents in Montgomery County is about 34.5 minutes while the mean travel time for all Prince George's County residents is 36.5 minutes (see Figure 16).

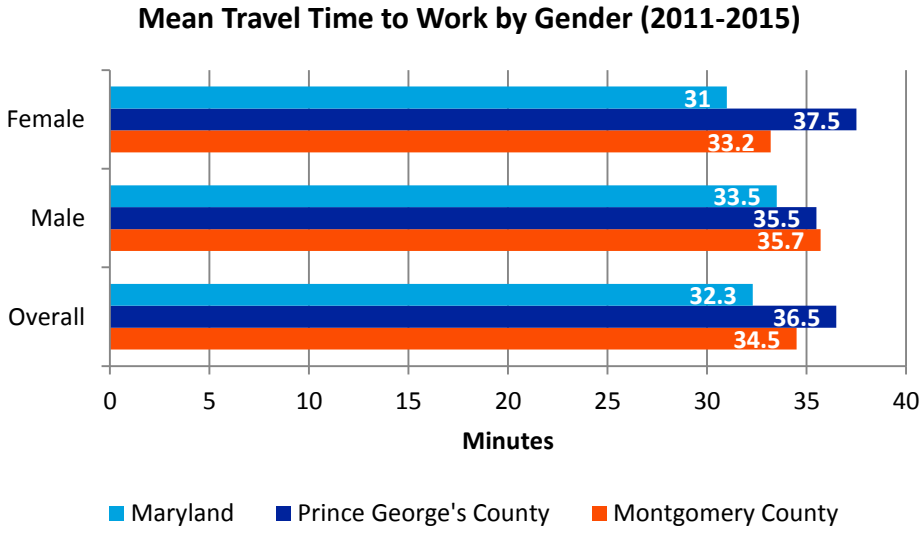

Figure 16. Mean Travel Time to Work by Gender, Prince George's County, Montgomery County, and Maryland, 2011-2015
(Source: Healthy Montgomery, 2017, PGC HealthZone, 2017)

Pedestrian Safety

The 2015 rate of pedestrian injuries in both Montgomery and Prince George's Counties are the same at 43.4 injuries per 100,000 population. The rate of pedestrian injuries for both counties has increased from 2014 as well (see Figure 17).

County	SHIP Objective	SHIP 2013 County Measure	SHIP 2014 County Measure	SHIP 2015 County Update	SHIP 2015 Maryland Update	Maryland SHIP 2017 Target
Montgomery	Reduce rate of pedestrian injuries	35.6	41.4	43.4	47.1	35.6
Prince George's		37.2	39.8	43.4		

Figure 17. Rate of Pedestrian Injuries per 100,000 Population, Prince George's County, Montgomery County, and Maryland, 2015 (Source: Maryland, SHIP, 2015)

The pedestrian death rate in Montgomery County has steadily increased from 2012 from 7 deaths in 2012 to 16 deaths in 2015 (see Figure 18-A). Comparatively, the pedestrian death rate in Prince George's County decreased from 24 deaths to 21 deaths in 2015 despite a sharp increase (30 deaths) in 2014 (see Figure 18-B). The traffic fatalities among occupants of all vehicle types in Prince George's County in 2015 (75 deaths) is more than double the number of traffic of fatalities among occupants of all vehicle types in Montgomery County (31 deaths) (see Figures 18-A and 18-B).

From 2012 to 2014, non-Hispanic white individuals in Montgomery County experienced the highest number of traffic fatalities among both vehicle occupants and non-occupants (see Figure 18-A).

Montgomery County Traffic Fatalities (2012-2015)					
Person Type by Race/Hispanic Origin		**2012**	**2013**	**2014**	**2015**
	Hispanic	2	5	4	1
	White Non-Hispanic	11	12	13	15
	Black, Non-Hispanic	7	6	4	6
	Asian, Non-Hispanic/Unknown	0	0	0	1
	All Other Non-Hispanic or Race	3	3	4	3
	Unknown Race and Unknown Hispanic	7	1	3	5
Occupants (All Vehicle Types)	**Total**	**30**	**27**	**28**	**31**
	Hispanic	0	1	1	0
	White Non-Hispanic	4	6	4	4
	Black, Non-Hispanic	2	4	1	5
	Asian, Non-Hispanic/Unknown	0	1	1	0
	All Other Non-Hispanic or Race	0	0	0	0
	Unknown Race and Unknown Hispanic	1	1	4	7
Non-Occupants (Pedestrians, Pedalcyclists and Other/Unknown Non-Occupants)	**Total**	**7**	**13**	**11**	**16**
Total	Hispanic	2	6	5	1

	White, Non-Hispanic	15	18	17	19
	Black, Non-Hispanic	9	10	5	11
	Asian, Non-Hispanic/Unknown	0	1	1	1
	All Other Non-Hispanic or Race	3	3	4	3
	Unknown Race and Unknown Hispanic	8	2	7	12
	Total	**37**	**40**	**39**	**47**

Figure 18-A. Montgomery County Fatalities by Person Type, Race and Ethnicity, 2012-2015
(Source: National Highway Traffic Safety Administration, 2015)

Prince George's County Traffic Fatalities (2012-2015)					
Person Type by Race/Hispanic Origin		**2012**	**2013**	**2014**	**2015**
Occupants (All Vehicle Types)	Hispanic	5	7	3	0
	White Non-Hispanic	7	8	8	13
	Black, Non-Hispanic	36	35	47	35
	All Other Non-Hispanic or Race	0	3	1	6
	Unknown Race and Unknown Hispanic	15	17	9	21
	Total	**63**	**70**	**68**	**75**
Non-Occupants (Pedestrians, Pedalcyclists and Other/Unknown Non-Occupants)	Hispanic	1	0	4	0
	White Non-Hispanic	4	1	6	4
	Black, Non-Hispanic	14	10	12	6
	All Other Non-Hispanic or Race	0	0	0	0
	Unknown Race and Unknown Hispanic	5	6	8	11
	Total	**24**	**17**	**30**	**21**
Total	Hispanic	6	7	7	0
	White Non-Hispanic	11	9	14	17
	Black, Non-Hispanic	50	45	59	41
	All Other Non-Hispanic or Race	0	3	1	6
	Unknown Race and Unknown Hispanic	20	23	17	32
	Total	**87**	**87**	**98**	**96**

Figure 18-B. Prince George's County Fatalities by Person Type, Race and Ethnicity, 2012-2015
(Source: National Highway Traffic Safety Administration, 2015)

Maryland Traffic Fatalities (2012-2015)					
Person Type by Race/Hispanic Origin		**2012**	**2013**	**2014**	**2015**
Occupants (All Vehicle Types)	Hispanic	20	22	14	1
	White Non-Hispanic	234	192	176	203
	Black, Non-Hispanic	90	83	93	118
	American Indian, Non-Hispanic/Unknown	2	0	1	0

	Asian, Non-Hispanic/Unknown	4	1	1	2
	All Other Non-Hispanic or Race	12	18	10	18
	Unknown Race and Unknown Hispanic	46	32	38	68
	Total	**408**	**348**	**333**	**410**
Non-Occupants (Pedestrians, Pedalcyclists and Other/Unknown Non-Occupants)	Hispanic	3	5	6	1
	White Non-Hispanic	49	54	57	43
	Black, Non-Hispanic	35	42	27	26
	Asian, Non-Hispanic/Unknown	0	1	1	0
	All Other Non-Hispanic or Race	2	2	0	3
	Unknown Race and Unknown Hispanic	14	13	18	37
	Total	**103**	**117**	**109**	**110**
Total	Hispanic	23	27	20	2
	White Non-Hispanic	283	246	233	246
	Black, Non-Hispanic	125	125	120	144
	American Indian, Non-Hispanic/Unknown	2	0	1	0
	Asian, Non-Hispanic/Unknown	4	2	2	2
	All Other Non-Hispanic or Race	14	20	10	21
	Unknown Race and Unknown Hispanic	60	45	56	105
	Total	**511**	**465**	**442**	**520**

Figure 18-C. Maryland Fatalities by Person Type, Race and Ethnicity, 2012-2015
(Source: National Highway Traffic Safety Administration, 2015)

Education

Graduation and Educational Attainment

In 2015, 89.83 percent of Montgomery County high school students graduated within four years. The four-year graduation rate for Montgomery County is higher than that of the state (87.61 percent). Despite both Maryland and Montgomery County reaching the Healthy People 2020 high school graduation rate goal of 87 percent[4], Prince George's County (81.44 percent) did not (see Figure 19).

[4] 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

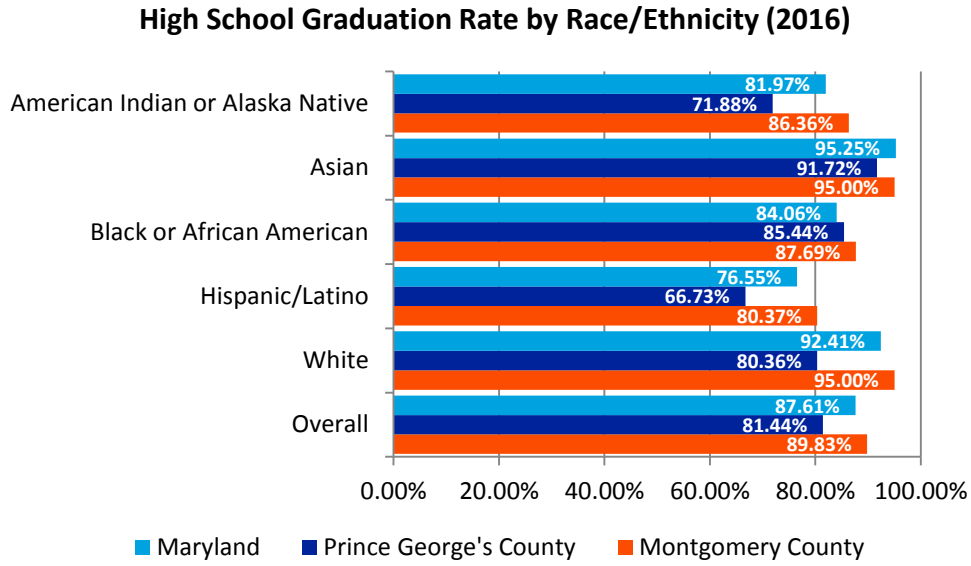

Figure 19. High School Graduation Rates by Race/Ethnicity, Prince George's County, Montgomery County, and Maryland. 2016 (Source: 2017 Maryland Report Card)

Racial and ethnic disparities in education are more evident at the higher level. The overall percentage of adults aged 25+ in Montgomery County with a bachelor's degree or higher is 59.2 percent. This is higher than both the state (39.3 percent) and Prince George's County (31.9 percent). However, when stratified by race and ethnicity, whites have the highest percentage in Montgomery County (71.6 percent), but more Asians over 25 have a bachelor's degree or higher in both Prince George's County (51.8 percent) and Maryland (62.5 percent) (see Figure 20).

