



Dimensions Healthcare System

Laurel Regional Hospital

COMMUNITY BENEFIT REPORT

FISCAL YEAR 2011

Laurel Regional Hospital
7300 Van Dusen Road
Laurel, MD 20707

Introduction & Background:

Laurel Regional Hospital was founded in 1978 and is a not-for-profit, full-service community hospital serving residents of Prince George's County and Montgomery, Howard, and Anne Arundel counties. Laurel Regional Hospital is conveniently located in Laurel, Maryland and a member of Dimensions Healthcare System, the largest provider of healthcare services in Prince George's County. In addition to providing high quality, efficient healthcare services, Laurel Regional Hospital also offers a variety of free health services, health and wellness education opportunities for the communities it serves.

Leadership: Chairman, Board of Directors – C. Philip Nichols, Jr.

CEO – Neil Moore (Acting)

Chief Operating Officer – John O'Brien

Chief Nursing Officer – Gloria Ceballos

Location: 7300 Van Dusen Road, Laurel, Maryland 20707

Facility type: Full-service community hospital

Licensed Bed Designation: 128

Inpatient Admissions for FY 2011: 6,564

No. of employees: 706

Services:

Laurel Regional Hospital provides a comprehensive range of inpatient and outpatient services including:

- Behavioral Health Services (including inpatient psychiatric unit for adults and outpatient partial hospitalization program)
- Cardiac Catheterization (diagnostic peripheral vascular studies, cardioversions, TEE's, pacemaker insertions)
- Cardiopulmonary Services (Echo, EKG, Stress tests, EEG, PFT)
- Critical Care Services (includes coronary care and 10-bed intensive care unit)
- Diabetes Services (inpatient and outpatient services provided)
- Emergency Services (24-hour emergency care provided)
- Infusion Services (outpatient intravenous infusion services provided)
- Maternal and Child Health
- Medical / Surgical Services (virtually all adult specialties performed)

- Physical Rehabilitation (only hospital-based accredited inpatient rehabilitation unit in the County)
- Sleep Wellness Center (comprehensive sleep disorders treatment center)
- Wound Care & Hyperbaric Medicine Center

Facilities:

- Surgical services houses 7 operating suites, a 10-bed intensive care unit, cardiac catheterization lab and 2 endoscopy suites.
- Emergency department includes 14 acute rooms, 10 intermediate rooms, 6 fast track rooms (ambulatory care) and one resuscitation/trauma room, 4 isolation rooms and 3 more that can be converted to negative pressure isolation rooms, POC (Point of Care) lab, and blood bank is located in the main lab.

Ownership:

Member of Dimensions Healthcare System, the largest not-for-profit provider of health care services in Prince George’s County.

Demographics for Communities Served:

Laurel Regional Hospital’s community benefit service area is Prince George’s County and portions of Anne Arundel County. Located in the heart of the Baltimore-Washington Corridor, the hospital’s primary service area encompasses Howard and Montgomery Counties as well, but for the purpose of this report the larger portion of its community base comes from Prince George’s and Anne Arundel counties. The population estimate for Prince George’s County in 2010 was 863,420 with 64.5% African American, 19.2% White and 14.9% Hispanic or Latino in origin. Anne Arundel County has a population of 537,656 with 75.4% White, 15.5% African American and 6.1% Hispanic or Latino in origin. In Prince George’s County the median household income was 69,545 and the percentage of persons below poverty level was 7.8 % and the median household income in Anne Arundel County was 79,843 with the percentage of persons below poverty level being 6.8 % in 2009 (U.S. Census Bureau State and County QuickFacts).

The two counties have similar household incomes and poverty levels. Additionally, there is similarity in educational attainment with Anne Arundel having a slightly higher percentage, roughly 90 and 35 percent respectively, of high school and college graduates than Prince George’s County with 86 percent and 30 percent. Education and socio-economic status of residents in both counties affect how they seek medical care.

In Prince George’s and Anne Arundel counties smoking, obesity and excessive alcohol consumption are health risk factors. Between the two counties, 9-12% of the population is 65 years of age or older and approximately 7-8% are Medicaid recipients. Access to primary health care services remains an issue of concern in Prince George’s County with approximately twenty-

two percent of residents under the age of 65 are uninsured according to the County Health Rankings data and fifteen percent in Anne Arundel County. Hypertension, heart disease, cancer, HIV, and diabetes are amongst the most prevalent health challenges within Prince George's County.

Identification of Community Needs:

A strategic goal within Dimensions Healthcare System, and a key priority in the delivery of quality health care services for Laurel Regional Hospital, is alignment with the federal, state, and local government health initiatives to improve health care access and quality and to lower costs. In 2009, the Prince George's County Council sponsored a health assessment of the county which was conducted by the RAND Corporation. The results of this health assessment reemphasized the need to provide accessible and affordable health services to uninsured and low-income populations in the county. The assessment also revealed that health conditions and concerns focus on racial health disparities like cancer mortality due in part to lack of preventive treatment (i.e. screenings).

Laurel Regional Hospital staff and clinicians have devoted more than 4000 hours of their time to providing free health screenings and education to community members at various locations throughout the county. Events and programs like the hospital's annual Step Forward to a Healthier Life Community Health Fair, Senior Dining and Lecture series and Blood Pressure Screening/Education program respond to the need to provide health services and education to the community to promote awareness and prevention. These efforts also aid in connecting the community to health resources to improve health status.

The goal of the community health fair is to provide free health services to community members, especially those who cannot access them easily, and to promote healthy living through wellness and preventive education, as well as to disseminate a variety of health resource information. With asthma, hypertension, obesity, and diabetes being amongst the most prevalent health conditions in the county and state, this event offers relevant services like lung function and blood pressure screenings. In addition, diabetes clinicians and nutritionists educate participants about how weight management and healthy eating habits can reduce health risks for conditions like diabetes and hypertension.

The Senior Dining and Lecture series is a bi-monthly, program designed to educate seniors in the community about health topics such as diabetes and hypertension. It also provides them with health services/resource information to improve their health status. The Blood Pressure Screening & Education program provided monthly free blood pressure screening and information about heart health, blood pressure and weight to seniors at a local community center. Laurel Regional Hospital is already planning to improve and adapt health programs of this type into sustainable community-based programs to impact the overall health and wellness of the community in a positive way. This service expansion and adaptation will be achieved through collaborative partnerships with community organizations as well as state and local health agencies.

As LRH builds more community partnerships, community benefits will improve significantly. LRH is in the process of developing more health initiatives to promote awareness of risk and prevention associated with health conditions such as obesity, diabetes, cancer and hypertension as well as

infant mortality.

The Decision Making Process:

Leadership at LRH has input in the planning process for current community benefit programs like the health fair and ongoing community health screenings. Management at the departmental level report on community benefits offered to the community through health education as well as screenings. Due to recent financial challenges, the hospital has not devoted significant human or capital resources to the development of a comprehensive community benefit program. However, hospital leadership has begun to develop a plan to conduct a formal health needs assessment to meet requirements stipulated in the Patient Protection and Affordable Care Act.

Community Benefit Program Evaluation:

The current Community Benefit Program is evaluated based on its charity care expenditures and physician subsidies which allow the hospital to continue to meet its mission to provide quality health services to the community. The evaluation process will be improved upon as measures are established to develop more structured and sustainable community-based programs. This process will focus more on outcomes and measurable benefits of specific programs for targeted community populations to promote prevention and chronic disease management.

I. GENERAL HOSPITAL DEMOGRAPHICS AND CHARACTERISTICS:

Please list the following information in Table I below. For the purposes of this section, “primary services area” means the Maryland postal ZIP code areas from which the first 60 percent of a hospital’s patient discharges originate during the most recent 12 month period available, where the discharges from each ZIP code are ordered from largest to smallest number of discharges. This information will be provided to all hospitals by the HSCRC.

Table I

Bed Designation:	Inpatient Admissions:	Primary Service Area Zip Codes:	All other Maryland Hospitals Sharing Primary Service Area:	Percentage of Uninsured Patients, by County:	Percentage of Patients who are Medicaid Recipients, by County:
115 + 9 Bassinets	6564	20707, 20708 20705, 20724 20904, 20723 20770, 20706 20740, 20783 20784	1. Washington Adventist Hospital 2. Howard County General Hospital 3. Doctors Community Hospital	Prince George’s –22% Anne Arundel –15% Montgomery –17% Howard –14% <i>Source:</i> http://www.countyhealthrankings.org/	Prince George’s –7% Anne Arundel –8.4% Montgomery –7.1% Howard –6.3% <i>Source:</i> http://www.census.gov/hhes/www/hlthins/data/acs/off.html ;

1. For purposes of reporting on your community benefit activities, please provide the following information:
 - a. Describe in detail the community or communities the organization serves. (For the purposes of the questions below, this will be considered the hospital’s Community Benefit Service Area – “CBSA”. This service area may differ from your primary service area on page 1. Please describe in detail.)