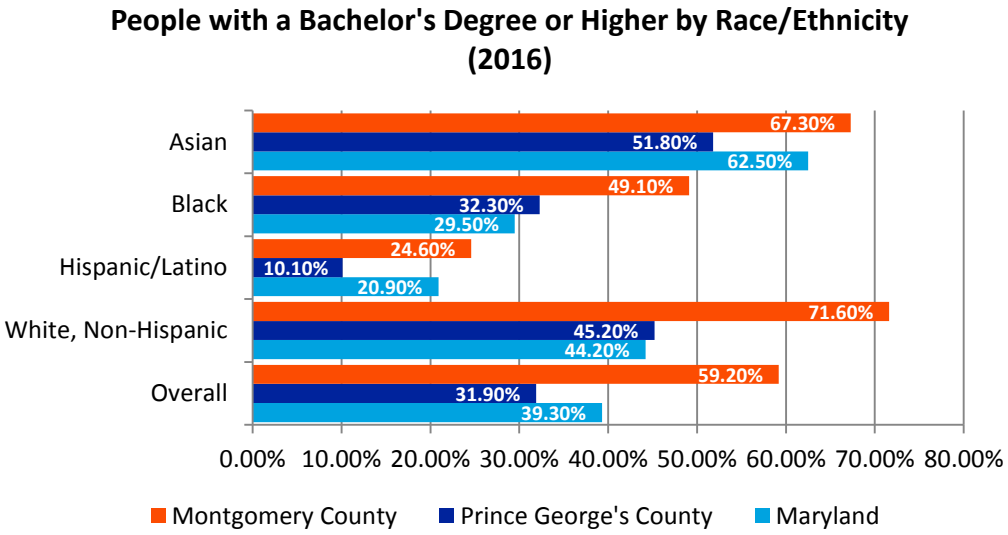

Figure 20. People with a Bachelor's Degree or Higher by Race/Ethnicity, Prince George's County, Montgomery County, and Maryland, 2016 (Source: U.S. Census Bureau, 2016 1-Year ACS Estimates)

English and Algebra Proficiency

The Maryland High School Assessment (HSA) indicates that at least 95 percent of white students and 93.6 percent of Asian 12th grade students proficient in English compared to 73.7 percent of Hispanic and about 75 percent of Black students in Montgomery County. There are racial and ethnic disparities among 12th graders in English proficiency in Prince George's County as well as 89.2 percent of white students tested proficient in English compared to 63.6 percent of Hispanic students. More Asian 12th grade students tested proficient in English in the state compared to Black students with the lowest proficiency overall (64.8 percent) (see Figure 21).

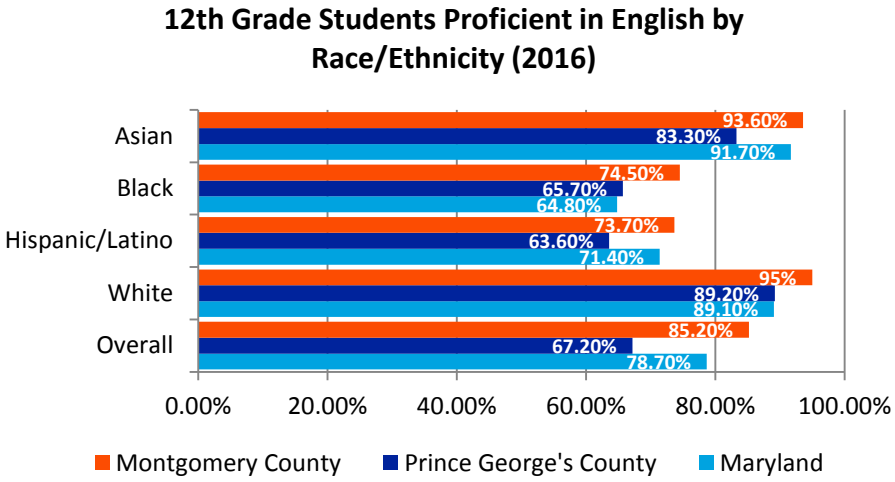

Figure 21. 12th Grade Students Proficient in English by Race/Ethnicity, Prince George's County, Montgomery County, Maryland, 2016
(Source: 2017 Maryland Report Card)

A similar trend can be seen in algebra proficiency among 12th grade high school students. Asians and whites hold the highest algebra proficiency across the board in Montgomery County (95 percent for both), Prince George's County (86.1 percent and 87.7 percent, respectively), and Maryland (95.5 percent and 94.2 percent, respectively). Black students had the lowest proficiency in algebra in both Montgomery County (77.6 percent) and Maryland (69.1 percent) while Hispanic students held the lowest proficiency in Prince George's County (64.8 percent) (see Figure 22).

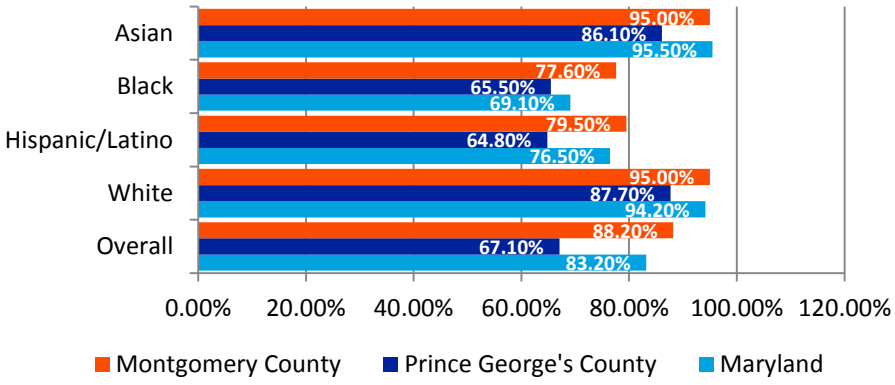

Figure 22. 12th Grade Students Proficient in Algebra by Race/Ethnicity, Prince George's County, Montgomery County, Maryland, 2016
(Source: 2017 Maryland Report Card)

Readiness for Kindergarten

The percentage of children entering kindergarten ready to learn in Montgomery County increased from 48 percent in 2014 to 49 percent in 2015 and is higher than the overall Maryland readiness score, but significantly lower than the Maryland 2017 target of 85.5 percent readiness. Hispanic children were among those least likely to be prepared for kindergarten in Montgomery County (28 percent) and Prince George's County (22 percent). Asian and white children were more likely to enter kindergarten ready to learn for both counties (see Figure 23).

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	Percentage of children who enter kindergarten ready to learn	34%	38%	Asian–46%; AA-45% Hispanic-22% White-59%	45%	85.5%
Montgomery		48%	49%	Asian–58%; AA-40% Hispanic-28% White-68%		

Figure 23. Percentage of Children Entering Kindergarten Ready to Learn, Prince George's County and Montgomery County, 2015
Notice: Race/Ethnicity data for 2015 is unavailable
(Source: Maryland SHIP, 2015)

Housing Quality

Housing Quality

The condition of a person's home and neighborhood environment is a crucial determinant of health status. Across the U.S., a disproportionate percentage of minority households experience severe or moderate housing problems. The majority of both severe and moderate housing problems are experienced by American Indians or Alaskan Natives followed by Blacks (see Figure 24).

At the local level, 17 percent of households in Maryland, 17 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 in 2017: overcrowding; high housing costs; and lack of kitchen or plumbing facilities.[5]

[5] University of Wisconsin – Population Health Institute. (2017). Compare counties. *County Health Rankings*. Retrieved from: http://www.countyhealthrankings.org/app/maryland/2017/compare/snapshot?counties=24_031%2024_033

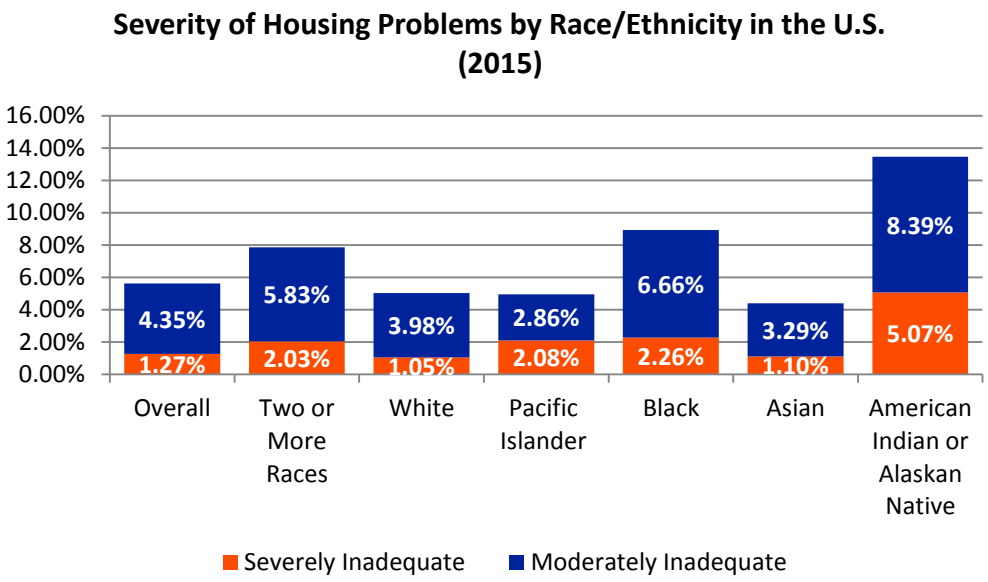

Figure 24. Severity of Housing Problems by Race/Ethnicity in the U.S., 2015
Note: Physical problems include plumbing, heating, electrical and upkeep
(Source: U.S. Census Bureau, American Housing Survey, 2015)

Montgomery County Housing Statistics

- Renters spending 35 percent or more of household income on rent: 50.0 percent
- Homeowner vacancy rate: 0.8 (2015)
- Housing units in multi-unit structures: 34.2 percent
- Housing units: 390,563
- Homeownership rate: 64.7 percent
- Median value of owner-occupied housing units: $474,900 (2015)
  (Source: U.S. Census Bureau, ACS, 2016 1-Year Estimate & U.S. Census Bureau, ACS 2015 1-Year Estimate)
- 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: 49.1 percent (2016)
- Homeowner vacancy rate: 1.7 (2015)
- Housing units in multi-unit structures: 32.7 percent
- Housing units: 332,569
- Homeownership rate: 60.7 percent
- Median value of owner-occupied housing units: $272,200 (2015)
  (Source: U.S. Census Bureau, ACS, 2016 1-Year Estimate & U.S. Census Bureau, ACS 2015 1-Year Estimate)
- 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.

A Point-in-Time Enumeration survey by the Metropolitan Washington Council on Governments indicates a steady decrease in homeless people in Montgomery and Prince George's Counties from 2015 through 2017 (see Figure 25). Montgomery County had the third largest reduction in the number of persons experiencing homelessness from 2016 to 2017[6].

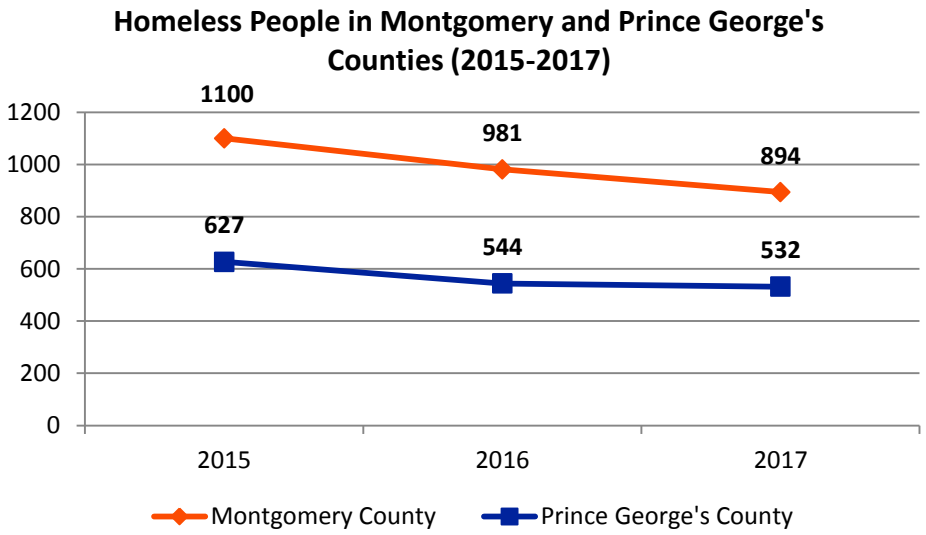

Figure 25. Number of Homeless People in Montgomery County and Prince George's County, 2015-2017 (Source: Metropolitan Washington Council on Governments, Homelessness in Metropolitan Washington: Results and Analysis from the 2017 Point-in-Time Count of Persons Experiencing Homelessness)

In 2017, the homeless population in Montgomery County included 86 homeless families comprised of 106 adults and 172 children (see Figure 26-A). The 103 homeless family units in Prince George's County consisted of 124 adults and 214 children (see Figure 26-B).

[6] Metropolitan Washington Council on Governments. (2017). *Homelessness in metropolitan Washington: Results and analysis from the annual point-in-time (PIT) count of persons experiencing homelessness*. Retrieved from: https://www.mwcog.org/documents/2017/05/10/homelessness-in-metropolitan-washington-results-and-analysis-from-the-annual-point-in-time-pit-count-of-homeless-persons-homelessness/

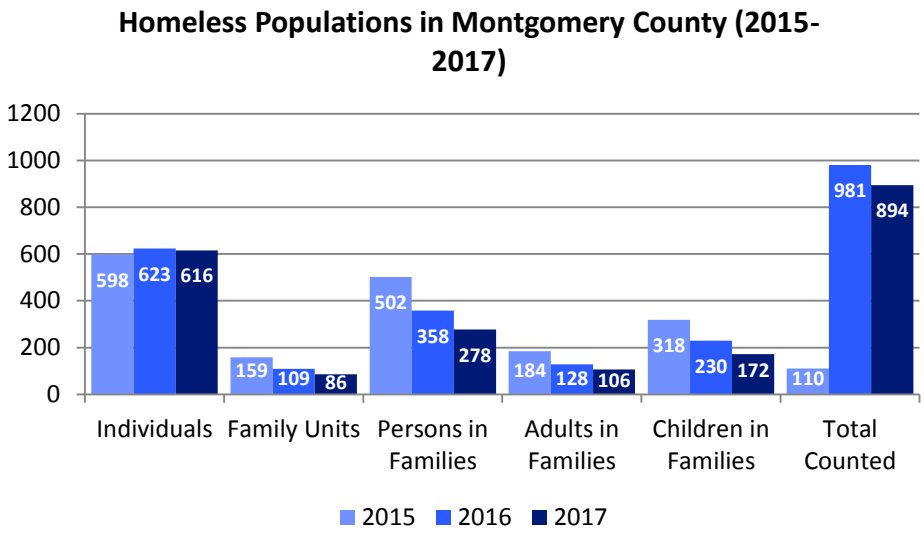

Figure 26-A. Homeless Populations in Montgomery County, 2015-2017
(Source: Metropolitan Washington Council on Governments, Homelessness in Metropolitan Washington: Results and Analysis from the 2017 Point-in-Time Count of Persons Experiencing Homelessness)

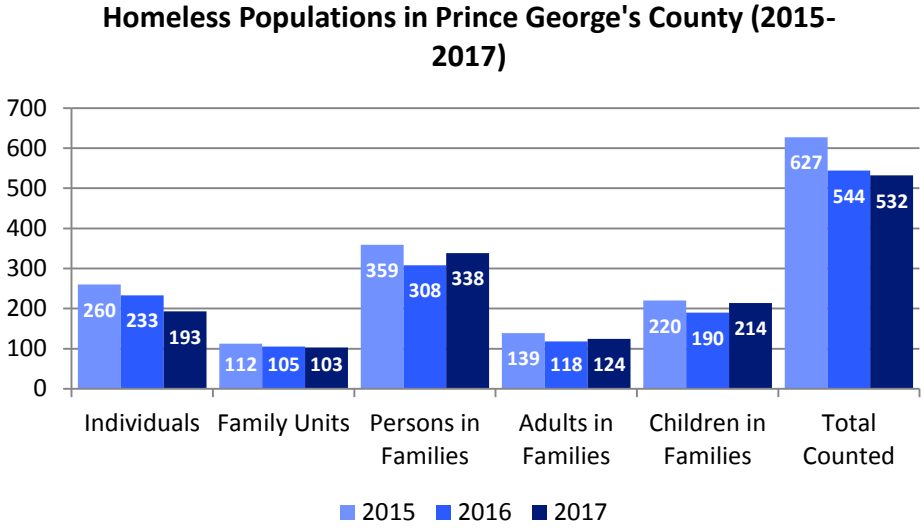

Figure 26-B. Homeless Populations in Prince George's County, 2015-2017
(Source: Metropolitan Washington Council on Governments, Homelessness in Metropolitan Washington: Results and Analysis from the 2017 Point-in-Time Count of Persons Experiencing Homelessness)

Among the already vulnerable homeless population, there are numerous subpopulations and individuals with various health, mental, and physical issues. In 2017, Montgomery County had 159 chronically homeless individuals, 175 individuals with a severe mental illness, and 162 with a chronic health problem. Prince George's County had 29 chronically homeless individuals, 54 individuals with a severe mental illness, and 65 individuals with a chronic health problem (see Figure 25).

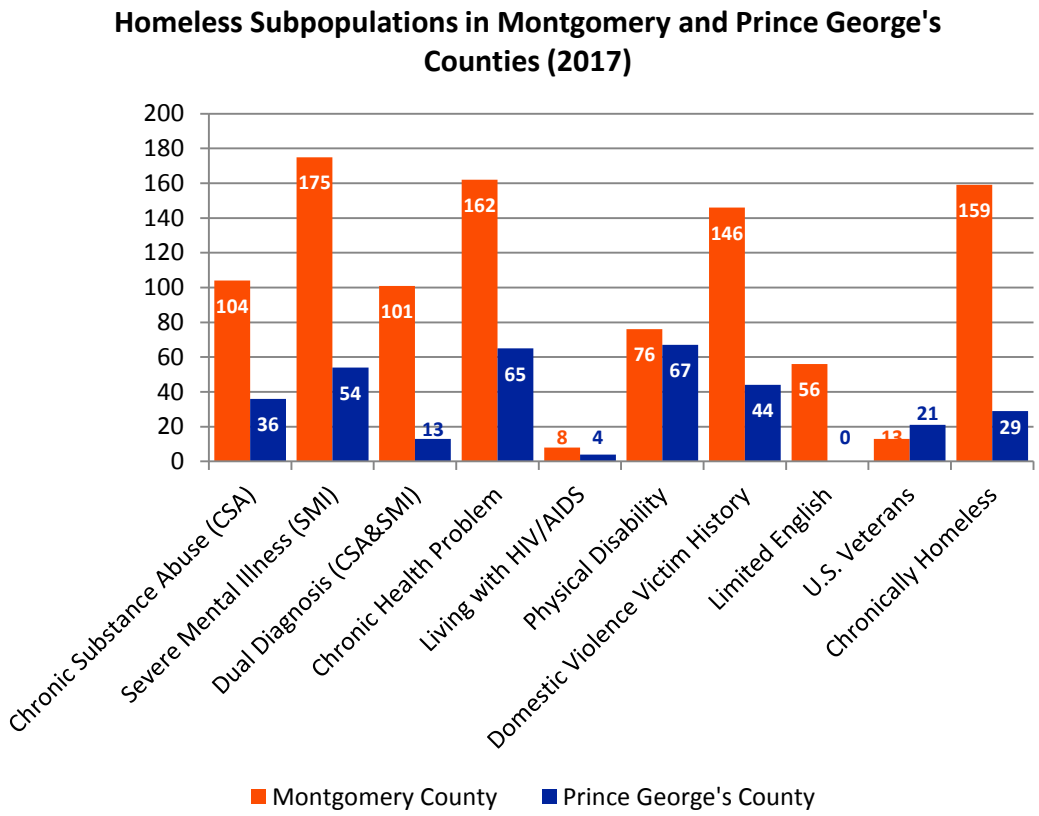

Figure 27. Adult Homeless Subpopulations in Montgomery County and Prince George's County (2017)
(Source: Metropolitan Washington Council on Governments, Homelessness in Metropolitan Washington: Results and Analysis from the 2017 Point-in-Time Count of Persons Experiencing Homelessness)

Exposure to Environmental Factors that Negatively Effect 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 C 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 (898lbs) 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.

http://ship.md.networkofcare.org/ph/county-indicators.aspx

[7] Healthy Communities Institute. (2017). Annual ozone air quality, 2013-2015. *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. (2017). Annual ozone air quality, 2013-2015. *PGC HealthZone*. Retrieved from: http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=167&localeId=1260

[9] Healthy Communities Institute. (2017). Recognized carcinogens released into air. 2016. *PGC HealthZone*. Retrieved from: http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=389&localeTypeId=2&localeId=1260

Demographics	Montgomery County	Prince George's County	Maryland
Total Population*	1,043,863	908,049	6,016,447
Age, %*			
Under 5 Years	6.4%	6.6%	6.1%
Under 18 Years	23.4%	22.5%	22.4%
65 Years and Older	14.5%	12.3%	14.6%
Race/Ethnicity, %*			
White	60.9%		26.5%
Black or African American	19.5%	65.0%	30.7%
Native American & Alaskan Native	0.7%	1.1%	0.6%
Asian	15.5%	4.6%	6.6%
Native Hawaiian & Other Pacific Islander	0.1%	0.2%	0.1%
Hispanic	19.1%	17.8%	9.8%
Language Other than English Spoken at Home, % age 5+**	39.6%	22.5%	17.2%
Median Household Income†	$99,763	$79,184	$78,945
Persons below Poverty Level, %†	9.10%	6.70%	9.70%
Pop. 25+ Without H.S. Diploma, %**	91.2%	85.6%	89.4%
Pop. 25+ With Bachelor's Degree or Above, %**	57.9%	31.1%	37.9%

Sources:
**U.S. Census Bureau. (2016).QuickFacts. Retrieved from: https://www.census.gov/quickfacts/fact/table/MD,princegeorgescountymaryland,montgomerycountymaryland/HSD310215#viewtop*
*** indicates data is from 2011-2015*
†U.S. Census Bureau. (2016). American Community Survey. Poverty status in the past 12 months 2016 1-Year ACS Estimates. Retrieved from: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S1701&prodType=table

II. COMMUNITY HEALTH NEEDS ASSESSMENT

1. **Within the past three fiscal years, has your hospital conducted a Community Health Needs Assessment that conforms to the IRS requirements detailed on pages 1-2 of these instructions?**

   _X_Yes
   ____No

   Provide date here. 12/28/2016 **(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).
   https://www.adventisthealthcare.com/app/files/public/3951/2017-CHNA-PHR.pdf

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

   _X_Yes 5/15/2017 **(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.
   https://www.adventisthealthcare.com/app/files/public/4201/2017-CHNA-PHR-ImplementationStrategy.pdf

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 specific description of how CB planning fits into the hospital's strategic plan. If this is a publicly available document, please provide a link here and indicate which sections apply to CB planning.
      As a part of Adventist HealthCare, Adventist HealthCare Rehabilitation (Rehab) is dedicated to Community Benefit which aligns with the system's core mission and values. The Strategic Plan for Rehab as well as all of Adventist HealthCare (AHC) is based on six pillars of success: People, Quality and Safety, Patient Experience, Finance, Growth, and Population Health. Each of these pillars is centered on measurable objectives and targets, and is led by an overarching council with several committees reporting up to it. Included within the Population Health pillar are the hospital's community benefit efforts. The strategic plan is not a publicly available document.

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

i. Senior Leadership

1. **_X_CEO**
2. **_X_CFO**
3. **_X_ Other (please specify:** AVP Rehabilitation; Associate VP of Operations **)**

Describe the role of Senior Leadership.
The senior leaders listed above play a large role in the community benefit planning for Adventist Rehabilitation. This leadership group 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. Senior Leadership as a part of the Operational Leadership team, was presented with key data findings for the 2017-2019 CHNA. A sub group of these individuals including the AVP of Rehabilitation and the Associate VP of operations then reviewed the data in more detail and completed the prioritization process for the hospital. Both of these individuals also took the lead in the hospital's implementation strategy development, and currently take the lead on monitoring the progress of each of the initiatives.