See Demographics for Communities Served section above.
 - b. In Table II, describe significant demographic characteristics and social determinants that are relevant to the needs of the community and include the source of the

information in each response. For purposes of this section, social determinants are factors that contribute to a person’s current state of health. They may be biological, socioeconomic, psychosocial, behavioral, or social in nature. (Examples: gender, age, alcohol use, income, housing, access to quality health care, having or not having health insurance.) (Add rows in the table for other characteristics and determinants as necessary).

Table II

<p>Community Benefit Service Area(CBSA) Target Population (target population, by sex, race, and average age)</p> <p>Sources: http://quickfacts.census.gov/qfd/states/24000.html, http://www.countyhealthrankings.org/</p>	<p>Prince George’s County Population- 863,420, Male -48% Female- 52% , White – 19.2% Black- 64.5% American Indian & Alaskan- .5% Asian- 4.1% Hispanic/Latino- 14.9%, Average age- 34.9</p> <p>Anne Arundel County Population- 537,656, Male- 49.3% Female – 50.6% , White – 75.4% Black- 15.5% American Indian & Alaskan- .3% Asian- 3.4% Hispanic/Latino- 6.1%, Average age- 38</p>
<p>Median Household Income within the CBSA</p> <p>Source: http://quickfacts.census.gov/qfd/states/24000.html</p>	<p>Prince George’s County- \$69,545</p> <p>Anne Arundel County- \$79,843</p>
<p>Percentage of households with incomes below the federal poverty guidelines within the CBSA</p> <p>Source: http://quickfacts.census.gov/qfd/states/24000.html</p>	<p>Prince George’s County- 7.8%</p> <p>Anne Arundel County- 6.8%</p>
<p>Please estimate the percentage of uninsured people by County within the CBSA</p> <p>Source: http://www.countyhealthrankings.org/</p>	<p>Prince George’s County- 22%</p> <p>Anne Arundel County- 15%</p>
<p>Percentage of Medicaid recipients by County within the CBSA.</p> <p>Source: http://www.census.gov/hhes/www/hlthins/data/acs/aff.html;</p>	<p>Prince George’s County- 7.0 %</p> <p>Anne Arundel County- 8.4%</p>
<p>Life Expectancy by County within the CBSA.</p> <p>Source: http://www.worldlifeexpectancy.com/usa/maryland-life-expectancy-by-county-male</p>	<p>Prince George’s County- M- 73.5 years, F-79.2</p> <p>Anne Arundel County- M- 75.7 years, F-80.2</p>
<p>Mortality Rates by County within the CBSA.</p> <p>Source: http://www.countyhealthrankings.org/</p>	<p>Prince George’s County- 8374/100,000</p> <p>Anne Arundel County- 7036/100,000</p>

<p>Access to healthy food, quality of housing, and transportation by County within the CBSA. (to the extent information is available from local or county jurisdictions such as the local health officer, local county officials, or other resources)</p> <p>Sources: http://www.countyhealthrankings.org/ http://www.communityhealth.hhs.gov/Demographics.aspx?GeogCD=24003&PeerStrat=9&state=Maryland&county=Anne%20Arundel</p>	<p>Prince George's County- Access to healthy food - 91% Risk Factors for Premature Death: No exercise 24.6% Few Fruits/Vegetables 72.1% Obesity 25.5% High Blood Pressure 26.2% Smoker 17.8% Diabetes 8.3%</p> <p>Anne Arundel County- Access to healthy food - 56% Risk Factors for Premature Death: No exercise 20.1% Few Fruits/Vegetables 71.5% Obesity 23.3% High Blood Pressure 28.2% Smoker 22.4% Diabetes 7.5%</p>
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II. COMMUNITY HEALTH NEEDS ASSESSMENT

According to the Patient Protection and Affordable Care Act (“ACA”), hospitals must perform a community health needs assessment either fiscal year 2011, 2012, or 2013, adopt an implementation strategy to meet the community health needs identified, and beginning in 2013, perform an assessment at least every three years thereafter. The needs assessment must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and must be made widely available to the public.

For the purposes of this report, a community health needs assessment is a written document developed by a hospital facility (alone or in conjunction with others) that utilizes data to establish community health priorities, and includes the following:

- (1) A description of the process used to conduct the assessment;
- (2) With whom the hospital has worked;
- (3) How the hospital took into account input from community members and public health experts;
- (4) A description of the community served; and
- (5) A description of the health needs identified through the assessment process.