The AVP of Rehabilitation acts as a champion for the implementation strategy initiatives and serves on the AHC Community Benefit Council on behalf of Adventist HealthCare Rehabilitation. The CFO and Manager of Finance at Physical Health & Rehabilitation work closely with AHC finance and provide final approval of financials submitted.

ii. Clinical Leadership

1. **_X_Physician**
2. **___Nurse**
3. **___Social Worker**
4. **_X_Other (please specify:** Athletic Training Program Supervisor**)**

Describe the role of Clinical Leadership
Clinical leadership assists with the planning and implementation of community benefit activities including identifying needs in the community. The Athletic Training Program Supervisor manages the day to day for the Athletic Trainer Concussion Program including tracking outcomes. He also works closely with other clinical leadership to develop training and educational content for the program.

iii. Population Health Leadership and Staff

1. **_X_Population Health VP or equivalent (please list:** SVP of Population Health/Post-Acute Care Services**)**
2. **_X_Other population health staff (please list:** Director for Population Health Management**)**

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

The SVP of Population Health is directly over the Center for Health Equity and Wellness which coordinates and manages AHC's community benefit efforts and reporting. She 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 as well as the CHNA committee.

iv. Community Benefit Operations

1. **___the Title of Individual (please specify FTE)**
2. **_X_Committee (please list members:** Community Benefit Council, Community Partnership Fund, CHNA Committee**)**
3. **_X_Department (please list staff:** Center for Health Equity & Wellness, Finance**)**
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** (CHEW) coordinates the implementation and reporting of community benefit for the entire hospital system. This includes compiling 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. CHEW organizes and leads the CHNA committee, the Community Benefit Council and the Community Partnership Fund. CHEW includes an Executive Director, Director of Operations, Manager for Health Equity and Cultural and Linguistic Programs, Data Coordinator, Program Assistant for Health Equity, Coordinator for Cultural and Linguistic Programs, and several clinical and non-clinical community health educators and program coordinators.

The **Finance** department completes the financial spreadsheet for the annual community benefit reports. They also work closely with CHEW to ensure complete and accurate community benefit tracking and reporting. Members of the department also sit on the Community Benefit Council as well as the Community Partnership Fund. Finance department members include the Financial Reporting Manager, IT Accountant, and two Project Accountants.

Rehab has a **CHNA committee** that led the CHNA prioritization process as well as the implementation strategy development. The group currently meets regularly and monitors the progress of each of the implementation strategy initiatives. It includes the AVP of Rehabilitation, Associate VP of Operations, and the Athletic Training Program Supervisor.

Adventist HealthCare has a **Community Benefit Council** with representatives from each of the 4 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

- Manager, Health Equity and Cultural and Linguistic Program, Center for Health Equity and Wellness
- Coordinator, Data Management, Center for Health Equity and Wellness
- Director of Operations, 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
- AVP, Behavioral Health and Wellness Operations
- IT Accountant, Adventist HealthCare
- Financial Reporting Manager, Adventist HealthCare
- PR Marketing Coordinator, Adventist HealthCare
- VP, Mission Integration and Spiritual Care

The **Community Partnership Fund** provides funding for organizations whose activities support the Adventist HealthCare Mission, especially those that have poor 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
- VP Public Relations/Marketing
- VP, Mission Integration and Spiritual Care
- VP Development, Chief Development Officer (WAH)
- Director, Government Relations
- Financial Reporting Manager
- VP of Business Development (WAH)
- AVP, Rehabilitation
- Sr. VP/CQIO
- Executive Director, Center for Health Equity and Wellness
- Director of Operations, Center for Health Equity and Wellness
- SVP of Population Health/Post-Acute Care Services
- AVP, Behavioral Health and Wellness Services
- CMO, SGMC

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, members of the Finance and Center for Health Equity and Wellness departments meet 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 Adventist HealthCare Board of Trustees reviewed and approved the Community Health Needs Assessment and Implementation Strategy. The Board of Trustees only meets twice per year so they have not yet had a chance to review this report.

e. Are Community Benefit investments incorporated into the major strategies of your Hospital Strategic Transformation Plan?

_____yes __X__no

If yes, please list these strategies and indicate how the Community Benefit investments will be utilized in support of the strategy.

Adventist HealthCare Rehabilitation does not have a Hospital Strategic Transformation Plan.

IV. COMMUNITY BENEFIT EXTERNAL COLLABORATION

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

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

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

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 indicating the roles and responsibilities of each partner and indicating the approximate time period during which collaborative activities occurred (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	Adventist HealthCare collaborates with Healthy Montgomery (HM), which serves as the Local Health Improvement Coalition in Montgomery County. AHC contributes $50,000 annually to support the infrastructure of HM. AHC worked with HM to complete a 2016 Community Health Needs Assessment, which helped to inform our CHNA, and the website maintained by HM provides current data which was utilized by AHC to identify needs and set priorities. AHC was also represented on the HM Steering Committee, which sets the direction for the group.

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

If the response to the question above is yes, please list the counties for which a member of the hospital organization co-chairs the LHIC.

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

__X__yes _____no

If the response to the question above is yes, please list the counties in which a member of the hospital organization attends meetings or is a member of the LHIC.

Several Adventist HealthCare representatives take part in Healthy Montgomery as members of the steering committee as well as additional committees and planning groups. Healthy Montgomery is the LHIC for Montgomery County.

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/), or from the County Health Rankings and Roadmaps website, here: http://tinyurl.com/mmea7nw.*
(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. For collaborating organizations, please provide the name and title of at least one individual representing the organization for purposed of the collaboration.*

h. *Impact of Hospital Initiative: Initiatives should have measurable health outcomes and link to overall population health priorities such as SHIP measures and the all-payer model monitoring measures.*

   Describe here the measure(s)/health indicator(s) that the hospital will use to evaluate the initiative's impact. The hospital shall evaluate the initiative's impact by reporting (in item "i. Evaluation of Outcome"):

   i. *Statistical evidence of measurable improvement in health status of the target population. If the hospital is unable to provide statistical evidence of measurable improvement in health status of the target population, then it may substitute:*

   ii. *Statistical evidence of measureable improvement in the health status of individuals served by the initiative. If the hospital is unable to provide statistical evidence of measureable improvement in the health status of individuals served by the initiative, then it may substitute:*

   iii. *The number of people served by the initiative.*

   Please include short-term, mid-term, and long-term population health targets for each measure/health indicator. These should be monitored and tracked by the hospital organization, preferably in collaboration with appropriate community partners.

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? To what extent do the measurable results indicate that the objectives of the initiative were met? (Please refer to the short-term, mid-term, and long-term population health targets listed by the hospital in response to item h, above, and provide baseline data when available.)*

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? If not, why? 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 amount, if any, was provided through a restricted grant or donation?

Initiative: Athletic Trainer and Concussion Program

Identified Need Was this identified through the CHNA process?	The CDC estimates that there are more than 3.8 million sports-related concussions per year in the United States. Data from the 2004 to 2009 college sports season shows sports-related concussions comprised 9.2% of all injuries sustained in women's soccer, 7.4% in football, 6.3% in field hockey, 5.5% in men's soccer and 4.1% in women's volleyball[10]. A high school sports-related injury surveillance study for the 2014-2015 school year found that head/face concussions comprised 20.9% of overall injuries sustained during both competitions and practice[11]. In 2014, 4,279 Marylanders were hospitalized as a result of a traumatic brain injury (TBI) and 39,177 emergency department visits in Maryland were attributed to TBI-related injuries[12]. Moreover, from 2006 to 2010, Montgomery County had the highest percentage of TBI-related emergency department visits in the state as well as the fourth highest percentage of TBI-related hospital discharges[13]. From 2010 to 2011, Adventist HealthCare Rehabilitation had a higher percentage (12.78 percent) of brain injury discharges than the region (11.4 percent) and the nation (10.73 percent)[14]. The need was identified in the 2016 CHNA findings.
Hospital Initiative	Athletic Trainer and Concussion Program
Total Number of People within the Target Population	The target population included 11,581 student athletes at 13 Montgomery County High Schools.
Total Number of People Reached by the Initiative within the Target Population	The total number of people reached for the 2017 athletic seasons was 4,727
Primary Objective of the Initiative	The primary objective of this initiative is to help improve concussion diagnoses and treatment among Montgomery County Public School student athletes. Adventist HealthCare Rehabilitation has partnered with the Montgomery County Public school system to provide baseline concussion testing in 13 of the 25 high schools. Baseline testing is a pre-season exam conducted by trained professionals to assess an athlete's cognitive functions including learning and memory skills, ability to concentrate and problem solving skills. In the event that the athlete suffers a concussion, the results from these tests can be used in comparison with similar post-injury tests. Adventist HealthCare Rehabilitation uses ImPACT™ (Immediate Post-Concussion Assessment Cognitive Test), a web-based, computerized tool used to measure memory, processing speed, reaction time, attention span and problem solving skills. It is not an IQ

[10] Datalys Center: Sports Injury Research and Prevention, 2004-2009

[11] National High School Sports-Related Injury Surveillance Study: 2014 – 2015 School Year Convenience Sample Summary Report. http://www.ucdenver.edu/academics/colleges/PublicHealth/research/ResearchProjects/piper/projects/RIO/Documents/Convenience%20Report_2014_15.pdf

[12] Maryland Traumatic Brain Injury Advisory Board (2016). Annual Report. Retrieved from http://www.biamd.org/uploads/8/5/7/7/85779996/2016_maryland_traumatic_brain_injury_advisory_board_report.pdf

[13] Department of Health and Mental Hygiene, 2006-2010.

[14] Patient Outcomes Report. Adventist Rehabilitation Hospital of Maryland. 2011. http://www.adventistrehab.com/app/files/public/213/pdf-ARHM-Patient-Outcomes.pdf

	test. This test takes between 30 to 45 minutes and is considered one of the standard baseline tests for athletes.
	
	In addition to the baseline testing, Adventist HealthCare Rehabilitation has assisted with implementing an athletic trainer program at each of the 13 schools. This has included training and placing an athletic trainer in each of the schools to assist with timely on-site injury prevention and management. Additional details are described below.
	
	Specific objectives for the initiative include:
	
	1. Reduce the number of concussions among student athletes at the participating Montgomery County Schools.
	2. Reduce the number of injuries among student athletes at the participating Montgomery County Schools.
	3. Increase knowledge and awareness of concussion symptoms and care, as well as self-efficacy for identifying and reporting concussion symptoms among student athletes at the participating Montgomery County Schools.
	
	Strategies for this initiative include:
	
	• Increasing knowledge and awareness of concussion risks; concussion identification, care, and management in the community and the Montgomery County Public School system
	• Implementing ImPact™ baseline testing for student athletes in 13 Montgomery County high schools (with each student baseline tested every 2 years and retested following a concussion)
	• Maintaining and making available baseline test results to students, parents, and students' health care providers at no cost
	• Providing retests following a concussion at no cost (analysis and treatment are an additional cost)
	• Providing follow-up testing and analysis for students as needed at a reasonable rate
	• Serving as a resource on concussion education for students, parents, and coaches
	• Training and placing full-time athletic trainers in 13 Montgomery County high schools
	  ○ Trainers attend all 'home' athletic events as well as 'away' varsity football games
	  ○ Trainers perform functions within the six domains of athletic trainers as established by the National Athletic Trainers Association: prevention; clinical evaluation and diagnosis; immediate care; treatment, rehabilitation, and reconditioning; organization and administration; and professional responsibilities.
	  ○ In addition, trainers assist in implementing school and system wide responsibilities related to the health and safety of student athletes.
	• Providing American Heart Association CPR/AED recertification for athletic staff at 13 Montgomery County high schools

Single or Multi-Year Initiative Time Period	This is a **multi-year** initiative that began in the fall of 2013 and will continue into 2018 with the potential to continue for an additional 3 years thereafter (contingent on agreement renewal with Montgomery County Public Schools).

Key Collaborators in Delivery of the Initiative	**Key partners involved in this initiative include:** • Montgomery County Public Schools ○ Churchill, Clarksburg, Einstein, Kennedy, Richard Montgomery, Northwest, Paint Branch, Poolesville, Rockville, Springbrook, Watkins Mill, Wheaton, Wooton

Impact/Outcome of Hospital Initiative	**Baseline Concussion Testing**
	
	• Baseline concussion testing was coordinated with school personnel for 13 Montgomery County Schools during the 2017 school year
	• ImPact™ baseline testing was completed at 13 Montgomery County high schools
	  • A total of 4,727 student athletes were baseline tested for the 2017 school year
	
	Athletic Trainer Program
	
	• 13 certified athletic trainers were present for the 2017 athletic seasons in 13 Montgomery County high schools and will be present for the 2018 school year
	  • For the 2017 athletic school year (January- November):
	  ▪ A total of 612 injuries were evaluated and documented
	  ▪ A total of 107 concussions were diagnosed or suspected
	• CPR/AED recertification was provided by Physical Health & Rehabilitation staff:
	  • 155 staff were recertified during the 2017 athletic school year
	
	Concussion Education Presentations for Student Athletes
	
	• The goal of the Concussion Education presentations is to increase knowledge and awareness of concussion symptoms, acute treatments, importance of recovery, and effects on every day activities beyond sports. The presentations will cover topics such as traumatic brain injury, causes and symptoms, anatomy, and mechanism of injury, just to name a few.
	• Two concussion education presentations have been scheduled for mid-December 2017 at John F. Kennedy High School. Both classes are expected to have approximately 20-25 students.
	• Athletic Trainers will measure change in knowledge with a 15-question pre and post-test.

Evaluation of Outcomes	The Maryland State Board of Education established The Traumatic Brain Injury/Sports-Related Concussion Task Force in 2012 to research existing best practices regarding the prevention and treatment of TBI/concussions and to propose prevention, recognition, and management recommendations for schools in Maryland. In 2013, the Task Force submitted seven recommendations[15], some of which include: using the public health Levels of Prevention Model to implement prevention strategies; using educational programs to train coaches, athletic trainers, school nurses, teachers, counselors, student-athletes; promoting educational opportunities related to the evaluation and management of concussions; and improving communication with student-athletes, parents/guardians, schools, athletic

[15] Maryland State Department of Education. Report of the Traumatic Brain Injury/Sports-Related Concussions Task Force, January 2013. http://www.marylandpublicschools.org/w/ConcussionTaskForceReport_012013.pdf

<table>
<tr><td></td><td colspan="2">departments and health care providers. Adventist HealthCare Rehabilitation's Athletic Trainer and Concussion Program has been working towards the continued implementation of the Task Force's recommendations in Montgomery County high schools by raising awareness of concussion risks, teaching ways to identify, treat and manage concussions, providing baseline testing for every student-athlete, making test results available for students and family, placing trained full-time athletic trainers at all 13 Montgomery County high schools, and much more. The Athletic Trainer and Concussion Program has been successfully working towards the improvement of concussion diagnoses and treatment in the 13 Montgomery County high schools.</td></tr>
<tr><td>Continuation of Initiative</td><td colspan="2">Adventist HealthCare Rehabilitation will continue this initiative into 2018, at which point the contract with Montgomery County Public Schools will be up for renewal, for a potential additional 3-year term. An additional educational component has been added to the program in 2017 in order to better measure participant knowledge.</td></tr>
<tr><td>A. Total Cost of Initiative for Current Calendar Year
B. What amount is from Restricted Grants/ Direct offsetting</td><td>A. Total Cost of Initiative

Total Estimated Costs (2017): $484,968</td><td>B. Direct offsetting revenue from Restricted Grants

Funding from Montgomery County Public Schools (MCPS): $212,200</td></tr>
</table>

Adventist HealthCare Rehabilitation's Additional Community Programs addressing Identified Community Health Needs			
Focus Area	**CHNA Findings***	**Goal**	**Action**
Traumatic Brain Injury	Traumatic Brain Injury is a major cause of death and disability in the United States. The Traumatic Brain Injury Model Systems National Database found that males account for nearly 75% of the traumatic brain injury cases in 2015 with an average age of 41. Most common sources of traumatic brain injuries are falls, vehicle related collisions, violence, sports injuries, and combat related injuries. Across the nation, Whites are the most burdened racial group, followed by Blacks and Hispanics. In Maryland, Whites have the highest TBI-related emergency room visit, hospitalization, and death rates when compared to Prince George's County.	Provide support and education to individuals living with both traumatic and non-traumatic brain injuries.	**Brain Injury Support Group:** For those with both traumatic and non-traumatic brain injuries, this group provides support and education, as well as guidance around available community resources. Participants are encouraged to bring family and friends. **Grupo de Apoyo para Personas con una Lesión Cerebral:** In addition to the English language brain injury support group, an additional group is offered in Spanish.
Stroke & Neurology	Stroke is the fifth leading cause of death in the United States, about 1 in every 20 deaths. Stroke is a major cause of disability and reduces mobility in more than half of stroke survivors age 65 and over. In Maryland, stroke is the third leading cause of death. African-Americans die from stroke at a higher rate than whites and other races at both the national and state levels. Currently, only Montgomery County meets the Healthy People 2020 target for rates of stroke-related deaths.	Provide support and education to individuals living with cognitive and speech-language needs.	**Cognitive Game Night:** Led by a speech-language pathologist, game nights provide a fun environment for cognitive stimulating games. Education and discussion is also provided around cognitive strategies, as well as methods for continuing cognitive rehabilitation at home. **Community Aphasia Group:** Led by a speech-language pathologist, this group provides opportunities for individuals to work on successful communication and social interaction in a supportive, positive, and small group setting.
Amputee	There are 507 amputations per day across the Unites States. The majority of amputations are caused by complications of vascular	Provide emotional support and counseling to amputee individuals experiencing challenges.	**Amputee Support Group:** This group focuses on the emotions and challenges of living life as an amputee. It is the groups focus to be positive, creative and resourceful in

Adventist HealthCare Rehabilitation's Additional Community Programs addressing Identified Community Health Needs			
Focus Area	**CHNA Findings***	**Goal**	**Action**
	diseases such as diabetes and peripheral arterial disease. Other causes are trauma and cancer, which accounts for less than 2% of amputations nationwide. In Maryland, there were a total of 3,053 amputations in 2013. The majority of amputee patients are White; however, the Black population is most disproportionately affected by amputations.		examining an amputee's experiences. Many topics are discussed including prosthetic development, therapeutic devices and training, as well as emotional counseling and support.

2. **Were there any primary community health needs identified through the CHNA that were not addressed by the hospital? If so, why not? (Examples: the fact that another nearby hospital is focusing on that identified community need, or that the hospital does not have adequate resources to address it.) This information may be copied directly from the section of the CHNA that refers to community health needs identified but unmet.**

Areas of Need not Directly Addressed by Adventist HealthCare Rehabilitation & Rationale	
Focus Area	**Rationale**
Spinal Cord Injury, Lymphedema, Orthopedics	Adventist HealthCare Rehabilitation does not currently provide ongoing community outreach or programs specific to spinal cord injury, lymphedema, and orthopedics due to limited resources, and a focus on areas that were identified as higher priority during the CHNA prioritization process.
Cardiovascular Health, Cancer, Obesity, and Diabetes	Adventist HealthCare Rehabilitation does not currently provide ongoing community outreach or programs specific to chronic disease due to limited resources, and a focus on areas that were identified as higher priority during the CHNA prioritization process. Chronic disease is being addressed by other organizations in the community including Washington Adventist Hospital and Shady Grove Medical Center, both of which are part of the Adventist HealthCare system.
Social Determinants of Health: • Food Access • Housing • Education	Adventist HealthCare Rehabilitation does not currently provide ongoing community outreach or programs specific to housing, food access, and education due to limited resources, and a focus on areas that were identified as higher priority during the CHNA prioritization process.

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

   The 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 Rehabilitation's community benefit operations/activities are aligned with many of these initiatives. For example, the Adventist HealthCare Rehabilitation initiative to build a comprehensive concussion screening and treatment program provides services to student athletes at high schools across Montgomery County. The initiative includes baseline testing every two years, where tests are offered at a discounted rate or free of charge for students with economic difficulties. Athletic trainers are also placed at high schools, and attend all home games and away varsity football games. A Concussion Clinic is also provided to community members. With Montgomery County having a high percentage of traumatic brain injury-related emergency department visits, these initiatives help to promote the health of students in our community (while also promoting physical activity) and provide health services to those who may not otherwise have access to them.

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.**

   In 2014, 10.4 percent of Montgomery County adults and 11.4 percent of Prince George's County adults reported being unable to afford to see a doctor (Figure 28). When stratifying the data, disparities can be seen across different ages, races, and ethnicities. For instance, the percentage of Hispanic adults unable to afford to see a doctor is nearly twice that of the overall county numbers in Montgomery, and nearly three times the overall numbers in Prince George's (Figure 29). For Montgomery County overall, the percent of adults unable to afford to see a doctor has decreased from 10.4 percent overall in 2014 to 8.2 percent in 2015. [16] However, the number of people unable to afford to see a doctor in Prince George's County increased from 11.4 percent in 2014 to 13.4 percent in 2015. [17]

   Additionally, 6.1 percent of non-institutionalized Montgomery County residents and 10.3 percent of Prince George's County residents do not have health insurance.[18] This leads to untreated conditions and adverse health outcomes, which often result in emergency room visits.

   Adventist HealthCare Rehabilitation is committed to providing access to quality patient care. As a member of Adventist HealthCare, we are the only specialty provider of inpatient rehabilitation care in the county. We are also CARF accredited for our Amputee, Brain Injury, Spinal Cord and Stroke programs, which indicates that our

[16] Healthy Communities Institute. (2017). Community Dashboard. *Adults unable to afford to see a doctor*. Retrieved from: http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=53&localeId=1259&periodId=241

[17] Healthy Communities Institute. (2017). Community Dashboard. *Adults unable to afford to see a doctor*. Retrieved from: http://www.pgchealthzone.org/index.php?module=indicators&controller=index&action=view&indicatorId=53&localeId=1260

[18] U.S. Census Bureau. (2016). Selected characteristics of the uninsured in the United States: 2012-2016 American community survey 5-year estimates. Retrieved from: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_5YR_S2702&prodType=table

programs and services have demonstrated that they substantially meet internationally recognized standards of care.

In addition to our inpatient care, we also offer support groups for our patients and their families as they return to their lives outside of our facility. Our support groups, which include amputee, brain injury, aphasias, and Parkinson's, in addition to cognitive game nights, a cultural diversity group, and a Spanish language brain injury support group, meet monthly and are open to all of our patients.

In providing this care, our expenses outweigh the revenue associated with providing the care detailed above. Accordingly, to provide a continuum of quality care and narrow the gap in availability of providers to the uninsured / underinsured, we subsidize our physician practices.