1. Identification of Community Health Needs:

Describe in detail the process(s) your hospital used for identifying the health needs in your community and the resource(s) used.

At this time, no formal health needs assessment has been conducted but the RAND Corporation’s 2009 Health Assessment of Prince George’s County which was sponsored by the Prince George’s County Council has been reviewed and used to identify community health needs in relation to disparities and at risk, underserved and uninsured populations.

2. In seeking information about community health needs, what organizations or individuals outside the hospital were consulted?

The RAND Corporation

3. When was the most recent needs identification process or community health needs assessment completed?

Provide date here. ___/___/___ (mm/dd/yy)

No formal health needs assessment has been conducted at this time but a formal health needs assessment will be completed by 6/30/2013.

4. Although not required by federal law until 2013, has your hospital conducted a community health needs assessment that conforms to the definition on the previous page within the past three fiscal years?

___ Yes

No

If you answered yes to this question, please provide a link to the document or attach a PDF of the document with your electronic submission.

III. COMMUNITY BENEFIT ADMINISTRATION

1. Please answer the following questions below regarding the decision making process of determining which needs in the community would be addressed through community benefits activities of your hospital?

- a. Does your hospital have a CB strategic plan?

___ Yes

No (LRH has a strategic plan that includes community benefit services but does not have a formal community benefit plan at this time.)

- 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 provide additional information if necessary):

- i. Senior Leadership

1. ___ CEO

- 2. CFO (The CFO and General Counsel are participating on the team to plan for the federally mandated CHNA)
- 3. Other (please specify) General Counsel

ii. Clinical Leadership

- 1. Physician
- 2. Nurse
- 3. Social Worker
- 4. Other (please specify)

iii. Community Benefit Department/Team

- 1. Individual (please specify FTE)
- 2. Committee (please list members)

Chief Financial Officer
 General Counsel
 Vice President, Reimbursement
 Vice President, Finance
 Director, Finance, Reporting & Operational Accounting
 Director, Strategic Planning and Analysis
 Manager, Community Based Health

- 3. Other (please describe)

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

Spreadsheet yes no
 Narrative yes no

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

Spreadsheet yes no
 Narrative yes no

IV. HOSPITAL COMMUNITY BENEFIT PROGRAM AND INITIATIVES

- 1. Please use Table III (see attachment) to provide a clear and concise description of the needs identified in the process described above, the initiative undertaken to address the identified need, the amount of time allocated to the initiative, the key partners involved in the planning and implementation of the initiative, the date and outcome of any evaluation of

the initiative, and whether the initiative will be continued. Use at least one page for each initiative (at 10 point type).

For example: for each major initiative where data is available, provide the following:

- a. Identified need: This includes the community needs identified in your most recent community health needs assessment.
- b. Name of Initiative: insert name of initiative.
- c. Primary Objective of the Initiative: This is a detailed description of the initiative and how it is intended to address the identified need. (Use several pages if necessary)
- d. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?
- e. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.
- f. Date of Evaluation: When were the outcomes of the initiative evaluated?
- g. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data when available).
- h. Continuation of Initiative: Will the initiative be continued based on the outcome?
- i. Identified need: This includes the community needs identified in your most recent community health needs assessment.
- j. Name of Initiative: insert name of initiative.
- k. Primary Objective of the Initiative: This is a detailed description of the initiative and how it is intended to address the identified need. (Use several pages if necessary)
- l. Single or Multi-Year Plan: Will the initiative span more than one year? What is the time period for the initiative?
- m. Key Partners in Development/Implementation: Name the partners (community members and/or hospitals) involved in the development/implementation of the initiative. Be sure to include hospitals with which your hospital is collaborating on this initiative.
- n. Date of Evaluation: When were the outcomes of the initiative evaluated?

- o. Outcome: What were the results of the initiative in addressing the identified community health need, such as a reduction or improvement in rate? (Use data when available).
- p. Continuation of Initiative: Will the initiative be continued based on the outcome?