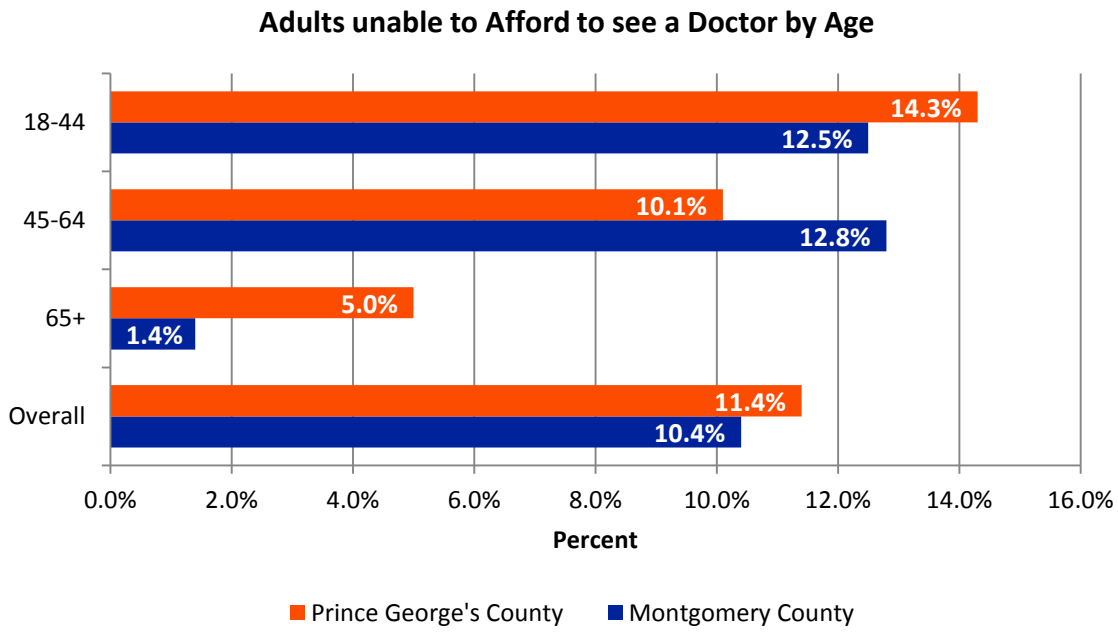

Figure 28. Percentage of Adults unable to Afford to see a Doctor by Age, Montgomery & Prince George's Counties, 2014 (www.HealthyMontgomery.org; www.pgchealthzone.org)

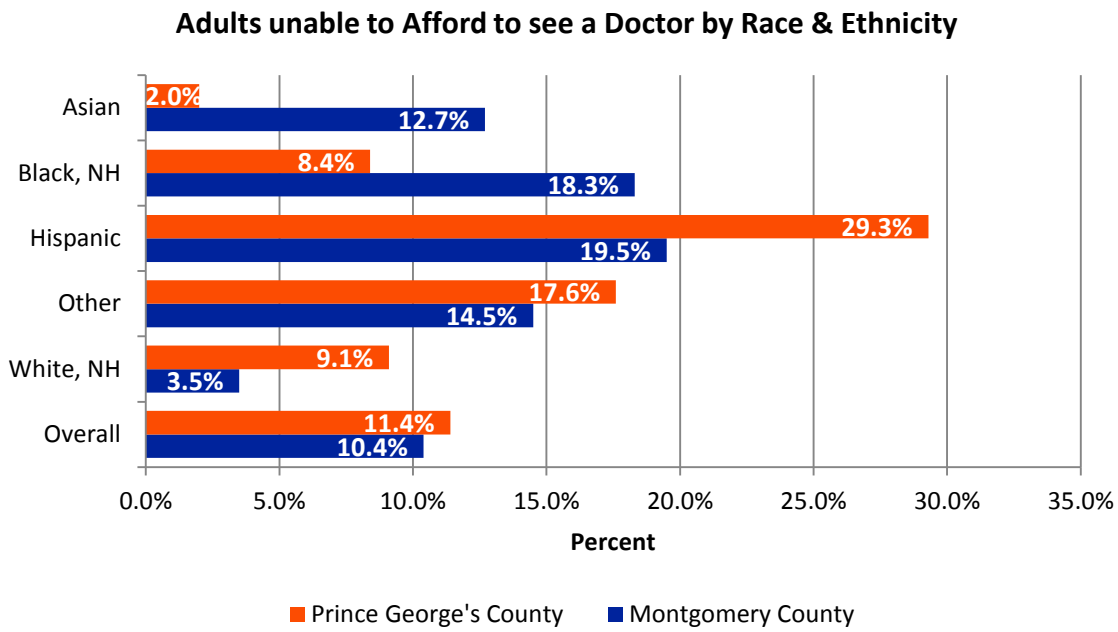

Figure 29. Percentage of Adults unable to Afford to see a Doctor by Race & Ethnicity, Montgomery & Prince George's Counties, 2014
(www.HealthyMontgomery.org; www.pgchealthzone.org)

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	$0.00	N/A
Coverage of Emergency Department Call	$0.00	N/A
Physician Provision of Financial Assistance	$0.00	N/A
Physician Recruitment to Meet Community Need	$221,648	Our recruitment of quality physicians is in direct response to patient need for our therapy services, both on the inpatient and outpatient spectrum. We actively recruit physicians who specialize in physical therapy, occupational therapy and speech therapy. This furthers our mission of extending God's care through the ministry of physical, mental and spiritual healing.
Other – (provide detail of any subsidy not listed above – add more rows if needed)	$0.00	N/A

VII. APPENDICES

To Be Attached as Appendices:

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

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

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

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

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

Appendix I

Financial Assistance Policy Description

In keeping with Adventist HealthCare's (AHC) mission to demonstrate God's care by improving the health of people and communities Adventist HealthCare provides financial assistance to low to mid income patients in need of our services. AHC's Financial Assistance Policy (FAP) provides a systematic and equitable way to ensure that patients who are uninsured, underinsured, have experienced a catastrophic event, and/or and lack adequate resources to pay for services can access the medical care they need. AHC provides emergency and other non-elective medically necessary care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage. In the event that third-party coverage is not available, a determination of potential eligibility for financial assistance will be initiated prior to, or at the time of admission. The FAP identifies those circumstances when AHC may provide care without charge or at a discount based on the financial need of the individual. AHC also contracts with a third party organization experienced in qualifying patients for Medicaid to review potential emergency room patients who may qualify for Medicaid.

AHC 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, business offices, and registration areas as well as on the Adventist HealthCare website 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.

As a standard process, plain language summaries of the FAP are provided during emergency department registration, during financial counseling sessions and upon request. The plain language summaries are also posted at all registration sites, in specialty area waiting rooms, and in specialty area patient rooms. Complete and current versions of the full FAP, plain language summary, and application form are posted on AHC hospital websites. All three documents, as well as the patient information sheet, are available in both English and Spanish.

The FAP policy applies to Adventist HealthCare Shady Grove Medical Center, Adventist HealthCare Washington Adventist Hospital, Adventist HealthCare Behavioral Health & Wellness Services, and Adventist HealthCare Rehabilitation. It has been adopted by the governing body of AHC in accordance with the regulations and requirements of the State of Maryland and with the regulations under Section 501(r) of the Internal Revenue Code. The FAP provides guidelines for:

- Financial assistance to self-pay individual patients receiving emergency and other non-elective medically necessary services based on medical necessity and financial need.
- Prompt-pay discounts (%) that may be charged to self-pay patients who receive medically necessary services that are not considered emergent or non-elective.
- Special consideration, where appropriate, for those individuals who might gain special consideration due to catastrophic care.

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 Rehabilitation is committed to providing medically necessary health care services for all patients admitted to our facility. Inpatient and outpatient rehabilitation services are provided to all patients regardless of their individual ability to pay for such services. For those patients without medical insurance or personal resources, Adventist Rehab has a Financial Assistance Policy that they may be eligible to receive. The Policy is designed to assist individuals who qualify for less than full coverage under available Federal, State and Local Medical Assistance Programs. The hospital considers Financial Assistance to any patient responsibility amount as long as the patient has followed our requirements.

The financial assistance application was most recently changed to match the Maryland State Uniform Financial Assistance Application.

Appendix III

ADVENTIST HEALTH CARE, INC.

Corporate Policy Manual

Financial Assistance

(Formerly "Charity Care")

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Effective Date	01/08	Policy No:	AHC 3.19
Cross Referenced:	Previously: Financial Assistance Policy (see AHC 3.19.1 for Decision Rules / Application)	Origin:	PFS / FC
Reviewed:	02/09, 9/19/13, 10/10/17	Authority:	EC
Revised:	05/09, 06/09, 10/09, 06/15/10, 3/2/11, 10/02/13, 2/01/16, 11/09/17	Page: 1 of 14	

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FINANCIAL ASSISTANCE POLICY SUMMARY

SCOPE:

This policy applies to the following Adventist HealthCare facilities: Shady Grove Adventist Hospital, Germantown Emergency Center, Washington Adventist Hospital, Adventist Behavioral Health, and Adventist Rehabilitation Hospital of Maryland, collectively referred to as AHC.

PURPOSE:

In keeping with AHC's mission to demonstrate God's care by improving the health of people and communities Adventist HealthCare provides financial assistance to low to mid income patients in need of our services. AHC's Financial Assistance Plan provides a systematic and equitable way to ensure that patients who are uninsured, underinsured, have experienced a catastrophic event, and/or and lack adequate resources to pay for services can access the medical care they need.

Adventist HealthCare provides emergency and other non-elective medically necessary care to individual patients without discrimination regardless of their ability to pay, ability to qualify for financial assistance, or the availability of third-party coverage. In the event that third-party coverage is not available, a determination of potential eligibility for Financial Assistance will be initiated prior to, or at the time of admission. This policy identifies those circumstances when AHC may provide care without charge or at a discount based on the financial need of the individual.

Printed public notification regarding the program will be made annually in Montgomery County, Maryland and Prince George's County, Maryland newspapers and will be posted in the Emergency Departments, the Business Offices and Registration areas of the above named facilities.

This policy has been adopted by the governing body of AHC in accordance with the regulations and requirements of the State of Maryland and with the regulations under Section 501(r) of the Internal Revenue Code.

This financial assistance policy provides guidelines for:

- Financial assistance to self-pay individual patients receiving emergency and other non-elective medically necessary services based on medical necessity and financial need.
- prompt-pay discounts (%) that may be charged to self-pay patients who receive medically necessary services that are not considered emergent or non-elective.
- special consideration, where appropriate, for those individuals who might gain special consideration due to catastrophic care.

BENEFITS:

Enhance community service by providing quality medical services regardless of a patient's (or their guarantors') ability to pay. Decrease the unnecessary or inappropriate placement of accounts with collection agencies when a charity care designation is more appropriate.

DEFINITIONS:

- **Medically Necessary:** health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine
- **Emergency Medical Services**: treatment of individuals in crisis health situations that may be life threatening with or without treatment
- **Non-elective services:** a medical condition that without immediate attention:
    - Places the health of the individual in serious jeopardy
    - Causes serious impairment to bodily functions or serious dysfunction to a bodily organ.
    - And may include, but are not limited to:
        - Emergency Department Outpatients
        - Emergency Department Admissions
        - IP/OP follow-up related to previous Emergency visit
- **Catastrophic Care**: a severe illness requiring prolonged hospitalization or recovery. Examples would include coma, cancer, leukemia, heart attack or stroke. These illnesses usually involve high costs for hospitals, doctors and medicines and may incapacitate the person from working, creating a financial hardship
- **Prompt Pay Discount**: The state of Maryland allows a 1% prompt-pay discount for those patients who pay for medical services at the time the service is rendered.
- **FPL** (Federal Poverty Level): is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the

United States, this level is determined by the Department of Health and Human Services.

- **Uninsured Patient**: Person not enrolled in a healthcare service coverage insurance plan. May or may not be eligible for charitable care.
- **Self-pay Patient**: an Uninsured Patient who does not qualify for AHC Financial Assistance due to income falling above the covered FPL income guidelines

POLICY

1. General Eligibility

1.1. All patients, regardless of race, creed, gender, age, sexual orientation, national origin or financial status, may apply for Financial Assistance.

1.2. It is part of Adventist HealthCare's mission to provide necessary medical care to those who are unable to pay for that care. The Financial Assistance program provides for care to be either free or rendered at a reduced charge to:

1.2.1. those most in need based upon the current Federal Poverty Level (FPL) assessment, (i.e., individuals who have income that is less than or equal to 200% of the federal poverty level (See Attachment A for current FPL).

1.2.2. those in some need based upon the current FPL, (i.e., individuals who have income that is between 201% and 600% of the current FPL guidelines

1.2.3. patients experiencing a financial hardship (medical debt incurred over the course of the previous 12 months that constitutes more than 25% of the family's income), and/or

1.2.4. absence of other available financial resources to pay for urgent or emergent medical care

1.3. This policy requires that a patient or their guarantor to cooperate with, and avail themselves of all available programs (including those offered by AHC, Medicaid, workers compensation, and other state and local programs) which might provide coverage for services, prior to final approval of Adventist HealthCare Financial Assistance.

1.4. **Eligibility for Emergency Medical Care:** Patients may be eligible for financial assistance for Emergency Medical Care under this Policy if:

1.4.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and

1.4.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and

1.4.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient).

1.5. **Eligibility for non-emergency Medically Necessary Care:** Patients may be eligible for financial assistance for non-emergency Medically Necessary Care under this Policy if:

1.5.1. They are uninsured, have exhausted, or will exhaust all available insurance benefits; and

1.5.2. Their annual family income does not exceed 200% of the current Federal Poverty Guidelines to qualify for full financial assistance or 600% of the current Federal Poverty Guidelines for partial financial assistance; and

1.5.3. They apply for financial assistance within the Financial Assistance Application Period (i.e. within the period ending on the 240th day after the first post-discharge billing statement is provided to a patient) and

1.5.4. The treatment plan was developed and provided by an AHC care team

1.6. **Considerations:**

1.6.1. Insured Patients who incur high out of pocket expenses (deductibles, co-insurance, etc.) may be eligible for financial assistant applied to the patient payment liability portion of their medically necessary services

1.6.2. Pre-approved financial assistance for medical services scheduled past the 2nd midnight post an ER admission are reviewed by the

appropriate staff based on medical necessity criteria established in this policy, and may or may not be approved for financial assistance.

1.7. **Exclusions:** Patients are INELIGIBLE for financial assistance for Emergency Medical Care or other non-emergency Medically Necessary Care under this policy if:

1.7.1. Purposely providing false or misleading information by the patient or responsible party; or

1.7.2. Providing information gained through fraudulent methods in order to qualify for financial assistance (EXAMPLE: using misappropriated identification and/or financial information, etc.)

1.7.3. The patient or responsible party refuses to cooperate with any of the terms of this Policy; or

1.7.4. The patient or responsible party refuses to apply for government insurance programs after it is determined that the patient or responsible party is likely to be eligible for those programs; or

1.7.5. The patient or responsible party refuses to adhere to their primary insurance requirements where applicable.

1.8. **Special Considerations (Presumptive Eligibility)**: Adventist Healthcare make available financial assistance to patients based upon their "assumed eligibility" if they meet on of the following criteria:

1.8.1. Patients, *unless otherwise eligible for Medicaid or CHI*P, who are beneficiaries of the means-tested social services programs listed below are eligible for free care, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:

1.8.1.1. Households with children in the free or reduced lunch program;

1.8.1.2. Supplemental Nutritional Assistance Program (SNAP);

1.8.1.3. Low-income-household energy assistance program;

1.8.1.4. Women, Infants and Children (WIC)

1.8.2. Patients who are beneficiaries of the Montgomery County programs listed below are eligible for financial assistance after meeting the copay requirements mandated by the program, provided that the patient submits proof of enrollment within 30 days unless a 30 day extension is requested. Assistance will remain in effect as long as the patient is an active beneficiary of one of the programs below:

1.8.2.1. Montgomery Cares;

1.8.2.2. Project Access;

1.8.2.3. Care for Kids

1.8.3. Additionally, patients who fit one or more of the following criteria may be eligible for financial assistance for emergency or non-emergency Medically Necessary Care under this policy with or without a completed application, and regardless of financial ability. IF the patient is:

1.8.3.1. categorized as homeless or indigent

1.8.3.2. unable to provide the necessary financial assistance eligibility information due to mental status or capacity

1.8.3.3. unresponsive during care and is discharged due to expiration

1.8.3.4. individual is eligible by the State to receive assistance under the Violent Crimes Victims Compensation Act or the Sexual Assault Victims Compensation Act;

1.8.3.5. a victim of a crime or abuse (other requirements will apply)

1.8.3.6. Elderly and a victim of abuse

1.8.3.7. an unaccompanied minor

1.8.3.8. is currently eligible for Medicaid, but was not at the date of service

For any individual presumed to be eligible for financial assistance in accordance with this policy, all actions described in the "Eligibility" Section

and throughout this policy would apply as if the individual had submitted a completed Financial Assistance Application form.

1.9. **Amount Generally Billed:** An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for assistance. The charges to which a discount will apply are set by the State of Maryland's rate regulation agency (HSCRC) and are the same for all payers (i.e. commercial insurers, Medicare, Medicaid or self-pay) with the exception of Adventist Rehabilitation Hospital of Maryland which charges for patients eligible for assistance under this policy will be set at the most recent Maryland Medicaid interim rate at the time of service as set by the Department of Health and Mental Hygiene.

2. **Policy Transparency:** Financial Assistance Policies are transparent and available to the individuals served at any point in the care continuum in the primary languages that are appropriate for the Adventist HealthCare service area.

2.1. As a standard process, Adventist HealthCare will provide Plain Language Summaries of the Financial Assistance Policy

2.1.1. During ED registration

2.1.2. During financial counseling sessions

2.1.3. Upon request

2.2. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the Plain Language Summary of the Financial Assistance policy

2.2.1. At all registrations sites

2.2.2. In specialty area waiting rooms

2.2.3. In specialty area patient rooms

2.3. Adventist HealthCare facilities will prominently and conspicuously post complete and current versions of the following on their respective websites in English and in the primary languages that are appropriate for the Adventist HealthCare service area:

2.3.1. Financial Assistance Policy (FAP)

2.3.2. Financial Assistance Application Form (FAA Form)

2.3.3. Plain Language Summary of the Financial Assistance Policy (PLS)

3. Policy Application and Determination Period

3.1. The Financial Assistance Policy applies to charges for medically necessary patient services that are rendered by one of the referenced Adventist HealthCare facilities. A patient (or guarantor) may apply for Financial Assistance at any time within **240 days after the date it is determined that the patient owes a balance.**

3.2. Probable eligibility will be communicated to the patient within 2 business days of the submission of an application.

3.3. Each application for Financial Assistance will be reviewed, and a determination made based upon an assessment of the patient's (or guarantor's) ability to pay. This could include, without limitations the needs of the patient and/or guarantor, available income and/or other financial resources. Final Financial Assistance decisions and awards will be communicated to the patient within 10 business days of the submission of a completed application for Financial Assistance.

3.4. Pre-approved financial assistance for scheduled medical services is approved by the appropriate staff based on criteria established in this policy

3.5. **Policy Eligibility Period:** If a patient is approved for financial assistance under this Policy, their financial assistance under this policy **shall not exceed past 12 months from the date of the eligibility award letter**. Patients requiring financial assistance past this time must reapply and complete the application process in total.

4. **POLICY EXCLUSIONS:** Services not covered by the AHC Financial Assistance Policy include, but are not limited to:

4.1. Services deemed not medically necessary by AHC clinical team

4.2. Services not charged and billed by an Adventist HealthCare facility listed within this policy are not covered by this policy. Examples include, but at are

not limited to; charges from physicians, anesthesiologists, emergency department physicians, radiologists, cardiologists, pathologists, and consulting physicians requested by the admitting and attending physicians.

4.3. Cosmetic, other elective procedures, convenience and/or other Adventist HealthCare facility services which are not medically necessary, are excluded from consideration as a free or discounted service.

4.4. Patients or their guarantors who are eligible for County, State, Federal or other assistance programs will not be eligible for Financial Assistance for services covered under those programs.

4.5. Services Rendered by Physicians who provide services at one of the AHC locations are NOT covered under this policy.

4.5.1. Physician charges are billed **separately** from hospital charges.

Roles and Responsibilities

4.6. **Adventist HealthCare responsibilities**

4.6.1. AHC has a financial assistance policy to evaluate and determine an individual's eligibility for financial assistance.

4.6.2. AHC has a means of communicating the availability of financial assistance to all individuals in a manner that promotes full participation by the individual.

4.6.3. AHC workforce members in Patient Financial Services and Registration areas understand the AHC financial assistance policy and are able to direct questions regarding the policy to the proper hospital representatives.

4.6.4. AHC requires all contracts with third party agents who collect bills on behalf of AHC to include provisions that these agents will follow AHC financial assistance policies.

4.6.5. The AHC Revenue Cycle Function provides organizational oversight for the provision of financial assistance and the policies/processes that govern the financial assistance process.

4.6.6. After receiving the individual's request for financial assistance, AHC notifies the individual of the eligibility determination within a reasonable period of time.

4.6.7. AHC provides options for payment arrangements.

4.6.8. AHC upholds and honors individuals' right to appeal decisions and seek reconsideration.

4.6.9. AHC maintains (and requires billing contractors to maintain) documentation that supports the offer, application for, and provision of financial assistance for a minimum period of seven years.

4.6.10. AHC will periodically review and incorporate federal poverty guidelines for updates published by the United States Department of Health and Human Services.

4.7. **Individual Patient's Responsibilities**

4.7.1. To be considered for a discount under the financial assistance policy, the individual must cooperate with AHC to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for healthcare, such as Medicare, Medicaid, third-party liability, etc.

4.7.2. To be considered for a discount under the financial assistance policy, the individual must provide AHC with financial and other information needed to determine eligibility (this includes completing the required application forms and cooperating fully with the information gathering and assessment process).

4.7.3. An individual who qualifies for a partial discount must cooperate with the hospital to establish a reasonable payment plan.

4.7.4. An individual who qualifies for partial discounts must make good faith efforts to honor the payment plans for their discounted hospital bills. The individual is responsible to promptly notify AHC of any change in financial situation so that the impact of this change may be evaluated against financial assistance policies governing the provision of financial assistance.

5. Identification Of Potentially Eligible Individuals

5.1. Identification through socialization and outreach

5.1.1. Registration and pre-registration processes promote identification of individuals in need of financial assistance.

5.1.2. Financial counselors will make best efforts to contact all self-pay inpatients during the course of their stay or within 4 days of discharge.

5.1.3. The AHC hospital facility's PLS will be distributed along with the FAA Form to every individual before discharge from the hospital facility.

5.1.4. Information on how to obtain a copy of the PLS will be included with billing statements that are sent to the individuals

5.1.5. An individual will be informed about the AHC hospital facility's FAP in oral communications regarding the amount due for his or her care.

5.1.6. The individual will be provided with at least one written notice (notice of actions that may be taken) that informs the individual that the hospital may take action to report adverse information about the individual to consumer credit reporting agencies/credit bureaus if the individual does not submit a FAA Form or pay the amount due by a specified deadline. This deadline cannot be earlier than 120 days after the first billing statement is sent to the individual. The notice must be provided to the individual at least 30 days before the deadline specified in the notice.

5.2. **Requests for Financial Assistance**: Requests for financial assistance may be received from multiple sources (including the patient, a family member, a community organization, a church, a collection agency, caregiver, Administration, etc.).