Blood Pressure Screening & Education Program

Identified Need	Hospital Initiative	Primary Objective of the Initiative	Single or Multi-Year Initiative Time Period	Key Partners and/or Hospitals in initiative development and/or implementation	Evaluation dates	Outcome	Continuation of Initiative
<p>As identified in the RAND Report and many other health reports, hypertension is a leading risk factor for heart disease and stroke. According to the CDC, about one out of three U.S. adults— 31.3%—has high blood pressure.</p>	<p>Blood Pressure Screening & Education Program</p>	<p>To provide free monthly blood pressure screening and information about heart health, blood pressure and weight and to increase awareness amongst seniors who are pre-hypertensive or hypertensive to seek medical treatment.</p>	<p>Multi-Year Initiative that recently ended due to relocation of the senior center where the service was provided. 2.5 hour monthly screening</p>	<p>The key partners for this initiative were Laurel Regional Hospital and the Phelps Senior Center.</p>	<p>The program is evaluated monthly via the screening statistic tool used to assess and reassess participants of the program.</p>	<p>150 people were enrolled in the program prior to its completion. Many didn't know that they had high blood pressure prior to enrollment seeking medical treatment as a result of participation in the program</p>	<p>We hope to restart the program at the new center location and expand it to other community centers in the county.</p>

2. Were there any primary community health needs that were identified through a community needs assessment that were not addressed by the hospital? If so, why not?

V. 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.

Description of gaps in availability of specialist providers for the uninsured:

All services offered by Laurel Regional Hospital are available to all patients, insured and uninsured. Occasionally, in our Emergency Department, the hospital experiences lapses in specialist coverage due to the demand of physicians for compensation for on call coverage

2. If you list Physician Subsidies in your data in category C of the CB Inventory Sheet, please 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.

VI. APPENDICES

To Be Attached as Appendices:

1. Describe your Charity Care policy:
 - 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 charity care policy. (Label appendix 1)

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

- posts its charity care policy, 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 policy, 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 policy, or summary thereof, and financial assistance contact information to patients with discharge materials;
- includes the policy, or a summary thereof, along with financial assistance contact information, in patient bills; and/or

- 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. Include a copy of your hospital's charity care policy (label appendix 2).

2. Attach the hospital's mission, vision, and value statement(s) (label appendix 3).

Community Benefits Report FY2011

Laurel Regional Hospital

7300 Van Dusen Road, Laurel, MD 20707

Appendix 1

Description of Financial Assistance Program:

Dimensions Healthcare System provides compassionate care for all, regardless of an individual's ability to pay. We serve as the safety net for the uninsured and underinsured. It is our mission to help save lives and improve the quality of living.

Dimensions Healthcare System through its health care services, provides financial assistance to those who need medical and health care services but do not have the resources to pay for that care...and it does so by preserving the dignity of the individual who needs assistance.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs may be eligible for free or discounted healthcare services based on established criteria.

Eligibility for the Dimensions Healthcare System Financial Assistance Program is based on income and family size. Should you be found eligible for financial assistance, patient will receive a Financial Approval Letter indicating your eligibility amount. Any balance due after the financial assistance allowance has been applied, will become the responsibility of the patient. Physicians bill separately and their charges are not included in the financial assistance program.

Community Benefits Report FY2011

Laurel Regional Hospital

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Appendix 2

See attached Dimensions Financial Assistance Program Corporate Policy #200-41

Appendix 3

See attached Dimensions Mission, Vision, and Values Corporate Policy #200-24

FINANCIAL ASSISTANCE PROGRAM

PURPOSE: To identify circumstances when Dimensions Healthcare System (DHS) may provide care without charge or at a discount commensurate with the ability to pay, for a patient whose financial status makes it impractical or impossible to pay for medically necessary services. This policy applies only to facility charges and not physician or other independent company billings. The provision of free and discounted care through our Financial Assistance Program is consistent, appropriate and essential to the execution of our mission, vision and values, and is consistent with our tax-exempt, charitable status.

Resources are limited and it is necessary to set limits and guidelines. These are not designed to turn away or discourage those in need from seeking treatment. They are intended to assure that the resources the Hospital can afford to devote to its patients are focused on those who are most in need and least able to pay, rather than those who choose not to pay. Financial assessments and the review of patients' assets and financial information is intended for the purpose of assessing need as well as gaining a holistic view of the patients' circumstances. Dimensions Healthcare System is committed to:

- Communicating this purpose to the patient so they can more fully and freely participate in providing the needed information without fear of losing basic assets and income;
- Assessing the patients' capacity to pay and reach payment arrangements that do not jeopardize the patients' health and basic living arrangements or undermine their capacity for self-sufficiency;
- Upholding and honoring patients' rights to appeal decisions and seek reconsideration, and to have a self-selected advocate to assist the patient throughout the process;
- Avoiding seeking or demanding payment from or seizing exempt income or assets; and
- Providing options for payment arrangements, without requiring that the patient select higher cost options for repayment.

CANCELLATION: This is a new corporate policy. It supersedes all policies on this subject at the facility level.

POLICY: Dimensions Healthcare System has a long tradition of serving the poor, the needy, and all who require health care services. However, our hospitals alone cannot meet every community need. They can practice effective stewardship of resources in order to continue providing accessible and effective health care services. In keeping with effective stewardship, provision for financial assistance will be budgeted annually. Our hospitals will continue to play a leadership role in the community by helping to promote community-wide responses to patient needs, in partnership with government and private organizations.

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon the Federal Poverty guidelines and will be updated annually in conjunction with the published updates by the United States Department of Health and Human Services. All open self-pay balances may be considered for financial assistance. If a determination is made that the patient has the ability to pay all or a portion of the bill, such a determination does not prevent a

reassessment of the person's ability to pay at a later date. The need for financial assistance is to be re-evaluated at the following times:

- Subsequent rendering of services,
- Income change,
- Family size change,
- When an account that is closed is to be reopened, or
- When the last financial evaluation was completed more than six months before.

To be considered for financial assistance, the patient must cooperate with the facility to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as Medicaid. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.

Appropriate signage will be visible in the facility in order to create awareness of the financial assistance program and the assistance available. At a minimum, signage will be posted in all patient intake areas, including, but not limited to, the Emergency Department, the Billing Office, and the Admission/Patient Registration areas. Information such as brochures will be included in patient services/information folders and/or at patient intake areas. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the facility's service area in accordance with the state's Language Assistance Services Act.

The necessity for medical treatment of any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

SPECIAL INSTRUCTIONS/FORMS TO BE USED:

DEFINITIONS:

- A. 1. *Assets:* Assets include immediately available cash and investments such as savings and checking as well as other investments, including retirement or IRA funds, life insurance values, trust accounts, etc. The following are to be considered exempt and shall not be considered in determining whether the uninsured patient qualifies for an uninsured discount:
- a. Homestead property
 - b. \$2,000 for the uninsured patient, or \$3,000 for the uninsured patient and one dependent residing together.
 - c. \$50 for each additional dependent residing in the same household.
 - d. Personal effects and household goods that have a total value of less than \$2,000.
 - e. A wedding and engagement ring and items required due to medical or physical condition.
 - f. One automobile with fair market value of \$4,500 or less.
 - g. Patient must have less than \$10,000 in net assets.

2. *Bad Debt Expense:* Uncollectible accounts receivable that were expected to result in cash inflows (i.e. the patient did not meet the facility's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected uncollectibles resulting from the extension of credit.
3. *Financial Assistance:* Health care services that were never expected to result in cash inflows. Financial Assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria.
4. *Financial Assistance Committee:* A committee consisting of the Chief Financial Officer, the Corporate Director of Patient Financial Services, the Risk Manager, the Director of Case/Care Management, and the Director of Patient Relations, or a similar mix of individuals.
5. *Contractual Adjustments:* Differences between revenue at established rates and amounts realized from third party payers under contractual agreements.
6. *Disposable Income:* Annual family income divided by 12 months, less monthly expenses as requested on the application in Attachment I.
7. *Family:* The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.
8. *Family Income:* Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, veterans benefits, training stipends, military allotments, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates and trusts.
9. *Qualified Patient:*
 - a. *Financially Needy:* A person who is uninsured or underinsured and is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the medical facility's eligibility criteria set forth in this policy.
 - b. *Medically Needy:* A patient who does not qualify as financially needy, but whose medical or hospital bills, even after payment by third-party payers, exceed 50% of their gross income. The patient who incurs catastrophic medical expenses is classified as medically needy when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.

10. *Medically Necessary Service*: Any inpatient or outpatient hospital service that is covered by and considered to be medically necessary under Title XVIII of the federal Social Security Act. Medically necessary services do not include any of the following:
 - a. Non-medical services such as social, educational, and vocational services.
 - b. Cosmetic surgery.