5.2.1. Requests received from third parties will be directed to a financial counselor.

5.2.2. The financial counselor will work with the third party to provide resources available to assist the individual in the application process.

5.2.3. If available, an estimated charges letter will be provided to individuals who request it.

5.2.4. **AUTOMATED CHARITY PROCESS** for Accounts sent to outsourced agencies: Adventist HealthCare recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Adventist HealthCare may employ an automated, predictive scoring tool to qualify patients for financial assistance. The Payment Predictability Score (PPS) predicts the likelihood of a patient to qualify for Financial Assistance based on publicly available data sources. PPS provides an estimate of the patient's likely socio-economic standing, as well as, the patient's household income size. Approval used with PPS applies only to accounts being reviewed by Patient Financial Services. All other dates of services for the same patient or guarantor will follow the standard Adventist HealthCare collection process.

6. **Executive Approval Board:** Financial assistance award considerations that fall outside the scope of this policy must be reviewed and approved by AHC CFO of facility rendering services, AHC Vice President of Revenue Management, and AHC VP of Patient Safety/Quality.

7. **POLICY REVIEW AND MAINTAINENCE:**

7.1. This policy will be reviewed on a bi-annual basis

7.2. The review team includes Adventist Health entity CFOs and VP of Revenue Management for Adventist Health

7.3. Updates, edits, and/or additions to this policy must be reviewed and agreed upon, by the review team and then by the governing committee designated by the Board prior to adoption by AHC.

7.4. Updated policies will be communicated and posted as outlined in section 2- Policy Transparency of this document.

CONTACT INFORMATION AND ADDITIONAL RESOURCES

Adventist HealthCare Patient Financial Services Department
820 W Diamond Ave, Suite 500
Gaithersburg, MD 20878
(301) 315-3660

The following information can be found at Adventist HealthCare's Public Notice of Financial Assistance & Charity Care:

Document Title
AHC Financial Assistance Plain Language Summary - English
AHC Financial Assistance Plain Language Summary - Spanish
AHC Federal Poverty Guidelines
AHC Financial Assistant Application - English
AHC Financial Assistant Application - Spanish
List of Providers not covered under AHC's Financial Assistance Policy

PLAIN LANGUAGE SUMMARY
Financial Assistance Policy

Adventist HealthCare is committed to meeting the health care needs of our community through the 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.

Availability of Financial Assistance: You may be able to get financial assistance if you do not have insurance, are underinsured, or if it would be a financial hardship to pay in full your expected out-of-pocket expenses for emergency and other medically necessary care that Adventist HealthCare provides.

Eligibility: Adventist HealthCare provides financial assistance based upon need. To determine need, we review your household income and compare it to the Federal Poverty Level guidelines set by the U.S. Department of Health and Human Services. We also review the amount of charges for which you are responsible.

If you and/or the party responsible for payment has combined income equal to or below 200 percent of the federal poverty guidelines, you will have no financial responsibility for the care that Adventist HealthCare provides. If you fall between 200 percent and 600 percent of the guidelines, you may qualify for discounted rates for our care.

If you are eligible for financial assistance under this policy, Adventist HealthCare will not charge more for your emergency or other medically necessary care than the amounts we generally bill to individuals who have insurance for such care. In certain cases, we may presume you are eligible for financial assistance if you already qualify for certain types of governmental aid.

You may be ineligible for financial assistance if you have sufficient insurance coverage or we determine your income is enough to pay for care. Please see the links below for our full policy, which provides more explanation and details.

How to Apply for Aid

Obtain a free copy of our application:

- Call our Patient Financial Services Department (PFS) at **301-315-3660**
- Visit PFS at: **Adventist HealthCare**
  PFS Department, 5th Floor
  810 W. Diamond Avenue
  Gaithersburg, MD 20878
- Download at AdventistHealthcare.com/FinancialAssistance

PLAIN LANGUAGE SUMMARY
Financial Assistance Policy

☎ **If you need help with the application or have questions:**

- Call PFS at **301-315-3660**
- Visit us at: **Adventist HealthCare**
  PFS Department, 5th Floor
  810 W. Diamond Avenue
  Gaithersburg, MD 20878

Mail or drop off your application with the required documentation to**:**
Adventist HealthCare
PFS Department, 5th Floor
810 W. Diamond Avenue
Gaithersburg, MD 20878

Translation Services: The Financial Assistance Policy, application form and this plain language summary is available in English or Spanish. Adventist HealthCare can provide assistance through a qualified bilingual interpreter upon request.

Additional Resources

HHS FPL Guidelines

RESUMEN EN LENGUAJE SENCILLO
Política de Asistencia financiera

Adventist HealthCare asume el compromiso de satisfacer las necesidades de atención médica de nuestra comunidad a través del ministerio de curación física, mental y espiritual. Todos los pacientes, independientemente de su raza, credo, sexo, edad, nacionalidad o situación financiera, pueden solicitar asistencia financiera.

Disponibilidad de la Asistencia financiera: Usted podría recibir asistencia financiera si no tiene seguro, si su seguro es insuficiente, o si pagar la totalidad de sus gastos de bolsillo por atención de emergencia y otra atención médicamente necesaria que Adventist HealthCare brinde le causaría dificultades económicas.

Elegibilidad: Adventist HealthCare proporciona asistencia financiera en base a la necesidad. Para determinar la necesidad, analizamos los ingresos de su hogar y los comparamos con las pautas del Nivel Federal de Pobreza establecido por el Departamento de Salud y Servicios Humanos de los EE. UU. También analizamos el monto de los cargos por los que es responsable.

Si usted o el responsable de realizar el pago tiene un ingreso combinado igual o menor que el 200 por ciento de las pautas federales de pobreza, no tendrá responsabilidad financiera por la atención que Adventist HealthCare proporciona. Si usted se encuentra entre el 200 por ciento y el 600 por ciento de lo establecido por las pautas, podría calificar para acceder a tarifas con descuento por nuestra atención.

Si usted es elegible para recibir asistencia financiera bajo esta política, Adventist HealthCare no le cobrará más por su atención de emergencia u otra atención médicamente necesaria que los montos que generalmente le facturamos a las personas que tienen seguro para dicha atención. En algunos casos, asumiremos que usted es elegible para recibir asistencia financiera si ya califica para recibir ciertos tipos de ayuda gubernamental.

Es posible que no sea elegible para recibir asistencia financiera si tiene cobertura de seguro suficiente o determinamos que sus ingresos son suficientes para pagar la atención. Visite los siguientes enlaces para consultar nuestra política completa, que tiene una explicación más detallada.

Cómo solicitar ayuda

Obtenga una copia gratuita de nuestra solicitud:

- Llame a nuestro Departamento de Servicios Financieros para Pacientes (PFS) al **301-315-3660**
- Visite PFS en: **Adventist HealthCare**
  Departamento de PFS, 5to piso
  810 W. Diamond Avenue
  Gaithersburg, MD 20878

RESUMEN EN LENGUAJE SENCILLO
Política de Asistencia financiera

- Descárguela en AdventistHealthcare.com/FinancialAssistance

☎ **Si necesita ayuda con la solicitud o tiene preguntas:**

- Llame a PFS al **301-315-3660**
- Visítenos en: **Adventist HealthCare**
  Departamento de PFS, 5to piso
  810 W. Diamond Avenue
  Gaithersburg, MD 20878

Envíe su solicitud por correo o entréguela con la documentación requerida a:
Adventist HealthCare
Departamento de PFS, 5to piso
810 W. Diamond Avenue
Gaithersburg, MD 20878

Servicios de traducción: La Política de Asistencia financiera, el formulario de solicitud y el resumen en lenguaje sencillo están disponibles en inglés y español. Adventist HealthCare puede brindarle asistencia mediante un intérprete bilingüe calificado si lo solicita.

Recursos adicionales

Pautas del Nivel federal de pobreza de HHS

Appendix IV

Patient Information Sheet

Maryland Hospital Patient Information

Hospital Financial Assistance Policy

Adventist Healthcare Physical Health and Rehabilitation is committed to meeting the health care needs of its community through a ministry of physical, mental and spiritual healing. This hospital provides care to all patients regardless of their ability to pay.

In compliance with Maryland law, Adventist Healthcare Physical Health and Rehabilitation 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.

Adventist Healthcare Physical Health and Rehabilitation 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 speak with a Patient Access representative for a referral.

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

Maryland Hospital Información para el paciente

Política de Asistencia Financiera del Hospital

Salud Adventista Salud Física y Rehabilitación está comprometida a satisfacer las necesidades de atención médica de su comunidad a través de un ministerio de sanación física, mental y espiritual. Este hospital proporciona atención a todos los pacientes independientemente de su capacidad de pago.
En cumplimiento con la ley de Maryland, Adventist Healthcare Physical Health and Rehabilitation tiene un Política y programa de asistencia financiera. Es posible que tenga derecho a recibir servicios hospitalarios de costo gratuito o a costo reducido. Esta facilidad excede la ley de Maryland proporcionando asistencia financiera basada en la necesidad del paciente, nivel de ingresos, tamaño de la familia y recursos financieros. La información sobre la política y el programa de asistencia financiera se puede obtener de cualquier Representante de Acceso a Pacientes y de la Oficina de Facturación.

Derechos de los pacientes

Como parte de la misión de Adventist HealthCare, los pacientes que cumplan con los criterios de asistencia financiera pueden recibir asistencia del hospital para pagar su factura.
Los pacientes también pueden ser elegibles para Maryland Medical Assistance - un programa financiado conjuntamente por gobiernos estatales y federales. Este programa paga el costo total de la cobertura de atención médica para individuos de bajos ingresos que cumplan con criterios específicos (ver información de contacto a continuación). Los pacientes que creen que han sido referidos erróneamente a una agencia de recaudación tienen el derecho de solicitar asistencia del hospital.

Obligaciones de los pacientes

Los pacientes con la capacidad de pagar su factura tienen una obligación
Para pagar el hospital de manera oportuna. Salud Adventista Salud Física y Rehabilitación hace todo lo posible para facturar correctamente cuentas de pacientes. Los pacientes tienen la responsabilidad de proporcionar información demográfica y de seguro correcta. Los pacientes que crean que pueden ser elegibles para recibir asistencia bajo la política de asistencia financiera del hospital, o que no pueden pagar la factura en su totalidad, deben comunicarse con un Consejero Financiero o
El Departamento de Facturación (ver información de contacto a continuación). Al solicitar asistencia financiera, los pacientes tienen la responsabilidad de proporcionar información precisa,
Completar la información financiera y notificar al Departamento de Facturación
Si su situación financiera cambia. Los pacientes que no cumplan con sus obligaciones financieras pueden ser referidos a una agencia de cobro.

Información del contacto

Para hacer los arreglos de pago de su factura, por favor llame al (301) 315-3660 para ayuda.

Para solicitar asistencia con su factura, llame a la Oficina de Facturación al (301) 315-3660.

Para informarse sobre la Asistencia Médica, por favor hable con un representante de Paciente para una referencia.

**** Nota: Los servicios médicos proporcionados durante su estancia no se incluyen en el estado de cuenta del hospital y se facturarán por separado.***

Appendix V

Hospital Mission, Vision, and Value Statements

Adventist HealthCare Mission Statement: *We extend God's care through the ministry of physical, mental and spiritual healing.*

Values: *Adventist HealthCare has identified five core values that we use as a guide in carrying out our day-to-day activities:*

1. ***Respect:*** *We recognize the infinite worth of each individual.*
2. ***Integrity:*** *We are conscientious and trustworthy in everything we do.*
3. ***Service:*** *We care for our patients, their families, and each other with compassion.*
4. ***Excellence:*** *We do our best every day to exceed expectations.*
5. ***Stewardship:*** *We take ownership to efficiently and effectively extend God's care.*