B. Financial Assistance Guidelines and Eligibility Criteria (see PFS Department for current form)

- a. To be eligible for a 100 percent (100%) reduction from the patient portion of billed charges (i.e. full write-off) the patient's household income must be at or below 150 percent of the current Federal Poverty Guidelines. 150 percent (150%) of the Federal Poverty Guidelines represents an individual earning minimum wage.
- b. Patients with household income that exceeds 150 percent (150%) but is less than 300 percent (300%) of the Federal Poverty Guidelines will be eligible for a sliding scale discount of the patient portion of billed charges.
- c. Medically needy patient accounts will be considered on a case-by-case basis by the Financial Assistance Committee. The discounts to be applied will be based on a determination of what the family could reasonably be expected to pay, based on a review of current disposable income and expenses.
- d. Individuals who are deemed eligible by the State of Maryland to receive assistance under the Violent Crime Victims Compensation Act or the Sexual Assault Victims Compensation Act shall be deemed eligible for financial assistance at a level to be determined on a case-by-case basis by the Financial Assistance Committee.
- e. Financial assistance applications will be considered as long as an account is open or when a change in patient financial status is determined.
- f. After the financial assistance adjustment has been computed, the remaining balances will be treated in accordance with Patient Financial Services policies regarding self-pay balances. Payment terms will be established on the basis of a reasonable proportion of disposable income negotiated with the patient. No interest charges will accrue to the account balance while payments are being made. This also applies to payments made through a collection agency.

PROCEDURE:

A. Identification of Potentially Eligible Patients:

- | | |
|-----------|--|
| Admitting | <ol style="list-style-type: none"> 1. Where possible, prior to the admission of the patient, the Hospital will conduct a pre-admission interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission interview is not possible, this interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission, the Hospital's evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial interview, the following information should be gathered: <ol style="list-style-type: none"> a) Routine and comprehensive demographic data. b) Complete information regarding all existing third party coverage. 2. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process. 3. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance. |
| Dir., PFS | <ol style="list-style-type: none"> 4. Prior to an account being authorized for the filing of suit, a final review of the account will be conducted and approved by the Corporate Director of Patient Financial Services to make sure that no application for financial assistance was ever received. Prior to a summons being filed, the CFO's approval is required. Dimensions Healthcare System Facilities will not request body attachments from the court system for payment of an outstanding account; however it is recognized that the court system may take this action independently. |

B. Determination of Eligibility:

- | | |
|-----|--|
| PFS | <ol style="list-style-type: none"> 1. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. If this evaluation is not conducted until after the patient leaves the facility, or in the case of outpatients or emergency patients, a Patient Financial Services representative will mail a financial assistance application to the patient for completion. In addition, whenever possible, patient billing and collection communications will inform patients of the availability of financial assistance with appropriate contact information. When no representative of the patient is available, the facility should take the required action to have a legal guardian/trustee appointed. 2. Requests for financial assistance may be received from: <ol style="list-style-type: none"> a. the patient or guarantor; b. Church-sponsored programs; c. physicians or other caregivers; d. various intake department of the institutions; e. administration; |
|-----|--|

- f. other approved programs that provide for primary care of indigent patients.
- 3. The patient should receive and complete a written application (Attachment I) and provide all supporting data required to verify eligibility.
- 4. In the evaluation of an application for financial assistance, a patient’s total resources will be taken into account which will include, but not be limited to, analysis of assets (identified as those convertible to cash and unnecessary for the patient’s daily living expense), family income and medical expenses. A credit report may be generated for the patient as well as for the purpose of identifying additional expense, obligations, assets and income to assist in developing a full understanding of the patients’ financial circumstances.
- 5. If a patient qualifies as medically needy, then the application should be referred to the Financial Assistance Committee for review and determination.
- Dir., PFS 6. Approval for financial assistance for amounts up to \$50,000 should be approved by the Director of Patient Financial Services. Those greater than \$50,000 should be approved by the CFO.
- PFS 7. Upon completion of the application and submission of appropriate documentation, the Patient Financial Services representative will complete the Financial Assistance Worksheet (see PFS Department for current form). The information shall be forwarded to the Director of Patient Financial Services or their designee for determination. Financial assistance approval will be made in accordance with the guidelines and documented on the worksheet (see PFS Department for current form).
- 8. Accounts where patients are identified as medically needy or accounts where the collector or Director has identified special circumstances that affect the patient’s eligibility for financial assistance will be referred to the Financial Assistance Committee for consideration and final determination. The Committee’s review of accounts that do not clearly meet the criteria and the decisions and rationale for those decisions will be documented and maintained in the account file (see PFS Department for current form).
- 9. A record, paper or electronic, should be maintained reflecting authorization of financial assistance (see PFS Department for current form). These documents shall be kept for a period of seven (7) years.

C. Notification of Eligibility Determination:

- PFS 1. Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision, which provides a reason(s) for denial will be provided, generally within thirty (30) days of

receipt of a complete application. Patients will be notified in the denial letter that they may appeal this decision and will be provided contact information to do so.

- FAC 2. If a patient disagrees with the decision, the patient may request an appeal process in writing within seven (7) days of the denial. The Financial Assistance Committee will review the application. Decisions reached will normally be communicated to the patient within two (2) weeks, and reflect the organization’s final and executive review.
- 3. Collection activity will be suspended during the consideration of a completed financial assistance application or an application for any other healthcare bracket (i.e., Medicare, Medicaid, etc.). A note will be entered into the patient’s account to suspend collection activity until the financial assistance process is complete. If the account has been placed with a collection agency, the agency will be notified by telephone to suspend collection efforts until a determination is made. This notification will be documented in the account notes. The patient will also be notified verbally that the collection activity will be suspended during consideration. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be established on the basis of disposable income.
- 4. If the patient complies with a payment plan that has been agreed to by the Hospital, the Hospital shall not otherwise pursue collection action against the patient.
- Patient 5. If the patient has a change in their financial status, the patient should promptly notify Patient Financial Services. The patient may request and apply for financial assistance, or a change in their payment plan terms.

D. Availability of Policy:

- PFS 1. Every hospital, upon request, must provide any member of the public or state governmental entity a copy of its financial assistance policy.

E. Application Forms:

- PFS 1. Every hospital must make available, upon request by a member of the public, a copy of the application used by the Hospital to determine a patient’s eligibility for financial assistance.

F. Monitoring and Reporting:

PFS 1. A financial assistance log from which periodic reports can be developed shall be maintained aside from any other required financial statements. Financial assistance logs will be maintained for a period of seven (7) years. At a minimum, the financial assistance logs are to include:

- a. account number,
- b. date of service,
- c. application mailed (y/n),
- d. application returned and complete (y/n),
- e. total charges,
- f. self-pay balances,
- g. amount of financial assistance approved,
- h. date financial assistance was approved.

2. The cost of financial assistance will be reported annually in the community Benefit Report. Financial will be reported as the cost of care provided (not charges) using the most recently audited Medicare cost report and the associated cost to charge ratio.

ORIGINATOR: Administration

APPROVAL:

G. T. Dunlop Ecker
President & Chief Executive Officer

Financial Assistance Program 200-41 (1/23/2008)

ATTACHMENT:

Application for Financial Assistance

APPLICATION FOR FINANCIAL ASSISTANCE

Information About You

Name _____
 First Middle Last

Social Security Number _____ - _____ - _____

Marital Status: Single Married Separated

US Citizen: Yes No

Permanent Resident: Yes No

Citizenship status does not affect your ability to qualify for financial assistance.

Home Address _____

Phone _____

City State Zip Code

Country _____

Employer Name _____

Phone _____

Work Address _____

City State Zip Code

Household Members:

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

Services for Which You Are Requesting Financial Assistance

Dates of service _____
 Total amount of bill _____
 Amount of assistance requested _____

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

Account number _____ Medical record number _____

Family Income

Please list the amount of your monthly income from the following possible sources and include copies of your federal tax return and other documents to show proof of income. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pensions benefits	_____
Social Security benefits	_____
Public Assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self-employment	_____
Other income source	_____

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

Other Assets

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

Home		Approximate value	_____
Automobile	Make _____ Year _____	Approximate value	_____
Additional vehicle	Make _____ Year _____	Approximate value	_____
Additional vehicle	Make _____ Year _____	Approximate value	_____
Other property		Approximate value	_____

Monthly Expenses

Amount

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

Other Expenses

Do you have any other unpaid medical bills? Yes No

For what service? _____

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

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

Applicant Signature

Date

MISSION, VISION AND VALUES STATEMENTS

MISSION

Within the Dimensions Healthcare System, it is our mission to provide comprehensive health care of the highest quality to residents, and others who use our services while strengthening our relationships with universities, research and health care organizations to ensure best in class patient care.

VISION

To be recognized as a premier regional health care system.

VALUES

Dimensions Healthcare System:

- **Respects** the dignity and privacy of each patient who seeks our service.
- Is committed to **Excellent Service** which exceeds the expectations of those we serve.
- Accepts and demands **Personal Accountability** for the services we provide.
- Consistently strives to provide the highest **Quality** work from individual performance.
- Promotes **Open Communication** to foster partnership and collaboration.
- Is committed to an **Innovative Environment**; encouraging new ideas and creativity.
- Is committed to having its hospitals meet the highest standards of **Safety**.

APPROVAL:

Kenneth E. Glover
President & Chief Executive Officer

Mission, Vision, Values and Service Priorities 200-24 (6/6/2006, 4/16/2009, 11/1/2010, 7/14/2011)